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COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

THE RELATIONSHIP BETWEEN DEMAND FOR HEALTH INSURANCE AND CIVIL CONFLICT IN PASTORALIST COMMUNITIES: A CASE OF LIBEN DISTRICT IN OROMIA REGIONAL STATE

BY

DERA GIRMA (BSC)

A THESIS SUBMITTED TO SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF PUBLIC HEALTH, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER IN PUBLUC HEALTH IN HEALTH ECONOMICS.

ADDIS ABABA, ETHIOPIA

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By:Dera Girma (BSC)

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December, 2020

Addis Ababa, Ethiopia

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This is to certify that the thesis prepared by Dera Girma Diriba, entitled: The Relationship between Demand for Health Insurance and Civil Conflict in Pastoralist Communities: a case of Liben District in Oromia Regional State and submitted in fulfillment of the requirements for the Degree of Master in Public Health in Health Economics complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

Signed by the Examining Committee:

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Chairman, Examining Committee   Sign   Date

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Internal Examiner   Sign   Date

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Advisor   Sign   Date

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ABSTRACT

Background: In sub-Saharan Africa, out-of-pocket expenditures constitute approximately 40% of total health expenditures, imposing financial burdens and limiting access to care in some of the poorest countries around the globe. Out of pocket (OOP) health care spending is one of the main sources for financing the Ethiopian health system. To reduce the catastrophic health expenditure the Community-Based Health Insurance (CBHI) scheme, implemented since 2011, is being progressively scaled up and targets informal sector workers and the poor in rural areas.There are a lot of impacts on health due to conflict it is possible to understand those drivers of health status that are direct measures such as mortality and indirect measures that is morbidity.

Objective: - This study aims to explore the relationship between demand for health insurance and civil conflict in pastoralist communities in Liben district of Oromia Regional State, 2020.

Methods: -a cross-sectional study was conducted by using Systematic random sampling technique among395 householdsthose are the residents of Liben woreda.Each household was interviewed using structured questionnaire. Descriptive statistical methods were used to generate frequencies and the results were presented using table and graphs. Logit regression model were used for data analysis to explore if there is a link between demand for health insurance and the civil conflict.

The study wasconducted from May up to June, 2020 with 43,642.50 ETH. Birr budget.

Result: Fifty eight percent of the study households were members of CBHI and 75.6% of the households also faced civil conflict.Household with family size of 9-11 were 3.82 times more enrolled to CBHI than those their household family size of with 3-5.The finding of this study indicate (AOR=6.17, CI=3.25, 13.84) those people who did not experience severe losses of income since the onset of the conflict had 6.17 times more enrolled to CBHI than those who experience severe losses of income.

Conclusion: -The findings in this study reveal the adverse effect of conflict on demand for health insurance. The enrollment rate of CBHI among non-affected by conflict was higher. The implication of the study finding is that the need to control civil conflicts in order to enhance utilization of health service and provide financial protection using health insurance schemes.

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ACRONOMYS AND ABBREVIATIONS

AOR- Adjusted odds ratio

CBHI -community based health insurance

CI- Confidence interval

COR- Crude odds ratio

ETB -Ethiopian Birr

KII -Key informant interview

OOP -Out of pocket

SHI- Social Health Insurances

SNNPR - South Nation and Nationality People Region

WHO -World Health Organization

WorHO - Woreda Health Office

ZHD - Zonal Health Department

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1. INTRODUCTION

1.1 Background of the study

In sub-Saharan Africa, out-of-pocket expenditures constitute approximately 40% of total health expenditures, imposing financial burdens and limiting access to care in some of the poorest countries around the globe (1).

Out of pocket (OOP) health care spending is one of the main sources for financing the Ethiopian health system. The three main sources for financing the Ethiopian health system are 40%, 37%, 21% from international development assistance from bilateral and multilateral donors,out-of pocket health spending by individuals and the public budget respectively on 2014. Because of high reliance on OOP health care spending, coping with health shocks could be catastrophic for households particularly for the ultra-poor(2).The challenge for these countries is how to modify their health financing system in order to achieve universal coverage(3).

The Government of Ethiopia was enacted a National Health Insurance Strategy in 2008 with the aim of achieving universal health coverage. To achieve this aim the Community-Based Health Insurance (CBHI) scheme, implemented since 2011, is being progressively scaled up and targets informal sector workers and the poor in rural areas. Despite there are variations across pilot districts, it was designed to provide indigent subsidy for 10% of the poorest households in the CBHI districts. The Indigent group is whose premium is covered from budget allocated by district and regional governments.CBHI was piloted initially in 13 woredas in Amhara, Oromia, south nation and nationality people (SNNP), and Tigray regions. The government encouraged by the early successes of those CBHI pilots, began in July 2013 expanding the pilot initiatives to an additional 161 woredas know(2, 4, 5).

According to key informant at Oromia Health Bureau, Oromia regional state had designed the regional community based health insurance scheme which was begin in 2011 only in four pilot districts and till 2019 it had been expanding to 247districts.Among these Liben district is one of the pastoralist and ten expanding districts of Guji zone.

Majorly of the population in Liben woredas are pastoralist communities and their livelihood is basically based on livestock. As a result of searching for water and grazing, there are social conflicts among pastoralist communities.There are many public health concerns during conflict.

Conflict will inevitably cause loss of lives, physical injuries, widespread mental distress, a worsening of existent malnutrition particularly among children and outbreaks of communicable diseases.Internally displaced and refugee populations due to civil conflict are particularly exposed to different types of health risk. As more people are covered by insurance, they are more likely to get medical care and treatment they may need if hurt during conflict(6, 7).

Attacks on health workers, health facilities and patients are a common threat to medical care in conflict zones. Insecurity and instability in conflict affected contexts create challenges both for populations trying to access health services and for health actors trying to access populations in need. Traveling to and from health facilities can be difficult and dangerous (8).

One of the main ways conflict can cause economic damage. Insecurity can disrupt economic activity through a number of channels, and the effects can be large and long lasting. Fear resulting from violence and destruction can hinder economic activity directly through an increase in transport costsor postponing of investments. This economic impact of conflict lead to additional barriers to accessing health services such as user fees for patients or increased out-of-pocket charges. Many cannot afford these payments due to the impact of the conflict on their livelihoods and income. In Iraq in 2015, the cost of health services was identified as the single biggest challenge to accessing healthcare(8)

1.2 Statement of the problem

Pastoralists are among the most disadvantaged of the world's poor.They are geographically and socially marginalized groups, inhabiting large regions, unsuitable for agriculture and infrastructural development(9). In Ethiopia there are many challenges related to pastoralist communities including food insecurity and consequently the widespread acute and chronic malnutrition is directly or indirectly associated with chronic poverty, poor infrastructure, ecological constraints, limited arable land, absence of irrigation, disease, poor water and sanitation, inadequate nutritional and health knowledge and ethnic conflicts(9). Low performance of healthcare service are common inpastoralist areas mainly associated with pastoralist lifestyles that include dispersed settlement pattern, seasonal mobility which, prolong underutilization of services even when and where the health services are available.In responses to low utilization, high out of pocket expenditure, and quality of services, one way to facilitate

access and overcome unaffordable expenditure is through a health insurance mechanism, whereby risks are shared and financial inputs pooled through cross subsidizations within people

who sick frequently and unable to afford for health care, and people who are healthy but pay premium for CBHI scheme within households (10).

Conflict damages the health, water, and sanitation facilities, creating the ideal condition for disease to spread. During conflict, health facilities' supply chains often break down, creating shortages of necessary medicines, medical commodities, and basic medical equipment, a lack of continuous supply, or even oversupply of certain types of medicines. Supply chain breakdowns can also lead to the use of lower-quality medicines(8).

More than half of health expenditure in poor countries is covered by out-of-pocket (OOP) payments incurred by households. An increase in such expenditure can have catastrophic effects and may deplete a household's ability to generate current and future income and have inter-generational consequences as households may be compelled to incur debt, sell productive assets, draw down buffer food stocks, or sacrifice children's education. Out of pocket health payments (OOP) are a substantial burden as well as barrier to accessing health care(2).

