



**ASSESSMENT OF FACTORS AFFECTING UPTAKE OF COMMUNITY BASED HEALTH INSURANCE AMONG SABATA HAWAS WOREDA COMMUNITY, OROMIYA REGION**

**BY:**

**SHIFERAW SHIBESHI NIGUSSIE (BSC)**

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***ADVISOR:***

***DR. ABABI ZERGAW (PHD)***

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**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  
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Grant is forwarded as the result of this application.

Name of the student: **Shiferaw Shibeshi Nigussie**

Date. \_\_\_\_\_ Signature \_\_\_\_\_

**Approval of the primary Advisor**

Name of the primary advisor: **Dr. Ababi Zergaw(PHD)**

Date. \_\_\_\_\_ Signature \_\_\_\_\_

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## Acronyms and abbreviations

- AOR-Adjusted odd ratio
- CBHI- community based health insurance
- CI- confidence interval
- COR-crude odd ratio
- FGD- Focus group discussions
- HH –House hold
- ID-identification card
- Km -kilometer
- LMICs-low and middle-income countries
- OPP –out of pocket payment
- PHCU- Primary health care unit
- SSA: Sub Saharan Africa
- UHC -Universal health coverage
- WTJ: willingness to join

## Abstract

**Background:** Many households in low and middle income countries face financial catastrophe and impoverishing effects of paying for health services out-of-pocket. There is increasing advocacy for community-based health insurance schemes as part of a broader solution to health care financing problems in low-income countries, but up to date there were very limited uptake of CBHI scheme

**Objective:** To assess factors affecting up-take of community based health insurance scheme

**Methods:** Both qualitative and quantitative study designs were used. For the quantitative method, cross-sectional study was conducted in December 2016, to assess factors affecting uptake of CBHI in Sabata Hawas Woreda. To support quantitative study, qualitative study was conducted using three focus group discussions. Quantitative data was entered in to EPI info then exported to SPSS for cleaning and analyzing while qualitative data were transcribed and translated into English and then manipulated manually by grouping the ideas into similar thematic sets.

**Results:** Among 630 study participants who were interviewed, 503(79.8%) were male. This study revealed that uptake of CBHI scheme among HH heads whose their annual income <40,000 birr/year were less likely than those whose their income  $\geq$  40,000 birr/year, OR=0.562; 95% CI (0.371, 0.850). Uptake of CBHI among respondents whose their family size  $\leq$ 5 were less likely than those who have >5 family, AOR =0.404; 95% CI (0.271, 0.603). Uptake of CBHI among study participants who have no awareness about CBHI less likely than who have awareness, AOR =0.148; 95% CI (0.039, 0.565). Uptake of CBHI among study participants who were not experienced illness in the last six months during the study period were less likely than who fallen , AOR=0.606; 95 % CI (0.406, 0.904). Uptake of CBHI among respondents who thought payment of premium is to finance future health care needs were more likely than who were not, OR=2.046 ;95% CI (1.256, 3.334). Uptake of CBHI among respondents who didn't know whether CBHI is like saving scheme will receive interest and get money back were less likely than who knew as if interests and money paid couldn't get back in cash, OR=0.374 ;95% CI (0.171, 0.816). Uptake of CBHI among respondents who trust their local CBHI management were more likely than those who didn't know whether trustful or not, AOR= 2.006(1.301, 3.091)

**Conclusion and recommendations:** From this study it was concluded that, family size, annual income, awareness about CBHI, illness experience and perception towards payment of premium is to finance future health care needs, CBHI is like saving scheme receive interest and get money back and trust on local CBHI management were factors which influences uptake of CBHI. Many efforts needed to improve availability of drug and prolonged waiting time to get health services as well as on awareness creation and on concepts of the features of CBHI so as to familiarize the community with the scheme.

# 1. Introduction

## 1.1 Background

Many low and middle-income countries (LMICs) are faced with the challenge of raising sufficient funds to finance health services in an equitable way. Although it is expected that governments should play a leading role in this regard, most governments in these countries are constrained by the high proportion of informal workers. Also, other economic contexts such as high public debt and population growth rate in most of these countries have made it difficult to increase government spending on health. As a result only a small fraction of government revenue is allocated to provide healthcare services for the population. Similarly, the burdens of disease in these countries are higher than those in high-income countries. In fact, LMICs account for 90 % of the global burden of disease and only 12 % of global health spending (1, 2).

In many of these LMICs direct out-of-pocket payments dominate healthcare financing. Such direct payments are inequitable and inefficient in financing healthcare services. This is because they are generally regressive; accounting for a higher proportion of poorer households' income compared to richer households. Thus, many households in LMICs lack adequate financial protection; households face financial catastrophe and impoverishing effects of paying for health services out-of-pocket. In fact, annual estimates show that about 44 million households (representing more than 150 million individuals) face catastrophic expenditure globally while about 25 million households (representing more than 100 million people) are impoverished because of direct healthcare payments. Over 90 % of these occur in LMICs (3).

There is strong evidence that CBHI improves resource mobilization to improve health service utilization and provide financial protection for members in terms of reducing their out-of-pocket. Studies on the impact of CBHI on resource mobilization for health showed an overall positive effect. For example, studies in Bangladesh, Cambodia, the Democratic Republic of the Congo and India reported improved cost recovery ratios after implementation of CBHI(4).

A study done on dropping out of Ethiopia's community-based health insurance scheme documented that enrolment after inception increase from 41% to 48% a year later. Of those who enrolled in the first year only 82% renewed their subscriptions (5).

As part of health care financing strategy in general and its health insurance strategy in particular, Even though the government of Ethiopia endorsed and launched CBHI pilot CBHI scheme in some selected woredas of different Region, still its uptake in Oromia Region, particularly in Sabata Hawas Woreda remain the main challenge. Socio-demographic, awareness and perception about CBHI as well as health related factors take a great share for low uptake of CBHI. Moreover, there was no study conducted in Oromia Region that documented the factor which affects uptake of community based health insurance scheme.

## **1.2 Statement of the problem**

Financial barriers are major bottlenecks of access and use of health services. The majority of the poor around the world have to rely on their own resources to finance medical expenditures, as many governments have failed to establish formal protection mechanism and social safety nets. Health related financial shocks are further exacerbated when the primary income earner in poor households are the ones that require the expensive health care treatments (6).

Low-income and middle-income countries (LMICs) have difficulties achieving universal financial protection, which is primordial for universal health coverage. A promising avenue to provide universal financial protection for the informal sector and the rural populace is community-based health insurance (3, 6 7).

Lack of health insurance promotes delay in seeking care and noncompliance with the treatment regime and results in an overall poor health outcome. World Health Organization recommended compulsory health insurance as the best form of health-care financing even though many factors affect clients' participation(8).

Evidence from Ghana Demographic and Health Surveillance data showed that, health insurance determines antenatal, delivery and postnatal care utilization. Among uninsured women, more than half of the women lived in poverty had two to four children and engaged in manual labor. Approximately one-third of the women had difficulty in reaching health care facility. Above all, insured women were more frequently engaged in skilled labour. Uninsured women more often indicated having difficulty in accessing the health facility(9).

There is increasing advocacy for community-based health insurance (CBHI) schemes as part of a broader solution to health care financing problems in low-income countries, but still there is very limited uptake of CBHI schemes (10).

In Ethiopia even though there is high burden of diseases, utilization of modern health care services is limited. One of the reasons for low utilization of healthcare services is the user-fee charges. Moving away from out-of-pocket charges for healthcare at the time of use is an important step towards averting the financial hardship associated with paying for health service. To avert the difficulties of out of pocket payments Ethiopia launched the CBHI scheme as solution, however, still the CBHI scheme is not accustomed well (8).

In Sabata Hawas Woreda, even though the CBHI scheme pilot lasts for more than two years ago, still its uptake has been remains stagnant and very limited which accounts according to administrative report of Sabata Woreda health office of July, 2016 around 44%. As to my knowledge, in Ethiopia two studies were conducted on subjects related to community based health insurance, which mainly focused on dropping out from the scheme and willingness to join the CBHI scheme. There was no study that documented on factors affecting uptake of community based health insurance in Ethiopia in general and in Oromia Regional State in particular. Hence, this study assessed factors affecting uptake of community based health insurance in Sebeta Hwas Woreda, Oromia Regional State, Ethiopia.

### **1.3 Rational and significance of the study**

Ethiopia is committed to achieve universal health coverage by expanding high quality health care services that are equitable and accessible to all. Because financial risk protection is a critical component of UHC, Ethiopia has begun establishing a comprehensive and sustainable risk protection system with health care financing mechanisms adapted to our country's needs so as to improving financial access to health care services; improving quality of health care service and increase resource mobilization in the health sector through community based health insurance. However the objective is there, the uptake of CBHI scheme is very low. Therefore, the subject should be studied and it provide information on factors affecting uptake of community based health insurance so as to design interventions to increase uptake and this study could also served as a base line for future similar studies.

## 2. Literature review

Uptake of community based health insurance in developing countries is generally low and it is also affected by various factors. A systematic review done in low and middle income countries on the acceptance of CBHI demonstrated that, low levels of income and lack of financial resources as major factors affecting enrolment. Poor healthcare quality (including stock-outs of drugs and medical supplies and long waiting times) were found to be associated with low CBHI coverage. Trust in management of CBHI scheme found to affect enrolment. Educational attainment (less educated were willing to pay less than highly educated), men were willing to pay more than women, younger were willing to pay more than older individuals and larger households were willing to pay more than households with fewer members also influenced CBHI enrolment (3).

Socio economic and health related factors play a significant role in uptake of CBHI. Study in Burkina Faso reported that since the launch of CBI the enrolment rate has been low ranging from 5.2% to 6.3%. The drop-out rate, however, has been high ranging from 30.9% to 45.7%. It was found that, female household heads, higher age or lower education of a household head, lower number of illness episodes in the past six months of during the study period, fewer children, poor perceived health care quality and less seeking care were increased the drop-out rate (11).

Number of illness episodes family experienced and the use of traditional medicine is also plays a paramount role in uptake of CBHI scheme. Evidences from systematic review conducted in low and middle income countries reported that, households with more sick members were willing to pay more, which supports the notion that families with high illness rates or more prone to being ill, had a greater tendency to participate or to be members of the health prepayment scheme. Alternatively, lower number of illness episodes in a specified period of time led to higher drop-out from the scheme as seen in India. The use of modern medicine is also an important factor for enrolling into CBHI since the scheme requires the regular use of modern means of treatment; hence those who use modern medicine have been found to be willing to pay more than those who use other means of treatment(3).

Regarding utilization of the availability of health service, those who insured is more likely utilized than others. Studies evidenced that, Compared with those who were not enrolled in the CBI, the overall increase in outpatient visits given illness in the insured group was about 40% higher (12).

The CBHI implementation status varies significantly depending on the level of support, political commitment, leadership and its legal background. Studieis in Nigeria on challenges to uptake and integration CBHI schemes revealed that ,poor support for CBHI, lack of clear legislative and regulatory frameworks as well as inadequate financial support were resulted in unrealistic enrolment, hence repeatedly linked with failure (13).

