PERCEPTION OF HOUSEHOLD MEMBERS ON UBUDEHE CATEGORIES IN COMMUNITY BASED HEALTH INSURANCE IN RWANDA

A CASE STUDY OF HUYE DISTRICT

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DECLARATION

This research project is my original work and has not been presented for a degree in any other university.

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DEDICATION

This research project is dedicated to my husband and best friend, Musonera Edouard and my lovely children Arlette, Armel and Alve.

ACKNOWLEDGEMENTS

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LIST OF ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
CBHF	Community Based Health Insurance Fund
CBHI	Community Based Health Insurance
CBHIS	Community Based Health Insurance schemes
CBHPS	Community Based Health Planning and Services
CHF	Community Health Fund
CHI	Community Health Insurance
CHPS	Community-based Health Planning and Services
DRC	Democratic Republic of Congo
HIV	Human Immuno Virus
MHI	Mutual Health Insurance
MMI	Military Medical Insurance
MoH	Ministry of Health
NGOs	Non-Governmental Organizations
OECD	Organization for Economic Cooperation and Development
RAMA	La Rwandaise d'Assurance Maladie
SHI	Social Health Insurance
SNNPR	Southern Nations Nationalities and People's Region
SPSS	Statistical Package for Social Sciences
TB	Tuberculosis
UNESCO	United Nations Educational Scientific and Cultural Organization
WHO	World Health Organization

ABSTRACT

The purpose of the study was to determine the perception of household members on Ubudehe categories used by the government of Rwanda in Community Based Health Insurance schemes. Specifically the study intended to find out the perception of households on CBHI based on Ubudehe categories, identify the barriers to access to healthcare using the Ubudehe categories and explore ways of improving access to healthcare insurance in Huye district. The study was undertaken in Rwanda, Southern Province, Huye district. The specific sectors of focus were Tumba (urban) and Rwaniro (rural). Purposive sample technique was used to pick a sample of73 respondents. This consisted of community members as key respondents and authorities (local and government) as key informants. The study used primary data collected through the use of questionnaires. The collected data was then analyzed using SPSS and thematic coding. Finally, descriptive statistics were generated (descriptive statistics) and presented in form of tables, charts and prose form for interpretation. The study found that the perception of the households on the CBHI based on the Ubudehe categories is positive primarily because the policy is well received by the community. The study also found out that the main barrier of Ubudehe is lack of movement from one category to the next according to the changes in the household income levels. It is also found out that it is difficult for people with larger families to pay the required sum at once due to other family commitments. Finally, the study found that the authorities have no problems in implementing Ubudehe process despite the poor participation by the local community. The study recommends that the government and the stakeholders in the health sector need to make the Ubudehe program flexible to allow free movement and registration of people into various categories to reflect the changes in the economic status of the community and the households. They need to change criterion of categorization, naming and description of the categories, proper editing and time allocation for the community to participate in the categorization. The provision of adequate and accurate information by the government to the community and the household on the Ubudehe categorization to enhance full participation of the community is also recommended.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Health security is increasingly being recognized as integral to any poverty reduction strategy. While the objective of poverty reduction remains of major concern, there has been a shift of focus away from poverty reduction specific to social risk management. This is due to the growing appreciation of the role that risk plays in the lives of the poor; of all the risks facing households that are poor, health risks probably pose the highest threat to their lives and livelihoods. Health setback leads to direct expenditures for medicine, means of transport and treatment but also to indirect costs related to a reduction in labor supply and productivity (Asfaw, 2003).

Most developing countries have not been able to fulfill healthcare needs of their poor people. Shrinking budgetary support for healthcare services, disorganization in public health provision, an undesirable low quality of public health services, and the resultant burden of user charges are reflective of the state's inability to meet healthcare needs of the poor (World Bank, 1993). In the last decade the ''healthcare crisis'' led to the emergence of many Community Based Health Insurance Schemes (CBHISs) in different regions of developing countries, particularly in sub-Saharan Africa (Preker, 2004).

The success of community-based microcredit schemes may have also contributed to the emergence of community-based health initiatives designed to improve the access through risk and resource sharing (Dror and Jacquier, 1999). Elsewhere, particularly in Asia and Latin America, community-based health initiatives have come about independently and as part of income protection measures or to fill the void created by lack of community based health initiatives. However, the CBHI concept is theoretically appealing; its merits still have to be proven in practice. According to Dror and Jacquier, (1999), CBHISs are a potential instrument of protection from the impoverishing effects of health expenditures for low-income populations. He

further argues that CBHISs are effective in reaching a large number of poor people who would otherwise have no financial protection against the cost of illness.

High disease burden which has a risk of creating a sickly, unproductive labor force in Rwanda, formal and well-functioning health schemes are mainly affordable to the very few who are employed in the formal sector. For the majority, healthcare is available through out-of-pocket expenditure, which in many instances may lead to poor access and utilization of healthcare services. As a result, the expenditure on health services could be substantially high with more divergence across the income divide. Thus, households spend equal amounts to their health well being but with evidently worse health outcomes.

One of the reasons could be due to lack of a functioning health insurance scheme to protect residents from illness that is related to income or expenditure shocks. The formal health insurance schemes for the rural farmers and the self-employed are difficult to put up due to a number of reasons. Community Based Health Insurance Schemes (CBHISs) are providing alternatives for healthcare system that is cost sharing which hopefully also leads to better access to healthcare services, reduce illness that is income shocks related and eventually lead to a fully functioning and sustainable universal healthcare system though a section of the citizens have reservation with the manner in which categories are set for the scheme (Shimeles, 2010).

However, the provision of health care to the poor who live in the informal sector or live in the rural areas is considered as one of the most difficult challenges that are faced by many developing countries.(Preker and Carrin, 2004).The World Bank reports 1993 and 1995(as cited in WHO 2002) reveal that illness, death, and injuries stand as the main causes that have led people into poverty. Poverty is also argued to be among root causes of many health problems, such that poor people can neither afford modern medical care nor decent living conditions. The effectiveness of Community Based Health Insurance is that it can reach a big number of people who would not have been able to insure themselves against health problems due to health problems and associated costs making community based health insurance to be considered a potential instrument for mitigating the impoverishment effects associated with the health expenditure.

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Rwanda, as a developing country, is not spared from health care provision challenges. In addressing such issues, the government of Rwanda initiated Community Based Health Insurance as a strategy of improving accessibility to health care services for poor people from rural and urban settings (Schneider and Diop, 2001). The implementation and extension of mutual health organizations in Rwanda began in 1999, when the government initiated pilots at three sites in the Byumba, Kabutare and Kabgayi health districts. The fixed annual premium fees for enrolment was 2500 RwF (4.5 US $) per family up to seven persons affiliated with preferred health center.

In 2005, after realizing that the pilot CBHI witnessed success in improving the access to health services have become very popular such that, community and political authorities tried to scale them up at national level (Kagubare, 2006). In 2007, the annual subscription was raised to RWF 1000 (around US $ 1.8) per person per household. This increase was made so as to raise internal resource mobilisation for sustainability of community based health insurance and to improve health services provision and expanding basic package of curative services (MoH 2009).

In 2008, a formal legal framework for Mutual Health Insurance (MHI) was created with the adoption of a law on. This set a new milestone towards universal coverage by making health insurance compulsory. This law also introduced formal cross-subsidization between existing health insurance schemes leading the way forward for a possible national pool. Currently, MHI membership remains voluntary in practice, although the 2008 law stipulates the need for all Rwandans to be part of an insurance scheme (Musango L, Doetinchem O, Carrin G 2008). CBHI schemes play an important role in Rwanda and their development has been facilitated by strong government involvement and commitment towards providing access to health services to all. To reduce inequity, the Government of Rwanda adopted a new CBHI contribution scheme based on social economic stratification in 2010.

In this new approach, the population is subdivided in different socio-economic categories based on the household level of income. Category one is Abatindi nyakujya (those living in abject poverty). This category of population owns no property, live on begging and help from

others, and consider it lucky if they died. Category two is Abatindi (very poor). These people have no house, live on poor diet which they can afford with difficulty, work every day for others for their survival, have tattered clothes, own no portion of land, and do not own cattle. Abatindi nyakujya and abatindi form CBHI category one of Ubudehe and pay 2000 RwF per year and per individual and they are sponsored by the Government and other sponsors.

Category three is Abakene (poor). These people depend on food deficit in nutrients, own a small portion of land, have low production and their children cannot afford secondary education. Category four is Abakene bifashije (resourceful poor). These people own some land, cattle, a bicycle, have average production; their children can afford secondary education, and have less difficulties in accessing health care. Abakene and Abakene bifashije form CBHI category two of Ubudehe and pay 3000 RwF per year and per individual.

Category five is Abakungu-jumba (food rich). This category includes people who basically own big lands, eat balanced food diets and liven in decent houses. They employ others, own cattle, and their children easily afford university education while category six is Abakire (money rich). This category is comprises of people with money in banks, receive bank loans, own a beautiful house, a car, cattle, fertile lands, sufficient food and is permanently employers. Abakungu-jumba and abakire form CBHI category three and pay 7000RwF per year and per individual (MoH, 2010).

1.2 Statement of the Research Problem

Of all the risks facing poor households, health risks pose the greatest threat to the lives and livelihoods of citizens in any given economy (Tabor, 2005). According to Carrin(2003), scarce economic resources, low or modest economic growth, constraints on the public sector and low organizational capacity explain why the design of adequate health financing systems in developing countries, especially the low income ones, remains cumbersome and the subject of significant debate.

Arthur (2010) adds that although CBHI in Rwanda provides a comprehensive benefit package, the availability and completeness of products, commodities, and services needs to be

improved as there are major challenges: first one is the flat premium rate (about 2 US$ per year per person) which is regarded to be too high for the very poor to the extent that given a choice, they would rather defer healthcare expenditure until when it is vitally needed; second one is that of the very poor people becoming members of CBHISs that they may not be in a position to fully utilize its provisions.