To protect households against burden from out of pocket, pre-payment mechanisms like CBHI is valid. Additionally, to deal with inequality in health care among households, there is widespreadconsensus that providing universal, sustainable, affordable and quality health services underpinsefforts to achieve equitable health outcomes. Consequently, community based health insuranceis one approach and alternative to finance healthcare provision in the informal sector to increaseutilization of health services; rather than waiting for top-down tax-based financing or socialhealth insurances (SHI) development, bottom-up or CBHI has been introduced to low-incomecountries over the past two decades for rural community and people who engaged in the informalsector (10).

1.3 Significance of the study

There are limited studies about community based health insurance in pastoralist setting area in Ethiopia. In addition previous studies did not examine the interconnection between conflict and enrollment in Community based health insurance. Therefore, the current study will provide policy relevant evidence and add knowledge to the literature by investigating the link between enrollment in CBHI scheme and conflict in pastoralist area.

2 LITERATURE REVIEW

2.1 Theoretical Literature

2.1.1 Community based health insurance schemes

CBHI is a risk-pooling approach that tries to spread health costs across households with different health profiles to prevent catastrophic expenditures that come with unexpected health events or chronic diseases, and enables cross-subsidies from rich to poor populations. In theory Community based health insurance schemes have five characteristics. The first characteristic is dynamic risk pooling, where the schemes are organized by and for individuals who share common characteristics like geographical, occupational, ethnic, religious, gender, etc. The second characteristic is solidarity, where risk sharing is as inclusive as possible within a given community and membership premiums are independent of individual health risks. Participatory decision making and management, nonprofit character and voluntary affiliation are the rest three characteristics of communitybased health insurance(11).

2.1.2 Civil conflict and health

Conflict damages the health, water, and sanitation facilities, creating the ideal condition for disease to spread. During conflict, health facilities' supply chains often break down, creating shortages of necessary medicines, medical commodities, and basic medical equipment, a lack of continuous supply, or even oversupply of certain types of medicines. Supply chain breakdowns can also lead to the use of lower-quality medicines(8, 12).

The most immediate and direct impact of violent civil conflict on health is death. Violent civil conflict devastating the health outcome those tend to be concentrated in vulnerable populations: children, adolescents and women. The health outcomes of violent civil conflict can be divided into four categories: economic and infrastructural, environmental, policy and social. Health is affected by the damage done to a country's healthcare infrastructure this includes physical damage to hospitals, clinics, and other medical facilities, the death of medical personneland their flight to safer areas. These impediments lead to lowered quality of care for patients and more medical errors leading to death or disability (13).

Health is impacted by disruptions in transportation, the water and food supply and power grids. When transportation is interrupted, patients are unable to access medical careand medical

personnel are unable to report for duty. Without electricity or water, health facility is unable to perform basic functions, lowering quality of carewhich can result in death, disability or disease.

Together, these direct and indirect measurements support an effective health response that accounts for conflict as a social determinant and moves towards the realization of health as a human right. It is important to note children are, due to their size and weight as well as social vulnerability, affected first in an emergency. It is important to measure various aspects of child health, as the early deterioration of these indicators can potentially be the first signal of the impact of a conflict on affected populations (14).

Health actors face numerous constraints to delivering healthcare in conflict-affected settings. First, they face constraints related to the health system. Conflict damages health and health-related infrastructure and leads to shortages in medicines, medical supplies, health personnel, and financial resources. It also increases the burden on already strained health systems. Second, armed conflict makes it more difficult for health workers to access populations in need and for these populations to access health services. This occurs due to increased insecurity, legal and administrative barriers, the militarization and politicization of healthcare, poor governance, displacement, and the exacerbation of existing vulnerabilities. Conflict-affected settings present a wide variety of challenges for health actors. These range from constraints on the health system itself to challenges delivering and accessing health services. Such challenges make the work of health actors difficult and, at times, dangerous (8).

2.2 Empirical Literature

2.2.1 Factors driving Community based health insurance enrolment

Knowledge of community to ward CBHI

The household survey conducted in Ethiopia on 2015 showed that most households in the pilot woredas both member and non-member correctly understand the role and concept of CBHI. More than 96 percent of member and 87 percent of non-member households know that not only the sick should enroll in CBHI. A larger percentage of members than non-members also know that both the poor and the non-poor should enroll, and that CBHI is not like saving scheme, that is, they will not earn interest on their premium payment nor will the premium be returned even if they do not use health services, but rather that the premium is a payment to finance future health

costs whereas the study conducted in Fogera district of North West Ethiopia on 2013 showed that328(62.1%) had good knowledge about the benefits of community based health insurance (1, 11).

Socio- demographic status of household

Many factors included under this variable, including gender of head of the household, having families with young children, families headed by the elderly(11). The most significant variables that have positive association with enrollment in the CBHI pilot schemes in Ethiopia were found to be size of household, age, and sexof the head of the household.The gender and age distribution of household members may affect CBHI uptake. For instance, households with more children, a greater proportion of elderly household members or adult females in the reproductive age group may be more likely to demand health insurance and health care (15). Also more likely to join are those who are literate and especially those who completed primary school. Female-headed households are more likely to join than male-headed ones(11). Cultivated land size (not own land) is important determinant for membership, it is the most significant variables that have positive association with enrollment in the CBHI pilot schemes in Ethiopia (15). Study showed that a higher proportion of household heads whose wealth index category was the richest were enrolled in CBHI compared with households whose wealth index category was the poorest (16)Systematic review on 18 papers 11(61%) of them find statistically significant evidence of exclusion of the lowest income groups from CBHI schemes. Even when such households become members, they tend to use healthcare services less intensively as compared to higher income groups potentially due to their inability to afford co-payments and other related costs such as transportation and forgone income. Educational status of head of household is one of the most significant variables that have positive association with enrollment in the CBHI pilot schemes in Ethiopia (15).

Availability and quality of care

There is a clear and discernible link between the quality of care on offer and CBHI uptake. For instance, availability of blood testing equipment in the closest health facility increases the probability of CBHI enrolment by 31 percentage points. Average waiting time to see a health care professional, a measure of quality in its own right and a proxy for facility staffing levels,

exerts a negative effect on enrolment (15). The issue of quality of health care from supply side before mobilizing demand and possibility to set up a viable insurance scheme is one of the necessary conditions to increase the willingness to pay for the schemes.Quality of health service provision from healthcare institutions has been addressed by various issues. Under this quality of care overall quality of services, drug availability, improvements in laboratory services, is waiting time, referral system, staff motivation, availability of staff and cleanness of the health care facilities (10).

Health status of household

This health status of household variables indicating past illness events, incidence of chronic disease, use of outpatient and inpatient care, outpatient and impatient health care expenditure, and household self-reported health status.The study done in rural community of Fogera District, North West Ethiopiathe health status of the seventy one (13.4%) household are of the member of the household had chronic illness while one hundred fifty two (29.2%) had any acute illness during the last one year(1).

Access to finance and social networks

Access to formal and informal sources of credit and membership in social networks may have a positive or a negative effect on demand for health insurance. As a negative effect it belonging to a network may reduce the incentive to participate in the CBHI scheme while at the same time such networks may be sources of finance to purchase insurance and may also help enhance understanding of health insurance as positive effect (15).

2.2.2Adverse effects of conflict on health

There are a lot of impacts on health due to conflict;it is possible to understand those drivers of health status that are direct measures such as mortality and indirect measures that is morbidity indices that are contextually relevant. Direct measures are the most common during a conflict and in post-conflict impact analysis. These include mortality, access to care, medication access, and sanitation coverage. Approximately 310,000 deaths were caused by conflict in the year 2000 with more than half occurring in sub-Saharan Africa. However, indirect measures are feasible and perhaps easier to measure before, during, and after a conflict. The World Health

Organization (WHO) estimated that 0.70 percent of the global burden of disease in the year 2000 was due to conflict (13, 14)

3. OBJECTIVE OF THE STUDY

3.1 General objective

To explorethe relationship between demand for health insurance and civil conflict in pastoralist communities of Liben district.Oromia Regional State, 2020.

