ADDIS ABABA UNIVERSITY

SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF HEALTH ECONOMICS

AWARENESS AND WILLINGNESS TO PARTICIPATE IN A COMMUNITY BASED HEALTH INSURANCE SCHEME IN DUBTI WOREDA OF, AFAR REGION

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SUBMITTED TO:- Advisor Dr Anagaw Derseh

PROPOSAL WILL BE SUBMITTED TO DEPARTMENT OF HEALTH ECONOMICS, SCHOOL OF PUBLIC HEALTH, AND ADISS ABABA UNIVERSITY IN PARTIAL FULLFILLMENT OF THE REQUIRMENT S OF THE DEGREE OFMASTER IN HEALTH ECONOMICS.

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Name of advisor	Dr Anagaw Derseh (PHD)
Full title of the research project	Awareness and willingness to participatein community based health insurance scheme in Dubti woreda of, Afar region
Duration of project	Aug 2018 to June 2019.
Study area	Dubti woreda of, Afar region
Total cost of the project	34,783.35 Et. Birr
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Acronyms

CBHI Community based health insurance

EHIAEthiopian health insurance agency

GDPGeneral domestic product

HSTP Health sector transformation plan

LMIC Low middle income country

NGO Nongovernmental organization

NHIFNational hospital insurance fund

NHIS National health insurance scheme

OOPOut of pocket

SHISocial health insurance

UHCUniversal health coverage

WHOWorld health organization

WTPWillingness to pay

Summary

Background: In Ethiopia There are major challenges in the quality of services provided. First, contracted providers differ in their readiness in terms such as pharmacy services, laboratory facilities, reception, and outpatient services. Second, health facilities, especially hospitals, are frequently short of drugs and patients must buy items from outside (private) retailers. Health facilities attribute the shortages mainly to shortages at Pharmaceutical Fund and Supply Agency (PFSA) hubs. The practice of moral hazard by pharmacists at contracted health facilities was reported to exacerbate the shortages. Third, there are frequent breakdowns of medical equipment, due mainly to lack of preventive maintenance but also to health worker negligence and mishandling. Fourth, there are complaints about availability and capacity of staff. Finally, no pilot woreda has systematic, regular, and standard mechanisms for collecting and properly addressing complaints.

Evidence from the experience of countries worldwide informed Ethiopia's CBHI design, which eschewed small-scale, voluntary membership and included mechanisms to finance the membership of the poor. The willingness and ability to pay of the pilot woreda population conducted by HSFR during the design phase as well as the assessment of readiness of facilities in the pilot woredas to provide health services informed the design parameters.

Objectives: Awareness and willingness to participate in a community based health insurancescheme among household in Dubti woreda of, Afar region.

Methodology: community based cross sectional study will be conduct from July 2018 up to June 2019will use recorded information and, structured and pre-test questionnaire will develop and administer to gather information. The data collect from structured questionnaire will be intered in to epi info and analyse by using latest version spss version21. Descriptive statistics as well as bivariate logit analysis and multi variate logistic regression will be used to asses factors affecting participation in a community based health insurance schemes in the study are.

Budget: this study will be conduct in a way that minimizes cost, as try to mention below in budget break down34,783.35 Ethiopian birr will need to perform the study.

1. Introduction

1.1. Background of the study

Low allocation of budget and limited spending on health is one of the major concern to health system of developing nation. “Although the developing countries account for 90% of the global disease burden, they only contribute 20% of total GDP and only 12 percent of all health spending in the world”[2]. Most healthcare spending in developing countries is borne by healthcare-seekers through out-of-pocket (OOP) means. India is a good example: 70 percent of health spending is private; 86 percent of which is OOP[3]. This inequitable and inefficient health financing situation persists in other low-income countries as well. The solution proposed by WHO and other international bodies has been to strive toward universal health coverage (UHC) [3].

The catastrophic nature of this health care mechanism financing for the poor and often rural population has been a source of worry for the country and other low and middle income countries of Africa [4].Rural dwellers in Nigeria constitute over 70% of the country’s population. To get access to quality health facility, they have been migrate to urban center for medical treatment and result the loss of about 25% of their annual income treating sickness, increase risk of mortality of both children and adult, impaired productivity[4].Universal health coverage is a key component of the Federal Ministry of Health in Health Sector Transformation Plan (HSTP).

The contribution of health insurance mechanisms to health financing is negligible in Ethiopia; health insurance expenditure represented less than 1% of total health expenditure in 2010/11, mainly through private health insurance schemes. Moreover, health insurance coverage is still limited, and was only 1.2% at the national level in 2010/11 [5].In June 2011, the Government of Ethiopia launched a pilot Community-Based Health Insurance (CBHI) scheme, in 13 districts located in four main regions (Tigray, Amhara, Oromiya, and SNNPR) of the country by December 2012, enrollment reached 45.5% [6].

Following the introduction of health insruance schemes in Ethiopia, there are serveral studies investinging demand to join and pay for insurnace. One impotent gap on studies on willngess to pay for health insurnace is that the exsting studies focus on major four regions and no study was

conducted in the context of emerging.Second,most willingness to pay studies are concentrated on WTP for SHI and factors affecting enrollemnt in CBHI where the scheme is already implemented. In the proposed study, the aim is to examine willingness to participate in CBHI in Dubti woreda where is not currently CBHI schemes. This may provide relevant evidence in order to expand CBHI in pastoralist regions. thie study will also prove useful evidence related to trust on health institutions and perception on the availability of quality of care in the study area.

Afar pastoral communities is major challenges faced are the relative weakness in disease surveillanceand reporting systems, which hampers the detection and control of epidemics, this very fact makes it difficult to obtain the long-term linked data sets on climate and disease that are necessary for the developement of early warning systems. In general, access to health service in afar pastoral communities is lower compared to other regions in the country. Many health centers and health posts have been constructed in the last few years. But lack of electricity, laboratory, and other facilities, shortage of appropriate staff and budget are major problems hindering provision of adequate health services. Moreover, the health service is constrained by poor awareness of the society in making use of the health services [22].

1.2.LITERATURE REVIEW

1.2.1Concept of CBHI

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. Community based health insurance(CBHI) is not for profit type of health insurance that has been used by poor people to protect themselves against the high cost of seeking medical care and treatment [1]. Community-based health insurance schemes (CBHIs), which involve potential clients in determining scheme benefits and in scheme management, have been implemented in several developing countries[2]. In CBHI schemes, members regularly pay small premiums in to a collective fund which is then used to pay for health services that require. Many CBHI schemes are designed for people that live and work in rural areas or the informal sectors which are unable to get adequate public, private or employer- sponsored health insurance [1].

CBHI aims to facilitate access to healthcare and increase financial protection against the cost of illness, particularly for underprivileged population [13]. For instance, CBHI schemes have been implemented in low-income countries to insure rural population and informal workers that have been excluded from regular insurance schemes[21].

1.2.2. Design and Implement of CBHI in Ethiopia

The initiation by EHIA to launch SHI, which will be compulsory for all enterprises in the formal/salaried sector with more than 10 employees, and scale up CBHI to 200 districts, to eventually cover 80% of all the communities of the country for the informal/rural sector, is expected to add considerably to demand for reliable access to quality pharmaceuticals [5].

According to the CBHI design, there are three types of government subsidies to the schemes: targeted and general subsidies, and financing the scheme management costs (salaries, office space, and operational costs). The regional and woreda governments finance premiums of indigents using different arrangements. In Tigray, the regional government finances 70 percent of indigents' premium contribution and the woreda finance 30 percent. In Amhara, the split is 90/ 10. In SNNP and Oromia, woredas finance all the costs of indigents. Woreda governments also

finance the salaries and operational costs of all schemes. The federal government subsidizes 25 percent of the CBHI premiums, for both paying and non-paying members. Through the end of June 2013, the total amount of subsidy paid to the 13 pilot woredas was Birr 16.5 million: Birr 9.7 million from the general subsidy and Birr 6.8 million from the targeted subsidy. The total subsidy constituted about 42 percent of the total revenue generated by schemes. Of this, the general subsidy accounts for 25 percent and the targeted subsidy for 17 percent. Members' contribution/premium accounts for 58 percent of total revenue collected by the schemes. Of the total revenue generated from all pilot schemes, 35.3 percent was from Amhara, 27.3 percent in Oromia, 24.2 percent in Tigray, and 13.1 percent in SNNP. However, there is still a very strong government commitment to CBHI [20]. Key informants and FGDs with health facility staff confirmed that CBHI has increased the utilization of services and retained revenues in health facilities, particularly health centers. More than 90 percent of service utilization by members takes place in, and more than 90 percent of reimbursement is made to, health centers in Amhara, SNNP, and Tigray. In Oromia, hospitals account for only about 5 percent of CBHI member utilization but they took in about 31 percent of the total reimbursement paid out. Overall CBHI schemes seem to provide the correct utilization pattern (using lower-level facilities more) and payment trends also follow this pattern. The reasons for a large proportion of payment going to hospitals in Oromia needs to be further explored to reduce the undesirable impact on scheme financial status. In order to study 'fairness in financial contribution', we would need to know households' expenditure for health (either directly through direct payments, user fees and health insurance contributions, or indirectly through tax payments part of which are channeled subsequently to health) as well as their capacity to pay [20].

Overall, Ethiopia's CBHI schemes were able to finance the health service costs using financial resources generated from contributions. The reimbursement made to the health facilities stands at about 75 percent of contributions from paying and non-paying members (without any subsidy). However, CBHI schemes in three woredas (Fogera, Yirgalem, and Damot Woyde) would not have been able to finance their health service costs without the subsidy (owe more money from health facilities). When the targeted subsidy was included, all woredas except Yirgalem had a positive balance and a claims ratio of 57.4 percent. When the general subsidy was included in

this total (contribution and targeted subsidy), all woredas remained in good financial situation and the claims ratio became 43.2 percent. When we look at regional performance, schemes in Amhara, Tigray, and Oromia are financially healthy while those in the SNNP are the ones whose financial status is flagging, jeopardizing sustainability [20].