Ministry of Local Government and National Poverty Reduction Programme (2001) indicates that the most fundamental problem that faces Rwanda is poverty in terms of human deprivation and vulnerability which is the greatest obstacle to the sustainable economic development of Rwanda. Shimeles (2010) adds that some critiques of the Ubudehe program argue that CBHISs in Rwanda have the potential to further alienate those in abject poverty from utilizing health services as the flat premium rate (about 2 US$ per year per person)is considered to be too high and even if the poor join these CBHI programs, they may not fully utilize their provisions as costs such as transport, prescription drugs and the opportunity cost of time especially for the casual laborers is not covered.

The high demand by citizens for affordable health care prompted the Government of Rwanda to adopt a new CBHI contribution scheme based on social economic stratification in 2010. In this new approach the population is subdivided in different socio-economic categories based on the household level of income. The category determines the premium contribution that each household member must pay into the insurance pool. This stratification of the population is a key feature of the new CBHI policy. It is intended to improve the long term financial viability of the CBHI scheme. Additionally, the stratification is to improve the equity in contributions increase equity and fairness of the scheme as well as enhance solidarity among CBHI members. (MoH, 2012).

According to the National Agricultural Survey (2008), 90% of households in Rwanda practice traditional subsistence agricultural which makes it difficult to categorize the population according to their household income or assets. Many factors influence their level of income, and it is therefore necessary to look at the household perception especially in the case of Rwanda where the health insurance policy operates under classifications based on household economic

situation. This study therefore sought to examine the perception of household members on Ubudehe categories as used by the government of Rwanda especially with regard to community based health insurance schemes.

1.3 Research Questions

The study sought to answer the following questions:

1. What are the perceptions of members of households on CBHI based on Ubudehe categories?

2. What are the barriers to accessing healthcare using the Ubudehe categories as a basis for CBHI?

3. What are the ways of improving access to healthcare insurance in Huye district?

1.4 Objectives

The overall objective of the study was to determine the household perception on the access to the community based health insurance based on Ubudehe categories. The specific objectives included:

1. To find out the perception of households on CBHI based on Ubudehe categories.
2. To identify the barriers to access to healthcare using the Ubudehe categories.
3. To explore ways of improving access to healthcare insurance in Huye district.

1.5 Justification of the Study

A number of studies have been conducted on CBHI (Buss, 2008, Fowler et al (2009, Hanratty et al, 2007 and Makaka, Breen and Binagwaho, 2012), among others with little attention focused on household perception. In particular the Ubudehe categories in CBHI having been inexistence in Rwanda for only 3 years, very few studies have been done on the categorization aspect of the CBHI in Rwanda under the Ubudehe stratification with none of the studies covering on community perception about the stratification and the categories where they have been grouped.

Therefore this study informs policy makers on the way of improving CBHI based Ubudehe categories in Huye district. In addition, it would be of importance to other researchers who are researching on the Ubudehe categories in Rwanda and its impact on CBHI. The study would also be beneficial to policy makers, the village elders and the community at large in understanding and evaluating the Ubudehe process on the CBHI in Rwanda. Finally, the project would be of socio-economic help to the community as it seeks to address the community level of dissatisfaction with the Ubudehe categories that would improve on the level of motivation on community members if well addressed.

1.6 Scope and Limitations of the Study

The study was focused on the household perception on the Ubudehe categories in community health insurance in Rwanda. Specifically the study as confined on the perception of the member of households and the barriers to accessing health care using the community based health insurance based on Ubudehe categories. It was conducted in Rwanda, Southern Province, Huye district in October 2013 where the respondents were the members of the community and government and local authorities in health sector and the social health insurance scheme officers.

However, effective data collection was limited by accessibility of the community during data collection caused by the geographical locations of target population. There was also a problem regarding the willingness of the respondents to provide information for fear of victimization by leaders of the community who contribute towards the operations of the CBHI. The other challenge that greatly affected the study was the ability to get information from the authorities. It was not easy to get information from government authorities in the Ministry of Health and the local government due to their tight schedules and therefore in some cases their representatives were interviewed.

1.7 Definition of Concepts

Perception: the way in which something is regarded, understood, or interpreted (Oxford Dictionaries). As used in this study, it refers on how household's members of CBHI perceive Ubudehe categories in CBHI used by the government of Rwanda. It will be measured in a likert scale of 1-5 to where 1 is strongly disagreeing to 5 which is strongly agree.

Ubudehe: Ubudehe is the traditional Rwandan practice and cultural value of working together to solve problems, (Republic of Rwanda, 2007).In this study, it refers to a traditional Kinyarwanda word that defines the collective effort employed towards solving social problems.

Ubudehe Categories: Ubudehe categories are income categories used in Rwanda for household classification; the identification of which household belongs to which category is usually based on a community participatory approach and categorization depends on the economic status of each individual household (Binagwaho, Hartwig, Ingeri, and Makaka, 2012).In the context of the study, the categories are used to group the households in Rwanda according to their economic standards and ability to make contributions towards the community based health insurance.

Households: A domestic unit consisting of the members of a family who live together along with non-relatives such as servants or relatives (American Heritage Dictionary 2000). In this study, households are also taken as relatives and non-relatives that are living together and are dependent on one another.

Community Based Health Insurance (CBHI): according to Jutting (2003), it is an emerging and promising concept, which addresses health care challenges faced in particular by the rural poor. In this study, it is used to refer to the resource mobilization methods where there is predominant role in pooling and allocating resources, solidarity mechanisms, poor beneficiary population, and voluntary participation for the health benefit of the community.

CHAPTER TWO

LITERATURE REVIEW

2.1: Introduction

This section presents reviewed literature on community based health insurance programmes. The literature has been reviewed on the general understanding on the CBHI programme, its benefits, past studies on perception and barrier to participation on citizens to CBHI and ways in which citizens participation on social health programmes could be improved, theoretical and conceptual frameworks.

2.2: A General Overview of the Community-based Health insurance

Over the decades a focus on social health insurance schemes has been gaining strength. The WHO in 2005 passed a resolution that it would support a strategy to mobilize more resources for health, for risk pooling, increase access to health care for the poor and deliver quality health care (WHO, 2005) in all its member states but especially low income countries. This is a strategy supported by the World Bank (Hsiao, 2007).To support this there has been a proliferation of community-based health insurance (CBHI) schemes designed to provide financial protection against the costs of health care and expand access to modern health-care services to the informal and rural sectors, (Jorhon, 2013).

Community-based health insurance (CBHI) collects resources from individuals who voluntarily enroll and are often employed in the informal sector. CBHI thus offers an alternative for health insurance in settings where taxes are paid on only a small portion of national income (Bennett 2004; Ekman 2004).The common characteristics of various forms of CBHF are that they are run on a non-profit basis and they apply the basic principle of risk sharing (Jakab and Krishnan, 2001). Some schemes are integrated with the provider while others operate outside of the service providers. These are termed provider-based and community-based schemes, respectively.

There are a number of reasons behind the growth of interest in CBHI schemes in low-income countries, including the widespread imposition or increase in user fees for government health care services that occurred during the 1980s and 1990sin many low-income countries. At the same time there is a significant scale of use of private sector providers, even in relatively poor communities, the collapse of government health care services in certain countries e.g DRC. Congo due to prolonged conflict the difficulties faced in expanding formal health insurance coverage to people who are outside of formal sector employment (Preker, 2004).Musau (1999) argues that the decentralization process unleashed in these countries to empower lower layers of government and the local community further fueled their emergence. Their efficiency in the public health care system caused patients to avoid accessing lower level facilities first due to the low fees charged at all facilities (primary, secondary, tertiary).

In addition, the district or regional hospital may have been the only health facility that was geographically accessible to the local community and lastly, insufficient funding for the more cost- health care facilities lowered the quality of service they could provide, (inadequate supply of drugs and other commodities, inadequate staff)which also discouraged their use (Musau, 1999).The success of community-based micro-credit schemes may have also contributed to the emergence of community-based health initiatives designed to improve the access through risk and resource sharing (Dror and Jacquier, 1999).

2.3 Benefits of the Community Based Health Insurance

Existing literature such as Arhin, (1995), Bennett, Kelley, and Silvers (2004), Musau (1999) e.t.c suggests that Community Based Health Insurance has several strengths. It mobilizes resources thus improving access to health care by low income people, improves financial protection by reducing out of pocket payment and combats social exclusion by extending coverage to a large MN number of rural and low income populations who would have otherwise been excluded from collective arrangements to pay for health care. A study conducted by Jutting (2003) in rural Senegal (Thies region) showed that community health financing through prepayment and risk-sharing reduced financial barriers to health care as was demonstrated by higher utilization and lower out of pocket. It further showed that risk pooling no matter how small- scaled, could improve financial protection for the poor.

Arhin (1995) in assessing the viability of rural health insurance as an alternative to user fees also found that the scheme in Ghana removed a barrier to admission and led to earlier reporting of patients and increased utilization among the insured. CBHI is also useful as a component of a health financing system involving other instruments. Community-based health insurance schemes may complete or fill the gaps of other health financing schemes (social health insurance or government financing), or they may be a first step toward a larger-scale system (Gottret and Schieber, 2006).

Community Based Health Insurance may be very useful to supplement other forms of medical strengths of CBHF. Community-based schemes cannot provide medical coverage to the whole population, but can help meet the needs of specific categories of people, such as the rural middle class and in formal workers (Bennett, Kelley, and Silvers2004). For this reason, in many countries governments try to launch Community Based Health Insurance schemes (as in Rwanda) or use existing ones to extend health coverage to certain populations. In Tanzania, for instance, the Community Health Fund targets informal workers, while workers in the formal sector are covered through a new social health insurance scheme (Bennett, Kelley, and Silvers 2004).