3.2 Specific objectives

To examine health insurance awareness among population in pastoralist area

To identifysocio-demographic factor that affectparticipation in health insurance scheme in pastoralist areas.

To assess the relation between civil conflict and demandfor health insurance.

4. METHODOLOGY

4.1 Study design and period

Cross-sectional community based study design was used to assess the relationship between demand for health insurance and civil conflict in pastoralist communities in Liben district of Oromia Regional State, 2020. The study was conducted from May up to June 2020.

4.2 Study area

The study was conducted in Liben woreda, which is one of the 17 woredas in Guji Zone of Oromia Regional state. Liben Woreda is one of the Woreda found in Guji Zone, at 650Km distance to south of Addis Ababa. There is functional three health center and one health center on construction and 19 health post in the woreda. The climate condition of Liben woreda is desert with temperature range from 25-33 degree Celsius, annual rainfall is 400-750ml. The district has 12 rural kebeles. According to 2007 Census projection, the district has total population of 93,648. There are 20,725 Women in reproductive age (15-49 years) and 15,415 under five children in the district (liben woreda administration).

4.3 Source population

The source population of this study was households live in the Liben District.

4.4 Study population

Selected household head who live in Liben Districtwas the study population of this study.

4.5 Inclusion and exclusion criteria

4.5.1 Inclusion criteria

Household live in sample kebeles of Liben District whose depend on informal sector.

4.5.2 Exclusion criteria

Households those arenot dependent on the informal sector as their mean of livelihood like government employer.

4.6 Sample size and sampling technique

4.6.1 Sample size determination

The samplewas estimated using single population proportion formulas with the following assumptions: 58%proportionof household in the study area were member of the scheme(3).A 5% margin of error, a 95% level of confidence and 5% non-response rate.

$$n=\frac{\left(Z\frac{\alpha}{2}\right)^2 .p}{d^2}$$

Where *n* is the sample size required for study, $Z\frac{\alpha}{2}$ is the Value of the standard normal distribution, *p*is the proportion of household those are member of the scheme, *q* is proportion of household those are not member of the scheme, and *d*the margin of error. By substituting those value to the equation,

$$n=\frac{\left(Z\frac{\alpha}{2}\right)^2 .p}{d^2} = \frac{(1.9\ \ )^2.(0.5\ \ ).(0.4\ \ )}{0.0\ \ ^2} =376$$

The calculated sample sizes was376, after adding 5% non-response ratethen sample size increase to 395.Finally 395 households wereused to collect the quantitative data andfourkey informant interviews were conducted for qualitative data.

4.6.2 Sampling procedure

A simple random sampling procedure was employed. From 12 kebele of Liben District, fourkebeles was randomly selected. A total of 382 households were included in the study; sampled households were proportionally allocated to each sampled kebeles. Then the first household was selected by simple random sampling to select a number between one and the sampling interval which turned out to be 17.

4.7 Operational definition

Civil conflict: occurs within and across state boundaries, has political antecedents typically relating to competition for power and resources, isprotracted in duration, expresses existing social, political, economic, and cultural structures and cleavages, and is often characterized by one sector preying on other parts of the community(13).

Pastoralist communities: those whose livelihood depends on and typically derive at least 50% of food and income from their livestock. So mobility is a key to the dynamics of their life and mode of adaptation to semi-arid and arid environments and mobility in search of water and grazing areas(17).

Indigent groups:are people 10% from the total population of the District who are poor of the poor and are unable to afford premium payment of CBHI scheme(10).

Severe losses of income:Inability to lead their life of households due to loss of income as result of conflict.

4.8 Variable of the study

4.8.1 Dependent variable

- Demand to enroll to community based health insurance for community

4.8.2 Independent variable

- Socio-demographic variables
- Health and health related factors
- Awareness of health insurance
- Access to finance and social network
- Experience of conflict and Perception of towards conflict

4.9 Data collection procedure and technique

Data were collected on the relationship between demand for health insurance and civil conflict in pastoralist communities in Liben district by mixed approach. Quantitative approaches wereused to collect data from household level at the same time qualitative approaches were used by key informant interview. Four diplomagraduate data collectors were engaged and trained. Face-to-face interviews with the household heads were conducted using structured questionnaires that were prepared in English, translated into Afan Oromo.

Both the qualitative and quantitative questions are adapted from previous survey related CBHI and survey related to conflict setting area.

4.9.1 Quantitative Survey

The survey of sampled head of households intended to examine health care seeking behavior, quality of service provisions, their attitude towards CBHI scheme and perception towards conflict. In order to give each respondent within the population an equal chance, stating from each kebele health post and the representative samples were selected systematically to collect quantitative data from representative sample using semi-structured questionnaire that comprises close ended questions supplemented with open-ended questions from 395 head of households.The data were collected by 4 clinical nurses.

4.9.2 Qualitative survey

Key Informant Interview (KIIs)was used to collect qualitative data. Key informant interviews wereundertaken with community based health insurances official and health professionals from health facilities and district health office, in order to get diverse perspectives.

Key Informant Interview was collected by researcher or principal investigator.

4.10 Data quality management

The Qualities of data wasassured by using validated questionnaire, translation, retranslation and pretesting of the questionnaire. Pre- test wasdoing on 5% of the respondents from the same population of Liben District.The questionnaire was translated from English language Afan Oromo by a translator and back to English language by second other translator who is health professional to compare its consistency.Data collectors and supervisors were trained for three days on the study instrument and data collection procedure. The principal investigator and the supervisors were strictly followingthe overall data collection activities such as the completeness of questionnaire, check whether the data is missed or not.

4.11. Data analysis procedures

The collected data wasedited, cleaned and entered into computer usingepidata version 3.1and exported to stata version 12.The data were analysed usingstata 12. The data were analyzed using logit regression to determine the effect of various factors on the outcome variable. Bivariate analyses were done to choice the variable for multivariate analysis, accordingly the variable with p-value less than 0.2 were included to multivariate analysis. The results were presented in the

form of tables, and text using frequencies and summary statistics such as mean and percentage to describe the study population in relation to relevant variables.The degree of association between dependent and independent variables were assessed using odds ratio and coefficient with 95% confidence interval and p-value less than 0.05.

4.12. Ethical consideration

The study proposal was reviewed and approvedby Ethical Review Committee of college of public health and medical science of Addis Ababa University. Furthermore, letter of permission was obtained from Guji zone health department and Liben woreda health offices. Consent was obtained from the study subjects after explaining the study objectives and procedures and their right to refuse to participate in the study and interrupt at any time they want.

4.13 Dissemination of the Result

The final report of the study will be submitted to Addis Ababa University School of public health as partial fulfillment of master's degree in public health.

The result of the study will be reported to Guji zone health department and Liben woreda health offices and to those governmental and nongovernmental organizations that potentially could benefit from the study outcome.

5. RESULT

5.1 Introduction

In this chapter response rates and demographic information detailswere identified and described.The results were displayed by different techniques and discussions based on results found. Associations of dependent variables and independent variables were justified.

5.2 Response Rate

Four kebeles in Liban Disrtict were included in the study.A total of 382respondents with response rate 96.7% were participated.

5.3 Demographic Data

Of the total head of household respondents, 91.4% of them were male and the remaining 8.4% were female.About 36.7% of the respondents were within the age range of 36-50;about 24.3%of respondents were between age group of 18-35.

Regarding to marital status of respondents 84.3% were married, 5.5%of the respondents were divorced and the remaining 10.2%were widowed.Though there are religious variations, majority 62.8% of household heads were Muslim, 24.4 % were protestant, 12.3% were wakefata and orthodox Christians accounts a small portion 0.5%of respondents.Regarding ethnicity, 72% were Oromo, 25%were Somale, and the remaining 3% were Amhara.Concerning occupational status of household’s head59.4% were pastoralists and 17.5% were farmers.