Occasionally, enrollment status in community-based insurance lead to poorer quality of care. This were evidenced by study carried out in Nouna health district, Burkina Faso , the declining quality of care due to the CBHI provider payment method was a source of significant professional stress and role strain for health workers. Health workers felt increased financial volatility of health facilities, dissatisfaction with eligible costs to be covered by capitation, increased pharmacy stock-outs, limited financial and material support from the CBHI and lack of mechanisms to increase provider motivation to support the CBHI. Above all, CBHI impeded their ability to fulfill professional roles and responsibilities (14).

As far as reality is there, CBI enrollees want to receive quality of care in contractually signed health institution but study showed that, even though CBI patient's perceived better quality of care, they objectively receiving worse quality of care, compared to patients who were not enrolled in CBI (15).

Being member of CBHI scheme does not always resulted in well utilization of the health services. Study done in Savannakhet Province, Laos on impact of Community Based Health Insurance in enhancing better accessibility and lowering the chance of having financial catastrophe due to health service utilization, the findings showed that, insured households are not significantly better off under community-based health insurance. However, compared to uninsured households, insured households do have better accessibility and a lower probability of reaching the financial catastrophe threshold(4).

The intervention cohort demonstrated substantially higher understanding of insurance concepts than the control group and CBHI understanding was a positive determinant for enrolment. Awareness-raising is an important prerequisite for voluntary uptake of CBHI schemes and that interactive, contextualized awareness tools are useful in enhancing insurance understanding (16)

Study done in Ethiopia on dropping out of community-based health insurance in the case of Ethiopia's pilot CBHI scheme reported that, more than two-thirds of the respondents (69%) have awareness about health insurance but low contract renewal rates have been identified as one of the challenges facing the development of community-based health insurance schemes (5).

Study done in Ethiopia on Willingness to join community-based health insurance among rural households of Debu Bench District revealed that, educational status, wealth index and annual incomes had also statistically significant associations with the households' decision in willingness to join community based health insurance scheme. Respondents who had no education were about three times more likely to join the scheme than those who completed grade 1–8. Households who were in the highest wealth quintile were more than 4 times more likely to join the scheme than those who were in the second wealth quintile. (8).

The Study also illustrated that, age had negative associations with the probability of WTJ the CBHI scheme. The younger were 6% more likely to join the scheme than the older. In comparison with heads of the households; spouses were 59% less likely to join the scheme. In comparison to married, the single were 87.7% less likely to join the scheme. Occupationally, housewives were more likely to join the scheme than farmers. Size of the family was positively associated with WTJ decisions of the households. As the number of the household members increase, the probability of WTJ increased by 69% (8). Above all, the above all findings strongly implied that, further investigation of factors that affecting uptake of CBHI is much needed at different settings of CBHI scheme implementation area as one study findings doesn't fit for all.

### **3. Objectives**

#### **3.1 General objective**

To assess factors affecting the up-take of community based health insurance scheme among Sebeta Hawas Woreda community residents.

#### **3.2 Specific objectives**

- 1) To assess socio-demographic factors that affect uptake of community based health insurance
- 2) To assess individual factors such as awareness and perception of the community in line with uptake of CBHI scheme
- 3) To assess health related factors that affect uptake of community based health insurance

## 4. Methods

### 4.1. Study design

Quantitative cross-sectional study design was employed using interviewer administered questioners and supplemented by qualitative focus group discussions (FGDs).

### 4.2 Study area

The study was conducted in Oromia Regional State, Oromia Special Zone surrounding Finfine, Sabata Hawas Woreda. Sabata Hawas woreda is located 25 kilo meter far from Addis Abeba city towards the West. The woreda is bounded by walmera woreda in North, Tole woreda in the West, Kersa kondality woreda in South and Addis Abeba City Government in the East. The woreda has been one of the pilot CBHI implementation area's begging from 2014. The Woreda has a total population of about 113,552 and a total of 23,657 households according to data received from woreda Health Office in July, 2016. The woreda has a total of 38 kebeles, among those, 36 are rural and 2 are urban. Regarding health facility, the woreda has six health centers, thirty six health posts and twelve different private health institutions.

### 4.3. Source population

The source population for the study was all households found in Sabata Hawas Woreda.

### 4.4. Study population

The study population was all households found in randomly selected kebele of Sabata Hawas woreda.

### 4.5. Inclusion and exclusion criteria

**Inclusion:** All head of house hold/spouse/Defacto heads that were capable of being interviewed.

**Exclusion criteria:** Head of households/spouse/ Defacto heads that have been mentally not capable were not interviewed.

## 4.6. Sample size determination

### 4.6.1. Sample size for quantitative study

The sample size was determined using single proportion formula, with the assumptions of 5% margin of error and 95% CI;  $Z_{\alpha/2}$  = Critical value =1.96, 10% non response rate and design effect 1.5.

Where, **n= required sample size.**

✚ The proportion of demand for community based health insurance: 51.5% (8).

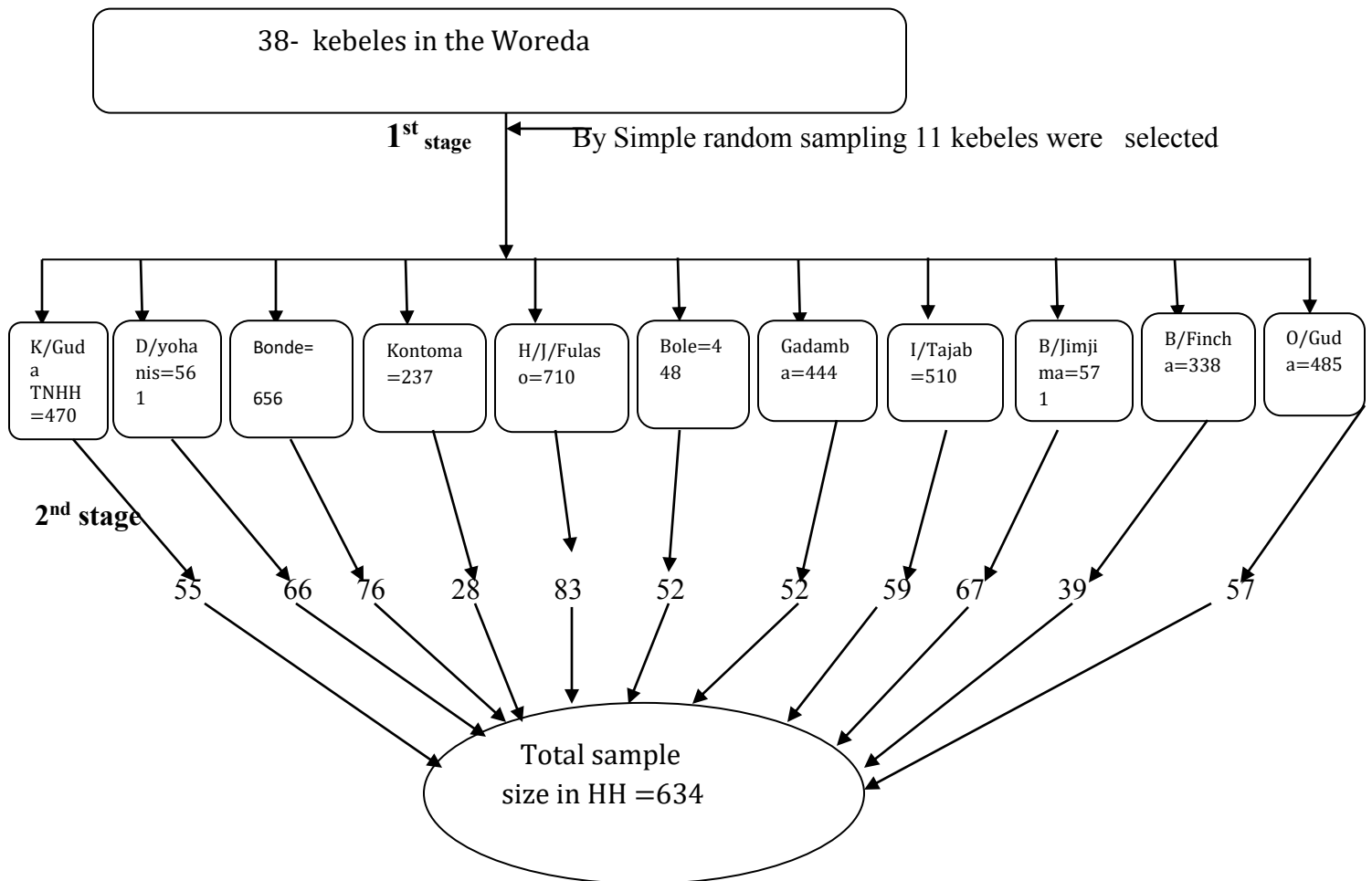
$$n = (Z_{\alpha/2})^2 p (1-p) = (1.96)^2 \times 0.515(0.485) = 3.8416 * 0.25 = 384.1 \approx 384$$

$$d^2 \quad (0.05)^2 \quad 0.0025$$

$$n=384 \times 1.5 \text{ (design effect)} = 576 + (576 * 10\%) \text{ non-response rate} = 634$$

Therefore, final sample size for this study was considered **634**.

**Figure1: Sampling Frame**



#### 4.6.2. Sample size for qualitative study

This was guide to fill the gaps which were inadequately addressed by the quantitative study. A Focus group discussion with husband/spouse/de facto head with three conveniently selected groups with eight participants in each group and a total of 24 participants to get detailed information were involved.

#### 4.7. Sampling Procedures

##### **For quantitative data**

The study was conducted in Sabata Hawas Woreda. To get study subjects, the respondents were selected using a two –stage sampling design. Formerly out of a total of thirty eight kebeles of the woreda’s eleven kebeles were selected randomly by simple random sampling. Then, the number of households that were included in to the study determined proportionally in accordance with the total number of households in the sampling frame of the selected kebeles. The sampling frame (list of all households) was obtained from family folder (community health information system) at health posts. Finally, the respondents were selected by simple random sampling from the framed list.

##### **For qualitative data**

Three groups, each group having eight participants were selected purposively from head of households/spouse/de facto head that were forwarded necessary information in relation to the objective of the study. Three focus group discussions were conducted on participants by excluded those who were participated in the quantitative part of the study in assumed that to increase the sources of information so as to explore and generate more and more idea qualitatively, hence strengthened quantitative data.

#### 4.8. Variables

##### 4.8.1 Dependent variables:

- Uptake of community based health insurance

#### **4.8.2 Independent variables:**

- Socio –economic and demographic variables such as:  
Age, sex, marital status, ethnicity, religion, educational status, family annual income, house hold size, location (distance from health institution)
- Health related factors variable such as: Quality of care such as waiting time and availability of drug, satisfaction with service given, household illness experience and health status
- Individual factors variable such as Perception and awareness

### **4.9. Data collection procedure**

#### **4.9.1. Quantitative data collection methods**

A Standardized and structured questionnaire was developed based on previously available information. The questionnaire was prepared initially in English and then translated into local language (Afan Oromo) for interview.