Musau (1999) in his study of Community Based Health Insurance Schemes in East Africa; attributes long-terms sustainability of the schemes to their design and management. He further says that the problems experienced by the schemes was not a failure of the concept of health insurance and its applicability to low-income communities, but were due to difficulties encountered in their design and implementation.

Eckman (2004) in his systematic review of36 papers and 178 schemes of CBHI found that voluntary CBHI could be a viable option for sustainable financing of primary health care in low-income countries. They were found to mobilize sufficient amounts of resources. The study found evidence that CBHI provided financial protection by reducing spending and by increasing access to health care, as seen by increased rates of utilization of care.

For instance the Tanzanian government introduced the Community Health Fund (CHF) in 1995 as a new element in the country's health financing strategy. The CHF is a district-level voluntary prepayment scheme, introduced in parallel with user fees at public health facilities, that targets the 85% of the population living in rural areas and/or employed in the informal sector. It was introduced in Tanzania as part of the Ministry of Health's (MoH) endeavor to make health care affordable and available to the rural population and the informal sector.

The scheme started in 1996 with Igunga acting as a pilot district, and was later expanded to other districts (MoH, 1999). Several studies have shown an improvement in the provision of and access to health care services after the introduction of CHF. For example, Shaw (2002) shows that the CHF fund helped to purchase microscopes, reduce drug stock-out, and improved the availability of or introduced other important equipment and supplies in various hospitals. Other studies have also shown an increase in health service utilization for CHF members (Msuya, Jutting et al. 2004; Musau 2004). However, CHF is faced with low enrolment and coverage (MOH- Tanzania, 2003). The barriers to enrolment identified by evaluations are: a wide spread inability to pay membership contributions, the poor quality of available services, a failure among communities to see the rationale for protecting against the risk of illness, and a lack of trust in CHF managers (Mwendo2001; MOH- Tanzania, 2003).

Rwandan experience is arguably one of the most dramatic recent experiences of CBHI-based National Health Insurance in sub-Saharan Africa today, at least in terms of population coverage. After successfully initiating pilot schemes in 1999, the Government decided to go to scale in a rapid fashion. As of October 2007, it is reported that the schemes had enrolled about 75% of the total population. By 2009, the schemes coverage had exceeded 86%, reduced out-of-pocket spending for health from 28% to 12% of total health expenditure, and increased service use to 1·8contacts per year. Over the last decade in Rwanda, deaths from HIV, TB, and malaria dropped by 80percent, maternal mortality dropped by 60percent, life expectancy doubled all at an average health care cost of $55 per person per year, which could be attributed to the success of the CBHI scheme (MoH- Rwanda, 2010).

To support the growth of the schemes, the Government of Rwanda has created a special solidarity or risk-pooling fund, into which transfers from the Ministry of Finance via the Ministry of Health are made to cover the costs of indigents and people living with HIV/AIDS. The Global Fund to fight AIDS, Tuberculosis and Malaria is providing financial support for five years to cover the Government subsidy, (MoH- Rwanda, 2010).

2.4: Literature Review

Social protection in health is a major issue in most developing countries: Governmental health sector policies and the private (commercial) insurance sector are either generally insufficiently developed or these arrangements are only accessible for people working in the formal sector; however, a large part of the population in Rwanda work in the informal economy and thus are under-served by proper healthcare financing mechanisms.

In developed economies such as Germany, (Buss, 2008) indicates that public health insurance also known as social health insurance (SHI) is compulsory for all citizens earning €48,000 per year, including dependents who are included in the insurance. This applies to around 75% of the population but those earning above €48,000 per year they can remain in the SHI health insurance scheme or purchase private health insurance. He concludes that the publicly financed health insurance scheme covers about 88% of the population and in total, 10% of the population are covered by private health insurance companies, with less than 1% of the population having no insurance coverage. He however does not bring out the public perception about the schemes and especially the perception of the poor members of the society which is the basis of this study.

Fowler et al (2009), limited to the population in the United States, sought to determine whether differences in critical care access, delivery, and patient outcomes were associated with health insurance status. The results indicated that uninsured critically ill patients do not receive appropriate care and may experience worse clinical outcomes. Where as it is true, they it did not examine the implication of the insurance status on the financial well being of the population on how they perceived the extra expenses affected their financial status. Therefore the current study

evaluates how the populations participating in the social insurance health programmes perceived the programmes against their financial well being.

Hanratty et al (2007) focused on equity in use of curative health services in universal systems, was limited to developed countries and did not specifically examine the impacts of health insurance. The results indicated a pro-rich bias in use of specialist hospital services and a equitable access to primary health care by different socioeconomic groups. This study did not look at the take into consideration the important aspect of pooling health care resource together from citizens in a given country. The study failed to recognize the significance of having a common kitty of funds to aid even the poorest members of the society.

In a country such as Guinea-Conakry, Carrin (2003) indicates that CHI was introduced active purchase of health insurance, for example, a contract was established between the Health Centre of Youndé and other health service providers in to purchase primary care services for a pre-existing list of health problems which included emergency transport of patients to hospitals via a contract with a local transport company. This study did not take into consideration that a healthy nation is not about just dealing with pre-existing list of health problems but rather make health services accessible to all the members of the society regardless of their economic status.

An extensive WHO study was made in 82 non-profit health insurance schemes for people outside formal sector employment in developing countries (Bennett et al. 1998). It was observed that very few of these schemes covered large populations or even covered high proportions of the eligible population unless government or others facilitated their membership through subsidies (Bennett *et al*.1998). However, the study did not address the challenges impeding on effective participation of all citizens in the social health programmes.

As is seen in sub-Saharan Africa, healthcare service provision is at its best for those in the formal sector while the majorities are forced to access healthcare through out-of-pocket expenditure which in some instances results into poor healthcare as people seeks healthcare services to avoid cutting into family income expenditure patterns (Shimeles, 2010). As a result, Shimeles explains that expenditure on heath related needs in some of these countries could be

substantially high with visible divergence across the income divide as households in poorer countries generally tend to spend as much as those living in relatively richer countries, but evidently with worse health outcomes due to lack of adequate functioning of health insurance schemes to protect households from illness related income or expenditure shocks. Where as it is true for the above author, he does not look at accessibility of health services as a universal programme which should not discriminated people based on the economic well being but rather find a frame work in which all the members in a given society can have the chance to freely access these services regardless of the health needs.

Carrin (2003) indicates that there are alternative health financing systems which have yet to be exploited in sub-Saharan Africa which de-link utilization from direct payment, and thereby protects any given population especially vulnerable groups from resorting to various coping mechanisms. She adds that financing of healthcare is based either on general tax revenues or social health insurance contributions but risk-pooling by acting in large groups especially for the poor is a core characteristic of an efficient healthcare system thus enabling health services to be provided according to people's need rather than to their individual capacity to pay for health services.

Jorhon (2013) aimed to rigorously evaluate the effect of the Community Based Health Insurance scheme on access to health-care services and financial protection. The study was conducted in 12 CBHI pilot districts and four control districts in four mail regions (Tigray, Amhara, Oromiya, and SNNPR) of Ethiopia. The control areas were selected on the basis of the same criteria used to select the intervention districts. In these districts, sample households were randomly selected before the introduction of the pilot scheme. The participants of the study were people in the informal sector. The sample covered 1203 randomly selected households from intervention districts and 429 households from non-intervention districts. About 41% (489 of 1203) of the sample households from the CBHI districts were members of the scheme.

This study investigates the effect of CBHI on the outcomes of interest. The primary outcomes of the study are outpatient visits and inpatient days spent in modern health-care providers. In order to properly address the proposed issues, this study uses a mixed approach (quantitative and qualitative). The econometrics models used in the analysis include ordinary

least-square and fixed-effect regressions. Moreover, for the sake of sensitivity checks, propensity-score-adjusted fixed-effect estimates were also employed.

The study found out that among different groups of the population, the benefit of the scheme in terms of creating access to care is more pronounced for the rich than for the poor, (Jorhon, 2013). Where as the above study focused on the effects on the CBHI on outcome interest in the four districts in Ethiopia, the current study examines the perception of beneficiaries of the CBHI under the Ubudehe programme in Huye district of Rwanda. The researcher argues that CBHI intervention could play a supportive role in creating access to cheaper outpatient care instead of relatively expensive inpatient care for the population in the informal sector.

According to Makaka, Breen, & Binagwaho, (2012), Rwanda tried on multiple occasions to develop a suitable health insurance program that would benefit its population but failed to having incurred major setbacks during the 1990's due to the Rwanda genocide but in 1999, aiming to make health services more accessible to the poor again, the government started the testing of pre-payment, community based, mutual insurance schemes. This was a major success due to the fact that the people of Rwanda, especially in rural areas, have a tradition of coming together to work in groups and teams which builds social capital and strengthen relationships of trust and reciprocity (Joseph, 2005).This was known as Ubudehe which according to Mupenzi, (2010), is made up of two distinct processes, one at the community level and one at the household level.

He indicates that at the community level, individual poverty profiles are drawn with the help of facilitators and trainers based on individual evaluation of one's lifestyle and also establish the causes and consequences affiliated with individual poverty levels which is followed by drawing of the village social map that includes names of heads of households and development infrastructure of the region. Mupenzi adds that at another level, the household level, the community is equipped with a model that encourages them at a household level to overcome poverty by analyzing and identifying the household's survival strategies with the help of Ubudehe facilitators and community leaders, and develop strategies that address the promotion and improvement of the living conditions within the household, (Mupenzi, 2010).