With regard to level of education, respondents with informal education constituted 37.2% and those with primary education (1-6) were 25.4%.Majority of the respondents (62%) reported for having a family size of 6-8 individuals. A sizeable number of respondents (27%) were reported for having a family size of3-5 in their households.

Table 5.1: Socio-demographic characteristics of respondents, Liben Woreda, Southern Oromia, Ethiopia, 2020 (n=382)

Variables	Frequency	Percentage
Sex		
male female	349	91.4
	33	8.6
Age		
18-35	93	24.3
36-50	140	36.7
51-64	52	13.6
>=65	97	25.4
Ethinicity		
Oromo	275	72
Somale	96	25.1
Amahra	11	2.9
Religion		
Muslim	240	62.8
Protestant	93	24.4
Orthodox	2	0.5
Wakefata	47	12.3
Marital status		
Married	322	84.3
Divorced	21	5.5
Widowed	39	10.2
occupation of head		
pastoralist	227	59.4
Farmer	67	17.6
Merchant	54	14.1
Daily laborer	16	4.2
Petty trader	18	4.7
Educational status of head		

No education at all	73	19.1
Informal education	142	37.2
Primary	97	25.4
Secondary and above	70	18.3
Family size		
3-5	103	27
6-8	237	62
9-11	42	11

5.4 Knowledge of community to ward CBHI scheme

Most households in the sampled kebeles both member and nonmember correctly understand the role and concept of CBHI. As shown in Table 5.2,more than 94% of member and 88% of non-member households know that not only the sick should enroll in CBHI. A larger percentage of members (95%) and non-members (86.3%) also know that both the poor and the non-poor should enroll.Ninety nine percent of member and ninety eight percent of non-member answer that, CBHI is not like saving scheme, that is, they will not earn interest on their premium payment nor will the premium be returned even if they do not use health services. About 100% of member and 99.4% of non-member response the premium is a payment to finance future health costs.

Table5.2:Responses about the Role and Concept of CBHI (%)

Issues of `understanding CBHI	Correct understanding in respondents (in %)		Pearson chi2 test (p-value)
	CBHI members	CBHI non-members	
Have you ever heard about community based health insurance program (CBHI)?	100	91.8	18.67 (0.000)

Only those who fall sick should consider enrollment in CBHI. (Incorrect)	94.1	88.8	3.63 (0.057)
Only the very poor who cannot afford to pay for health care need to join the schemes. (Incorrect)	95	86.3	9.11 (0.003)
Under the CBHI program, you pay money (premiums) in order for the CBHI to finance your future health care needs, if need arise. (Correct)	100	99.4	1.39 (0.238)
CBHI program are like scheme, you will receive interest and get your money back.(Incorrect)	99.1	98.1	0.68 (0.409)

5.5 Status of enrollment

Of the total 382 households interview 222(58.1%) were member to CBHI program and the remaining 160(41.9%) were non-member. Of the 222 CBHI member households interviewed for the household survey, 80.2%paid their own registration. The remaining 19.8% were enrolled through the local government subsidy. About88.3% enrolled were get their membership in 2010E.C and 2011E.C, only 11.7% were enrolled in 2009E.C. The survey also asked the member those who have plan to renew their membership in the future for their highest amount they will to renew their membership, accordingly about46.4% were willing to pay 200 Ethiopian Birr (ETB), about 30.1%were willing to pay 250ETB, 18.5% were willing to pay 190ETB and only 5.2% were willing to pay 300ETB.

Members were asked why they joined the CBHI scheme. Regarding reasons for enrolling, 41.5 percent said illness occurs frequently in their households, 21.6 percent because the premium is lower than the OOP payments, 19.8 percent becausegovernment paid their registration fees and premiums and 17.1 percent to seek more care so as to improve their health status.

Table 5.3: Reasons for Joining the CBHI Scheme

Reasons	frequency	%
Illness and/or injury occurs frequently in our HH	92	41.44
our HH members need health care	38	17.12
CBHI registration and premium is paid by the government	44	19.82
Premium is low compared to the user fee price to obtain medical treatment	48	21.62

The survey also asked non-members their reasons for not being enrolled in the CBHI scheme. For 24.4% of the respondents, the registration fees and the premium are notaffordable. For 23.8% of respondent's illness not occur frequently in their households, for another 23.8% quality of services is low. The remaining 23.1%and 5% the reason for not being enrolled were wanted to see the benefits of CBHI scheme from other before they would join and they would not know enough about CBHI scheme respectively.

Table 5.4: Reasons for not joining the CBHI scheme

Reasons	Frequency	%
Illness not occur frequently	38	23.8
Premium is not affordable	39	24.4
To confirm the benefits from others	37	23.1
Not know enough about the CBHI	8	5
Quality of service is low	38	23.8

The household survey asked respondents whether they would renew their CBHI membership, accordingly about 68.9% confirmed that they would renew.This survey asked non-members if they planned to join the scheme in the future, about71.3% of non-members said they did have plans to join the scheme in the future.

5.6Experience of conflict and perception towards conflict

Seventy five point six percent of house hold were experienced any form of civil conflict and 48.4% of house hold were experienced severe loss of income as a result of civil conflict.

The respondents were asked whether theirproduction crops, cattle or livestock has been harmed by conflict, accordingly 67.6% of members and86.9% of non-members were reported their production was harmed during conflict.

About 37.8 %of enrolled and62.2% of non-enrolled was experienced severe losses of income since onset of conflict in their locality. As shown in table 5.4, both member and non-member were asked for change to cope their loss, about 8.6% of member and 31.9% of non-member were displaced.

Table 5.5 Respondents measure to cope their loss due to conflict.

What change did you actually make to cope to this loss?	Status of membership			
	Members		Non-members	
	frequency	percent	Frequency	Percent
Moved to other location	19	8.6	51	31.9
Reduce amount of food	9	4.0	13	8.1
Reduce health sick	10	4.5	13	8.1
Change occupation	159	11.3	35	21.9
No copping strategy taken	94	71.6	48	30.0

Regarding their suspecting of conflict in their locality in the future about 28.4% of member and 39.4% of non-member suspect the occurrence of conflict in their locality.

Both member and non-member were asked whether the presence of civil conflict enhanced them to enroll and inhibit them to be non-enroll, only 2.7% of enrolled were enhanced and about 70.6%of non-enrolled were inhibited by the presence of civil conflict in their locality.

5.7 Factors influencing enrollment decision into CBHI scheme

The outcome variable (CBHI demand) was treated as a binary outcome: "1" for enrolled and "0" for un-enrolled households and 12 explanatory variables were considered in the econometric model.The econometrics logistic analysis showed that sex of household heads was significantly associated with CBHI enrollment. Female heads household the likelihood to join the CBHI scheme increased by 13.15 (AOR 13.15: CI =2.11, 81.25) than those male heads households.

Educational status of heads (AOR=4.56, CI =1.34, 15.50) those who attend secondary and post-secondaryschool had 4.56 times more enrolled to CBHI than those who did not educate at all. Heads occupation was significantly associated with CBHI enrollment. Accordingly, heads those their occupations'merchants were0.2 times less likely enrolled to CBHI scheme than those their occupation is pastoralist.

Household's family size was significantly associated with CBHI enrollment (AOR= 3.82; CI=1.13–12.93). Household with family size of 9-11 were 3.82 times more enrolled to CBHI than those their household family size of with 3-5.

Regarding the awareness of respondents towards CBHI programs, participants with good CBHI awareness on not only very poor who can't afford to pay for CBHI were 5.03 times more likely to join the scheme compared with their counterpart (AOR=5.03; CI=1.62–15.59).

The finding of this study indicate (AOR=6.17, CI=3.25, 13.84) those people who did not experience severe losses of income since the onset of the conflict had 6.17 times more enrolled to CBHI than those who experience severe losses of income.