The questionnaire was gathered data on the following areas: 1) Socio-demographic characteristics, 2) Awareness about CBHI, 3) Perceptions about CBHI and 4) Health related factors using structured, pre-tested, interviewer administered questionnaire prepared in Oromifa. Eleven trained data collectors and three supervisors were participated in the data collection. Data collectors were closely monitored by supervisors and principal investigator.

The qualitative data was collected by using focus group discussion guided with probing questions prepared in Oromifa language, moderated by principal investigator with the help of an assistant. The members of each FGD were selected purposively by the Principal Investigator.

Three focus group discussions (FGDs) which consisted of eight individuals in each group was conducted using open-ended questionnaires in order to provide more information about factors affecting uptake of CBHI scheme in the study area. Focus group discussion was held in suitable a place for discussion, tape recording was used and notes were taken.

#### 4.10. Operational definitions

- **Insurance:** is a contract that protects the insured from out of pocket payment
- **Health insurance:** is insurance against the risk of incurring medical expenses among individuals and families.
- **Community based health insurance:** is an insurance scheme arranged for informal sector, managed and operated by governmental structure that provides risk pooling to cover all or part of the costs of health care services.
- **Uptake of community based health insurance:** is acceptance and use of community based health insurance scheme.
- **Factor affects:** is influences or have an effect on and make differences.
- **Awareness a-** having information.
- **Perception** - the way of understanding/interpreting/.
- **Income  $\geq$  or  $<$  40,000 birr/households/year-**the income household/family earned in a year as a result of crops production and rearing of animals that is calculated in assuming each household has five average family size.

#### 4.11. Data management

**Quantitative data management-**to manage quantitative data properly, the collected data was reviewed and checked for completeness and relevance by the supervisors and principal investigator each day, the questionnaire was coded and then the data was entered into EPI info version-3.5.3 by the principal investigators. Data analysis and cleaning were done with SPSS version16.0.

**Qualitative data management-** the qualitative data was organized, transcribed and translated into English, and then manipulated manually by grouping the ideas into similar thematic sets.

#### 4.12 Data Analysis

**Analysis of quantitative data:** data was coded and entered into computer using EPI-info version 3.5.3 software and cleaned as well as edited before analyzed using SPSS version 16 computer

soft ware packages. Analysis of different variables frequency, percentages and tables were used to summarize the data accordingly. Presence and strength of associations were measured using crude and adjusted odds ratio, 95% confidence interval were used to measure statistical significance. Binary regression was done to control the effect of each explanatory variable on the outcome variables.

**Analysis of qualitative data:** Qualitative data was transcribed, analyzed manually using the thematic area analysis approach.

#### **4.13 Data quality management**

Pre-test was conducted on 33 respondents in non selected adjacent kebeles of the study area's before data collection. Appropriateness of the questionnaire on content, consistency, language and organization, were checked thoroughly and modified in line with standards, guidance and comments from colleagues and advisor. To assure data quality, relevancy of questionnaire to the objective of the study was looked carefully. Data collectors and supervisors were trained for two days on data collection process, accuracy and completeness. During data collection, supervisor were reviewed every questionnaire for completeness and logical consistency, which were counter checked by the principal investigator. When data collection was conducted supervision was undertaken on daily bases by supervisors and the principal investigator and each questionnaire was checked by supervisors during data collection and most of the questionnaires were checked by the principal investigator on same day of data collection, and at the time mistakes were observed, soon it was returned to data collectors for correction.

#### **4.14. Ethical considerations**

Before Commencement of the actual data collection, ethical clearance was obtained from Addis Ababa University, School of Public Health Ethical Review committee.

Formal letter was written to Oromia Regional Health Bureau from Addis Ababa University, School of public health. Again from Oromia Health Bureau letter was written to Oromia Special Zone Surrounding Finfine Health office, from Oromia Special Zone Surrounding Finfine Health office to Sabata Hawas Woreda Health Office. A written permission was obtained from the respective offices and a letter of support was written to all respective kebeles.

The information sheet and consent were provided for respondents to read for those who can read, whereas the interviewers were read the paper for those respondents who couldn't read. Before each interview, the aim of the study, possible benefit and side effects (if any) were clearly explained for study participants. Each respondent was assured that the information provided was confidential and used only for the purpose of research.

The information obtained from the respondents was identified by their code numbers. The study was conducted entirely on voluntary base. Informed consent was obtained from all study subjects after the explanation of the purpose of the study.

The study was not having any risk and no direct benefit to the participants for their participation. Respondents were have full right to withdraw themselves from the study any time or refused to respond to some of the questionnaires.

#### **4.15. Dissemination of study results**

The thesis will be presented to the School of Public Health as partial fulfillments of the requirements for the Masters Degree in Public Health. The finding obtained from this project will be submit for peer reviewed journals for publication after approved by approval committee and the abstract will be disseminated to the study area, sabata Hawas woreda Health Office for intervention purpose.

## 5. Results

### 5.1 Socio- demographic characteristics of respondents

Out of 634 respondents identified for the study, 630(99.3%) were responded to the interview. Four household's heads refused to participate in the study.

As shown in table1, from total study participants, 503 (79.8%) were males. The dominant ethnic group was Oromo, constituting 562 (89.9%) of the total. Two hundred seventy four (43.5%) of the respondents were illiterate and one hundred six (16.8) the study participants were not attend formal education but because of adult education they can read and write. The dominant religion was orthodox, 607(96.3%) and followed by Wakefata, 12 (1.9%) religion followers.

Regarding the age of the respondents, about 461 (73.2%) of them were from 15-49 years and the rest of them were 50 years and above. In line with marital status of study subjects, 552 (87.6%) married, 12 (1.9%) single, 35 (5.6%) widowed, 31 (4.9%) divorced. Concerning family size, three hundred twenty eight (52.1%) of respondents have five and less than five family members and the rest 302(47.9%) have above five family size.

With regard to annual income of study participants, 287(45 %) households earned less than 40,000 birr/year and 343(54.4%) earned 40,000 birr and above per year per households. Pertaining to accessibility of health facility, about 348 (55%) of the study participants traveled less than 5km to get health care services when required.

**Table 1: Socio- demographic characteristics of respondents, Sabata Hawas Woreda, 2016**

<b>Variables</b>	<b>Frequency</b>	<b>Percent (%)</b>
<b>Respondents (630)</b>		
HH head	495	78.6
Spouse	124	19.7
Defacto head	11	1.7
<b>Sex (630)</b>		
Male	503	79.8
Female	127	20.2
<b>Age (630)</b>		
15-49 year	461	73.2
≥ 50 year	169	26.8
<b>Religion (630)</b>		
Orthodox	607	96.3
Wakefata	12	1.9
Others	11	1.8
<b>Ethnicity (630)</b>		
Oromo	562	89.2
Amhara	34	5.4
Guragie	34	5.4
<b>Educational status (630)</b>		
Can't read and write	274	43.5
Can read and write	106	16.8
Grade 1-4	105	16.7
Grade 5-8	102	16.2
Grade 9-10	29	4.6
Grade 11-12	10	1.6
Diploma and above	4	0.6

**Table 1: continued .....**

<b>Marital status (630)</b>		
Married	552	87.6
Widower/Widowed	35	5.6
Divorced	31	4.9
Single	12	1.9
<b>House hold size (630)</b>		
<u>≤</u> 5	328	52.1
>5	302	47.9
<b>Annual income (630)</b>		
≥ 40,000 birr/year	343	54.4
<40,000 birr/year	287	45.6
<b>Distance from health facility (630)</b>		
<u>≤</u> 5km	348	55.2
>5km	282	44.8

## **5.2 Awareness of respondents about community based health insurance**

As shown in table 2, among 630 study participants, five hundred fifty five (88.1%) of respondents heard about CBHI scheme and they were thus classified as aware group. Among the aware group, two hundred ninety three (52.8%) of respondents informed by CBHI officials in public meeting, one hundred thirty three (23.9%) households by health professionals in health facility, sixty eight (12.3%) of study participants through CBHI house to house awareness creation campaign, forty nine (8.8%) respondents by their neighbors/friends, twelve (2.2%) study subjects through mass media.

**Table 2: Respondents awareness about community based health insurance, Sabata Hawas Woreda, 2016**

Variables	Frequency	Percent (%)
<b>Information about CBHI (630)</b>		
Yes	555	88.1
No	75	11.9
<b>Sources of information (555)</b>		
CBHI officials in public meeting	293	52.8
Health professionals in health facility	133	23.9
CBHI house to house awareness creation campaign	68	12.3
Neighbors/friends	49	8.8
Mass media such as ETV/radio	12	2.2

### **5.3 Perception of respondents towards community based health insurance scheme**

Pertaining to perception of respondents towards community based health insurance scheme as shown in table 3, five hundred nine(80.8 %) of respondents knew as not only fall sick should consider enrollment in CBHI scheme. Four hundred eighty nine (77.6 %) of the study participants responded as not only very poor that join CBHI scheme. Only about four hundred twenty one (66.8%) of study participants correctly identified the exact goal of payment of premium as to finance future health care needs. Only one hundred ten (17.5%) of respondents perceived that CBHI is not like saving scheme, that will receive interest and get money back. Four hundred forty two (70.2 %) of the study subjects thought that unless we make claim, CBHI premium will not be returned. About one hundred sixty eight (26.7%) of the study participants thought CBHI benefit package did not meet the requirements of their family and it was also noticed that only 331(52.5%) of respondents were trusted in their local CBHI management system.

**Table 3: Perception response of study participants towards features of community based health insurance, Sabata Hawas Woreda, 2016**

Characteristics	Frequency(630)	Percent (%)
<b>Only fall sick should consider enrollment in CBHI (630)</b>		
Agree	45	7.1
Disagree	509	80.8
Do not know	76	12.1
<b>Only very poor that join CBHI scheme (630)</b>		
Agree	70	11.1
Disagree	489	77.6
Do not know	71	11.3
<b>Payment of premium is to finance future health care needs (630)</b>		
Agree	421	66.8
Disagree	137	21.7
Do not know	72	11.5
<b>CBHI is like saving scheme, you will receive interest and get Your money back (630)</b>		
Agree	76	12.1
Disagree	110	17.5
Do not know	444	70.5
<b>If you don't make claims through CBHI your premium Will be returned (630)</b>		
Agree	79	12.5
Disagree	442	70.2
Do not know	109	17.3
<b>CBHI benefit package meet the need of your HH(630)</b>		
Yes	462	73.3
No	168	26.7

Table 3: **Continued** ....