Shimeles(2010) adds that the communities at village level go through a process of collectively mapping their community and come up with a community map drawn on a kaki'cloth facilitated by two trained community volunteers at village level and further go through a process of collectively defining and analyzing the nature of poverty in their community; look at local categories of poverty, characteristics of each category, and mobility between categories, the causes and impact of poverty, and so on. Then communities rank the problems identified in order of priority and the ones that the community wants to spend most of its time, effort and resources on; an action plan to address the problems they have prioritized is drawn and communities come up with about five projects to be funded. The communities clarify their role and participation.

Habiyonizeye and Mugunga (2012) indicate that Ubudehe is purposely targeted to the village level composed of about one hundred households, and is small enough to foster collective action; targeting this level is part of a broader attempt to increase community-level participation in governance and development. Ubudehe is a mechanism which enables the poorest and most vulnerable households to be identified by their fellow villagers and ensures that they are the priority recipients of any development partner or national level support available.

According to Niringiye (2012) the Ubudehe program involves the local community members themselves identifying development issues and deciding on priority actions to fight poverty in their neighborhoods. A team of national master trainers develops district trainers who then train 2 persons selected by the community of each cell/village who function as facilitators of the collective action process that moves from generating information in a visual / public process to creating an adaptive system but the final priority selected is not always first ranking, as the authorities of the sector or the district can consider this project as either already integrated into their own development plan, or not realistic with the funds at the disposal of Ubudehe. This proves a solid framework in decision making processes regarding community development projects.

International Health Partnership (2012) indicates that according to the latest information provided by the Ministry of Health in Rwanda, about 97% of population is covered by some sort of health insurance: 91% for Mutuelle scheme (mutual health insurance scheme based on

Ubudehe process) and an estimated 6% through other insurance schemes) which is considered to be one of the best health insurance schemes adopted by a developing economy in the world. This is heavily attributed to high political commitment evidenced by the issuance of a legal framework which makes health insurance compulsory for all Rwandans which does not give room for any form of health insurance coverage discrimination other than that of citizenship.

International Health Partnership (2012) indicates that given the multiple number of challenges in the rapid scaling up of CBHI coverage in Rwanda, the newly adopted CBHI policy outlines strategies to mitigate the emerging challenges of CBHI which include institutional capacity building, financial sustainability and equitable access to CBHI; these remain to be translated into concrete guidelines, actions and practice as it requires a lot of mobilization, communication and sensitization to ensure compliance with the new contribution rates and increase coverage under the new scheme.

Binagwaho, Hartwig, Ingeri, & Makaka (2012) add that under the new policy, citizens from the poorest two categories i.e. category 1 and 2 under the Ubudehe process, pay an individual annual contribution of 2,000 RwF (2.50 EUR) which is paid by Government and its partners while those in category 3 and 4 pay 3,000 RwF (3.75 EUR) per year and members of the richest two categories pay 7,000 RwF (8.75 EUR). A great factor which is considered key to the functioning of the system is the mandatory, family based enrolment aimed at enforcing risk sharing and limiting adverse selection into the scheme.

Acharya, et al., (2012) indicates that another identified problem is that there is fragmentation of the health insurance system (CBHI, RAMA, and MMI) which is comprehensive and requires frequent evaluation. (Makaka, Breen and Binagwaho, 2012) add that this is worsened by high poverty levels which have been identified where development partners like NGOs liaise with the districts to actually determine who to support using the social maps. They criticize the Ubudehe process arguing that it does not take into consideration the dynamism of the current global economy that is characterized by retrenchments and restructuring which result in income disparity that does not allow one to commit towards healthcare payments. This forms

the basis of the research paper in understanding the dynamics faced by the Rwandese population in facilitating effective healthcare.

2.2 Theoretical Framework

The study was premised on the social capital theory and participation theory. Social capital theory is the expected collective or economic benefits derived from the preferential treatment and cooperation between individuals and groups. Participation theory is a process which provides private individuals an opportunity to influence public decisions and has long been a component of the democratic decision-making process.

2.3 Social Capital Theory

Social capital is defined by Bourdieu, (1986) as the economic gain derived by the act of people coming together to solve a particular problem. He further indicates that social capital theory is the act of community bonding for economic gain. Social capital theory is widely used in the CBHI where its success revolves around community resources, actual or virtual that accrue to any individual or a group by virtue of possessing durable network of more or less institutionalized relationships of mutual acquaintance and recognition.

Many international organizations such as the OECD, the World Bank, the UNESCO, have emphasized on social capital as the foundation for CBHI, which they consider as a powerful tool for attaining the objectives of development actors both in developed and developing countries. In the 90s, one of the main goals of the World Bank was to use the potential of social capital to fight poverty and ensure availability and access to health, banking facilities and education. Therefore CBHI can only be effective and long-lasting with the aid of social capital in a community, as social capital has a positive effect on the community's demand for insurance (Coleman, 1998).

Coleman (1998), Putnam et al. (1993), acknowledge that social capital in a community acts positively on the importance people attach to their health. Thus a community with a high

level of social capital will be more inclined to go through change and therefore, they will be more ready to support a new, unknown health policy such as CBHI. Consequently, adhesion to a group and trust are necessary to enable poor communities establish social capital and have access to CBHI. On the one hand, if connections are lacking, or if the level of social capital among the members of the group is weak, there is an increasing risk of seeing egoistic behavior as the highest levels of moral risk and anti-selection. In addition, Baum et al. (2002) demonstrate that a high level of trust in the community will facilitate cooperation, aids, access to health care. Low-income households will have opportunities to increase their income and social well-being. Thus, CBHI which aims at managing risk and vulnerability may be well accepted by a community that possesses a high stock of social capital.

In the context of this study, social capital theory best describe the Ubudehe categories in Rwanda as the categories are clustered according to household income or the general health benefit of the public. The categories that represent social units in this case is composed of various households that are inclined towards solving common health problems that can best be achieved by a network of relationships.

2.4 Citizen Participation Theory

Citizen participation theory advocates for public involvement as a means to ensure that citizens have a direct voice in public decisions. The citizen participation theory is inclined towards giving the citizens an opportunity to participate in matters relating to their economic gain. This theory suggests that governments involve their citizens in decision making concerning national policy. This is also seen with the Global health systems that continue to be championed by biomedical scientists and health experts whose technocratic solutions to ill health provide community members with few opportunities to appropriate these solutions to local realities through community participations (Mompati and Prinsen, 2000).

Despite the revolutionary significance of viewing primary health care through the lenses of equity, social justice, and participation, shifts favoring community participation have been slow and saw a decline in the late 1980s and 1990s (Mompati and Prinsen 2000). More efforts on community participation on health care however, spearheaded by the 2008 Lancet special edition

to celebrate the 30 year anniversary of Alma Ata and the 2008 WHO report on Social Determinants of Health, have revitalized the message that community participation is key to the delivery of health care. Many countries, including Rwanda through their Community-based Health Planning and Services (CHPS) Programme, have since taken active steps to involve community members in addressing health problems at the community-level have fully embraced community participation on social health care.

Alongside these efforts, much work has been done to encourage community participation in CBHI to increase access to health services, improve health outcomes and promote health enhancing behaviors (Kelly, 2001). According to Mosso et al. (2001), "despite a growing interest in 'evidence-based public health' and the proliferation of theoretical literature into community participation, there remains a dearth of tools and indicators for evaluating how communities participate in and influence programmes in practice". In the context of the Ubudehe categories in Rwanda, the aspect citizen participation where the government involves the community on categorization process indicates that the programmes in inclusive and takes into account all the social structures of her citizens..

2.5: Conceptual Framework

In this study, Ubudehe based community health insurance is the dependent variable while perception of the households and barriers to access health care are the independent variables. The relationship has been presented as shown in figure 2.1.

Figure 2.1: Researcher's Conceptualization of the Variables

Independent variables   **Dependent variables**
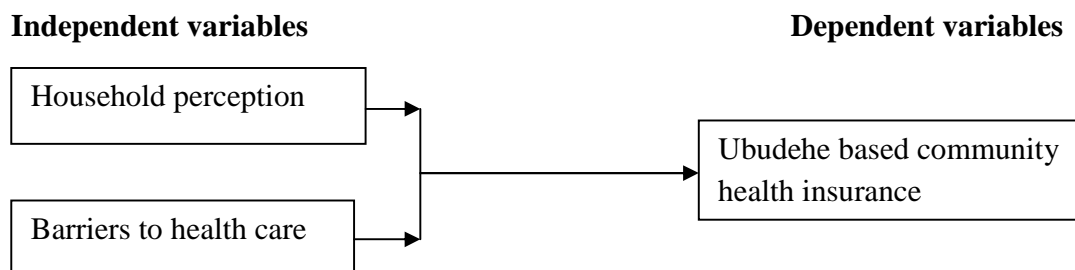
Source: Author 2013

The researcher argues that effective implementation of the Ubudehe based community health insurance is influenced by the perception of the household communities because the categorization on contribution and utilization is based on household assets economic well being of the people in Rwanda. This is also influence by the barriers barring people's access to health care services in the country.

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology used while conducting the research and obtaining, organizing and analyzing data. This enabled the researcher to effectively gather data and information on the subject matter of the study. This include the description of study area, target population, sampling techniques, mode of data collection and data analysis.

3.2 Study Area

The study was conducted in Rwanda, Southern Province, Huye district. This choice was based on the fact that one of the hospital (Kabutare) where CBHI was initiated by the Government of Rwanda as a pilot is located in Huye district. Huye district is one of the eight districts that make up Rwanda's Southern Province. It is composed of 14 Sectors namely: Mbazi, Kinazi, Simbi, Maraba, Rwaniro, Rusatira, Huye, Gishamvu, Mukura, Ruhashya, Tumba, Kigoma, Ngoma and Karama. It has a total surface area of 581.5 square Kilometers. It has fourteen sectors and 77 sub-sectors with a total of 509 cells. The district has a population of 314,022 with a density of 540 per square kilometer (District Development Plan, 2007). However, the researcher focused on key respondents from two sectors Tumba and Rwaniro. Tumba is considered one of urban sector and Rwaniro as a rural Sector.