1.2.3 Empirical evidence of willingness to participate in CBHI

In developing countries accounts 84% of world population, 90% of global disease burden and only 12% of global health spending. Global distribution of General domestic Product(GDP) and health expenditures in developing countries,2002 Total expenditures, $351billion(12% of global),among this high income countries 88%,middle income countries and low 10% and 2% respectively.(The world Bank ,2005 report). In addition, about 85% of Ethiopians live in rural areas. Rural households tend to suffer from higher level of ill health, mortality, malnutrition and inadequate health care(14).

In the near future, health insurance (both community and social) will be one major financing source. Health financing in Ethiopia has improved significantly over the years; total per capita health spending almost quadrupled between NHA I and NHA IV, from US$4.5 in 1995/96 to US$ 16.10 in 2007/08. According to the NHA-V report (2010/2011), the share of health expenditure out of the GDP reached 5.2%, which is a significant increment from the 4.5% in 2007/08 (MOFED, 2003 EFY). This is an acceptable level increment since it is above the WHO recommendation of a minimum of 5% of GDP spending on health. However, per capita health expenditure still remains low compared to the African and Low Income Countries' average, the government's contribution for total health expenditure has declined between successive NHA studies, from 40% in 1995/1996 to 22% in 2007/08,over 2 the same period, share of households' out-of-pocket payment declined from an as rounding 53% to 37%, which is still high and conversely, donors' contribution has increased from 22% (1999/00) to 39% (2007/08)[16].

.CBHIs can also help to improve quality and equity of health care services by creating greater competition among healthcare providers(16). a study of knowledge of community health insurance(CHI) among household heads in rural communities of Nigeria revealed awareness or those who have good knowledge on the principle of CHI is 2.5% and those with poor knowledge

73.3%, of National Health Insurance among surgical patient in Niger Delta region of Nigeria revealed an awareness of 3.06% and awareness of CHI in rural Cameroon was found to be 27.07% . a similar study among civil servants in Osun State revealed an awareness of 40%(4) Other Studies done by Federal Democratic Republic of Ethiopia, Ethiopian Health Insurance Agency On evaluation of community-based health insurance pilot schemes in Ethiopia: final report indicates "Knowledge about CBHI: 95 percent of both members and non-members in pilot woredas are aware of the CBHI schemes. The main sources of information are a neighbor, a CBHI official, or a house-to-house sensitization program; these three represent 100 percent of information sources in Amhara, 96 percent in Oromia, 86 percent in SNNP, and 81 percent in Tigray. More than 96 percent of member households and 87 percent 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 intensive sensitization work done by government and project" [20].

1.3. Statement of the problem

Every year, approximately 150 million people globally experience financial catastrophe, this means that they spend more than 40% of the income available to them on health care after meeting their basic needs. These high health care expenditures mean a short-term health shock and can lead to debt, asset sales, and removal of children from school there by creating long term increase in poverty [1].CBHI schemes reimbursed about Birr 16.9 million to contracted health centers and hospitals for services rendered.

Over 150 million people face catastrophic health expenditures each year, and most fall into poverty due to OOPs.Health problems and their associated costs are clearly an important cause of poverty, especially in countries that rely on OOPs . In 60 % of countries with incomes below $1000 per capita, OOP spending constitutes over 40 % of total public healthcare expenditure. About 1.3 billion people on very low incomes still lack access to effective and affordable drugs, surgeries, and other interventions due to weaknesses in health financing. An absence of any form of health insurance increases the risk of poverty due to high health care related costs. As the result, households may leave illness untreated or opt for the use of poor quality healthcare or self-administered medication. Governments of low-income countries face the challenge of reducing the regressive burden of OOP expenditure by expanding prepayment schemes that spread financial risk and reduce the spectrum of catastrophic healthcare expenditure. Due to only limited access to a well-developed health insurance system, about 80 % of private health expenditure in Ethiopia is via OOPs and only 1.5 % of private healthcare expenditure is covered by private insurance institutions. Providing healthcare to individuals working informally or who live in rural areas is a major challenge in developing countries. CBHI schemes are considered useful in addressing this problem. By pooling risks and resources, CBHIs promise better access to healthcare and risk protection for poor households against the cost of illness [my]. A national implementation pilot CBHI scheme was started in Ethiopia in mid-2011 The populations still rely mostly on OOP payments health spending in the poorest, which are associated with a higher probability of incurring catastrophic health expenditure and impoverishment. Health-related expenses remain the most important reason for households being pushed below the poverty line.

Such direct payments are inequitable and inefficient in financing healthcare services(12, 15).Community health insurance has emerged in developing countries as a response to the existing challenges in the health financing system which include low economic growth, constraint on public sector and low organizational capacity with different name The National Hospital Insurance Fund [NHIF] in Kenya,[CHI] in Nigeria(4), National Health Insurance Scheme (NHIS) in Ghana(7). In several countries, community health insurance have proven to increase access to health care services, especially among children, women, rural household and informal workers, majority of whom are excluded from formal insurance and the vulnerable group the population(2). The proposed study will help to identify demand side challenges in order to introduce and expand community based health insurance scheme in the pastoralist areas of Ethiopia.

1.4. Conceptual frame work

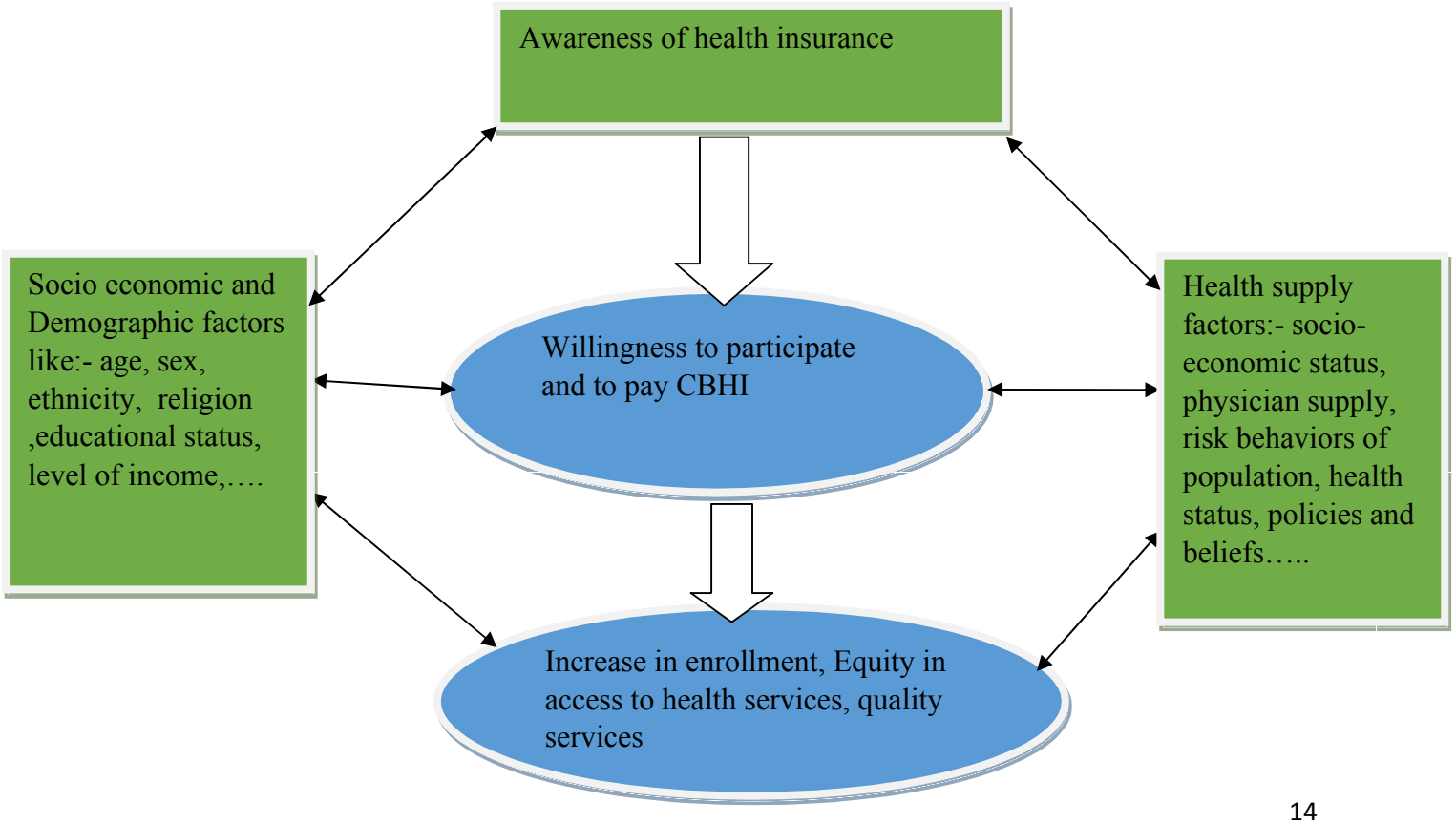

Figure1. Diagrammatic representation of conceptual frame work

1.5. Significance of the study

This study therefore seeks to determine the actual level of CBHIs awareness and to find out the sources of information in Dubti District, where willingness to participate is defined with respect to people's awareness towards community based health insurance and willingness to pay. Increase in participation regarding (CBHIs) will have an influence in the enrolment rate which helps to avoid catastrophic health care expenditure.

2. Objective of the study

2.1General objective

- Awareness and willingness to participate in a community based health insurance among household in Dubti woreda of Afar region.