**CBHI management is trust worthy(630)**

Agree	331	52.5
Disagree	92	14.6
Don't know	207	32.9

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### **5.4. Health related factors affecting uptake of community based health insurance**

Concerning health status, 66 (10.5. % of the respondents evaluated their family's health status as acceptable, 260(41.3% study participants as good and 255(40.5%) respondents as very good. Two hundred seventy-two (43.2%) family members have a history of illness episode within the last six months. Pertaining to uptake of community based health insurance, only two hundred seventy-two (43.2%) of households were insured (being members of community based health insurance and three hundred fifty-eight (56.8%) of households were not insured. As reported from the respondents who were being members of CBHI and experienced illness during the last six month, two hundred five(75.4%) of family members did not visit the contracted health facility to get health care service during the study period. Regarding major reason for not visiting the contracted health facility, sixty one (29.8%) the study participants replied that, they feel as wouldn't get quality care and 144(70.2%) them were due to others reason such as lack of CBHI membership ID card, facility distance and lack of money for transportation

Among those who were fallen ill during the last six months that visited contracted health facility to deliver health service, twenty seven (40.3%) of the respondents were not as such satisfied. Concerning weighting time to get the service, 26(38.8%) were replied that as if it took them from 30 to 60 minutes and 20(29.9%) of study participants from 1 to 3 hours. In line with availability of drug in the health facilities 15(22.4%) were responded as the drugs were rarely available and 8(11.9%) responded as drugs were not available.

Two hundred twenty nine (84.2%) of the respondents did not use CBHI membership to cover health costs. Major reasons for not benefitting from being members of the community based health insurance scheme, one hundred twenty-two (53.3%) of the study participants reported due to no one in our HH has visited health facility 18(7.9%) replied still they were paid other additional costs for treatment, 44(19.2%) of respondents responded, the quality of service for CBHI members were not as good as for out of pocket paying patients, 45(19.6%) of study participants responded due to delays in issuance and distribution of CBHI ID card.

From the total members of community based health insurance (insured households), 90(33%) of the members were not have interests to renew CBHI membership for the next fiscal year. Among the concrete reason they planed not to renew the current CBHI membership, 50(55.5%) of respondents reported, the quality of service for CBHI members were not as good as for out of pocket paying patients, 21(23.4%) study participants replied, there were limited availability and poor quality of health services, 17(18.9%) respondents responded, illness and injury does not occur frequently in our households.

**Table 4: Health related factors affecting uptake of community based health insurance, Sabata Hawas woreda, 2016**

Health related factors	Frequency	Percent (%)
<b>Respondents evaluation of their families health status(630)</b>		
Very good	255	40.5
Good	260	41.3
Acceptable	66	10.5
Poor	46	7.3
Very poor	3	0.5
<b>Fallen ill in the last six months(630)</b>		
Yes	272	43.2
No	358	56.8
<b>Currently member of CBHI(630)</b>		
Yes	272	43.2
No	358	56.8
<b>Visited the contracted health facility for the illness felt in the last six month(272)</b>		
Yes	67	24.6
No	205	75.4
<b>Satisfaction with the service given(67)</b>		
Very satisfied	12	17.9
Satisfied	28	41.8
Indifferent	21	31.3
Dissatisfied	3	4.5
Very dissatisfied	3	4.5

**Table 4 continued....****Waiting time to get the services(67)**

Less than 30 minutes	16	23.9
30 to 60 minutes	26	38.8
1 to 3 hours	20	29.9
3 to 6 hours	3	4.5
More than a day	2	2.9

**Availability of drug in the health facility(67)**

Always available	14	20.9
Usually available	30	44.8
Rarely available	15	22.4
Not available	8	11.9

**Major reason why didn't visit the health facility(205)**

Did not feel that I would get quality care	61	29.8
Others /lack of money for transportation/ lack of ID card	144	70.2

**Uses of CBHI membership to cover health costs (272)**

Yes	43	15.8
No	229	84.2

**Why CBHI members not benefitted from scheme(229)**

No one in my HH has visited health facility	122	53.3
We still pay other additional costs for treatment	18	7.9
The quality of service for CBHI members is not as good as for out of pocket paying patients	44	19.2
Delays in issuance and distribution of CBHI ID card	45	19.6

**Table 4: contd.....**

**Renewal of CBHI membership for the following year(272)**

Yes	182	67
No	90	33

**Reason plan not to renew the current CBHI membership(90)**

Illness and injury does not occur frequently in our HH	17	18.9
The registration fee and premiums are not affordable	2	2.2
There is limited availability and poor quality of health services	21	23.4
The quality of service for CBHI members is not as good as for out of pocket paying patients	50	55.5

## 5.5 Bivariate analysis

Educational status, annual income, family size, awareness about CBHI scheme, perception towards various features of community based health insurance and illness experiences show statistically significant difference ( $p < 0.05$ ) in line with uptake of community based health insurance. Uptake of CBHI among illiterate respondents were less likely than educated from grade 1-4,  $COR = 0.578$ ; 95%CI (0.365, 0.913). Uptake of CBHI among study subjects whose their family size  $\leq 5$  were less likely than those who have  $> 5$  family size,  $COR = 0.436$ ; 95%CI (0.316, 0.602). Uptake of CBHI among households whose their annual income  $< 40,000$  birr were less likely than those whose their income  $\geq 40,000$  birr,  $COR = 0.477$ ; 95%CI (0.345, 0.659).

Uptake of CBHI among respondents who have no awareness about CBHI were less likely than who have awareness,  $COR = 0.044$ ; 95%CI (0.014, 0.142). Uptake of CBHI among house hold heads who thought that, only fall sick should considered and join CBHI scheme were less likely than who thought not only fall sick,  $COR = 0.510$ ; 95%CI (0.268, 0.971). Uptake of CBHI among respondents who thought that, only very poor that join CBHI scheme were less likely than who thought not only poor,  $COR = 0.430$ ; 95 % CI (0.251, 0.739). Uptake of CBHI among respondents who understand payment of premium is to finance future health care needs were two times more likely than who were not,  $COR = 2.116$ ; 95% CI (1.417, 3.161).

Uptake of CBHI among respondents who didn't know whether CBHI is like saving scheme will receive interest and get money back were less likely than who knew as if interests and paid money couldn't get back in cash,  $COR = 0.115$ ; 95% CI (0.061, 0.215). Uptake of CBHI among study participants, who perceived paid premium returned unless claimed through CBHI were less likely than who were not perceived,  $COR = 0.465$ ; 95 % CI (0.280, 0.770). Uptake of CBHI scheme among house hold heads who thought that CBHI benefit package does not meet the needs of their HHs were less likely than those who thought the benefit package meet their needs,  $COR = 0.273$ ; 95% CI (0.181, 0.410). Uptake of CBHI among respondents who trust their local CBHI management were more likely than those who didn't know whether trustful or not,  $COR = 2.797$ ; 95% CI (1.940, 4.032) and Uptake of CBHI among study participants who were not experienced illness less likely than who were experienced illness in the last six months during the study period,  $COR = 0.699$ ; 95% CI (0.509, 0.962).

**Table 5: Bivariate analysis of uptake of community based health insurance among Sabata Hawas Woreda's community, 2016**

Variables	Uptake of CBHI		Crude OR (95%CI)
	Yes	No	
<b>Sex</b>			
Male	223(44.3%)	280(55.7%)	1.00
Female	49(38.6%)	78(61.4%)	0.789(0.530,1.175)
<b>Age</b>			
15-49 years	197(42.7%)	264(57.3%)	0.935(0.656,1.334)
≥50 years	75(44.4%)	94(55.6%)	1.00
<b>Educational status</b>			
Can't read and write	92(33.6 %)	182(66.4%)	<b>0.578(0.365, 0.913)**</b>
Can read and write	51(48.1%)	55 (51.9%)	1.060(0.617, 1.819)
Grade one to four	49((46.7%)	56(53.3%)	<b>1.00</b>
Grade five to eight	58(56.9%)	44(43.1%)	1.506(0.871, 2.606)
Grade nine to ten	17 (58.6%)	12(41.4%)	1.619(0.704, 3.722)
Grade eleven to twelve	4(40%)	6(60%)	0.762(0.203, 2.858)
Diploma and above	1 (25%)	3(75%)	0.381(0.038, 3.782)
<b>Marital status</b>			
Single	3 (25%)	9(75%)	0.833( 0.186, 3.729)
Married	251 (45.5%)	301(54.5%)	2.085(0.983, 4.423)
Divorced	8(25.8%)	23(74.2%)	0.870(0.293, 2.583)
Widower	10 ((28.6%)	25(71.4%)	1.00

**Table 5: continued ....****House hold(Family) size**

≤5	110(33.5%)	218 (65.5)	0.436(0.316, 0.602) ***
>5	162(53.6%)	140(46.4%)	1.00

**Annual income**

<40,000 birr/year	96(33.4%)	191(66.6%)	0.477(0.345,0 .659)***
≥ 40,000 birr/year	176 (51.3%)	167((48.7%)	1.00

**Distance from health facility**

≤ 5km	141(40.5%)	207(59.5%)	1.00
> 5km	131(46.5%)	151(53.5%)	1.273(0.572,1.378)

**Awareness about CBHI**

Yes	269((48.5)	286(51.5%)	1.00
No	3(4%)	72(96%)	0.044 (0 .014, 0.142)***

**Only fall sick should consider enrollment in CBHI**

Agree	15(33.3%)	30(66.7%)	0.510 (0.268, 0.971)***
Disagree	252(49.5%)	257(50.5%)	1.00
Do not know	5(6.6%)	71(93.4%)	0 .072(0.029, 0.181)***

**Only very poor that join CBHI scheme**

Agree	21(30%)	49((70%)	0.430(0.251, 0.739) ***
Disagree	244(49.9%)	245(50.1%)	1.00
Do not know	7(9.9%)	64(90.1%)	0.110(0.049 , 0.244)***

**Table 5: continued ....****Payment of premium is to finance future health care needs**

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Agree	221(52.5%)	200(47.5%)	<b>2.116(1.417, 3.161) ***</b>
Disagree	47 (34.3%)	90(65.7%)	1.00
Do not know	4((5.6%)	68(94.4%)	<b>0 .113(0.039, 0.328)***</b>

**CBHI is like saving scheme, you will receive**

**interest and get Your money back**

Agree	31 (40.8%)	45(59.2%)	0.647(0.395, 1.060)
Disagree	229(51.6%)	215(48.4%)	1.00
Do not know	12 (10.9%)	98(89.1%)	<b>0.115(0.061, 0.215)***</b>

**If you don't make claims through CBHI your premium**

**Will be returned**

Agree	26(32.9%)	53(67.1%)	<b>0.465(0.280, 0.770) ***</b>
Disagree	227((51.4%)	215(48.6%)	1.00
Do not know	19(17.4%)	90(82.6%)	<b>0.200(0.118, 0.339) ***</b>

**CBHI benefit package meet the requirements**

**of your HH**

Yes	235(50.9%)	227(49.1%)	1.00
No	37(22%)	131(78%)	<b>0 .273(0.181, 0.410)***</b>

**CBHI management is trust worthy**

Agree	184(55.6%)	147(44.4%)	<b>2.797(1.940, 4.032)***</b>
Disagree	24(26.1%)	68(73.9%)	0 .789(0.455 , 1.368)
Do not know	64(30.9%)	143(69.1%)	1.00