3.3 Sampling Technique

In this study, the researcher used purposive sampling in selecting respondents for data collection. The study focused on the community as the main respondents and authorities such as local and government agents as key informants to increase completeness of the information on the perception of CBHI based on the Ubudehe categories. The Government agents from the Ministry of Health provided information to the study based on its role on policy formulation. The study focused on Mayor and Vice-Mayor in charge of social affairs at the district level touching on their role of CBHI national policy implementation, coordination of activities, sensitization and enrolment of population to CBHI and the identification of indigents. The study further

involved one staff at the district level in charge of social protection and welfare to provide information based on his/her role on coordination of activities pertaining to health and facilitates; accessibility and quality of healthcare to the population.

The study focused on the authorities of CBHI at district level(director, the individual in charge of mobilization, sensitization and monitoring and the district hospital invoice auditor)as they coordinate all CBHI activities, the management of different CBHI database, sensitization of political and administrative authorities and population to adhere to CBHI. At the sector level, the study focused on the executive secretary and social affairs (in the 2 selected sectors) based on their role on CBHI policy implementation. The mobilization committees at cell and sector levels were interviewed because their main role is to inform the population about CBHI enrollment. Among the population, the criteria of selection was the category of Ubudehe in which the population belonged where based on the Ubudehe categories,7 people were selected from each category in the selected sectors. The total sample was 73 as summarized in table 3.1.

Table 3.1: Summary of the sample population

Categories of respondents	Respondent	Number
Authority of ministry	Ministry of health	1
Authority of the district	Mayor & Vice mayor in charge of social affairs	2
Staff	Social protection and welfare	1
Authority of CBHI	Director, the individual in charge of mobilization sensitization and monitoring, the Auditor of district hospitals care-related bills	3
Authority of Sector (in 2 selected sectors)	Executive Secretary & In Charge of Social Affairs	4
Mobilization committee (at sector & cell level)	Chairman, Vice-chairman, Secretary Two advisors	20
Community	7 respondents per categories (Ubudehe has 3 categories)	42
Totals		**73**

Source: Author 2013

3.4 Methods of Data Collection

The researcher used primary data for this type of study. Primary data was collected through the use of questionnaires. There were questionnaires designed for the key informants such as authorities of the districts, staff in charge of social protection and welfare at level, Executive Secretary & in Charge of Social Affairs at sector level and cell level (in the two selected sectors), Authority of CBHI at district level and the community. The questionnaires were structured in such a manner that all the objectives of the study were captured.

The researcher also used both open and closed questions for divergence response on the study topic. The researcher collected a letter of authority from the school department that then presented to the authority at district level requesting for permission to collect data;

questionnaires to the authorities at the district were administered through drop and pick method that gave reasonable time for them to be filled.

The questionnaires enabled the researcher to collect in-depth information about the population being studied and therefore giving the best results for the case study. The data was collected in local language (Kinyarwanda) then translated into English language. This was so because the community members in Rwanda were conversant with the local language than English. Secondary data was obtained from journals in the library and online publication by other scholars. Articles and books were formed part of the data collection materials.

3.5 Data Analysis

The researcher used quantitative and qualitative method of data analysis. For the quantitative analysis, the questionnaires were checked for completeness, and then coded using the statistical SPSS software for analysis in order to minimize margin of error, and accuracy during analysis. The analysis was applied using descriptive statistics; indices that describe a given sample. Qualitative data was analyzed through coding against the set objectives of the study. The researcher grouped individual responses according to the objectives they belong then meaningful information obtained from the grouped responses.

CHAPTER FOUR

STUDY RESULTS

4.1 Introduction

This chapter covers the findings of the study on perception of household members on Ubudehe based community health insurance in Huye district Rwanda. The section gives information on the respondents' gender aspects, age distribution and education level attained. It finalizes with the research questions where each of the questions is answered by the analysis of the obtained data and presented based in the research objectives.

4.2 Response rate

The study used sampled of 73 respondents for data collection for this study. Out of the 73 respondents, 67 of the respondents participated in the study comprising of both the members of the community and authorities. These has been distributed as shown in figure 4.1.

Figure 4.1 Response rate
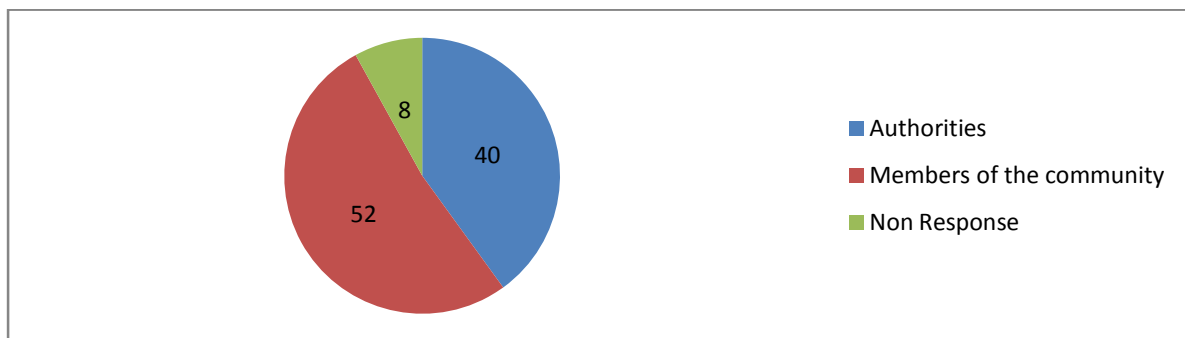
Source: Generated from study data, 2013

Figure 4.1 shows that from the initial sample size, 67respondents representing 92% participated in the study by filling and returning their questionnaires. This comprised of 52% (38) members of the community and 40% (29) authorities while those who did not take part in the study were rated at 8% (6).

4.3: Demographic Information

The demographic section sought information on the respondents ages, gender and education levels attained. Further the section presents information on the majors sources of income for the members of the community, status in their households, the number of people per household both adults and children, whether they are the main income earners in their household and whether they are the decision makers on monetary expenditures. The response for all the respondents on age, gender and levels of education has been presented on the table below.

Table 4.1: Demographic Distribution of the Respondents

Category		Age				Total	Level of education						Total
		18-29	30-39	40-49	50+		NE	PR	SE	CD	UD	PG	
Community	Male	-	1	3	8	**12**	3	2	4	-	3	-	**12**
	Female	4	5	7	10	**26**	10	7	6	-	3	-	**26**
Authority	Male	2	4	3	-	**9**	-	-	6	-	1	3	**9**
	Female	5	12	3	-	**20**	-	-	13	-	5	2	**20**
Total		**11**	**21**	**17**	**18**	**67**	**13**	**9**	**20**		**17**	**6**	**67**

Source: Generated from study data, 2013

Key: NE = No Education, PR = Primary, SE = Secondary Education, CD = College Diploma, UD = University Diploma, PG = Post graduate

The study found out that among the authorities, the variation between the male and female respondents was quite huge with a difference of 12 where the women were rated at 69% (20) while the female respondents were 31% (9). In terms of age distribution, most of the authorities are aged between 30-39 years at 55.1% (16) (4 men and 12 women). They were followed by those aged between 18-29 years with the women being the most at 17.2% (5) while the men were rated at 0.07% (2). The lowest ranked were those aged between 40 -49 years where

the men were ranked high at 10.3% (4) as well as the women were ranked at 10.3 % (3). The table further shows that more of the women are more educated at 24.1% (7) than men at 13.8% (4) with university degrees. They were followed by those with 'O' level education at 20.7% (6) for both men and women while the highest level of education was the post graduate degrees where the men ranked high at 17.2% (5) against the women 0.03% (1).

Among the members of the community, the senior members aged over 50 years were ranked highest at 26.3% (10) for men and 21% (8) for women. They were followed by those aged between 40-49 years at 10.4% for the women and 0.04 (3) for the men while the youngest members of the community aged between 30-39 years were ranked lowest at 0.7% for the women (5) and 0.01(1) men and the women aged between 18-29 years being rated at 0.6 (4). Furthermore most of the members of the community have very low levels of education with 13 of them having no education at all where 14.9% (10) were women and 0.8 % (3) were men. They were followed by those who have attained the 'O' levels at 16% (6) for women and 10.5% (4) for the men. The primary categories were ranked third at 18.4% (7) women and 0.05% (2) men while those had acquired the highest levels of educated were rated at 0.08% (3) for both men and women.

From these findings, it can be deduced that the members of the community have low standards of education where majority are illiterate and a significant number have acquired up to 'O' levels while the lowest level of education acquire by the authorities is the 'O' level with rest having higher education. Although majority of the women from the community possess the lowest level of education, the variation with the men for higher education is very small at 12% for men against 11% for women. Information on the experience by the authorities in the implementation of the CBHI is presented in figure 4.2.