2.2Specific objective

- To examine awareness of health insurance among the target population.
- To determine the factors that influence household willingness to participate in CBHI.
- To compare average willingness to pay for CBHI by different characteristics like gender, age, and socioeconomic status.

2.3Research question

- How many people have awareness about health insurance?
- What are the factors that affect willingness to participant and pay in CBHI?
- Are there significant variations in the average amount of willingness to pay for CBHI across different segments of the community .

3.Methodology

3.1Study area

Dubti woreda is one of the 32 woreda of Afar region, part of the administrative zone 1. It has total population of 77,692. It is 10 km far from the capital city of afar and 680 km far from adiss ababa.and it has 14 kebeles and from this, 2 kebeles are urban and the remain 12 kebeles are rural kebeles.Most of the woredas land coverd by cotton and recently it is changed to sugar cane production by sugar corporation.The average elevation in this woreda is 503 meters above sea level. Afar regional state is one of the nine regional states, administratively divided in to five zones and thirty two weredas, samara being its administrative capital city. The region is located bordering Eretria in the north, Dijibuti in the east, Tigray and Amhara in the west and Oromiya and somalia regional states in the south.The main economic activities of afar is 90% of the state of population is leading a pastoral life by rearing camels, cattle, goats, sheep, and donkeys, agriculture such as production of maize, beans, sorghum, papaya, banana, and orangeis also practiced. Cotton production is also typical to the region, commerce, especially of salt, is another area of occupation. When we see access to health service in afar pastoral communities is lower compared to other regions in the country. Many health centers and health posts have been constructed in the last few years. But lack of electricity, laboratory, and other facilities, shortage of appropriate staff and budget are major problems hindering provision of adequate health services. Moreover, the health service is constrained by poor awareness of the society in making use of the health services. In case of this health problem always has been in this region having one of the highest child mortality rates in the country and the most commonly reported diseases include malaria, communicable diseases, tuberculosis, and watery diarrhea. So, the study will be conduct to improve the above problem gaps by assessing factors affecting to participate community based health insurancein dubti woreda of, afar region.

3.2 Study period

The study will be conducted fromJuly 2018 up to June2019.

3.3 Study design

A community-based cross-sectional study design will be employed from July 2018 to June 2019.

3.4 Source and study population

3.4.1 Source population: -

Households found in Dubti district will be source of population for the study during the study period.

3.4.2 Study population: -

Head of family members who engaged in informal sector in each household, or with the available adult member of the family in case of the head not being present at the time of interview.

3.5 Inclusion criteria and Exclusion criteria

3.5.1 Inclusion Criteria

Household heads above the age of eighteen who engaged in informal sector and those who are not currently on any insurance scheme in the last one year will be included in the study.

3.5.2Exclusion criteria

Household heads below the age of eighteen those who are engaged in informal sector or those who are mentally disturbed, severely ill and not willing to participate in the study were excluded Sample size determination and sampling technique.

3.6 Sample size determination

The sample size for the study was determined by using the following assumptions; level of confidence taken to be 95%, 5% margining of error, p = expected interest to participate in CBHI which was assumed to be 50% with 95% CI [5]. Based on the above assumptions, the sample size for the study was calculated by single population proportion.

$$n= Z^2\alpha/2\ p\ (1-p)/d^2$$

Where, n= sample size

Z α/2= Critical value= 1.96

q= 1-p = 1-0.50= 0.5

d= marginal of error= 0.05

$n = (1.96)^2(0.5)\ (0.5)/\ (0.05)^2$

n= 0.96/0.0025=384

n≈ 384

With a non-response rate of 10% the total sample size of 422

3.7.1 Sampling technique

Number of kebeles, population, house hold and sample size will be select by using cluster sampling method.

3.8 Variables of the study

3.8.1 Dependent variable

- Awareness of CBHI
- Willingness to participate for CBHI
- Amount willing to pay for CBHI

3.8.2 Independent variables

Age, sex, household size, ethnicity, religion, marital status, educational status, occupational status and income of the household level, types of occupation, access to health facility, perception on quality of health service, trust on health institutions.

3.9 Data collection procedures and analysis

The questionnaires that are pre-tested semi-structured interviewer administered questionnaire will be used to generate quantitative data. The questionnaire will be adapted after reviewing of many relevant literatures that could address the objectives of the study will be gathered and adapted from previous similar studies and other materials. The questionnaires are translated to

local language Afar qafa and Amharic and back translated to check for consistency with the English version.

After collecting the data it will be cleared, checked and entered by using EPI INFO version7.1 software and code, entered and analyzed by using statistical package for social science (SPSS) Version 21. Descriptive statistics and bivariate logit analysis and multi variate logistic regression will be used to asses factors affecting willingness to participate in community based health insurance schemes. Moreover,frequency odds ratio 95% confidence intervals, X2 and p-value will compute.

3.10 Ethical Consideration

Official letter will be obtained from Addis Ababa University department of health economics Institutional Review Board to Afar Regional Health bearueand regional health insurance department to dubti woreda health office in order to conduct the study in that woreda and the objective of the study will be discussed with the district health office head to obtain desired cooperation, in addition Clients' consent was obtained before interview and The nature of study, participation status, benefits of the study and confidentiality issues will make clear to the respondents.

3.11 Dissemination of the result

The result of the study will be disseminated to Addis Ababa University school of public Health department of health economics, afar regional health insurance bearue and regional health bearue, Dubti woreda district administrative office and other concerned bodies through reports, defense and publication on an appropriate journal.

4. RESULT

Socio-demographic characteristics of the respondents

Among384households participated in the study,about 299(77.9%) females and 333(26%) were in 31-45 years age category.Most of them were married 208 (54.2%) and Muslim religion followers (27.8%).About 69(18%) of participants attained grade nine and above education and about 97(25.3%) were government employed. Moreover, 120(31.3%) earning less than 20, 000 while209(54.4%)of them have 3-5 household members.

Variables	Categories	Frequency(%)
sex	Male	85(22.1%)
	Female	299 (77.9%)
Age category	Less than or equal to 30	
	31-45 years	
	46-60 years	
Marital status	Single	83(21.6%)
	Married	208(54.2%)
	Divorced	57(14.8%)
	Separated or widowed	36
Religion	Muslim	
	Orthodox	
	protestant	
	Catholic	
	Other	
Educational level	Not able to read and write	115(29.9%)
	Can read and write	113(34.6%)
	Grade 1-8	67(17.4%)
	Above grade 9	69(18%)
Status in the household	Female head of household	147(38.3%)
	Male head of household	111(28.9%)

	Wife	90(23.4%)
	Other	36(
Ethnicity	Afar	141(36.7%)
	Oromo	74(19.3%)
	Amhara	130(33.6%)
	Tigre	26(6.8%)
	Other	13(3.4%)
Occupation	farmer	132(34.4%)
	merchants	130(33.9%)
	government employee	97(25.3%)
	daily labour	20(5.2%)
	other	5(1.3%)
Annual income	less than 2000 ETB	120(31.3%)
	21000-50000 ETB	163(42.4%)
	51000-10000 ETB	68(17.7%)
	above 100000 ETB	33(18.6%)
Number of household members	1-2	114(29.7%)
	3-5	209(54.4%)
	greater than 5	61(15.9%)

Health seeking behaviour of respondents

Out of 384household participated in the study,231(60.2%) of them goes more than 10km to get health care services. The majority of them 197(51.3%) seek health care services fromGovernment HC or hospital. Moreover, about 154(40.1%) of study participants visited health facilities twice a year or more while about 165(43%) of illness were due to typhoid.

Variables	Categories	Frequency (%)
Distance from health facilities	0-10km	153(39.8%)
	11-20km	140(36.5%)
	21-30km	73(19%)
	more than 30km	18(4.7%)
Place for treatment during sickness	Private clinic	92(24%)
	Government HC or hospital	197(51.3%)
	Traditional or homeopathic healer	72(18.8%)
	Clinic run by a NGO or church	20(5.2%)
	Other	3(0.8%)
Frequency of seeking healthcare at health facilities	Twice a year or more	154(40.1%)
	Once per year	133(34.6%)
	Less than once a year but at least twice in past 5 years	71(18.5%)
	Once in past 5 years	21(5.5%)
	Never in past 5 years	5(1.3%)
Type of illness in past one month	Malaria	106(27.6%)
	Typhoid	165(43%)
	Diarrhea	80(20.8%)
	Hypertension	24(6.3%)
	Other	9(2.3%)

Awareness towards Community Based Health Insurance Scheme

More than half 227(59.1%)have heard CBHI scheme while 192(50%)have knowledge about CBHIS.Among 227 study participants,109(48%)heard CBHI scheme from health workers while 12(---%) haven't knowledge of Principles of CBHI.Out of all respondents, 104(27.1%) thought that the main source health sector finance were from government or tax payers.