**Table 5: continued...**

**Illness experience's in the last six month**

Yes	131(48.2%)	141(51.8%)	1.00
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No	141(39.4%)	217(60.6%)	<b>0.699(0.509, 0.962)*</b>
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**P-value < 0.05 = \* p-value < 0.01 = \*\* p-value < 0.001 = \*\*\***

### 5.6. Multivariate analysis

Households family size, annual income, awareness about CBHI, perception towards some features of CBHI scheme and illness experiences show statistically significant difference ( $p < 0.05$ ) in factor influencing uptake of community based health insurance. Uptake of CBHI scheme among households whose their annual income <40,000 birr/year were less likely than those whose their income  $\geq 40,000$  birr/year, AOR= 0.562; 95% CI (0.371, 0.850). Uptake of CBHI among respondents whose their family size  $\leq 5$  were less likely than those who have >5 family size, AOR =0.404; 95% CI (0.271, 0.603). Uptake of CBHI among study participants who have no awareness about CBHI, less likely than who have awareness, AOR =0.148; 95% CI (0.039, 0.565). Uptake of CBHI among respondents who thought payment of premium is to finance future health care needs were more likely than who were not, AOR=2.046 ;95% CI (1.256, 3.334). Uptake of CBHI among respondents who didn't know whether CBHI is like saving scheme will receive interest and get money back less likely than who were knew as if interests and paid money could not get back in cash, AOR=0.374 ;95% CI(0.171, 0.816). Uptake of CBHI among households heads who trust their local CBHI management were more likely than those who didn't know whether trustful or not, AOR= 2.006(1.301, 3.091) and Uptake of CBHI among study participants who were not experienced illness in the last six months during the study period were less likely than who experienced illness, AOR=0.606; 95 % CI (0.406, 0.904).

**Table 6: Multivariate analysis of uptake of community based health insurance by selected variables among Sabata Hawas Woreda's community,2016**

Variables	Uptake of CBHI		(95%CI)	
	Yes	No	Crude OR	Adjusted OR
<b>Educational status</b>				
Can't read and write	92(33.6 %)	182(66.4%)	<b>0.578(0.365, 0.913)**</b>	1.073 (0.623, 1.848)
Can read and write	51(48.1%)	55 (51.9%)	1.060(0.617, 1.819)	1.177 (0.625, 2.218)
Grade one to four	49((46.7%)	56(53.3%)	<b>1.00</b>	1.00
Grade five to eight	58(56.9%)	44(43.1%)	1.506(0.871, 2.606)	2.741 (0.964, 3.523)
Grade nine to ten	17 (58.6%)	12(41.4%)	1.619(0.704, 3.722)	3.192 (1.096, 9.294)
Grade eleven to twelve	4(40%)	6(60%)	0.762(0.203, 2.858)	0.753 (0.172, 2.297)
Diploma and above	1 (25%)	3(75%)	0.381(0.038, 3.782)	0.479 (0. .042, 5.432)
<b>House hold(Family) size</b>				
≤5	110(33.5%)	218 (65.5)	0.436(0.316, 0.602) ***	<b>0.404(0.271, 0.603 )***</b>
>5	162(53.6%)	140(46.4%)	1.00	1.00
<b>Annual income</b>				
<40,000 birr/year	96(33.4%)	191(66.6%)	0.477(0.345,0 .659)***	<b>0.562(0.371, 0.850)*</b>
≥ 40,000 birr/year	176 (51.3%)	167((48.7%)	1.00	1.00
<b>Awareness about CBHI</b>				
Yes	269((48.5)	286(51.5%)	1.00	1.00
No	3(4%)	72(96%)	0.044 (0 .014, 0.142)***	<b>0.148(0.039, 0.565)*</b>

**Table 6: continued.....****Only fall sick should consider enrollment in CBHI**

Agree	15(33.3%)	30(66.7%)	0.510 (0.268, 0.971)***	0.840 (0.372 ,1.901)
Disagree	252(49.5%)	257(50.5%)	1.00	1.00
Do not know	5(6.6%)	71(93.4%)	0.072(0.029, 0.181)***	0.282(0.090, 0.888)

**Only very poor that join CBHI scheme**

Agree	21(30%)	49((70%)	0.430(0.251, 0.739) ***	0.853(0.409, 1.778)
Disagree	244(49.9%)	245(50.1%)	1.00	1.00
Do not know	7(9.9%)	64(90.1%)	0.110(0.049 , 0.244)***	0.515(0.180, 1.471)

**Payment of premium is to finance future health care needs**

Agree	221(52.5%)	200(47.5%)	2.116(1.417, 3.161) ***	2.046(1.256, 3.334)*
Disagree	47 (34.3%)	90(65.7%)	1.00	1.00
Do not know	4((5.6%)	68(94.4%)	0.113(0.039, 0.328)***	0.947(0.252, 3.562)

**CBHI is like saving scheme, you will receive****interest and get Your money back**

Agree	31 (40.8%)	45(59.2%)	0.647(0.395, 1.060)	0.940(0.513, 1.721)
Disagree	229(51.6%)	215(48.4%)	1.00	1.00
Do not know	12 (10.9%)	98(89.1%)	0.115(0.061, 0.215)***	0.374(0.171, 0.816)*

**If you don't make claims through CBHI your premium****Will be returned**

Agree	26(32.9%)	53(67.1%)	0.465(0.280, 0.770 )***	0.528(0.290, 0.960)
Disagree	227((51.4%)	215(48.6%)	1.00	1.00
Do not know	19(17.4%)	90(82.6%)	0.200(0.118, 0.339) ***	0.562(0.274, 1.55)

Table 6: continued.....

**CBHI benefit package meet the requirements of your HH**

Yes	235(50.9%)	227(49.1%)	1.00	1.00
No	37(22%)	131(78%)	<b>0 .273(0.181, 0.410)***</b>	0.597(0.354, 1.006)

**CBHI management is trust worthy**

Agree	184(55.6%)	147(44.4%)	<b>2.797(1.940, 4.032)***</b>	<b>2.006(1.301, 3.091) *</b>
Disagree	24(26.1%)	68(73.9%)	0 .789(0.455 , 1.368)	1.88(0.544,2 .173)
Do not know	64(30.9%)	143(69.1%)	1.00	1.00

**Fallen ill in the last six month**

Yes	131(48.2%)	141(51.8%)	1.00	1.00
No	141(39.4%)	217(60.6%)	<b>0.699(0.509, 0.962)*</b>	<b>0. 606(0.406, 0.904)***</b>

Adjusted for family size, annual income, awareness about CBHI, perception towards Payment of premium is to finance future health care needs, CBHI is like saving scheme receive interest and get money back, and local CBHI management is trust worthy and illness experience.

**P-value < 0.05 = \* p-value < 0.01 = \*\* p-value < 0.001 = \*\*\***

## 5.7 Focus group discussion results

The qualitative study reiterated some crucial factors already highlighted in the quantitative study and also pointed out some variables not measureable using quantitative methods. This discussion was guided by open

ended questioner and a total of three focus group discussions with 24 discussants were made among purposively selected house hold heads both from members and non-members of community based health insurance scheme. In this study the discussion was targeted on awareness on CBHI scheme, perception towards community based health insurance, socio- economic and on health related factors affecting uptake of community based health insurance.

### **5.7.1 Awareness about Community based health insurance**

Most people reported that the main aim of health insurance is to help members to meet costs of treatment when they fell ill, and that this was important because of the uncertainty associated with illnesses and the high costs of treatment. The role of health insurance was described in various ways: being covered for healthcare when ill; saving money for illness; and protecting oneself from unexpected events.

The findings of the FGDs clearly indicate that all participants of the target groups have awareness about community based health insurance. Almost all participants of the target groups had basic information about community based health insurance and they well explained that as CBHI pool risks and protect households from out-of-pocket expenditures by paying 240 Eth birr once per year to get services from the contracted health facility while among family members faced illness. All groups were clearly stated that for those who could not afford the premium, the government plays a significant role in financing the poor and insured them based on the fee waivers selection criteria.

### **5.7.2 Perception towards features of community based health insurance scheme**

One of the group members said that, “in community based health insurance scheme, setting money aside for health care couldn’t attract disease and would rather considered like “Idir”, paying premium of CBHI with very minimum payment once per year, one day when we faced health problem, we could receive an important health care services from the contractual health facility regardless of the cost incurred” (a 40- Years old male, members of CBHI scheme).

All discussants agreed that, setting money aside/budgeting/ for health care through CBHI scheme, help their core families and themselves to go to health facility soon and able them promptly to seek health care service for faced illness rather than attracting disease.

One of the group’s member reported that, “there were differences from time to time towards payment of registration fee and premium to be insured but still many efforts needed from us to bring attitudinal change on non- insured’s family members as they are huge in numbers ( a 37- years old male, members of CBHI scheme)”.

### **5.7.3 Socio- economic as well as health related factors that affects uptake of community based health insurance**

Some of the group members stated, those households heads, who have CBHI ID card, they were getting facility based health care service while their family members encountered health problem but in the similar way some households head and their family members who were paid registration fee and premium did not getting health care service because of lack of CBHI ID cards due to delays in issuance and distribution of it from woreda health office. As a result some people regretting for being paying the registration fee and premium. Above all, peoples have been blaming the Woreda health sector for making the community based health insurance system futile exercise.

As stated by majority discussants, affordability was a key factor affecting uptake of community based health insurance. Some non-insured individuals identified a lack of financial means as the primary reason for not enrolling. One of the challenges was the of CBHI contributions. Because a flat enrolment fee was charged, both the poor and the rich contribute the same amount in premium. From this premise, it was conceivable to find that the poor were unwilling to join the schemes.

Among the commonly agreed reason(factors) by majority of group members, why majority of the households heads were not being members of the community based health insurance, almost all group members were said that, those non -insured households family members didn't know enough about CBHI scheme, those households head, who were being member of community based health insurance were not utilizing the health services due to lack of CBHI card, households who obtained CBHI card were not getting health service as needed due to unavailability of drug, un functionality of laboratory service in health center and during referral patients were not handled carefully in Hospital settings.

#### **Suggested solution to increase uptake of community based health insurance**

As stated by all group members, the best solution to increase uptake of Community based health insurance, for those households' heads that paid premium, CBHI membership ID cards should be given so as to access to health service when they need, quality of health care service should be improved in the health facility, and

referral linkage with hospital should need much improvement. Since CBHI is a new scheme in our setting, continuous awareness creation is much needed so as to able all to take equally collective decision in involvement of community based health insurance scheme regardless of economic status.

## **6. Discussion**

This community based cross sectional study has attempted to assess factors affecting uptake of community based health insurance among Sabata Hawas Woreda's rural community. It tried to explore an issue about which relevant studies were not yet done in our country. In this study there was no significant association

observed between educational status, age, sex and marital status in line with uptake of community based health insurance.