Figure 4.2: Experience of the authorities in the implementation of the CBHI
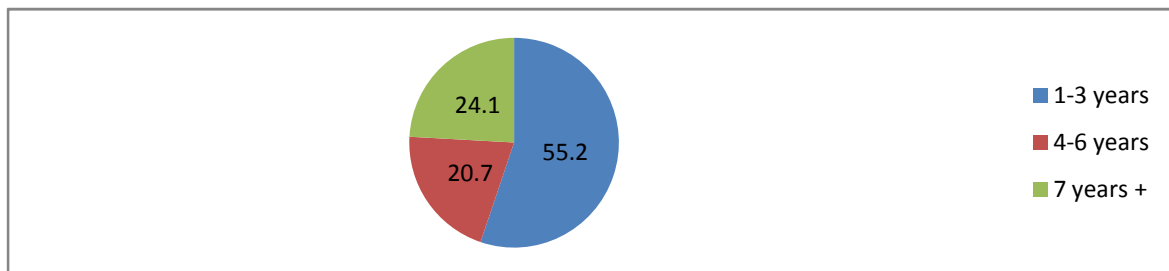
Source: Generated from study data, 2013

The studybfound that most of the authorities are quite experienced in the implementation of the CBHI having worked with the organization for 4-6 years at 55.2% and 7 years at 24.1%. Those who are less experienced have worked with the organization for 1-3 years. This implies that the authorities charged with the implementation of the CBHI are competent enough to handle the implementation process effectively.Finding on the sources of income for the households in the community is presented in the figure below.

Figure 4.3: Sources of income for the household
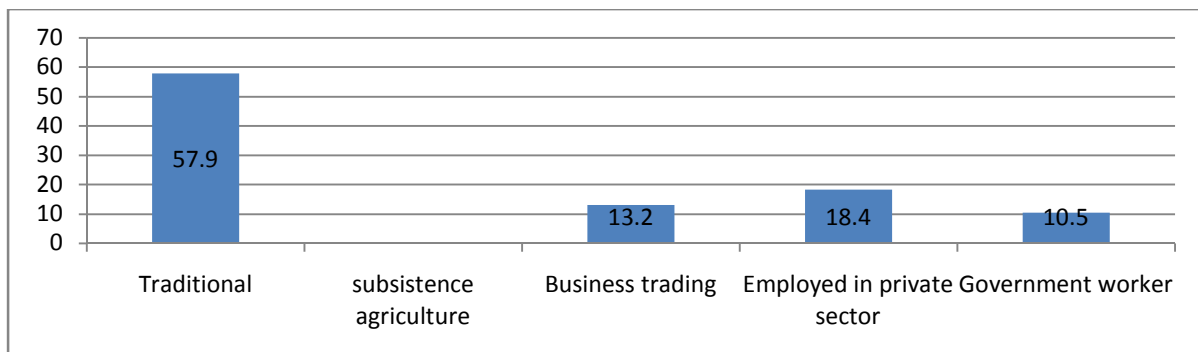
Source: Generated from study data, 2013

The study found out the most of the households depend on traditional sources of income at 57.9% such as farming. Those who are working in the private sector and doing businesses were rated at 18.4% and 13.2 % while those who are working with the government were ranked at 10.5%. This implies that the households rely on traditional sources of income and working in the private sector with the government jobs being less common with the households. Information on positions of the households is presented in the figure below.

Figure 4.4: Positions of the respondents in the household
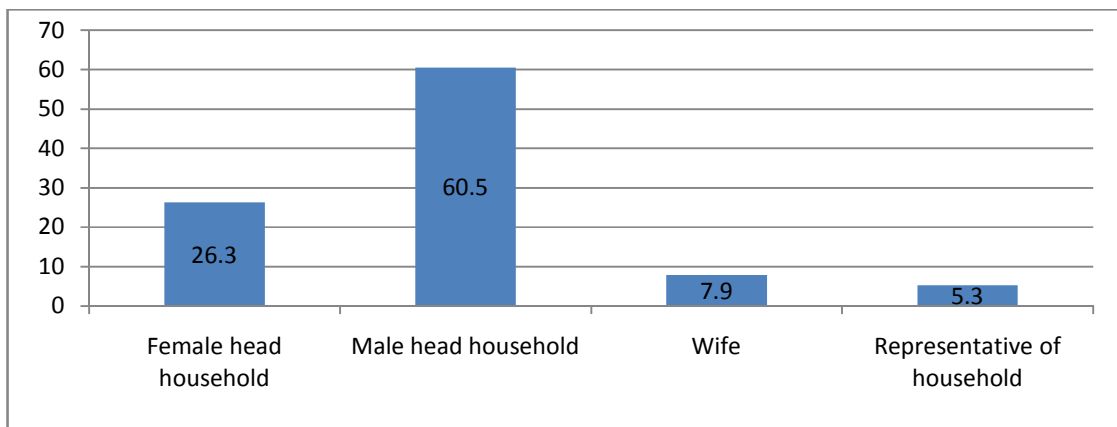
Source: Generated from study data, 2013

The results (fig.4.4) revealed that most of the households are headed by men at the rate of 60.5 %. They were followed by the female headed household at 26.3%. The households headed by wives were rated at 7.9 % while those headed by representatives were ranked lowest at 5.3%. This implies that just like other families, the men are the ones who bear the responsibility of taking care of their families while for the households without the fathers (men) because most of the men were killed during the Genocide which rendered the women widows, the women have been left to take care of the families. Information on the number of people per house hold is presented in figure4.5 below.

Figure 4.5: Number of People per Household
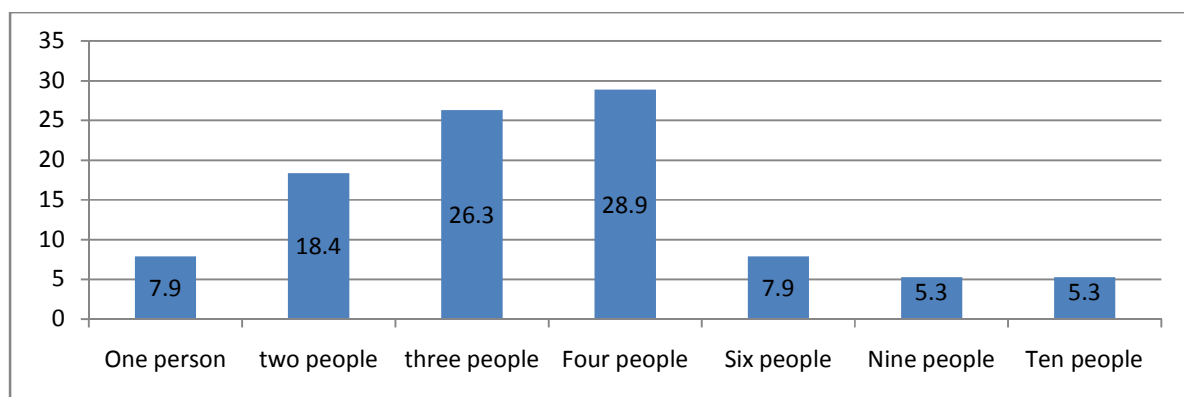
Source: Generated from study data, 2013

Fig.4.5 above indicates that most of the households had a family size of four people at 28.9%. They were followed by the households with three people family size at 26.3%. The households with two people came third at a response rate of 18.4%. Then households with 1 person and six people were rated at 7.9% each with the largest families of nine and ten people ranking lowest at a response rate of 5.3% each. This implies that Rwandese are effectively practicing family planning where majority have small families of 3 to 1 people. Information on the number of adults per households is presented in the figure below.

Figure 4.6: Number of adults in the household
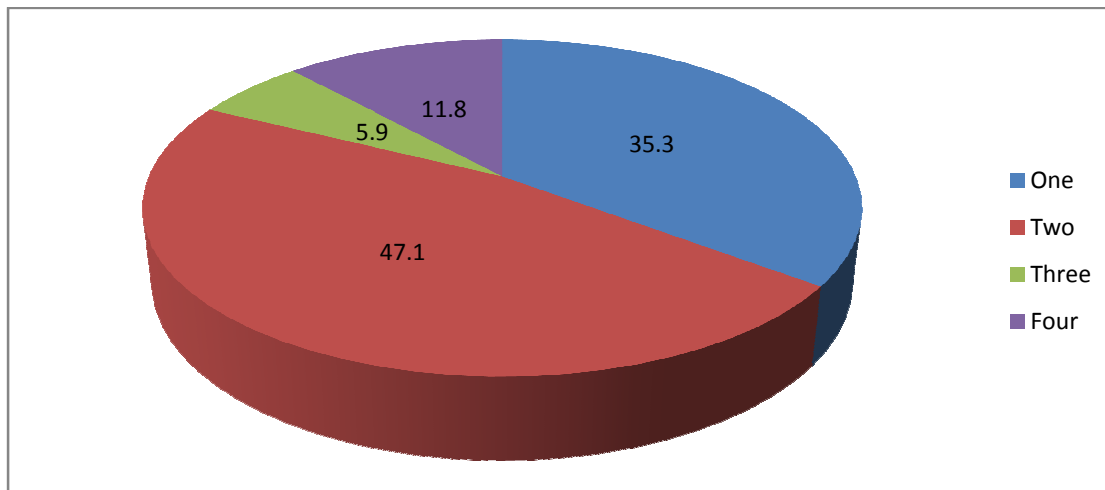
Source: Generated from study data, 2013

In terms of the adult members of the families, the study found out that 47.1% of the house household had two adults. They were followed by the households with one adult at a response rate of 35.3%. Those with four adults were ranked at 11.8% while the households with the highest number of adults were rated at 5.6%. This implies that adults found in most of the households are the parents (mother and father).The study sought information on the number of children per household. The response is presented in Figure 4.7.