Regarding the kebeles of respondents,(AOR=0.30 CI=0.14, 0.63)respondents those kebele of residence was Miesa were 0.30 times less likely enrolled to CBHI programs as compared to residence of Siminto. Similarly (AOR= 0.39 CI= 0.16, 0.94) respondents those kebeles was Kalada were 0.39 times less likely enrolled to CBHI as compared to residence of Siminto. Lastly (AOR=0.19 CI=0.07, 0.54) respondents those kebele of residence was Bura dhera were 0.19 times less likely enrolled to the schemes than those residence of Siminto kebele.

Table 5.6:Logistic regression of drivingCBHI enrolmentLiben Woreda, Southern Oromia, Ethiopia, 2020 (n=382).

Variables	Enrolment to CBHI		COR	AOR	P-value
	Yes	No			
Sex					
Male	192	157	1	1	
Female	30	3	8.17(2.45,27.29)	13.15(2.11,81.25)	0.006
Age					
18-35	38	55	1	1	
36-50	84	56	2.17(1.27,3.70)	1.19(0.51, 2.76)	0.681
51-64	30	22	1.97(0.99,3.93)	0.72(0.24, 2.21)	0.578
>=65	70	27	3.75(2.04,6.88)	2.23(0.74, 6.76)	0.154
Marital status of head					
Married	172	150	1	1	
Divorced	16	5	2.78(0.99, 7.79)	0.93(0.20, 4.32)	0.914
widowed	34	5	5.93(2.26, 15.55)	2.12(0.58, 7.81)	0.259
Educational status of heads					
No education at all	46	27	1	1	
Informal education	91	51	1.05(0.58, 1.88)	1.09(0.47, 2.52)	0.835
Primary	49	48	0.59(0.32,1.12)	2.58(0.96, 6.91)	0.059
Secondary&above	36	34	0.62(0.31,1.21)	4.56(1.34, 15.50)	0.014
Occupation of heads					
Pastoralist	150	77	1	1	
Farmer	41	26	0.81(0.46, 1.42)	1.03(0.49, 2.19)	0.931
merchant	25	26	0.44(0.24, 0.81)	0.19(0.07, 0.51)	0.001
Daily labourer	0	16	1	1	
Petty trader	6	12	0.26(0.09, 0.71)	0.11(0.03, 0.52)	0.005
Family size					
3-5	45	58	1	1	
6-8	144	93	1.99(1.25, 3.18)	1.79(0.85, 3.79)	0.125
9-11	33	9	4.72(2.05, 10.87)	3.82(1.13, 12.93)	0.031
Only those who fall in the sick should consider enrolment in CBHI					
correct	13	18	1	1	
not correct	209	142	2.04(0.97,4.29)	0.67(0.23, 1.95)	0.466

Variable	Count 1	Count 2	COR	AOR	p-value
Only very poor who can't					
afford to pay for CBHI	11	22	1	1	
Correct	211	138	3.06(1.42, 6.50)	5.03(1.62, 15.59)	0.005
Not correct					
Production crops/cattle/ livestock has harmed by conflict					
Yes	150	139	1	1	
No	72	21	3.18(1.85, 5.44)	1.73(0.70, 4.23)	0.233
Experience severe losses of income since the outset of the conflict					
Yes	70	115	1	1	
No	152	45	1.71(1.28, 2.16)	6.17(3.25, 13.84)	0.000
Anticipation of conflict in their locality					
Yes	63	63	1	1	
No	159	97	1.63(1.06,2.52)	1.66(0.93, 2.97)	0.087
Kebeles (location)					
Siminto	70	30		1	
Miesa	86	68		0.30(0.14, 0.63)	0.002
Kalada	44	29		0.39(0.16, 0.94)	0.037
Buradhera	22	33		0.19(0.07, 0.54)	0.002

6. DISCUSSION

This study aimed to explore the relationship between demand for health insurance and civil conflict in pastoralist communities of Liban District, and the study identified factors for CBHI enrolment.

According to the data obtained from the survey, socio-demographically, consistent with Tehuledere District of South Wollo Zone most (91.4%) respondents were male. This might be in rural areas decision making power is more common for male and public activities were more determined by men. Regarding the age the highest present (36.6%) respondents were with age group of 36-50, and majority belongs to the same religious category that's Muslim. Similar to study done in South wollo,most of therespondent are married. This might be due to most Ethiopian believed marriage is sanctioned by God or Allah(10).

Regarding family size, in contrast to study done in South wollo majority (73%)of respondents does have family size of 6-11 members. The discrepancy might be due to member those some members of the household are not enrolled in CBHI, said that some members are not their nuclear family members.

The finding of this study similar to other studies; like evaluation of CBHI pilot schemes in Ethiopia, more than 94% of member households and 88 % of non-member households know that it is not only those who are sick who should enroll in CBHI. This clearly shows the value of the concentrated sensitization in community work done by government (11). In contrast to evaluation of CBHI pilot scheme, only 68.7% of households enrolled as CBHI members indicated their intention to renew their membership when the current one expires. The discrepancy might be due to differing socioeconomic status, geographical location and their life style (11).

The average amount of money willing to pay per household per annual was 218 ETB. The mean amount money willing to pay in the study is greater than study in North West Ethiopia (16).

Consistent with study done in Kewiot and EfratanaGedem Districts of Amhara Region, Households with larger family size are willing to pay a higher amount than households with smaller family size; in these study households with family size of 9-11 are willing to pay high

amount by 12% more than households with family size 3-5. This might be as a result of the huge financial burden faced by households when they seek health care services (18).

During times of conflict, the health providers are unable or unwilling to provide adequate health services to its population. Health actors face numerous constraints to delivering healthcare in conflict-affected settings. First, they face constraints related to the health system. Conflict damages health and health-related infrastructure and leads to shortages in medicines, medical supplies, health personnel, and financial resources. It also increases the burden on already strained health systems. Second, armed conflict makes it more difficult for health workers to access populations in need and for these populations to access health services (8). As CBHI is one of risk sharing program to give health service for community, is hard to mobilize people to enroll to the scheme. Similarly, one of the key informants professional stated his experiences about community mobilization on CBHI as follow:

As enrollment of CBHI is at kebele level, during the conflict at least three health posts was closed since 2008 and 2009E.C. At that time community mobilization and service provision to people at kebele level is hard to health extension workers and kebele leaders. (Key informant 3)

The finding of this study similar to the above narrative, about 88.3% enrolled were get their membership since 2010E.C and 2011E.C, only 11.7% were enrolled since 2009E.C , this might be as a result of cessation of conflict since 2010 E.C.

The finding of the study discloses the association of socio-demographic characteristics and the outcome variable. Consequently, the test statistics infers characteristics such as sex, educational status, occupational status, and family size were statistically significant; and shows group differences on the abovementioned variables on CBHI demand.Unlikely, differences in religious affiliation and age group and marital status is not significant, and there were no differences on CBHI demand between those group categories.

Chi-square test statistic was done for understanding of CBHI and CBHI enrollment. Accordingly heard about CBHI program and not only very poor who cannot afford to pay for health care need to join the CBHI schemes were significant. Ever heard about community based health insurance program and CBHI enrollmentare associated with each otherwith the value of the chi square statistic of 18.67 and p-value of 0.000. Similarly not only the very poor who

cannot afford to pay for health care need to join the schemes and CBHI enrollment are associated with each other with the value of chi square statistic of 9.11 and p-value of 0.003.

Civil conflict has negative effect on demand for health insurance, accordingly the finding of this study indicate [OR=6.17, CI (3.25, 13.84)] those people whodid not experience severe losses of income since the onset of the conflict had 6.17 times more enrolled to CBHI than those whoexperience severe losses of income.This could be because of lack of income when there is conflict.

7. LIMITATION AND STRENGTH OF THE STUDY

7.1 Strength of the study

Pre-test was performed that increases the study's validity and reliability.Three days training were given for the data collectors.