One of factors that affected uptake of the CBHI scheme was the household size. This study found that, uptake of CBHI among households whose family size  $\leq 5$  were less likely than those who have  $>5$  family size. The findings of this study was comparable with Studies conducted in India and Nigeria which found that larger households (six members and above) were willing to pay higher amounts than relatively smaller households (3). This may be due to as the number of family size increases, the probability and frequency of people getting illness may be increased, hence out of pocket payment for seeking treatment may be resulted in impoverishing effect, therefore people who have large family size may wish to be insured.

The basic assumption involving different parts of the population with different income level, members of a community with high income and low income can participate in the service equally. This in turn will help to share the health risk of the community equally. However, the findings of this study showed that, uptake of CBHI among household's heads, whose their annual income  $< 40,000$  birr were less likely than those whose their annual income  $\geq 40,000$  birr. Therefore, household's income level was an important parameter and determinants in uptake of CBHI. These findings were also guided by qualitative study (FGD) that the group members reported; both the poor and the rich contribute the same amount in premium. From this premise, it was conceivable to find that the poor were unwilling to join the scheme.

Majority (88.1%) of the study participants have awareness about community based health insurance. Those who had no information about CBHI, their uptake were less likely than those study participants that have awareness. The focus group discussion also implied that as if discussants have awareness and there have been awareness in the community. They described health insurance scheme in various ways: being covered for healthcare when ill and protecting oneself from unexpected events. The figure of this study was little bit above the study done on

dropping out of Ethiopia's community-based health insurance scheme which was documented; more than two-thirds of the respondents (69%) have awareness about health insurance(5). Since the study done on dropping out of Ethiopia's community-based health insurance scheme was lasts about two years ago, there might be possibility of slight increment of awareness status of community on health insurance. This could be a possible explanation for the differences.

Among those who have awareness, 52.8%) of respondents informed by CBHI officials in public meeting, 23.9%) households by health professionals in health facility, 12.3%) of study participants through CBHI house to house awareness creation campaign. Therefore, the sources of information about community based health insurance implied as if there were multi-directional sources so as to help to take community collective decision towards the CBHI scheme but the uptake was very limited. This indicated that, simply hearing of the information without having deep concept about the scheme.

Understanding CBHI scheme features facilitates for high uptake of CBHI scheme. This study demonstrated that, uptake of CBHI among respondents who thought payment of premium is to finance future health care needs were more likely than who were not. This also supported by FGD results, discussant describe that, CBHI scheme is like “Idir”, paying premium with very minimum payment once per year, one day when we will face health problem, we could receive an important health care services from the contractual health facility regardless of the cost incurred. Uptake of CBHI among household's heads who trust their local CBHI management were also more likely than those who didn't know whether trustful or not. To avoid hesitation, disclosure particularly about financial management of the scheme has paramount significant to the local community so as to trust in scheme. Studies done in Nigeria and Cambodia revealed that household heads that have greater trust in the scheme management were willing to join more the scheme than their counterparts(1).

Although in this study no particular illness was identified, the result of this study revealed that households with history of illnesses' within the last six months during the study period were became more membership of community based health insurance. On the other hand, not experienced illnesses in a specified period of time had a negative effect on uptake of community based health insurance scheme. The findings of this study similar with the study done in Cameroon that documented, families with high illness rates have a greater tendency to

participate or to be members of the health prepayment scheme(3).This may be due to as the frequency of getting illness increases, visiting health facility and seeking medical treatment increases, hence the medical cost may be three or four fold of the amount paid for premium. Then people may be forced to be insured by their own time.

This study illustrated that, only 43.2% of households who were being member's of community based health insurance scheme. Among households being members of CBHI scheme experienced illness during the last six months of the study period, majority of them were not visited the contracted for seeking treatment. One of the reasons respondents perceived as if they couldn't get quality care. This study also showed, 40.3% of the respondents, who were being member of community based health insurance as well as fallen ill during the last six month and visited the contracted health facility, regarding to satisfaction on health care given, study participants reported as if they were not expected. This was due to long weighting time to get health service and unavailability of drug in health care facility as needed.

Additionally, this study revealed that, among households members of community based health insurance, 33% of them of had no interest for renewal of CBHI membership for proceeding year. The major cause for this as reported from respondents were, because of the quality of services for CBHI members were not as good as for out of pocket paying patients and there were limited availability and poor quality of health services. This findings also supported by qualitative study(FGD), discussants stated that, households who obtained CBHI card were not getting health service as needed due to unavailability of drug and un functionality of laboratory in health center. This were similar by the study done on drop-out analysis of community-based health insurance membership in Burkina Faso, docommented that , poor health care quality and less seeking care increasing the drop-out from the scheme (11)

## **7. Strength and limitation of the study**

### **Strength of the study**

- In this study bias was minimized by training of data collectors, regular supervision and use of random sampling method. Confounders controlled by the use of multivariate analysis.

- The mixed method (quantitative and qualitative) data collection enables us to have better information.
- Since there was no similar study done particularly on factor affecting uptake of CBHI, it can contribute a lot as baseline information for future studies.

### **Limitation of the study**

- The factors expected to influence uptake of community based health insurance was may not be exhaustive. There could be other influencing factors which this study did not reveal.
- Since based on estimation, determination of household income may lack accuracy
- Lack of similar studies particularly in Ethiopia made difficult in comparing results and discuss some of the findings as needed

## **8. Conclusion**

- ✚ The study was conducted to assess factor affecting uptake of community based health insurance. The findings of the study indicated that, most of the respondents have awareness about community based health insurance.
- ✚ In this study, family size, annual income, awareness about CBHI, illness experience, perception towards some features of CBHI scheme like, payment of premium is to finance future health care needs, CBHI is like saving scheme receive interest and get money back and trust in CBHI local management were found to be an influencing factor for uptake of community based health insurance
- ✚ Lack of availability of drugs, prolonged waiting time to get of health service and delays in issuance of CBHI membership ID card for those respondents who paid premium also contributing factor for low uptake of CBHI and an important reason for non-renewal of CBHI membership.

## **9. Recommendations**

This study demonstrates factors influences uptake of community based health insurance scheme, hence based on the findings, the following points are recommended:

- Regional Health Bureau, Zonal and woreda health office should work to improve availability of drugs and reduced waiting time for clients to get health service in contracted health facilities so as to attract new and more members in community based health insurance scheme.

- Woreda health offices and primary health care unit should Strength information and communication activities in continuous manner to increase awareness and to understand futures of CBHI, hence enables the local community to be member of CBHI and benefitted from the scheme regardless of number of family size, annual income and illness experiences.
- CBHI administrators should make timely assessment to monitor and evaluate overall functionality of Woreda CBHI schemes to pinpoint and to solve problems before they become major issues like delay in issuance of community based health insurance membership ID card. .
- Since more information is needed to explore the reason for low uptake of community based health insurance, further a study is recommend.

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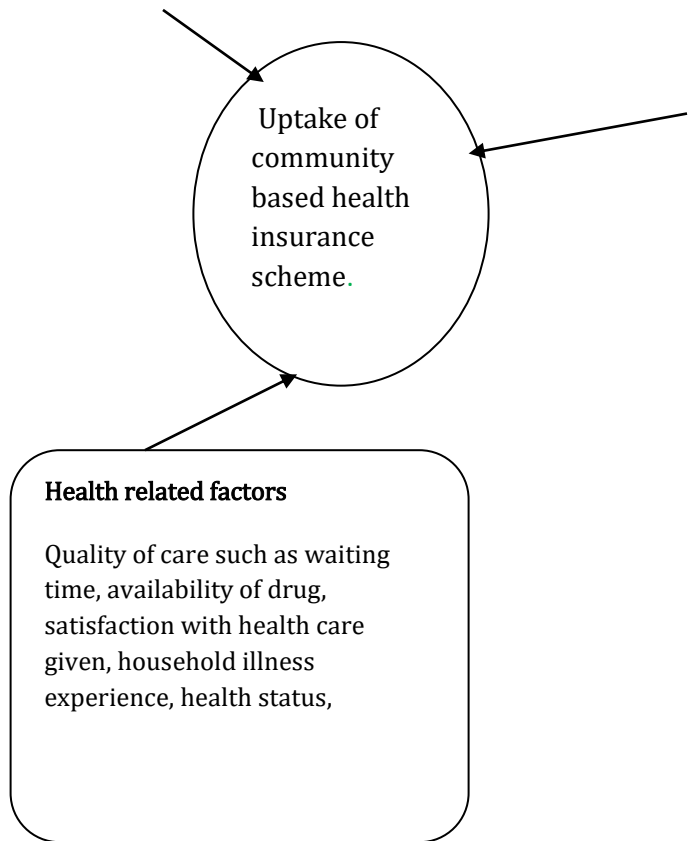
## Annexes

### Annex 1: Conceptual framework for factors affecting uptake of community based health insurance scheme

**Individual factors**  
(perception and awareness)

**Socio-economic and demographic factors**

Age, sex, marital status, ethnicity, religion, educational status, income of the households, house hold size, location and



## Annex2.Consent form English version

**Addis Ababa University, School of public health**

### **Questionnaire Consent Form**

Good morning/afternoon. My name is \_\_\_\_\_

(Interviewer)

My name is-----and I am going to conduct an interview with you on behalf of **Mr. Shiferaw Shibeshi** a postgraduate student at Addis Ababa University, school of public health. He is now conducting a research entitled “to assessing factor affects the uptake of community based health insurance in Sabata Hawas Woreda". As the study is directly related to head/spouse/de facto head of households, you are one of them who selected randomly to participate in this study. Therefore, you are kindly requested to participate in this study and provide the information required from you. I would like to ask you a few questions if I may, but you can refuse to answer any question I ask. You may end the interview at any time. You can also refuse to participate in the study entirely. Your refusal will not restrict you from obtaining the required medical care when you need. The interview will last approximately 20 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 uptake of community based health insurance so as to access to health service in avoiding financial barrier.

Are you voluntary to respond to the questions? **If yes**; proceed with the interview, if No; thank him/her and end.

### **CRITERIA FOR RESPONDENT**

Only head of household or spouse can be used as respondents. The head of HH has to be a living member of the HH and determined by the HH members themselves. The head of HH can be female. (If the head of household or spouse cannot provide information the interviewer can ask the de facto head of HH (e.g. member who earns main income).