Figure 4.7: Number of children per Household
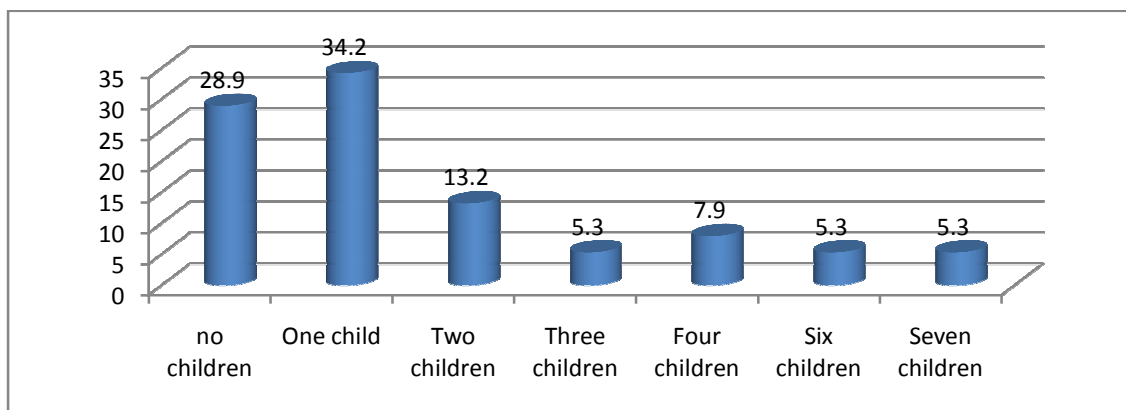
Source: Generated from study data, 2013

The finding shows that most of the households had only 1 child at a response rate if 34.2%. They were followed by households without children at 28.9%. Those with two and four children were rated at 13.2% and 7.9% while the rest had three, six and seven children at a response rate of 5.3% in each case. This implies that the households in Rwanda have embraced the idea of keeping small families by practicing family planning. Information on whether the respondents were the main income earners among the households is presented in the figure below.

Figure 4.8: Main income earners among the Households
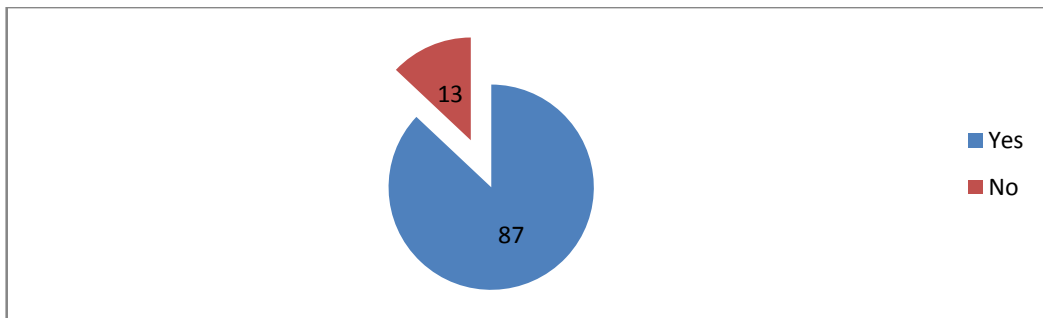
The study findings in figure 4.4 indicate that 87% (n=33) of the respondents are the main source of income in their households while only 13% (n=5) of the respondents indicated they are not main source of income. This in agreement with the response on figure 4.4 confirming the male household were the main participants in this study. The respondents are also the main decision makers in their families as shown in the figure below.

Figure 4.9: Main decision makers among the households
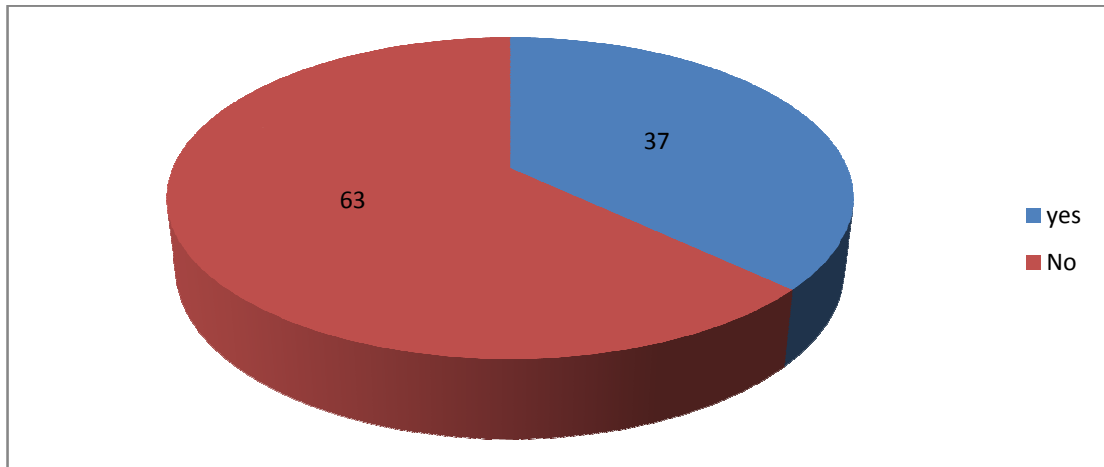
The research findings in figure 4.9 indicates that 63% of the respondents considered themselves as the main source of decision making in their households on how they spend money while 37% indicated they are not the main decision makers. Since most of the respondents are

34

also the bread winners in their families and are also the people who make decisions among the households.

4.4: Perception of the households on CBI based on Ubudehe categories from the Authorities perspective.

The first objective sought to find out the categories where the authorities belonged in the Ubedehe based CBHI schemes. The response is presented in figure 4.10 below.

Figure 4.10: Category of Belonging for the Authorities
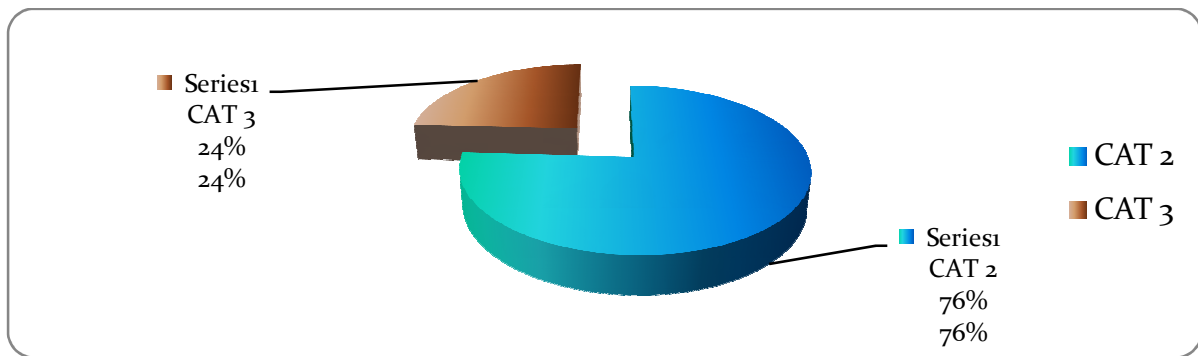
Source: Generated from study data, 2013

The study findings in figure 4.10 indicates that majority of the authorities belong to category 2 of the Ubudehe accounting for 76% (n=22) of the respondents while 24% (n=7) belong to category 3. This is because they are salaried people with stable sources of income who can afford the 3000 RwF and therefore do not have a lot of challengs contributing in the programme. The other group that contributes in category 3 are senior employees who can afford the 7000 RwF recommended under this category.

The study sought to find out whether the authorities were satisfied with their categories they belong in. The response is presented in the table below.

Table 4.2: Satisfaction with the Category of Belonging

Satisfaction	Frequency	Percentage
Yes	25	86.2
No	4	13.8
Total	**29**	**100**

Source: Generated from study data, 2013

Most of the authorities are satisfied with the categories they belong to at a rate of 86.2% while 13.8% were not satisfied. For those who indicated that they were satisfied, they said that it matches with each one's economic status, because they get monthly salary and money from their business and that the category where they belong is better than other categories. Of those who indicated thay were not satisfied, they indicated that they category match with economic status or they get monthly income. This implies that the way the categories have been grouped is one of the greatest determinants to where the people are categorized and there they feel that they are manageble. The authorities were asked whether the members of the public are comfortable with the specific categories. The response is presented in the table below.

Table 4.3: Authorities Opinion on whether community members are comfortable with the categories

	Reasons given					Total
	Not comfortable with specific categories due to rigidity	Lack of participation by some people in the community	Economic status not recognized	Done by merit due to categorization	Population participated in categorization	
Yes	0	0	0	2	3	5
Percent	0.0%	0.0%	0.0%	0.07%	10.3%	
No	15	12	5	0	0	24
Percent	51.2%	41.4.0%	17.2%	0.0%	0.0%	
Total	15	12	5	2	3	29

Source: Generated from study data, 2013

The study findings in table 4.15 indicates that most of the community members are not comfortable with specific categories where they belong as indicated by 51.2% (n=15) of the authorities respondents because of lack of comfortability with the categories given because of the rigidity of the categories. 41.4% of the respondents indicated that the members of the public were not comfortable with categories due to lack of participation, while 17.2% of the respondents felt that the economic status of the community is not recognized in the categorization.

For those who are comfortable, the study found out that 0.07 % felt that the categorization was done on merit and 10.3% indicated that the population was involved in the process of categorization. This implies that effective participation in the Ubudehe based CBHI programmes have been impeded by the rigidity of the categories, lack of participation by the

members of the community and because the economic status of the members of the communities were not put into consideration during formulation of the Ubudehe categorization.

The researcher identified statements suggesting perceptions about the Ubudehe based CBHI. There respondents were then asked to indicate their level of agreement with the statements on an ordinal scale. The response is presented in table 4.4 below.