Variables	Categories	Frequency (%)
Heard CBHI scheme	No	157(40.9%)
	Yes	227(59.1%)
Source of CBHI information	Health workers	109(48%)
	Radio and TV	53(23.3%)
	Family, friends, neighbors and colleagues	62(27.3%)
	Other	3(1.3%)
Type of CBHI pillars aware of	Community(Beneficiaries)	74
	Health facilities	191
	Health Insurance Scheme	70
	Others	49
Knowledge of Principles of CBHI	Pooling of fund	145
	Risk Sharing	116
	Equity	92
	Participation/empowerment	18
	Solidarity	1
	Don't know	12
Source of finance for health sector	From government(tax payers)	104(27.1%)
	From NGO and donors	214(55.7%)
	From Out of pockets(OOP)	43(11.2%)
	from other sources	23(6%)
Knowledge of CBHIS	No	192(50%)
	Yes	192(50%)

Attitude and perception towards Community Based Health Insurance Scheme

Slightly more than half (52.2%) have knowledge about CBHIS while 68.9% indicated interest to participate. About 81% were willing to pay for a premium while 65.2% will pay between the ranges of approx. $3.3-$16.4 (N 1, 000 – 5,

Variables	Categories	Frequency (%)
Importance of CBHI scheme	Not important at all	131(34.1%)
	Alittle bit important	138(35.9%)
	Somewhat important	54(14.1%)
	Extremely important	61(15.9%)
Accessto affordable healthcare due to CBHI	none	84(22.7%)
	low	140(36.5%)
	Medium	124(32.3%)
	High	33(8.6%)
CBHI improve household health consumption patterns	none	93(24.2%)
	low	145(37.8%)
	Medium	117(30.5%)
	High	29(7.6%)
CBHI ensure constant availability of drugs at health facilities	none	96(25%)
	low	122(31.8%)
	Medium	136(35.4%)
	High	30(7.8%)
CBHI to improve the quality of services	none	70(18.2%)
	low	138(35.9%)
	Medium	139(36.2%)
	High	37(9.6%)
Sector for whom CBHIS is important	none	87(22.7%)
	poor and low income	165(43%)
	Middle income	118(30.7%)
	high income	14(3.6%)

Relationshipbetween HCF and CBHIS	no	197(51.3%)
	yes	187(48.7%)
HCF reform used to give quality and equity health services, so it can help us to strengthen the CBHIS.	I will strongly disagree	106(27.6%)
	I will Disagree	42(10.9%)
	Unsure	35(9.1%)
	I will Agree	4(1%)

Willingness to participate and pay for Community Based Health Insurance scheme

Of the 384study households, 300(78.1%) were agreed to participate in community based health insurance scheme. Moreover, out of 234(60.9%) agreed to pay the specified premium per yearwhile 202(52.6%) of participants responds that they can pay the initial BID if the premium is 200 ETB. Moreover, of 384(100%) households there isn't household willing to accept BID if the payment is doubled. However, the maximum amount they willing to pay were___(SD). About, ___ (__ %)were willing to accept the bid if the premium is halved while the maximum amount they willing to pay was___(SD).of those willing to pay the zero bid,-----(--%) of them were thoughthey in doubt about the management of the fund.

Variables	Categories	Frequency (%)
Willingness to participate	yes	300(78.1)
	no	84(21.9)
Reason for not participate	amount of payment	25(29.8%)
	duration of payment	20(23.8%)
	insufficient services	25(29.8%)
	distance of health center	14(16.7%)
willingnessto pay the specified amount per year as a premium	no	150(39.1%)
	yes	234(60.9%)
initial bid have you taken	200 ETB	202(52.6%)
	250 ETB	97(25.3%)

	300 ETB	76(19.8%)
	above 400 ETB	9(2.4%)
WTP if the premium is doubled	no	384(100%)
	yes	0
maximum how much shall you pay per year per household	mean	
WTP if the premium is halved	no	
	yes	
maximum how much shall you pay per year per household	mean	
If the answer is 0 birr for Q 36, why is your household not willing to pay for the scheme	I doubt the management of the fund	
	It is the responsibility of the government to pay for such a programme	
	Because of lack of money	
	Other members of the society should pay for the programme	
	Other	
Frequency of yearly payment	Annual flat rate	194(50.5%)
	Bi-annual flat-rate	180(46.9%)
	Quarterly a year flat-rate	8(2.1%)
	Monthly	2(0.5%)

Determinants of Respondents' Awareness towards CBHI Scheme

The crude logistic regression results indicated thatfactors like sex, number of household size, distance from health facilities, marital, educational and occupational status of the household were significantly associated with awareness toward CBHIS. However, in multivariate analysis only

occupation of household anddistance from health facilitieswere significant factors determininghousehold awareness towards CBHI scheme. In this finding, household living less than 10km was more likely to have good awareness about CBHIS. Moreover, employed households were two times more likely to information about CBHI scheme compared to merchants.

Categories	Awareness toward CBHI		COR(95%CI)	AOR(95%CI)
	Yes (%)	No (%)		
marital status				
single	52(62.7)	31(37.3)	0.74(0.44,1.24)	0.78(.43, 1.43)
married	115(55.3)	93(44.7)	1	1
divorced	38(66.7)	19(33.3)	1.19(0.59,2.42)	1.11(0.50,2.39)
separated /widowed	22(61.1)	14(38.9)	0.92(0.38,2.22)	0.86(0.32,2.32)
no of household member				
1-2	74(64.9)	40(35.1)	0.71(0.44,1.12)	1.27 (.70, 2.28)
3-5	118(56.5)	91(43.5)	1	1
more than five	35(57.4)	26(42.6)	0.73(0.39,1.38)	0.81(0.38, 1.72)
distance from health facility				
0-10km	70(45.8)	83(54.2)	2.42(1.51,3.90)	2.63(1.53,4.54)
11-20km	94(67.1)	46(32.9)	1	1
21-30km	48(65.7)	25(34.3)	2.28(1.28,4.06)	2.89(1.46,5.71)
more than 30km	15(83.3)	3(16.3)	5.93(1.65,21.31)	5.34(1.36,21.01)
Sex				
male	45(52.9)	40(47.1)	1.38(0.85,2.25)	1.79(1.00,3.22)
female	182(49.3)	187(50.7)	1	1
educational status				
not able to read and write	56(48.7)	59(51.3)	2.13(1.28, 3.58)	1.76(0.92,3.37)
can read and write	89(66.9)	44(33.1)	1	1
1-8	38(56.7)	29(43.3)	1.38(.75, 2.53)	0.88(0.44,1.78)
grade nine and above	44(65.7	25(34.3)	1.85(1.01, 3.42)	1.94(0.86,4.39)
employment				
farmer	65(49.2)	67(50.8)	2.24(1.35,3.70)	1.69(0.94,3.03)
merchant	89(68.5)	41(31.5)	1	1
employed	56(57.7)	41(42.3)	1.41(0.83,0.74)	1.93(1.01,3.66)
other	17(68)	8(32)	3.09(1.06,9.00)	2.58(0.83,8.00)

Determinants of Respondents' Willingness to Participate in CBHI Scheme

The crude logistic regression results indicated that factors like sex, number of household size, distance from health facilities, educational and occupational status of the household were significantly associated with willingness to participate for CBHI scheme. However, in multivariate logistic regression analysis only education level and sex have significant association withhouseholdwillingness to participate for CBHI scheme. Those who were unable to read and write were two times more likely to participate for CBHI compared to those whocan read and write. Moreover, male were more likely to participate in CBHI compared to their counterpart.

Categories	Willingness to participate		COR(95%CI)	AOR(95%CI)
	Yes (%)	No (%)		
no of household member				
1-2	92(80.7)	22(19.3)	1.08(0.61,1.92)	1.35 (.67, 2.67)
3-5	116(73)	43(27)	1	1
more than five	42(68.9)	19(31.1)	1.89(0.93,3.86)	1.48(0.67, 3.27)
distance from health facility				
0-10km	123(80.4)	30(19.6)	1.26(0.72,2.20)	1.63(0.85,3.10)
11-20km	107(76.4)	33923.6)	1	1
21-30km	70(77)	21(23)	1.55(0.81,2.97)	1.86(0.87,3.96)
Sex				
male	72(84.7)	13(15.30	1.73(0.90,3.30)	1.93(1.06,3.78)
female	228(95.4)	11(4.6)	1	1
educational status				
not able to read and write	94(81.7)	21(18.3)	1.93(1.06, 3.51)	1.93(1.06, 3.51)
can read and write	93(70)	40(30)	1	1
1-8	56(83.6)	11(16.4)	0.88(.40, 1.96)	0.88(.40, 1.96)
grade nine and above	57(82.6)	12(17.4)	0.94(.43, 2.06)	0.94(.43, 2.06)
employment				
farmer	104(78.8)	28(21.2)	0.72(0.38,1.34)	0.68(0.34,1.39)
merchant	109(83.9)	21(16.1)	1	1
employed	69(71.1)	28(28.9)	1.51(0.82,1.76)	2.01(0.98,4.14)
0ther	18(72)	793)	1.59(0.56,4.52)	1.29(0.42,3.99)

Determinants of Respondents' Willingness to pay for CBHI Scheme

The crude logistic regression results indicated that factors like sex, number of household size, distance from health facilities, marital, educational and occupational status of the household were significantly associated with willingness to pay for CBHI. However, in multivariate analysis only income and sexhave significant association withhouseholdwillingness to pay for CBHI scheme. Occupation significantly influenced WTP for CBHI among informal workers. Households with lowannual income were more likely to have higher WTP for CBHI. Male household were was more likely to have higher WTP compared to their counterpart.