## Annex3.Questionnaire for quantitative studies English version

### Identification Information

Code No. ----- Kebele ----- Sub-kebele/village/Gott-----  
 Household ID No. ----- Date ----- Time started-----Time ended-----

Tick the only you interview 1. Head 2.Spouse 3. De facto head

### Section 1: Socio -economic and demographic characteristics of respondents

No	Questions	Alternative responses(Circle the response	Skip to	Code
101	Sex of respondent	1. Male 2. Female		
102	How old are you?	_____years		
103	What is your religion?	1. Orthodox 2. Protestant 3. Catholic 4. Muslim 5.Wakefata 6.Others(specify)_____		
104	To which ethnic group do you belong?	1. Oromo 2.Amhara 3.Tigre 4.Guragie 5.Other ,specify -----		
105	What is the highest level of school you have completed?	1. Can't read and write (illiterate) 2. Can read and write 3. Grade 1-4 4. Grade 5-8 5. Grade 9-10 6. Grade 11-12 7. Diploma and Above		
106	What is your Current marital status?	1.single 2.Married 3.Divorced 4.Widower/widowed		
107	How many numbers of families (HH Size) you have?	-----number		
108	In the past 12 months, how many Kilo grams/kuntal/ of different crop did you produce/harvest?	Write production volume for all crop a total -----		
109	What was the price of your sell per kg?	Write sell price for all crops in Eth birr----- -----		
110	Do you have animals?	1.Yes 2.No		
111	If yes how many animals do this household currently own?	Write in Number-----		
112	If you owned those animals, can you estimate the price of all?	_____ Eth .Birr		

113	Generally, how money is your total family annual income in Birr?(how many income you get annually in birr)	_____ Eth .Birr		
114	How far is the health Facility from your residential area?	(in Kilo meter) -----		

### Section2. Awareness of CBHI

201	Have you ever heard about community based health insurance program (CBHI)?	1.Yes 2.No	No 301	
202	If the answer for Q no 301 is yes, from whom did you hear about CBHI?	1.neighbors/friends 2.CBHI officials in public meeting 3. CBHI house to house awareness creation campaigns 4.mass media: ETV, radio 5.health professionals in health facilities 6.others, specify _____ _____		

### Section 3. Perceptions about CBHI

301	Only those who fall sick should consider enrollment in CBHI.	1. Correct 2. Not correct 3. Do not know		
302	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		
303	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		
304	CBHI program are like savings scheme, you will receive interest and get your money back	1. Correct 2. Not correct 3. Do not know		

305	If you do not make claims through CBHI, your premium will be returned.	1. Correct 2. Not correct 3. Do not know		
306	Do you think that the CBHI benefit package meets the requirements of you household?	1. yes 2. No		
307	Do you think that CBHI management is trust worthy?	1. Disagree 2. Do not know 3. Agree		

**Section 4. health related factors**

401	How do you rate the health status of you and your family?	1.very good 2.good 3.acceptable 4.poor 5.very poor		
402	Have you and your family fallen ill in the last 6 months?	1.Yes 2.No		
403	Is currently member of CBHI scheme?	1.Yes 2.No	If the answer is No go to Q no 413	
404	Has visited the contractual health facility for the illness felt in the last 6 month?	1.Yes 2.No	No 408	
405	How satisfied is with the services given?	1.Very satisfied 2.Satisfied 3.Indifferent 4.Dissatisfied 5.very dissatisfied		
406	How much time you and your family Wait to get the services	1. Less than 30 minutes 2.30 to 60 minutes 3.1to 3 hours 4.3 to 6 hours 5. 6 hours and more 6.More than a day		
407	What the availability of drugs/supplies looks like?	1.Not available 2.Rarely available 3.Usually available 4. Always available		
408	What was the major reason why did not visit a health facility?	1.did not feel it was necessary 2.facility too far		

		3. lack of money for transportation 4. did not feel that I would get quality care 5. other, specify		
409	Have you made use of your CBHI membership to cover health costs till now? (For CBHI members only)	1. Yes 2. No	No 410	
410	Why has your household not benefitted from CBHI?	1. No one in my HH has visited health facilities 2. We still pay other additional costs for treatment (specify) 3. The quality of service (waiting time, staff attitude, medicine, diagnostics) for CBHI members is not as good as for out of pocket paying patients (non-CBHI members) 4. Delays in issuance and distribution of CBHI ID cards 5. others, specify		
411	When your current membership expires, would you renew your CBHI membership for the following year? (for members only)	1. Yes 2. No	No 412	
412	Why do you plan not to renew your CBHI membership (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. there is limited availability and poor quality of health services 4. The quality of service (waiting time, staff attitude, medicine, diagnostics) for CBHI members is not as good as for out of pocket paying patients (non-CBHI members) 5. other, specify		

**Thank you very much for your cooperation!**

Name of interviewer/data collector -----Date----- Signature-----

Name of supervisor-----Date----- Signature-----

## **Annex4.Informed consent form for focus group discussion and topic guide English version**

Assessment of factors affecting the up-take of community based health insurance scheme among Sebeta Hawas Woreda community residents, Ethiopia 2016

Good morning/afternoon and thank you all for coming.

My name is----- My colleague next to me is called ----- We came from school of public Health, Addis Ababa University

Read the following as it is:

“After we conduct some brief introduction, we will be talking about several different issues.

We will be asking you questions about community based Health insurance in your locality and questions regarding factors affecting uptake of CBHI scheme. We will conclude the session by asking you for your recommendations on how such program might be implemented in your community in the future”.

Potential use of gathering of this information is to gain further insight to increase uptake of community based health insurance.

### **Major rules**

#### **Issue of confidentiality**

Please be assured that any information collected here will be strictly kept confidential. The staff of the research group and other participants will not directly share the information in a way that would reveal an individual’s personal identity.

#### **Consent for participation and tape-recording**

At this point it is important that we obtain your consent for conducting the session.

Understand that this is more for your protection than anything else.

Read consent form out loud to the group

“Your remaining in the session indicates that you voluntarily agree to participate in this discussion program. You have the right to refuse to answer any questions and to end the discussion if you find it necessary to do so. For the sake of accuracy and efficiency, we will also be tape recording these sessions, unless any one has any objections”.

#### **Role of moderator/note taker**

The moderator will be in charge of facilitating the discussion .The moderator will bring the discussion back to the topic at hand should it go beyond the main issues.

The moderator will not give any indication (verbal or physical) that would encourage certain types of comments or discourage other types of comments. In short, the moderator will guide the discussion when necessary, being careful not to lead the discussion. It is our role to facilitate, but your role to tell us what you think. The note taker will have the sole responsibility of capturing the sessions as accurately as possible. This will include not only participants' responses, but nonverbal actions, physical environment, atmosphere of the session, as well as other vital characteristics of the session.

### **Importance of focus group**

In this group everybody should feel free to talk. Each and every opinion is important and wanted. It is very important that all the people in the group get a chance to express their opinions.

### **Agreement to disagree**

In this group there is no right or wrong answers. Everybody should express the opinions or attitude pertinent to him or her. When you express your opinions you are encouraged to be honest in your views about factors affecting uptake of community based health insurance. We want you to focus your comments on the program and not toward each other or members of the staff.

## **Annex 5. Questions for Focus Group Discussion English version**

1. Did you hear about CBHI?
2. According to your view, what is the importance of Community based health insurance scheme?
3. Do you think that setting money aside for health care could attract disease?
4. What is the attitude of community to use the preexisting CBHI scheme?
5. How is the practice of CBHI scheme in your village?
6. Why majority of the households were not member of CBHI scheme?
7. What is the major socio- economic, demographic as well as health related factors that affect uptake of CBHI?
8. Finally, what suggestions will you give in general about CBHI scheme

**Thank you for your cooperation.**

## **Uunkaa 1: Waliigaltee**

Yuuniivarsiitii Finfinnetti kutaa Eegumsaa Fayyaa Hawaasaa irraa sababoota ittifayyadama inshuransii Fayyaa hawasaa irraatti dhibaa fidaa jiran adda basuuf gaafii qophaa'ee.

Maqaan kiyaa Shifara Shibashii jedhama. Yuuniivarsiitii Finfinne, kollajji saayinsii fayya barata Fayyaa Hawaasaatti. Diigrii 2ffaa koo xumuruuf mata duree sababoota itti fayyadama inshuransii fayya hawaasa irratti dhiibaa fida jiran jedhuratti qo'annoo gaggessaa jira . Kaayyoon qo'anno kanas sababota ittifayyadama inshuransii fayyaa hawasa jiratoota Aanaa Sabataa Hawas irratti dhibbaa fidaa jiran ilaalchiise oddeffanno walitti qabachuu fi rakkoo karaa kanaan umamuu dandaa'aniif furmaata fiiduuf akka gargaaru tarkaanfiiwwan fudhatamaniif karoora baasuudhaf.

Kanaafu, gaaffilee askeessaa jiraniif ifaa fi amanamumadhan deebiisuudhaan gargaarsii isiin gootaan baayyee kan dinqiisifamu yammu ta'uu, kaayyoo qo'anno kana galmaan gahudhaaf qooda olanaa ni qaba.

Iccitii deebii debiistaniif eegudhaaf jeecha fuula kamirrayu maqaa keessan barreesuun barbaachisaa miti. Akasuumas deebii hoojetaan qo'anno kana irratti hirmaate dhaabata kamiifiyyu dabarfame hin kennamu. qo'annoo kana irratti waan hirmaatef faayidaas ta'ee miidhaa kan sirraan hin geessisne ta'uu isaa hubachisa.

Gaafiilee kanneen keessaa gaafii deebii deebisu kan hin barbaadne ykn gaafiilee hundaa deebii kennu yoo hin barbaadne mirgii keessan kan eegame dha. Gaffiilee deebiisuudhaan walta'iinsa kessani yoo agarsiistan fixaan ba'iinsa qo'anno kanaatiif qoodaa keessan baataniirtu jechuu dha.

Gaafiilee deebiisuuf fedhii ni qabdu?

Eeyyee yoo jetan, \_\_\_\_\_ 1 itti yaa fuufnu, Lakkii \_\_\_\_\_ 2 yaa dhabnuu

Waanta qulqulufatanii fi rakkoo kamifuu bilbilaa fi tessoo qorata

**Lak.bilb -0912074620 [E-mails-shiferomi@yahoo.com](mailto:E-mails-shiferomi@yahoo.com)** tessoo Finfinnee kutaa bulchinsa N/silki Laftoo

**Gummachaa nuuf gootaaniif guddaa galatoomaa!**

**Gaffiin kan gafatamu qabu Abba warra/hadha warra/Bakka bu'aa abba mana/hadha mana**

**✚ Odefanno adda basuuf ragaa nugargaru**

Maqaa gandaa-----Goxxii-----Lakk Manaa-----Kodii-----

Sa'aatii gaffiini fi debiin itti jalqabame-----sa'aatii gaffiin fi deebin itti xumurame-----

Gaffii kan gafatame mallatoo itti godhi 1. Abba mana 2. Hadha warra 3. bakka bu'aa abba mana

**❖ Kutaa 1<sup>ffaa</sup>: Gaaffii haala Hawwaassa –dinagdee fi ummaata ,debii filannodhaf ittimari kan kani barressi**

101). Saala: 1. Dhira 2. Dhala

102). Umurii waggadhan: \_\_\_\_\_

103). Amantaa: 1. Ortoodoksii 2. Pirootestantii 3. Kaatoolikii 4. Musiliima 5. Waqeefaataa 6.