7.2 Limitation of the study

Recall bias regarding the onset of conflict in the past 3 years might be a limitation of the study. As a questionnaire survey, our work is exposed to information bias.

8. CONCLUSION AND RECOMMENDATION

8.1 Conclusion

Conflict damages crucial health-supporting infrastructure such as food and water safety and supply, sanitation, electric power, transportation, and communication. Damaged agricultural infrastructure can lead to malnutrition, famine and poverty.The lack of essential services more generally increases a population's vulnerability to disease outbreaks. As a result of abovementioned problems capacity to afford for health care in conflict area is hard.

This study aims to examine the relation between civil conflict and demand for health insurance. It also assesses awareness of health insurance among the target population.

In order to conduct the study, primary data was gathered using structured questionnaire from 382 respondents and four key informant interviews.

The data were analyzed using logit regression to determine the effect of various factors on the outcome variable. Bivariate analyses were done to choice the variable for multivariate analysis, accordingly the variable with p-value less than 0.2 on bivariate analysis were included to multivariate analysis. The degree of association between dependent and independent variables were assessed using odds ratio with 95% confidence interval and p-value less than 0.05.

Out of total 382 households interview 222(58.1%) were member to CBHI program and the remaining 160(41.9%) were non-member.

Majority of member and non-member households know that it is not only those who are sick who should enroll in CBHI. This clearly shows the value of the concentrated sensitization in community work done by government.Participants with good CBHI awareness on not only very poor who can't afford to pay for CBHI were 5.03 times more likely to join the scheme compared with those believe only very poor who can't afford to pay for CBHI program.

Seventy five point six percent of house hold were experienced any form of civil conflict and 48.4% of house hold were experienced severe loss of income as a result of civil conflict.About 31.5% of enrolled and 71.9% of non-enrolled was experienced severe losses of income since onset of conflict in their locality.

Regarding the experience of conflict, those people who did not experience severe losses of income since the onset of the conflict had 6.17 times more enrolled to CBHI than those who experience severe losses of income.The findings in this study have shown that civil conflict can have a negative impact on the enrollment of CBHI, as the previous studies have also suggested the negative impact on the utilization of health services.

8.2Recommendation

- About 90% of non-member has adequate awareness about CBHI program; this is one opportunity for woreda CBHI office to encourage them to be member of the scheme.
- As 23.8 % of nonmember and 18.8% of member those doesn't have plan to renew their membership reason the quality of service is low, the local Government and Non-Government could increase the quality of service to increase the enrollment rate.
- Experience severe losses of income since the onset of the conflictsignificantly affect CBHI enrollment, so government and other concerned bodies to enhance effort in order to reduce incidence of conflict and to maintain peace in the area.

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10. ANNEX

ANNEX -I: DECLARATION

I, the undersigned, Public Health student declare that this thesis is my original work in partial fulfillment of the requirement for the degree of Master of Public Health.

Name: Dera Girma Diriba

Signature: ______________

Place of submission: Addis Ababa University

Date of Submission: _____________

This thesis work has been submitted for examination with my/ our approval as advisor(s).

Advisors

Name	Signature	Date
1 .Anagaw Derseh (PHD, Assistant Professor)	___________	________________
2.Berhan Tassew (MPH)	___________	________________

ANNEX-II: ASSURANCE OF PRINCIPAL INVESTIGATOR

The undersigned agrees to accept responsibility for the scientific, ethical and technical conduct of the research project and for provision of required progress reports as pre terms and conditions of the research and publications office in effect at the time of grant is forwarded as the result of this application.

Name of the Student: Dera Girma Diriba

Date: ________________ Signature: __________

Approval of the primary Advisor

Name of the primary advisor: Anagaw Derseh (PHD, Assistant Professor)

Date__________________Signature:__________

ANNEX-IIIQUESTIONNAIRE INFORMATION SHEET AND CONSENT FORM

The question below is to assess the Relationship between the demand for health insurance and conflict in pastoralist community of Liben District. The information obtained will be used only for the purpose of study, and also we need to assure that confidentiality is our value. So we politely request your cooperation to answer the questions accordingly. You do have the right not to respond or to withdrawal in the meantime, but your input has great value for the success of this research.

Questionnaire Consent Form

My name is Dera Girma (Interviewer)

This is a study to be conducted with the objective of assessing the Relationship between the demand for health insurance and conflict in pastoralist community of Liben District. As the study is directly related to community, you are one of the community members who have been selected to participate in this study. The interview will last approximately from 20-90 minutes. Your responses will be kept confidential and there will be no way of linking your individual responses to the final results of the study findings. We would like to inform you that the responses that you provide to the questions are very essential, not only, for the successful accomplishment of the study, but also for producing relevant information which will be helpful in the planning and implementation of intervention activities related to community based health insurance in your area . Are you voluntary to respond to the questions?

Yes; ----proceed with the interview

No; ---- thank her and End.

Name of interviewer who sought the consent: ______________________________

Date Signature: ______________________

Name of supervisor: ______________________

English Version Questionnaires

Identification Information

Questionnaire Code____________________

Kebele________________________________

House hold Number_______________

Part 1:-Socio-demographic characteristics

No	Questions	Possible choices/Answers	Remark
101	What is Sex of household head?	1.Male 2.Female Indicate code_______	
102	Age of the household heads (years)	____________years	
103	What is marital status of head?	1 single 2 married 3 divorced 4 widowed	
104	What is Head's educational level?	1.No education at all 2.Informal education 3.Primary 4.Secondary or postsecondary Indicate code_______	
105	What is your occupation?	1.pastoralist 2.Farmer 3.Merchant 4.Daily laborer 5.Petty trader Indicate code______	
106	What is your Religion?	1.Muslim	

		2.Protestant 3.Orthodox 4.Wakefata 5. Adventist 6.Other religion (specify)__________ Indicate code_______	
107	What is your ethnicity?	1.Oromo 2.Somale 3. Amhara 4. Gurage 5 Tigre 6. other (specify)_____ Indicate code	
108	How many person live with you in the same house	____________ person (s)	
109	Have you ever heard about community based health insurance program (CBHI)? [non-CBHI members only]	1.Yes 2.No Indicate code________	
110	Only those who fall sick should consider enrollment in CBHI	1. Correct 2.Not correct 3.Do not know Indicate code______	
111	Only the very poor who cannot afford to pay for healthcare need to join the schemes	1. Correct 2.Not correct 3.Do not know Indicate code______	
112	Under CBHI program, you pay money (premiums) in order for the CBHI to finance your future health care needs	1. Correct 2.Not correct 3.Do not know Indicate code______	

113	CBHI program are like savings scheme, you will receive interest and get your money back.	1. Correct 2.Not correct 3.Do not know Indicate code______	
114	Is your HH member enrolled in the CBHI program?	1.Yes 2.No Indicate code______	If No skip to no.135
115	When did you become a CBHI member?	Write the year |_d_|_d_|_m_|__m|__y|__y_|	
116	Are all members of your household enrolled in the CBHI program?	1.Yes 2.No Indicate code_______	If yes skip to no. 118
117	Why some members of the HH are not enrolled in CBHI?	1.members are healthy 2.do not have enough money to pay for all 3.members are not nuclear family members Indicate code: _______	
118	Why has your household or any of your HH members decided to enroll in the CBHI program (multiple answers allowed-list in order of importance)?	1.Illness and/or injury occurs frequently in our HH 2.our HH members need health care 3. CBHI registration and premium is paid by the government 4.Premium is low compared to the user fee price to obtain medical treatment 5.Pressure from other family members/community 6.Pressure from the kebele/tabia administration 7. others please specify Indicate code:______,_______,_______	
119	Who paid for the enrollment	1.HH contribution	

	fee?	2.local government (coverage for Indigent HH) Indicate code: _______	
120	How long does it take, after payment of registration fee and premium, to start utilizing health services?	_________ days	
121	When your current membership expires would you renew your CBHI membership for the following year?	1.Yes 2.No Indicate code________	If No skip no. 123
122	If yes, what is the highest amount you are willing to pay to renew your membership	________ETB	
123	Is your household enrolled in any other solidarity group (e.g. iddir, equb, microfinance, other informal systems etc) active in your area?	1.Yes 2.No Indicate code_______	
124	How do you feel about the adequacy of the current benefit package?	1.very adequate 2.adequate 3.neither adequate nor inadequate 4. inadequate 5.I do not know Indicate code_________	
125	How satisfied are you with overall quality of service?	1.Very satisfied 2.satisfied 3.Neither satisfied nor dissatisfied 4.dissatisfied	