Categories	Willingness to participate		COR(95%CI)	AOR(95%CI)
	Yes (%)	No (%)		
marital status				
single	41(49.4)	42(50.6)	1.74(1.04,2.92)	1.08(.59, 1.98)
married	131(63)	77(37)	1	1
divorced	38(67.9)	18(32.1)	2.16(1.07,4.40)	2.83(1.21,6.59)
separated	19(67.9)	9(32.1)	2.16(0.88,5.33)	0.95(0.33,2.74)
widowed	4(50)	4(50)	1.03(0.24,4.37)	1.44(.24,8.75)
income status				
less than 20000 ETB	58(48.3)	62(51.7)	2.26(1.39,3.68)	2.15(1.30,3.54)
21000-50000 ETB	110(67.9)	52(32.1)	1	1
51000-100000 ETB	43(63.2)	25(36.8)	1.84(1.00,3.38)	1.76(.94,3.29)
above 100000 ETB	22(66.7)	11(33.3)	2.14(0.95,4.80)	2.10(.91,4.76)
no of household member				
1-2	66(58.4)	47(41.6)	1.34(0.87,2.22)	1.05 (.58, 1.92)
3-5	138(66)	71(34)	1	1
more than five	29(47.5)	32(52.5)	0.65(0.35,1.21)	0.53(0.24, 1.16)
distance from health facility				
0-10km	85(55.9)	67(44.1)	1.38(0.86,2.20)	1.01(0.57,1.81)
11-20km	89(63.6)	51(36.4)	1	1
21-30km	47(64.4)	26(35.6)	1.43(0.80,2.54)	0.84(0.41,1.72)
more than 30km	12(66.7)	6(33.3)	1.58(0.56,4.42)	1.91(0.56,6.52)
Sex				
male	33(38.8)	52(61.2)	3.22(1.95,5.30)	3.1(1.87,5.13)*
female	200(67.1)	98(32.9)	1	1
educational status				
not able to read and write	74(64.4)	41(35.6)	10.84(.50, 1.40)	1.15(0.59,2.23)
can read and write	80(60.2)	53(39.8)	1	1

1-8	51(76.1)	16(23.9)	1.77(.90, 3.48)	2.06(0.95,4.50)
grade nine and above	28(41.2)	40(59.8)	0.39(.21, 0.72)	0.63(0.27,1.48)
employment				
farmer	90(68.2)	42(31.8)	0.77(0.46,1.29)	0.79(0.41,1.54)
merchant	81(62.3)	49(37.7)	1	1
employed	46(47.9)	50(52.1)	0.43(0.25,0.74)	0.45(0.22,0.91)
other	16(64)	9(36)	0.87(0.32,2.33)	1.38(0.45,4.25)

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8;-ANNEXES

Annex 1: English version Information Sheet and Consent Form

Greetings

Hello! My name is Lubaba Mohammed I came from Adiss Ababa University College of health Sciences Department of Public Health .I am conducting a study on Community Based Health Insurance Scheme among the house hold in Dubti district. You are kindly requested to be included in the study, which will have importance in improving health financing and other health service delivery system. The interview will take about 30 minutes. No information concerning you, as individual will be passed to another individual or institution without your agreement.

Your participation is voluntary and you have the right not to participate fully or partially. If you agree to be included in the study I will start my questions by asking general identification points. Only honest answers would contribute to improvement of health planning.The study has approval from Adiss Ababa University College of health science. “May I continue?”

YES	NO

Consent form

I have been briefly informed about the study and I clearly understood the objective. Since it doesn't affect my personal life, I don't need any remedy. Consequently, I here approve my consent to take part in the study as an interviewee with my signature.

Signature_____

Date …….

Pre-Interview Information

This part should be filled by the enumerator before the interview
Code number: _____

What is the respondent's home address_____?

Name of the interviewer: _____

What is the date of interview ____/___/____

What time did the interview start: _____

Please, enter the appropriate number representing the answer given in the spaces provided. Please note that throughout the questionnaire, if YES write 1 in the box, if NO, write 0 in the box. ***All boxes MUST be filled.For question number 20****,Scores of respondents on Knowledge of Principles of CBHIs they know; Poor Knowledge= 0[ ],Fair Knowledge = 1-2 [ ], Good Knowledge =3- 4[ ] and Very Good Knowledge = 4-5[ ]*

PART- I. SOCIO DEMOGRAPHIC CHARACTERSTICS

No	Questions	Coding Categories	Skip

1	Respondents age _____years		
2	Respondents sex	1.Male [ ] 2.Female[ ]	
3	What is your status in this household? [ ] *[Enumerator: Only the head of the household should be interviewed or in his/her absence the spouse should be interviewed or another adult income earner]*.	0 = female head of household; [ ] 1 = male head of household; [ ] 2 = wife; [ ] 3 = grandmother; [ ] 4 = representative of household[ ]	
4	Marital Status	1.Single[ ] 2.Married[ ] 3.Divorced[ ] 4.Wedowed[ ] 5.Separated[ ]	
5	Your Ethnicity	1.Afar[ ] 2.Amhara[ ] 3.Oromo[ ] 4.Tigrie[ ] 5.Other[ ] (Specify)_____	
6	Your Religion	1. Islam[ ] 2.Orthodox[ ] 3.Protestant[ ] 4.Catholic[ ] 5. Other [ ] (Specify_____	
7	Your Educational level	1. Not able to read write. [ ] 2.Can read and write[ ] 3.Grade 1-8[ ] 4.Grade 9 and above[ ]	
8	How Many people are living with you in your house hold	1.1-2[ ] 2. 3-5[ ] 3.Greater than 5[ ]	
9	How many adults (greater than or equal to 18 years) live here? [ ] No. of adults		
10	How many younger people (less than 18 years) live here? [ ] No. of other people		
11	The main occupation of the head of the house hold	1.Farmer[ ] 2. Merchant[ ] 3. Government employers[ ] 4. Daily laborers[ ] 5. Others specify[ ]	
12	Your Estimated Annual income	1.<20,000ETB[ ] 2.21,000-50,000ETB[ ]	

		3.51,000-100,000ETB[ ] 4.Greater than100,000ETB[ ]	
	PART- II. HEALTH SEEKING BEHAVIOR		
13	How far do you live from the nearest health center or hospital?	1.0-10 kilometers[ ] 2.11-20 kilometers[ ] 3.21-30 kilometers[ ] 4.More than 30 kilometers[ ]	
14	Where do you usually go if you are sick, or to treat a general health problem? (Check all that are mentioned.)	1. Private clinic[ ] 2. Government HC or hospital[ ] 3. Traditional or homeopathic healer[ ] 4. Clinic run by a non governmental organization or church[ ] 5. Other: [ ]specify	
15	How often do you generally seek health care at a clinic or hospital? (Check one.)	1. Twice a year or more[ ] 2. Once per year[ ] 3. Less than once a year but at least twice in past 5 years[ ] 4. Once in past 5 years[ ] 5. Never in past 5 years[ ] 6. Other: [ ] Specify;	
16	What was the most recent type of sickness or poor health condition you had within the past one month?	a. Malaria [ ] b. Typhoid [ ] c. Diarrhea [ ] d. Hypertension [ ] e.Other [ ] Please specify:_____	
	PART-III. CBHIS k awareness		
17	Have you ever heard of Community Based Health Insurance Scheme (CBHIS)?	0.No [ ] 1.Yes[ ]	
18	If Yes, Where did you hear for the first time about CBHIS.(Multiple response is possible)	1. Health workers[ ] 2. Radio and TV[ ] 3. Family, friends, neighbors and colleagues[ ] 4. Kebele and Woreda Leaders[5. Other [ ] (please explain):_____	
19	From either your experience or understanding, What are the pillars of CBHIs?	1.Community(Beneficiaries) [ ] 2.Health facilities[ ] 3.Health Insurance Scheme[ ] 4.I don't know[ ] 5.Others _____ Specify….[ ]	
20	Knowledge of Principles of CBHIS.(Multiple	1.Pooling of fund[ ]	

	response is possible).	2.Risk Sharing[ ] 3. Equity[ ] 4. Participation/empowerment[ ] 5.Solidarity[ ] 6. Don't know[ ]	
21	What is the source of finance for health sector? (Multiple response is possible)	1.From government(tax payers)[ ] 2.From NGO and donors[ ] 3.From Out of pockets(OOP) [ ] 4.from other sources[ ]	
22	Knowledge of CBHIS(Willingness to Insure all Household Members)	0.NO [ ] 1.YES[ ]	
	PART-IV. CBHIS ATTITUDE AND PERCEPTION **(PERCEIVED IMPORTANCE OF CBHI)**		
23	Imlportance of Community based health insurance scheme(CBHIS)	1.Not important at all [ ] 2.alittle bit important [ ] 3.Some what important[ ] 4.Extremly important[ ]	
24	What do you think is the potential level of access by households to affordable healthcare due to community-based health insurance?	1 . none[ ] 2 . low[ ] 3 . medium[ ] 4. high[ ]	
25	How would you rate the potential of community-based health insurance to improve household health consumption patterns by ensuring that healthcare costs are reduced?	1. none[ ] 2. low[ ] 3. medium[ ] 4. high[ ]	
26	How would rate the potential of CBHI to ensure constant availability of drugs at health facilities in your community?	1. none [ ] 2. low[ ] 3. medium[ ] 4. high[ ]	
27	How would you rate the potential of CBHI to improve the quality of services provided by healthcare givers?	1.none[ ] 2. low[ ] 3. medium [ ] 4 .high[ ]	
28	CBHIS is very important especially, for whom (which part of our community)?	1.none[ ] 2.poor and low income [ ] 3.Middle income[ ] 4.high income[ ]	
29	Is there a relationship between HCF and CBHIS?	0.NO[ ] 1.YES[ ]	
30	If the answer for the above is yes what is the relationship? HCF reform used to give quality and equity health services, so it can help us to strengthen	1.I will strongly disagree[ ] 2.I will Disagree[ ] 3.Unsure[ ]	

	the CBHIS.	4.I will Agree [ ] 5.I will Strongly Agree[ ]	
	PART-V.WILLINGNESS TO PARTICIPATE AND PAY		
31	If you join the CBHI scheme will you pay the specified amount per year as a premium?	0.No 1.Yes	
32	Which initial bid have you taken	1. 200 ETB[ ] 2. 250 ETB [ ] 3. 300 ETB[ ] 4. 400 ETB [ ] 5. 500 ETB [ ]	If "no", skip to Q35
33	Will you pay if the premium is double of the specified Birr amount per year per household?	0.No [ ] 1. Yes [ ]	If "no", skip to Q38
34	Maximum how much shall you pay per year per household?	Specify the amount in Birr _____	Go to Q 38
35	If "no" for Q 33, will you pay (half of the initial bid)/year/HH?	0.No [ ] 1. Yes [ ]	If "yes", skip to Q 38
36	If "no" for Q35, maximum how much shall you pay per year per household?	Specify the amount in birr ____	Go to Q 37, if answer = 0 birr; go to 38 if >0 birr.
37	If the answer is 0 birr for Q 36, why is your household not willing to pay for the scheme?	1. I doubt the management of the fund [ ] 2. It is the responsibility of the government to pay for such a programme[ ] 3. Because of lack of money [ ] 4. Other members of the society should pay for the programme [ ] 5. Other [ ] (specify)_____	Stop the interview here
38	How frequently do you want to pay the yearly premium?	1. Annual flat rate [ ] 2. Bi-annual flat-rate [ ] 3. Quarterly a year flat-rate [ ] 4. Monthly [ ] 5. Other[ ] (specify)_____	

39. Are there comments that you wish to make about the community-based health insurance scheme? [ ] 0 = no 1 = yes

40. Whatarethey?

_____

_____

_____

Thank you

Enumerator: Record the time at which the interview ended _____.