Kan biro(yaibsamu)-----

104). Sabummaa: 1. Oromoo 2. Amaara 3. Tigree 4. Guraagee 5. Kan biraa yaa ibsamuu-----

105). Sadarka barnootaa 1. barressuu fi dubbisuu hin danda'uu 2. Dubbisuu fi barreessuu danda'a 3. Kutaa 1-4 4. Kutaa 5-8 5. Kutaa 9-10 6. Kutaa 11-12 7. Diplomaa fi isaa ol

106). Haalaa ga'iilaa : 1. Hin fuune/heerumne 2. Fuudhera/heerumeera 3. Wal hiikne 4. jala kan du'e/dute

107). Ba'yyinni maatii keetii Meeqa ? Lakkofsan baressi-----

108). Wagga darbee miidhan fi fuduralee fi kuduralee gosaa gara garaa kuntala meeqa oomishtan? Lakkofsan kuntaala -----

109). Gatiin gurgurta omisha gosa adda adda kilogramiidhan meeqa? Lakk-----

110). Horii mana (beeladota) qabdu? 1. Eyye 2. lakkii.

111). Gaaffii lakkofsa 10ffaaf deebiin eyye yoo ta'ee, horii meeqa qabda? lakk-----

112). Horii kee kana gara qarshiti yoo tilmaamtu meeqa ni baasu ? qarshii-----

113). Galiin matii ketti kan wagga tokko qarshiidhan meeqa ni ta'a? qarshii-----

114). Dhabbanni fayya/Bufanni Fayya / mana keessan irra hagam fagataa? Kiilometirii-----

**kutaa 2<sup>ffaa</sup> Bekumsa (awarnesii)waa'ee iinsuraansii fayya hawaasa ilaalchise**

201). Wa'ee saganta iinshuransii fayya hawaasa dhaggeche beekta? 1. Eyyen 2. Lakki

202). Gaaffii 201f deebin eyye yoo ta'ee, waa'ee inshuransii fayyaa hawasaa enyuura dhagechee ? 1. Ollaa(hiriyya) 2. waltajji uummatatti, waa'ee inshuraanssii fayya hawaasa qamni mootumman kenne irraa

3. Dulla kaka'umsaa inshuransii fayya hawaasatif mana manatti gaggefame irraa 4. walqunnamtii ummata kan akka televejini,raadiyoo 5. Dhabata fayyattii kessatti ogummaa fayya irra 6. kan bira yoo jiratte barressii-----

❖ **kutaa 3ffaa, ilaallcha uummata waa'ee inshuuransii fayya kan hawaasa bu'ureefate ilaalchisee**

301).Nama dhukkubsatee qofaatu inshuransii fayya hawaasa kessatti galma'u qaba 1. Sirridha 2. Sirri miti 3. hin beeknu

302). Namoota baay'ee Iiyyeesa ta'an kan tajaajila fayyaa isanitif kaffaltii kaffalachu hin dandeenye qofatu misensa inshuransi fayyaa hawasa ta'u qaba. 1,Sirridha 2. sirri miti 3. hin beeknu

303).Saganta inshuransii fayya hawaasa jalatti kaffaltiin atii kaffaltu gara fulduratti yalii fayyaa keetii siif barbachisuufi 1. sirridha 2. sirri miti 3. hin beeku

304).Inshuransiin fayya hawaasa akkuma qusannatii birri jalqaba kafaltee sana fi dhala isaa boodaa ni fudhatama. 1. Sirridha 2. Sirri miti 3. Hin beeknu

305)Sagantaa Inshuransii fayya hawaasa kessatti mallaqa kafaltes yoo ittifayadamnef,mallaqni misensummaf kaffalte suun ni deebi'a. 1.Sirridh 2. Sirri miti 3. Hinku

306).Inshuransiin fayya hawaasa yaalii tajaajila fayyaa gosa adda addaa maatiin hundi barbaduu galman ni ga'a jette yaada? 1. Eyye 2. lakkii

307)Inshuransiin fayya hawaasa kun bulchinsii isaa amanamadha jette ni yaada? 1.waliihin galuu 2. garagarumma qaba 3. walii gala

**Kutaa 4 ffaa Fayyadhan walqabatni dhibba kan fiduu danda'an**

401). Fayyuma kee fi kan maatii kee haala kamiin teechista? 1. baayee gaariidha 2. gaariidha 3. fudhatamadha 4. gadi bu'aadha 5. baay'ee gadi bu'adha

402). Ji'oota ja'an darbe keessa atii fi maatiin keessan dhukkubsatanii beektu? 1. eyye 2. lakkii

403).yeroo amma kanatti atii miseensa inshuransii fayya hawaasatti? 1.Eyye 2.Lakkii **deebin lak gafii 403 lakki yoo ta'ee gara gafi lakk 413 tti darbi**

404).Ji'ota ja'an darbe keessatti ati yookin matiin kee dhukkuba sinqunameef haala waliigaltee inshuransii fayya hawaasa dhabata fayya waliin taasiste sana yalli fayyaa fayyadamtee beekta? Eyyee----lakkii (debiin lakki yoo ta'ee gafii lakk 408tti darbi)

405).Yoo gaaffii armaan oliitiif(404) eyyee ta'ee, tajaajila isaatii itti gammaderta? 1. baay'een itti gammade 2. itti gammade. 3 garagarumma qaba 4. Ittihin gammadne 5. baayee itti hin gammadne.

406).Tajaajila isaa argachuuf atii fi maatiin kee sa'aatii hagamii eegdu? 1. daqiiqa 30 gadii 2. daqiiqa 30 hanga 60 3. sa'aatii1 hanga sa'ati 3 4. sa'aatii 6 fi isaa ol 5. guyya tokko ol.

407). Dhiyeessii qoricha maal fakkata? 1. hin jiru 2. xiqqo xiqqo jira 3. yeroo tokko tokko jira 4. yeroo hunduma jira.

408) Sababni dhabata fayya hin deemne isin dhorku maalini ? 1 barbachiiisadha jenne wan hin yaadnef 2. Dhabatni fayya fagoo ta'uu isaa 3. geejjiban deemuuf rakkon mallaqa waan jiruuf 4. kunuunsa qulqullina qabu ni argana jenne waan hin yaadnef 5. kan bira yoo jiraate barressii--

409).Haga ammatii miseensa inshuransii fayya haawasa taatee gatii baastee sana itti fayyadamtarta? 1. Eyyee 2. lakkii

410)Yoo deebin gaffi lakk 409 lakki ta'ee ,maaliif maatiin kee inshuransii fayya hawaasa irra hin fayyadamne ?

1. Maatii keenya keessa namni tajaajila fayya kennamu hin hubaane 2,ammayuu yaalamuuf gatii dabalata kafala( barressii).

3.qulqullinni tajaajila (yeroon eeganuu,yaada hojjetoota,qoricha,qorannon taasifamu)kana warra inshuransii fayya hawaasa hin fayyadamnee waan hin geenyef 4.yeroon warraqaan eenyumma miseensa inshuransii fayya hawaasa itti dhufuu fi kennamu turuu 5. kan bira yoo jiraate barressi

411).miseensumman amma kun yoom tajaajilan ala ta'a?barootan dhufaniti waraqa miseensa inshuransii fayya hawaasa kana ni haaromsista?(miseensa qofaf) 1. Eyye 2. Lakkii

412.)Miseensummaa inshuransii fayya hawaasa kee maaliif hin haaromsisu jette karoorfate?(deebii baa'yeen ta'era barbaachisumma isaanitin tarressi).

1 dhukkubni fi miidhamni qaama maatii keenya keessatii yeroo gabaabadhan hin mul'atu 2. Gatiin galmee fi kan inshuransiif kaffalamuu waan hin danda'amnef 3. tajaajili fayya kennamu gadii bu'aa fi argachuuf waan rakkisuuf 4.qulqullinni tajaajila (yeroon eeganuu,yaada hojjetoota,qoricha,qorannon taasifamu)kana warra inshuransii fayya hawaasa hin fayyadamnee waan hin geenyef 5.kan bira yoo jiraate barreesi

**“Deegarsaa nuuf gotaaniif guddaa isiin galateefanaa !!”**

Maqaa nama raga funaane-----mallatoo-----Guyyaa-----

Maqaa to'ataa----- mallatoo-----Guyyaa-----

## **Uunkaa 2: Yaadaa marii Varshinii Afan Oromotiin**

Akkam bultan? Marii Keenya irratti argamu keessaniif ba'yyee isiin galaateefadha. Maqaan koo Shifarra Shibashi jedhama. Iddoon ani irraa dhufee Univarsiitii Finifinee, Kolleejii Saayinsii Fayyaa, Mana baarnoota Fayya Hawasummati .

Kanaan dhufeef waa'ee ittifayadama Inshuransii Fayyaa Hawasaa irratti sababota dhiibaa fidaa jiran jiratoota Aanaa Sabata hawas jiran irratti dhibbaa jiru adda basuu fi gara fuulduratii maal godhu akka qabnuu mari'achuufii. Deebiin keessan kara kaminiyyu waan nu gargaruuf deebiin kun sirrii immo sirii miti kan jedhamu hin jiru, odeefanoon isiin dhiyeesitan kamiyyuu baay'ee fudhatama qabaa. Yeroo marii gaggeesinuu kanatti vidiyoon ni warabamaa kayyon isaas yaada keessan walitti qabachuuf akka nutii toluufii. Maqaan nama kamiyyu waan hin bareesineef sooda kamiyyu malee qoraanoo kana irratti waan nuuf hirimataaniif galaatooma isinin jedha.

Qamni qorannoo kana keessatti hirmaatee dhimma qorannichaan walqabatu irratti gaaffiis ta'ee komii qabu kan qunnamuu qabu Shiferaw Shibeshi( lakk.bilbila 0912074620).Ykn. E.mail: shiferomi@yahoo.com Finfinnee/Ethiopia,

Tessoo gorsaa Dr. Ababi Zergaw lakk.bil +251 0911695936

## **Uunkaa 2ffaa Gaaffilee marii kan gareedhan irratti mariia'tamu**

1. Barbaachisumman inshuransii fayya hawaasa maaliini jettanii yaddan ?
2. Mallaqa fayya keessaaniif kawwachuun dhukkuba harkisaa jettanii ni yaaduu?
3. Naanno keessanitii misensumma fi itti fayyadamni inshuransii fayya hawaasa maal fakkata ?
4. Sagantaa Inshuraansii fayya hawaasa jiru kana itti fayyadamuuf ilaalchi ummata maal fakkata?
5. Maaliif abbotiin warra baa'yeen isaanii miseensa inshuransii fayya hawaasa hin taane ?
6. Qabxillen gurguddan karaa hawaasummaa, diinagide fi haala tessumma lafatiin akkasumas gama keninsa tajaajila fayyatiin wal-Qabatee akka inshuransii fayya hawaasa itti hin fayyadamne isiin rakkisuu maalinni?
7. Dhumarratti akka waliigalaatii misensa bayyee horachu fi ittifayyadama sagantaa inshuransi fayyaa hawasa dabaluf furmanni maal ta'uu qaba jettani yaddan?

**Marii keenyaa kanaa irratti waan argaamtaniif baay'ee galatoomaa!**