		5.Very dissatisfied Indicate code____	
126	How satisfied are you with Availability of drugs/medical supplies?	1.Very satisfied 2.satisfied 3.Neither satisfied nor dissatisfied 4.dissatisfied 5.Very dissatisfied Indicatecode______	
127	How satisfied are you with Availability of diagnostic facilities?	1.Very satisfied 2.satisfied 3.Neither satisfied nor dissatisfied 4.dissatisfied 5.Very dissatisfied Indicate code________	
128	If you have decided not to renew your CBHI membership, state the reason. (multiple response is possible	1.Illness and injury does not occur frequently in our household 2.The registration fee and premiums are not affordable 3.There is limited availability of health services 4.The quality of health care services is low 5.The benefit package does not meet our needs 6.CBHI management staff is not trustworthy 7.Waiting time to access services is longer for CBHI members 8.I am fee waiver beneficiary 9.Other reasons, please specify Indicate code ______,_______,________,________	
129	Do your production crops/cattle/livestock has been harmed by conflict?	1.Yes 2.No Indicate code_______	

130	Do you experience severe losses of income since the onset of conflict?	1.Yes 2.No Indicate code_______	
131	What change did you actually make to cope to this loss?	1. displaced 2.Reduce amount of food 3.Reduce health sick when member of house hold sick 4.Change occupation to increase income 5.No change Indicate Code________	
132	Can you suspect inter-ethnic fighting in your locality?	1.Yes 2.No Indicate code_______	
133	Do you renew your CBHI membership if conflict is there in your locality?	1.Yes 2.No Indicate code_______	
134	Is the presence of the conflict encouraged you to enroll to CBHI?	1.Yes 2.No Indicate code_______	
135	Why has your household decided not to enroll in the CBHI program (multiple responses allowed-list in order of importance)?	1.Illness and injury does not occur frequently in our HH 2.the registration fee and premiums are not affordable 3. want to wait in order to confirm the benefits of the scheme from others 4. we do not know enough about the CBHI scheme 5. there is limited availability of health services 6. the quality of health care services is low 7 .the benefit package does not meet our needs	

		8.Lack of confidence in scheme management 9. other reasons, please specify aIndicate code _______,________,_______	
136	Do you plan to enroll in the CBHI scheme in the future?	1.Yes 2.No Indicate code _______	
137	Is your household enrolled in any other solidarity group (e.g. iddir, equb, microfinance, other informal systems etc) active in your area?	1.Yes 2.No Indicate code_______	
138	Do your production crops/cattle/ livestock has harmed by conflict?	1.Yes 2.No Indicate code_______	
139	Do you experience severe losses of income since the outset of the conflict?	1.Yes 2.No Indicate code_______	
140	What change did you actually make to cope to this loss?	1.Displaced 2.Reduce amount of food 3.Reduce health sick when member of house hold sick 4.Change occupation to increase income 5.No change Indicate Code________	
141	Is the presence of the conflict	1. Yes	

	inhibiting you to enroll to CBHI?	2. No Indicate code_______	
142	Can you suspect inter-ethnic fighting in your locality?	1.Yes 2.No Indicate code_______	

"THANK YOU"

Interviewer

Date of data collection________________ Name of data collector________ Signature _____

Supervisor

Name of supervisor ______________________Signature ______

Afan Oromo Version Questionnaires

Gaaffilee qorannoo hariiroo fedhii inshuraansii fayyaa hawaasaa fi waliitti bu'iinsaa uummaataa giduu jiru kan naannoo hawaasaa horsiisee bultoota Libaan irraatti taasifamuuf qophaa'e.

Ragaa enyummaa

Koodii gaaffiilee: _________

Ganda______________________

Lakkoofsa Manaa____________

Kutaa 1ffaa: Oddeffannoo haala waliigalaa hawaasummaa fi diinagdee

Lakk	Gaaffilee	Filannoo/Deebii	yaada
101	Koorniyaa dursaa abbaa warraa maali?	1.Dhiira 2.Dhalaa Koodii muliisi________	
102	Umurii dursaa abbaa warraa meeqa?(waggaan)	Waggaa__________	
103	Haallifuudhaa fi heerumaakeessan kee?	1.Hinfuune/hinheerumne2.Heerumeera/Fuudheera 3.Hiikeera 4.Najalaadu'eera/tti 5.Kanbiraa(Ibsi) Koodii muliisi_________	
104	Sadarkaa barnoota abbaa warraa maali?	1.woma tokko hin barane 2.barnoota al-idilee 3.sadarkaa 1ffaa 4.sadarka 2ffaa fi isaa ol Koodii muliisi________	
105	Hojjiin kee maalii?	1.horsiisee bulaa 2.qonaan bulaa 3.daldalaa	

		4 hojii guyyaa 5.daldala xixiqaa Koodii muliisi____________	
106	Amantiin keessaan maali?	1. Islaama 2.Protestaantii 3.Ortodoksi 4.Waaqeeffattaa 5.Kan biraa(Ibsi) Koodii muliisi________	
107	Sabni kee maalii?	1.Oromoo 2. Somale 3.Amaaraa 4. Guraagee 5. Tigree 6.kan biraa (ibsi) Koodii muliisi_______	
108	Namoota meeqaatu sii waliin mana tokko keessaa jiraata?	Namoota__________	
109	Waa'ee sagantaa inshuuraansii fayyaa hawaasaa dhageesee beektaa?	1.eyyee 2.lakkii Koodii muliisi________	
110	Namoota dhukkubsaataan qofatu sagantaa inshuuraansii fayyaa hawaasaatti makamu qaba.	1. sirrii dha. 2. sirrii miti . 3. hin beekuu. Koodii muliisi_________	
111	Namoota baay'ee hiyyeessa ta'aan kun yaalaa fayyaa isaaniif kanfaluu hin dandeenye qofatu sagantaa	1. sirrii dha. 2. sirrii miti. 3. hinbeekuu. Koodii muliisi__________	

	inshuuraansii fayyaa hawaasaatti makaamu qaba.		
112	Sagantaa inshuuraansii fayyaa hawaasaa jalaatti qarshiin kanfalamuu feedhii yaalaa fayyaa gara fuulduraa uwiisuuf.	1. sirrii dha. 2. sirrii miti. 3.hin beekuu Koodii muliisi________	
113	Sagantaan inshuuraansii fayyaa hawaasaa akkuma tajaajila quusanaa bira dhala fi qarshii kanfaalee gara fuulduuraa fuudhaachuu dandeenya.	1. sirrii dha. 2. sirrii miti. 3.hin beekuu Koodii muliisi________	
114	Maatiin keessaan sagantaa inshuuraansii fayyaa hawaasaa jalatti hammatamee jira?	1.Eeyyee 2.lakkii Koodii muliisi________	Yoo deebiin lakkii ta'ee gara gaaffii 135tti ce'i
115	Yoom miseensa inshuuraansii fayyaa hawaasaa taatani?	waggaa |_G_|_G_|_J_|__J|__B|__B_| ___|___|___|___|___|___	
116	Maatii keessaan hundatu sagantaa inshuuraansii fayyaa hawaasaa jalaatti hammatamee?	1.Eeyyee 2.lakkii Koodii muliisi________	Yoo Eeyyee ta'e gara gaaffii 118tti ce'ii
117	Maaliif hundi isaani hin hammatamiin?	1.fayyaa waan ta'aniif 2.hundaaf kanfaluuf qarshiin waan dhabneef 3.kan hafaan maatii keenya dhiigaa waan hin taneef 4.Kan biraa(Ibsi) Koodii muliisi________,_______,________	