Annex 2: English version structured Questionnaire

በአሚኛየ ተዘጋጀመጣቅሪዊመጠይቆች

ቅደመመጠይቅመረጃዎች

ይህክፍልበመጠይቅሰብስበቢመጠይቅከመደረጉበፊትየ ሚሞላነ ው ፡

የ ኮደቁጥር----------

የ ምላሽሠጪዉአደሪሻ----------

የ መጠይቅአደራጊዉስም----------

እባክዎ ትክክለኛዉንመልስየ ሚከለዉንቁጥርበተቀመጠዉባዶ ታላይያስቀምጡ

እባክዎበመጠይቆቹዉስጥአስተዉላዉ፤ መልሱአዎከሆነ 1 በሳጥኑዉስጥይፃ ፉ፣ መልሱአይደለምከሆነ 0

በሳጥኑዉስጥይፃ ፉ ፡ ሀለምላጥኖችመሞላትአለባቸው ፡ ለጥያቄቁጥር 20፣ ተጠያቂዎችበጠፍ መድን መሆኖች (

principles of CBHI) ያላቸውን ዕውቀት ለሥጠት ምላሽ ወጪ፤ ዝቅተኛ ዕውቀት 0 ( )፣ መካከለኛ ዕውቀት 1-2 ( )፣ ጥሩ ዕውቀት 3-4 ( ) እና በጣም ጥሩ ዕውቀት 4-5 ( )

ክፍል 1 የማህበረሰብ ፀባያት

ተ.ቁ	መጠይቆች	የኮድ ክፍል	ይለፍ
1	የምላሽ ሠጭው ዕድሜ___________ ዓመት		
2	የመላሽ ፆታ	1.ወንድ [ ] 2.ሴት [ ]	
3	በቤተሰብ ውስጥ ያንተ/ቺ ድርሻ ምንድን ነው? [ ] *[Enumerator: አባዋራ ወይም እማዋራ ቅአለበት ወይም እሰብሌ ለበት ሚስት ብቻ ማለ የቅአለባት ወይም በቤተሰብ ውስጥ ገቢ ያለው ግለሰብ ብቻ ማለ ቅ አለበት].*	0 = እማዋራ; [ ] 1 = አባወራ; [ ] 2 = ሚስት; [ ] 3 = ሴት ልጅ/ወንድ; [ ] 4 = የ ቤተሰቡ ተወካይ[ ]	
4	የ ጋብቻ ሁኔታ	1.ያላገባ/ች [ ] 2.ያገባ/ች [ ] 3.የተፈታ/ች [ ] 4.በሞት የ ተለየ /ች [ ] 5.የ ተለያዩ [ ]	
5	ብሄርዎ	1.አፋር [ ] 2.አማራ [ ] 3.ኦሮሞ[ ] 4.ትግሬ [ ] 5.ሌላ [ ] (ይገ ለፅ)_________	
6	ሀይማኖትዎ	1. እስላም[ ] 2.ክርስትያን[ ] 3.ፕሮቴስታንት[ ] 4.ካቶሊክ[ ] 5. ሌላ [ ] (ይገ ለፅ_______	
7	የ ትምህርት ደረጃዎ	1. ማንበብና መጻፍ የ ማይችል/ትችል [ ] 2.ማንበብና መጻፍ የሚችል/ምትችል[ ] 3.ክፍል 1-8[ ] 4.ክፍል 9 እና ከዚያ በላይ [ ]	
8	በእርስዎ ቤተሰብ ውስጥ ምን ያህል ሠው ይኖራል	1.1-2[ ] 2. 3-5[ ]	

		3.ከ5 በላይ [ ]	
9	ምን ያህል ጎልማሶች (ዕድሜያቸው ከ18 ዓመት እና ከዚያ በላይ የሆኑ) ይኖራሉ? [ ] የጎልማሶች ብዛት		
10	ምን ያህል ወጣቶች (ከ18 ዓመት በታች) ይኖራሉ? [ ] ለልጆች ሰዎች ብዛት		
11	የቤተሰቡ ሃላፊ ሙያ ዳደሪያ ስራ ወምን ደንነ ው	1.ገበሬ [ ] 2. ነጋዴ [ ] 3. የመንግስት ሠራተኛ [ ] 4. የቀን ሰራተኛ [ ] 5. ሌላ ይገለፅ [ ]	
12	የእርስዎ ዓመታዊ ገቢ ምን ያህል ይሆናል	1.<20,000 የኢ.ብር [ ] 2.21,000-50,000 የኢ.ብር [ ] 3.51,000-100,000 የኢ.ብር [ ] 4.ከ100,000 በላይ የኢ.ብር [ ]	
	PART- II. HEALTH SEEKING BEHAVIOR		
13	ከሚኖሩበት ቦታ ቅርብ በጤና ጣቢያ ወይም ሆስፒታል ምን ያህል ይርቃል?	1.0-10 ኪሎሜትር [ ] 2.11-20 ኪሎሜትር [ ] 3.21-30 ኪሎሜትር [ ] 4.ከ30 ኪሎሜትር በላይ [ ]	
14	በሚታመሙ ጊዜ በአብዛሃኛው ወደየት ይሄዳሉ; ወይም ጥቅላላ የጤና ችግርን ለማከም? (የተዘረዘሩትን ሁሉ ያስተውሉ.)	1. የግል ክሊኒክ [ ] 2. የመንግስት ጤና ጣቢያ ወይም ሆስፒታል [ ] 3. ባህላዊ ወይም homeopathic healer [ ] 4. መንግስታዊ ባልሆነ ድርጅት የሚሮክሊኒክ or ቤተ-ክርስትያን [ ] 5. ሌላ: [ ] ይገለፅ	
15	በአጠቃላይ ጤናዎን ለመጠበቅ ወደ ክሊኒክ ወይም ሆስፒታል ምን ያህል ጊዜ ይሄዳሉ? (Check one.)	1. በአመት ሁለት ጊዜ ወይም ከዚያ በላይ [ ] 2. በአመት አንድ ጊዜ [ ] 3. በአመት ከአንድ ጊዜ ያነሰ ግን ሁለት ጊዜ ባለፉት 5 ዓመት [ ] 4. በ5 ዓመት አንድ ጊዜ [ ] 5. በ5 ዓመት ውስጥ አልሄድኩም [ ] 6. ሌላ: [ ] ይገለፅ;	
16	እርስዎ ወይም የእርስዎ ቤተሰብ በለፉት አንድ ወራት በቅርብ ከያዛቸው በሽታ ወይም የጤና ችግር ምን ነበር?	a. ወባ [ ] b. ታይፎይድ [ ] c. ተቅማጥ [ ] d. የደም ግፊት [ ]	

		e.ሌላ [ ] እባክዎይግለፁ:______	
	PART-III. ስለህብረተሰብጤናመድንዕውቀትእናግንዛቤ		
17	ስለህብረተሰብጤናመድን(CBHIS) ከዚህበፊትሰምተውያውቃሉ?	0.የለም[ ] 1.አዎ[ ]	
18	አዎካሉ; ለመጀመሪያጊዜስለህብረተሰብጤናመድንየሰሙትየትነበር? (ብዙምላሾችንመጠቀምይችላሉ)	1. ጤናሠራተኞች[ ] 2. ሬድዮእናቴሌቪዥን[ ] 3. ቤተሰብ, ጓደኛ, ጎረቤትእናየስራባልደረባ[ ] 4. ቀበሌእናወረዳአመራሮች[5. ሌላ [ ] (እባክዎይግለፁ):______	
19	ከእርስዎግንዛቤወይምእምነትየህብረተሰብጤናመድንመሠረቶች ምንድንናቸው?	1.ማህበረሰብ(ተጠቃሚ)[ ] 2.የጤናቁሳቁሶች[ ] 3.የጤናኢንሹራንስዘዴ[ ] 4.አላውቅም[ ] 5.ሌሎች ______ ይግለፁ….[ ]	
20	የህብረተሰብጤናመድንህግጋቶችዕውቀት(ከአንድበላይምላሽመስጠትይቻላል).	1. ገንዘብማሰባሰብ[ ] 2.ስጋትንመካፈል [ ] 3. ፍትሀዊነት [ ] 4. ተሳትፎ/ማህበራት [ ] 5.አንድነት [ ] 6. አላውቅም[ ]	
21	የጤናሴክተሮችየገንዘብምንጭምንድንነው? (ከአንድበላይምላሽይቻላል)	1.ከመንግስትከግብርከፋዮች)[ ] 2.ከመንግስታዊካልሆኑድርጅቶችእናሰጭዎች[ ] 3.ከኪስከሚወጣ [ ] 4.ከሌላምንጭ]	
22	የህብረተሰብጤናመድንዕውቀት (የቤተሰበአባሎችኢንሹራንስለመግባትፍቃደኝነታቸው)	0.አይደለም[ ] 1.አዎ [ ]	

	PART-IV.ስለህብረተሰብጤናመድንአመለካከትእናአቀባበል (የህብረተሰብጤናመድንስላለውጥቅምያላቸውግንዛቤ)		
23	የማህበረሰብየጤናኢንሹራንስመዋቅርያለውጥቅም (CBHIS)	1.በጥቅሉምንምጥቅምየለውም[ ] 2.በጣምጥቂትጥቅምአለው[ ]	

		3.በትንሹጥቅምአለዉ[ ] 4.በጣምጥቅምአለዉ[ ]	
24	የእርስዎቤተሰብየ ጠፍእንክብካቤበበማህበረሰብጠፍኢንሹራ ንስአማካኝነ ትለሚደረስያለወጓአቅምማግኘያስባሉ?	1 . ምንም[ ] 2 . ዝቅተኛ[ ] 3 . መካከለኛ[ ] 4. ከፍተኛ [ ]	
25	የማህበረሰብየ ጠፍኢንሹራንስለጠፍጥበቃዋጋዎትንመቀነ ስ ንበሚ,ጋገ ጥየ ቤተሰብዎንየ ጠፍአጠበበቅሀኔ,ታዓለማሻሻል ያለወጓአቅምእንደሕይወጣሉ,ታል?	1. ምንም[ ] 2. ዝቅተኛ [ ] 3. መካከለኛ[ ] 4. ከፍተኛ[ ]	
26	የህብረተሰብጠፍመድንበጠፍተቋማትዉጣለማህበረሰበቋሚ የሆነ የመሃኒትአቅርቦትእንዲኖርበሞረግያለወጓአቅም እንደሕይወጣሉ,ታል?	1. ምንም[ ] 2. ዝቅተኛ [ ] 3. መካከለኛ[ ] 4. ከፍተኛ[ ]	
27	የህብረተሰብጠፍመድንየ ጠፍእንክብካቤሥጭትየ ሚደርጉ ትንአገ ልግለትጥራትለማሻሻልያለወጓአቅምእንደሕይወጣሉ ,ታል?	1. ምንም[ ] 2. ዝቅተኛ [ ] 3. መካከለኛ[ ] 4. ከፍተኛ[ ]	
28	የህብረተሰብጠፍመድንበጣምከቃሚ ወፃተለይ , ለእነ ማን (ለየ ትኛውማህረሰብክፍልነ ው)?	1.ምንም[ ] 2.ደሃእናዝቅተኛገ በለለወ[ ] 3.መካከለኛገ በለለዉ[ ] 4.ከፍተኛገ በለለዉ[ ]	
29	በ ጠፍ አገ ልግለት ውጪእናየ ህብረተሰብጠፍመድንመካከልግንኙነ ትአለን?	0.የለም[ ] 1.አዎ[ ]	
30	ለላይኛውጥያቄመልሱአዎከሆነ ምንደንነ ወገንኙነ ታቸውየ ጠፍ አገ ልግለት ውጤነ (HCF) ማሻሻልጥራትያለወእናፍትሃዊየ ጠፍአገ ልግለትለማጠናከይ ጠቅሟል፣ ስለዚህየ ህብረተሰብጠፍመድንንእንዲጠፍከርይረዳናል	1. በጣምአልስማማም[ ] 2.አልስማማም[ ] 3.እርጠኛአይደለሁም[ ] 4.እስማማለሁ[ ] 5.በጣምአስማማለሁ[ ]	
	PART-V. ለመላተፍእናለመከፈልፍቃደንነ ታቸው		
31	የትኛውንየ መነ ሻዋጋይመነዳሉ	1. 200 የኢብር[ ] 2. 250 የኢብር [ ] 3. 300 የኢብር [ ] 4. 400 የኢብር [ ] 5. 500 የኢብር [ ]	
32	ወደህብረተሰብጠፍመድንመቀርቢቀላቀለእንደአን	0.አይደለም[ ]	“አይደለ

	ጋፋኑ ትምየ ተወሰነ ወጓየ ብርመጠንበዓመትይከፍላሉ ን?	1. አዎ[ ]	ም ካለወደጥ 35 ይለፉ
33	እንደአንጋፋኑ ትምበተወሰነ ወየ ብርመጠንበእጥፍበዉጅረበ ዓመትበቤተሰብዎልክይከፍላሉን?	0. አይደለም[ ] 1. አዎ[ ]	"አይደለ ም" ካለወደጥ 38 ይለፉ
34	ከፍተኛዋጋበዓመትበአንደቤተሰብምንያህልይከፍላሉ?	የ ብሩመጠንይገለጽ ______	ወደጥ38 ይሂዱ
35	ለጥ33 "አይደለም" ከሆነ , በዓመትየ መ ሻዋጋወጓግማሽበአንደቤተሰብይከፍላሉን?	0.አይደለም[ ] 1. አዎ[ ]	"አዎ" ከሆነ , ወደጥ38 ይለፉ
36	ለጥ35 "አይደለም" ከሆነ If "no" for Q35, ከፍተኛበዓመትምንያህልበአንደቤተሰብይከፍላሉ?	የ ብሩመጠንይገለጽ ____	መልሱ0 ብርከሆነ ወደጥ37፤ ከ›0 ብርከሆነ ወደጥ38 ይሂዱ
37	ለጥ36 መልሱ0 ብርከሆነ የ እርስዎቤተሰብለዚህመቅርከፍያፍቃደኛያልሆ ነ ወለምንድንነ ው?	1. የ ክፍያ ወጓቁጥጥርእጠራጠራለሁ[ ] 2. እንደዚህአይነ ትፕሮግራምክፍያ ሚፀምዋ ማግስት ሃላፊነ ትነ ው[ ] 3. ገ ንዘብስለለኝ [ ] 4. ሌለየ ማህበረሰብክፍልለዚህፕሮግራምመክፈልአለባ ቸው[ ] 5. ሌላ [ ] (ይገለፅ)_____	Stop the intervie w here
38	ዓመታዊወጓየ ክፍያጊዜበምንያህልጊዜመክፈልይፈልጋሉ?	1. በየ ዓመት [ ] 2. በየ ግማሽዓመት [ ] 3. በየ ሩብዓመት [ ] 4. በየ ወሩ [ ] 5. ሌላ [ ] (ይገለፅ)______	

39. ስለህብረተሰብጤናመድንማንኛውምማለትየሚፈልጉትነገርአለን? [   ]   0 = የለም   1 = አዎ

40. ካለምንምንናቸው?

____

____

____

አመሰግናለሁ

መረጃሰብሳቢ: ቃለመጠይቁያለቀበትንጊዜመዝግብ______.

8.Kataytem

1 haytoh:xaagoysiyyaa kee sitingey exxa qafar afat.

salaamatta:

Hayyeh: yi migaqa lubaaba mocaamed xiqsita kollegik qaafiyat kee sayinis xibartmentik ummattah qaafiyatih exxak emeete.

ummatta fanteena abtah tan qaafiyat inshuransih taamaay buxak buxal dubti daqaaral take sin aysixxigem faxa.isin ta tubaritik ceelah yan esserimiyya liton.woh kaadu qaafiyat qidaddoo kee qaafiyat ayfaafayih mattacol baxsale tuxxiq kee xalotleemih sabbatah, ta esserentih 30 wakti nee beele.atu abtah tan sittingey akkey waytok numtin amol hinnaay kaadu maktabah caddol geytimah yan xaagi miyana (mabna).kufayxik ugut abak abtah tan gabat aglee kee abtah tan gabat aglee kaadu Inkih hinnay galyabal (oggoltam or haysitam) ku fayxi. Ta tubaritit gaba tasgalluh fayxi teelek numtin amoh oytih celtah tan esserorah ximmo mak qimmiseyyo. qaafiyat taddeera xalot bahtuh (aysuh taysuh) muxxih kufayxiik uguttak abtac tan cato dubuk.

Ta kusaaqih exxa adiss ababa jaamiqatak qaafiyat kee sayinis kollegik le gabuk fatta koh gacissa.

Qimmisam duudaay?

yeey(duddah)   baleey(maduddah)

sittingey oli(cibta)

Ta kusaaqak baxxaqqa kee addafakoot elle leh yan innah tasmitem kee qaalam akak maca kinnim digga heeyo.ahaak naharal yok numtin amoh caddoh manol tutaqabi yok mabaahinna.

Tu mattaco akak mafaxa kaadu. qagitakaay, ta tu barit (kusaq yakkuh esser kee gacsal inni asta daffeyseyyo.

Asta:…….

Ayro:……..

2 haytoh katayle:Qaafar afi exxah kinnane le esserenta.

Esserentak naharsi caddoh xaagoyso.

Esser kee gacsak naharal le wannah gabat kibbimta exxa

-Koo nibro……

-Raddi abeenak buxa raceena……..

-Essero abeeni migaaqa…….

-Esserimiyyi edde yekke ayro……

-Esserimiyyi edde qimmise saaqata…….

Fakut tanih tan foxooxat ceelah yan raddi edde culussaanam faxximta.inkih tan esserentak inkih uktubah raddi yeey tekkek 1 sandug addal.

Inkih tan sandugwa kibbimtaam faxximta 20 haytoh esseroh raddi abemit CBHI loonuh yanin tu ixxiga yaaaxigeenim keenik faaximta.