118	maaliif maatiin keessaan sagantaa inshuuraansii fayyaa hawaasaa kana jalatti hammatamuuf murteesee?(deebiin tokko ol ni danda’ama)	1.dhibbee fi miidhaan irraa dedeebiin maatii keessaati mulataa 2.maatiin keenyaa tajaajila fayyaa barbaada 3.kanfaltii fayyaa keenya uwiisuuf 4.qarshii sagantaa kana motummaan waan nu kanfaluuf 5.kafaltiin sagantaa kana kan yeroo qarshii baasani yaalaman irraa waan xiqqaatuuf 6.dhiibbaa hawaasaatiin 7.dhiibbaa bulchiittoota gandaatiin 8. Kan biraa(Ibsi) Koodii muliisi_______,_______,______	
119	Qarshii miseensummaaeenyuutu kafale?	1= ga,ee maatii 2= mootummaa naannoo Koodii muliisi_______	
120	Kafaltii miseensummaan booda tajaajila fayyaa argachuuf hangam turtu?	Guyyaa________	
121	Yoo yeroon miseensumma ammaa qabdaan kun dhumatu bara itti aanuuf miseensummaa inshuuraansii fayyaa hawaasaa ni haroomsiifatu?	1.Eeyyee 2.lakkii Koodii muliisii________	Yoo lakkii ta’e gara gaaffii 123tti ce’i
122	yoo ni haaroomsata ta’ee hangi qarshii olaanaa ati kanfalte miseensumma kee haaroomsuu feetuu meeqa?	qarshii__________	
123	Maatiin keessaan waldaalee wal-gargarsa kaneen akka afooshaa, iquubii fi quusanaa	1.Eeyyee 2.lakkii Koodii muliisii________	

	biro amma hojjii irraa jiruutti hirmaatuu qaba?		
124	waa'ee itti quufiinsa huwiisa tajaajila ammaa kenamaa jiru maal yaada?	1=baayyee quubsaa dha 2= hanga tokko quubsaa dha 3= quubsaa miti 4=hinbeekuu Koodii muliisi________	
125	Itti quufiinsi ati keenaa tajaajila walii gala irraatti qabdu?	1. baayee itti quufeen jira 2.itti quufeen jira 3.itti hinquufne natis hinbadnee 4. itti hin quufnee 5. baayee itti hinquufnee Koodii muliisi_________	
126	Itti quufiinsi ati keenaa tajaajila qoriicha fh dhiyyeessi qoriicha irraatti qabdu?	1. baayee itti quufeen jira 2.itti quufeen jira 3.itti hinquufne natis hinbadnee 4. itti hin quufnee 5. baayee itti hinquufnee Koodii muliisi_________	
127	Itti quufiinsi ati keenaa tajaajila laabiraatoorii irraatti qabdu?	1. baayee itti quufeen jira 2.itti quufeen jira 3.itti hinquufne natis hinbadnee 4. itti hin quufnee 5. baayee itti hinquufnee Koodii muliisi_________	
128	yoo miseensummaa kee inshuuraansii fayyaa hawaasaa haaroomsu dhabuuf murteesiite sababni kee maali?(deebiin tokko ol ni danda'ama)	1=dhibbee ykn miidhaan maatii keenya irraa dedeebiin waan hin mudaneef 2=kafaltiin waan nuuti ulfaatuuf 3= tajaajili kenamuu ga'aa waan hin taneef 4= qulqullinni tajaajila kenamuu gad-aanaa 5= uwwiisni tajaajilli inni keenuu feedhii keenya	

		waan hin madaaleef 6= hojjaattooni bulchiinsa inshuuraansii fayyaa waan hin amanamneef 7= yeroon turtii tajaajila argachuu kan miseensoota waan dheeraatuuf 8=ani gargaarsa mootummaan miseensa waanan ta'eef 9= kan biro (ibsi) Koodii muliisi________,________,______	
129	kanaan dura omishni kee, loon kee sababa walitti bu'iinsaan miidhaamee beekaa?	1.Eeyyee 2.lakkii Koodii muliisi________	
130	Kanaan dura sababa walitti bu'iinsaan mudaannoon galiin kee itti hirate jireenyaaf raakate ni jira?	1.Eeyyee 2.lakkii Koodii muliisi________	
131	Galii kee kana sirreesuuf jijjiirama maal fudhaate?	1.ni godaane 2.Hanga nyaataa nyaanuu hiriifne 3.barbaacha yaalaa yoo miseensi maatii dhiibamu hiriisne 4.hojii dabalata jalqabne 5.homaa hin jijjiire 6.kan biro(ibsi) Koodii muliisi________	
132	Walitti bu'iinsi gosaa naannoo ati jiraatuutti ni	1.Eeyyee 2.Lakkii	

	mudata jette yaada?	Koodii muliisi________	
133	Yoo walitti bu'iinsi naannoo kee jiraate miseensumma inshuuraansii fayyaa hawaasaa kee ni haroomfataa?	1.Eeyyee 2.lakkii Koodii muliisi________	
134	Jiraachuun walitti bu'iinsaa miseensa akka taatuu si taasiisee jira?	1.Eyyee 2.lakkii Koodii muliisi________	
135	Maaliif maatiin keessaan sagantaa inshuuraansii fayyaa hawaasaan haammatamu dhabuuf murteese?deebiin tokko ol ni danda'ama)	1=dhibbee ykn miidhan maatii keenya irraa dedeebiin waan hin mudaneef 2=kafaltiin waan nuuti ulfaatuuf 3= faayiidaa saganticha warraa bira irraa mirkaneefachuu barbaadne 4=beekuumsa ga'aa waa'ee inshuuraansii fayyaa hawaasaa waan hin qabneef 5= tajaajili kenamuu ga'aa waan hin taneef 6= qulqullinni tajaajila kenamuu gad-aanaa 7= huwiisnni tajaajilli inni keenuu feedhii keenya waan hin madaaleef 8= hojjaattooni bulchiinsa inshuuraansii fayyaa waan hin amaanamneef 9= yeroon turtii tajaajila argachuu kan miseensoota waan dheerraatuuf 10= kan biro (ibsi) Koodii muliisii________,________,______	
136	gara fuul-dura karoooraa sagantaa inshuuraansii fayyaatiin haamatamu	1.Eeyyee 2.lakkii Koodii muliisi________	

	qabda?		
137	maatiin kee sagaanta wal gargaarsa naannoo kan akka afooshaa, iquubii fi kan kana fakkaataan kan ammaa hojii irraa jiru keessaatti hirmaatuu ni qaba?	1.Eeyyee 2.lakkii Koodii muliisi________	
138	kanaan dura omishni kee, loon kee sababa walliitti bu'iinsaan miidhaamee beeka?	1.Eeyyee 2.lakkii Koodii muliisi________	
139	Kanaan dura sababa walliitti bu'iinsaan mudaannoon galiin kee itti hirate jireenyaaf raakkateni jira?	1.Eeyyee 2.lakkii Koodii muliisi________	
140	Galii kee kana sireesuuf jijjiirama maal fudhaate?	1.ni godaane 2.hamma nyaataa nyaanuu hiriifne 3.barbaacha yaalaa yoo miseensi maatii dhiibamu hiriisne 4.hojii dabalaata jalqabne 5.homaa hin jijjiire 6.kan biro(ibsi) Koodii muliisii________	
141	Jiraachuun wallitti bu'iinsa akka miseensa inshuuraansii fayyaa hawaasaa hin tanee	1.Eeyyee 2.lakkii	

	sii tasiisee jira?	Koodii muliisi________	
142	Walitti bu'iinsi gosaa naannoo ati jiraatuutti ni mudata jette yaada?	1.Eeyyee 2.Lakkii Koodii muliisi________	

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