- kaxxa qaku le ixxiga = 0
- qaku le ixxiga = 1-2
- meqeh tan ixxiga = 3-4
- kaxxam meqeh tan ixxiga

Naharsi caddoh: ummattah weeloh [kinnanoh].

ixxima	essero	kooxmattaco kinnane	maybalaaqa
1	Raddi abeeni		

	karma…….sanatah…….	
2	Raddi abeeni nado	1. labih …… 2. sayih …….
3 4	Ta buxah addal annah tan caddo litooh? [maggaraqa : buxah abbah yanih yan raddi abeeni ane waa kaateh tekke kalah yanih yan (tanih tan) esserime enah culenti yamcoowele.] Digib weelo	0. buxa saqalah tan saynum…….. 1. buxa saqalah yan lab num…… 2. barra……. 3. ina maqaanxa…….4.buxa marakaw 1.Marihme…… 2.Rihmeh…….. 3.Cabtinto…… 4.deddaaral yan…….
5	Kido kinnane	1.Qafara……. 2.Amcara…….. 3.Oromo…….. 4.Tigraya…….. 5.Kalah yan mara (baxxaqis)…….
6	Diini kinnane	1. Islaama……. 2. orthodox……. 3. protestant……. 4. katoliki……. 5. kalah taniimi qaddos…….
7	Baritto Caddo	1. yakriyee yatkubem madiga……. 2. yakriyee yaktubem xiqa……. 3. 1-8 fanah yan caddo…… 4. 9 hayto kee wohuk daga……
8	Magide yakke mari yaniih ku buxah addal	1. 1-2 2. 3-5 3. 5 daga
9	Magideh kasle (18 karmay kee wohuuk dagah karmat taniimit gaytimtam	

	……..kasle anewaytek	
10.	Magideh cata 18 karmaak guba tanih iyya taniih kubuxal…… aki mari aneweek……..	
11.	Buxa saqalak nabah tan taama	1. buqure abeena …… 2. badaag abeena …… 3. doolat taama abeena…….. 4. xooquh xiinaytu…… 5. kalah taniimih xiine qaddos……..
12.	Culenti caddo kok	1. <20,000 bil…… 2. 21,000-50,000 bil…… 3. 51,000-100,000…….. 4. 100,000 birrik dagal ……..

2 Hytoh exxa – Daylak Dalkah caalata

13.siinil xayih tan qaafiyat aracak mannah yan deddaar siinil leeh?	1. 0-10 kilo metri……. 2.11-20 km……. 3.21-30 km…….. 4.30 km daga……
14.Beyaakittanah tannin waqdi mangih gexxanam daylimtaana gidih ankeey? inkih yan qaafiyat taqabih?(tunkutubeh tanim inkih kusaaqis)	1.numtin amoh qaafiyatih araca 2.doolat qaafiyatih fanteena 3.qaada hinnay qaada daylaaabeenitih araca 4.doolat akke sinni kilinikiiy koros buxat miracsima. 5.kalah yan araca qaddos…….
15.magideh adda daylimteeh sittat kilinikil kee hospitaalal.(inkitul esser)	1. Namma adda kee wohuk daga 2.Inki adda sanatat 3.Inki addak guba sanatat Laakin tatreh yan 5 sanatih addat Namma addak sugte 4.Inki adda tatreh yan 5 sanatat 5.Magexiyyo Inkinnah tatreh yan koona /5/ sanatat

	6.kalah tenek qaddos

16.Tatreh yan Alsih Addat koo Yibbixeh yan dalka qaafiyat dagnah kinnaane Macaay	1.Qaso 2.Tayfooxi 3.bagigexo 4.qablimanga 5.kalah tanim tenek qaddos

3.haytoh exxa-ummattah fanteena abah yan qaafiyat Inshuransih Ixxigaa kee tummabulu

17.ummattah fanteena abtah tan qaafiyat Inshuransih taamaa axcih toobbeh taaxigee?	0.Maabiyo /baleey/ 1.obbeh /yeey/
18.Raddi kok yeey tekkek naharsi addah UFQIT ankle toobbeeh? [Namma yakki raddi xiqqimah]	1.qaafiyat taamaabeentiti 2.Raadiyoo kee Televiziini 3.buxamarih afat kataysos luk cuggaanekk kalah Lih taamita 4.Awuda kee daqaar kee doonak 5.kalah tanim tenek qaddos
19.Litoh tan abak raaq kee oytik ugut abak UFQIT ik Makaadoh tanim macak teneeh?	1.ummatta/tuxxiq leela/ 2.qaafiyat arooca 3.qaafiyat Inshuransih gexsiti 4.Maaxiga 5.kalah tanim tenek qaddos
20.Ixxiga gexsiti ummatta fannteena yan qaafiyat Inshuransih gexsitih [Namma yakki gacsi yakkeh]gaba gacsi Faxximaay?	1.cato Maalu /lakqo/ 2.qawwalay lah catoh 3.Inkim abiyyah (Inkigide abiyah)

	4.gabat agle(Reedoonuh) 5.qaskaariyyoh. 6. maaxiga
21. qaafiya t mactab wak qidaddo cayli (makaado) keenik maacay?(Nammay yakki gacsi yakkeh)	1. doolat le gabuk (acweenitik) 2.meqem abitoh eglaalik kalah gaddaloolak 3.Iro culentak 4.kalah yan caylak
22. ummatta fanteena abah yan qaafiyat inshuransih gexsit ixxigal akah yakku inkih tan buxaaxih marah	0.mayakkay (baleey) 1.yakke (yeey)

4 haytoh caddo Ummatta fanteenal abah yan qaafiyat Inshuransih gexsit leh yan weeloo kee kinnim yaxigeenimih caddol (yafhimeenimih tuxxiq UFQIT)

23.Ummatta fanteena abah yan qaafiyat Inshuransih gexsitik tuxxiq	1. tu tuxxiq mali inkih 2.dagoh yan tuxxiq le 3.dagoh yan tuxxiq mali 4. kaxxannah naba tuxxiq le
24.Ummatta fanteena abah yan qaafiyat Inshuransih ayfaafay fooca fanah .yakke qaafiyat ayfaafay buxak buxal yamcawwuh maca tascubeeh?	1.miyana 2. dagoh 3.fanah yan 4.fayyale caddole
25.sissiikiih fooca fanah yakkeh yan ummatta faantena abah yan qaafiyat Inshuransih ayfaafay buxah abbah qaafiyat ayfaafay aysaasuk (dadlisak) Qaafiyat awqenta addah haak abaanamih caalat daabisaanamal maca taniih?	1.matana 2.dagoh 3.fanah tan 4.fayyale
26. sissiikiih fooca fanah yakkeh yan ummatta fanteena abah ya qaafiyat Inshuransih ayfaafay dabimuh waqdiik waqdi qaafiyat aracal geytimac yan dawaat (faxxiimah yan)anniyyi issin ummatta adday manna leeh?	1.Miyana 2.dagoh 3.fanah yan 4.fayyale

27..sissiikiih fooca fanah yakke yan ummatta fanteena abah yan qaafiyat inshuransih gexsit qaafiyat taama abeenitih garil dadal kee safale ayfaafay akah yakkennah abaanamih taama maca celtaah?	1.Miyana 2.Dagoh 3.Fanah yan 4.Fayyale caddole
28.Ummatta fanteena abah yan qaafiyat Inshuransih gexsit kaxxam tuxxiq le baxsaluk anni caddoh faxximah?(Ni ummattak anni caddol faxximah).	1.Miyana 2.gaba dagoytit kee dago culenta le marah 3.fanti culentale marah 4.fayyale caddoh culenta le marah
29.Ummatta fanteena abah yan qaafiyat Inshuransih gexsit kee qaafiyat ayfaafih fanteenanni angarab maca ceelaah?	0.Malon 1.Loonuh
30.Raddi dagah esserok yeey tekkek angaarab keenik macaa?qaafiyat ayfaafayih aracal safaleeh inkigide abah yan qaafiyat ayfaafay yaceenim kinni , tohuk amakkaquk ummatta fanteena abah yan qaafiyat Inshuransih ayfaafay gablusiyyah cato le.	1.baxsaluk sadah 2.sadah 3.akak axigem mayyu 4.Meqeh 5.kaxxam meqe

5 Haytoh Exxa Meklah fayxi loonumu

31. Naharsi addah beyte mekla tanii?	1. 200 Bil 3.300 Bil 5.500 Bil 2.250 Bil 4. 400 Bil
32.Ummatta fanteena abtah tan qaafiyat Inshuransih ayfaafayat gufne abtek aa tekkek sanatal koh tamacoowe tamixxigeh tan mekla(acwa) tanii?	0. matana 1. tanih
33. sanatal madqeenih yanin inshuransi meklak sudaduc mekla buxah abbah caddol tamacoowwe?	0.matana 2. tanih
34. Fayyale caddoh sannatal magide buxah abbah caddol tammacowwem faxximtam kot celtaah?	Loowol qaddos …….

35.33 haytoh essero gacsi matan /balee tekkek sanat meklak garab ugtumah buxah abbal yamcoowwe?	0.baleey 1. yeey
36. 35 haytoh esseroh gacsi baleey tekkek sanatal fayyaluk meklah magide tamcooweem faxximtaah buxah abbah caddol.	Loowol qaddos
37.36 esseroh gacsi 0 yekkek ta ayfaafay mekla ku buxah mari akah geyu duudeweem maca?	1. Ta xiinissoh mattacool asmat alleweek sarra. 2. kulli taddeerah mekla abtam faxximta doolat dirki kinni. 3.Lakqoh allewaytih sababa. 4.Raqteh tan ummattah exxaxi mekla abtah ta tadderah. 5.Kalah tani tenek qaddos.
38.sanat addal mekla magideh adda qagaaqagittam faxxah?	1.waktiik 2.waktik nammadda 3.waktik afaaradda 4.alsak 5.gersim teenek

39. Ummatta fanteena abah yan qaafiyat ayfaafayal loonuh yanin tummabul yeelleenik…….

0.Malon 1.Loonuh

40.Ma Tummabul loonuh? who macaay?

……

…….....

Gadda gey!!

lewanna /essero abeena/:esser kee gacsi gabakalah yan waqdi saaqat daffes/uktub/……..