Table 4.4: Authorities level of agreement on households perception about the Ubudehe based CBHI programme

Suggested Statements	Modal choice	Frequency	Percentage
Healthcare provision using Ubudehe categories is fair and not biased to a selected few individuals	Neutral	14	48.3
There is a sharing of information between authority	Neutral	13	44.8
There is no form of discrimination against any category in health care service provision	Strongly agree	20	69.0
The authority fairly judges each member level of wealth and livelihood to allow categorization of households.	Neutral	9	31.0
Households with greater and recurring health risks are given more priority in health insurance coverage than others	Strongly disagree	16	55.2
Strategies developed for effective continuity of health care in the categories are best suited to the needs of its members	Disagree	9	31.0
The government is persistent with the mobilization of the community on Ubudehe categories	Neutral	12	41.4

Source: Generated from study data, 2013

The authorities strongly agreed that there is no any form of discrimination against the application of the categories in health care services provision at 69%. The programmes do not give priority to households with greater and recurring health risks in health insurance coverage at a rate of 55.2% while 31% of the respondent disagreed that strategies developed for effective continuity of health care in the categories are best suited for the needs of its members. From the authorities perspective there is no discrimination in the categorization of the programme, it does not give priority to its beneficiaries based on health risks and the strategies developed for effective continuity of health care are best suited for the needs of its members. The study also sought the authorities' opinion on what should be done to improve the community participation the programme. The response is presented in the table below.

Table 4.5: What should be done to improve Ubudehe Categorization Process

Suggestions in what should be done for improvement	Responses	
	N	Percentage
Change criterion and name of Ubudehe categories	25	86.2%
Sensitization and mobilization of the communities	20	69%
There should be motivation of the population in the process of categorization	5	17.2%
Population should be informed before categorization	8	27.6%

Source: Generated from study data, 2013

The study findings in table 4.5 indicates that there should be sensitization and mobilization of the communities on criterion of the Ubudehe categories at 86.2% (n=25). The findings indicate that 69% (n=20) of the respondents indicated that the criterion used in the Ubudehe category should be changed, 27.6% (n=8) felt that the population should be informed while 17.2% (n=5) indicated that the population should be motivated in the process of categorization. The names are shameful to the households, for instance those in category 1 are categorized as the poorest who are leaving in abject poverty by begging and soliciting help from others and considered lucky if they are dead. The study also sought information from the

authorities on the number of times they receive complaints from community on the Ubudehe categories. The response is presented in the table below.

Table 4.6: Frequency of complaints on Categorization by the community

Frequency of complaints		Frequency	Percent
Valid	Daily	13	44.8
	Weekly	6	20.7
	Monthly	8	27.6
	Yearly	2	6.9
	Total	29	100.0

Source: Generated from study data, 2013

The results in table 4.16 indicates that majority of the authority respondents receive complaints on Ubudehe categories on daily accounting for 44.8% (n=13), 27.6 of the responsents indicated that they receive complaint on a monthly basis and for the those who get compliants on weekly basis they were rated at 20.7% while 6.9% (n=2) receive the complaints yearly. This families that the households have a lot of problems with the process and that has greatly increased the rates at which they make complaints to the authorities. The study sought information on the problems with the categorisation process. The response is presented in table 4.7.

Table 4.7: Problems with the Ubudehe Categorization

Problems with the Ubudehe Categorization	Responses	
	N	Percent
The shifting of the Ubudehe program	12	42.9
Lack of populations participation and unhappiness with the categorization process and low understanding of the Ubudehe category	16	57.1
Total	28	100.0

Source: Generated from study data, 2013

The results in table 4.7 indicates that, the problems experienced with the Ubudehe process was lack of population participation and unhappiness with the categorization process and low understanding of the Ubudehe process from the authorities' point of view at 57.1%. At the same time others indicated that the shifting of Ubudehe category is a major problem.as a result of shifting of the Ubudehe program at 42.9%. This means that the challenges to full implementation of the Ubudehe process include lack of participation by the households and shifting of categories without consultation. Then the researcher asked the respondents whether the mode of categorisation should be changed and what should be changed in that case. The response is presented in the figure below.

Figure 4.11:Households response on whether the mode of categorisation should be changed.
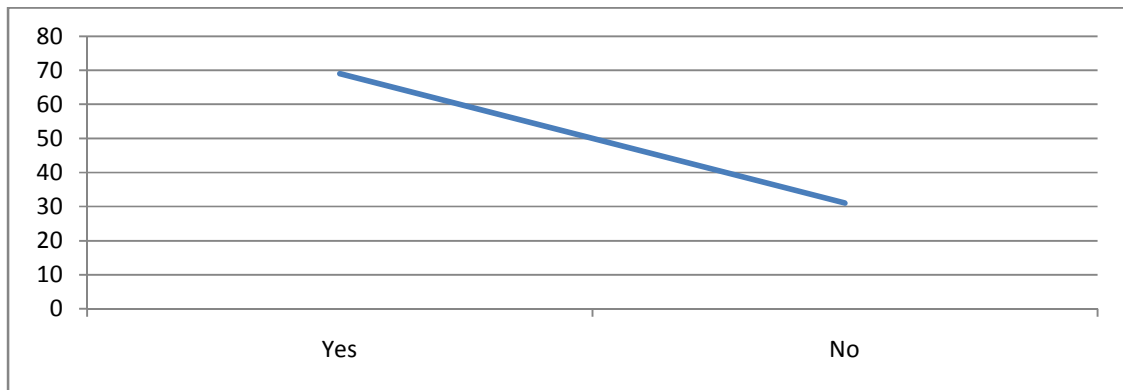
Source: Generated from study data, 2013

Figure 4.11 indicates that most of the respondents think that the mode of categorization should be changed, accounting for 69% (n=20), while 31% (n=9) think that it should not be changed. The respondents want the mode of categorization of Ubudehe changed because of the criterion on which CBHI is based while others believe that it should be changed because it is expensive.

4.5: Perception of the Households on CBHI based on Ubudehe Categories from the Community Perspective.

The second objective sought to establish the respondents' level of agreement on the following items. They were asked whether individuals can easily move within the categories. The response is presented in the table below.

Table 4.8: Individual easily move within categories

Ordinal scale		Frequency	Percent
	Strongly disagree	31	81.6
Valid	Neutral	3	7.9
	Strongly agree	4	10.5
	Total	38	100.0

Source: Generated from study data, 2013

This indicates that the majority of the respondents strongly disagreed that individuals are able to easily move between categories in the event of change in levels of income generation accounting for 81.6% (n=31) of the respondents while only 10.5% (n=4) strongly agreed that individuals are able to easily move between categories in the event of change in levels of income generation. This implies that switching between the various categories based on one's economic status. The respondents' level of agreement on acceptance of the products as the best is presented in table 4.9 below.

Table 4.9: Ubudehe acceptable as the best strategy for paying for health care services

Ordinal		Frequency	Percentage
	Strongly disagree	4	10.5
	Disagree	3	7.9
Valid	Neutral	2	5.3
	Agree	7	18.4
	Strongly agree	22	57.9
	Total	38	100.0

Source: Generated from study data, 2013

Table 4.9 shows that the majority of the respondents (57.9%, n=22) strongly agreed that Ubudehe categories are acceptable to them as the best strategy for paying for health care services. They were followed by those who agreed at 18.4% (n=7) while 10.5% (n=4) strongly disagreed that Ubudehe categories are acceptable to them as the best strategy for paying for health care services. This means that generally disbursing of CBHI programme through the

Ubudehe categories is still the most preferred health insurance scheme among the household in Huye District of Rwanda. The respondents were asked whether the Ubudehe categories meet the income levels among the household. The response is presented in the table below:

Table 4.10: Categories Meet Income Level

Ordinal Scale		Frequency	Percentage
Valid	Strongly disagree	22	58
	Disagree	2	5.2
	Neutral	1	2.7
	Agree	8	21
	Strongly agree	5	13.1
	Total	38	100.0

Source: Generated from study data, 2013

The data presented in table 4.10 indicates that majority of the community strongly disagree that the categories of Ubudehe process are the best and meet their income level with services they receive accounting (58%, n=22) while 21% (n=8) agreed with the same. This also indicates that 13.1% (n=5) of the respondents strongly agreed that the categories of Ubudehe process are the best and meet their income levels with services they receive. This means that the households do not believe that the categories meet the income levels. The household were asked whether they were happy with the categories they belong. Their response is presented in the table below.

Table 4.11: Happiness with Ubudehe category where one belongs

		Frequency	Percent
	Strongly disagree	17	44.8
	Disagree	3	7.9
Valid	Agree	4	10.5
	Strongly agree	14	36.8
	Total	38	100.0

Source: Generated from study data, 2013

Table 4.11 indicates that majority of the respondents (44.8%, n=17) strongly disagreed that they are happy with the Ubudehe category that they belong to while 36.8% (n=14) strongly agreed that they were happy with the categories they belonged to. The findings also indicate that 10.5% (n=4) of the respondents agreed that they are happy with the Ubudehe category that they belong to. Generally, most of the households were not happy with the categories as can be seen from the above response where 17 households strongly disagree and another 3 disagreed with the same. Further, the respondents were asked if they could register in the same category given the chance. The response is presented in the table below.

Table 4.12: If the Community would enroll for the same category given the chance

Ordinal		Frequency	Percentage
	Strongly disagree	19	50
	Disagree	1	2.6
Valid	Agree	4	10.5
	Strongly agree	14	36.9
	Total	38	100.0

This table 4.12 indicates that majority of the respondents (50%, n=19) strongly disagreed that they will enroll for the same category if they had a chance to register afresh while 36.9% (n=14) strongly agreed they could retain the same Ubudehe category. It is very clear that

the households are not happy with the categories and therefore would want to switch, given the chance.

Finally the respondents were asked whether Ubudehe process has categories that improve their access to health care service in the community, whether they are satisfied with the process including people under their care and whether the authorities give reasonable chances to the community to participate in the categorization process. The response is presented in table 4.13 below.

Table 4.13: Households perceptions on Ubudehe Process

Statements	Modal choice	Frequency	Percentage
Ubudehe process has good categories that improve our access to healthcare services in the community	Strongly agree	22	57.9
I am satisfied with the categorization of the entire household including people under my responsibility	Strongly disagree	16	42.1
The authority gives reasonable chance to the community to participate in the categorization	Strongly agree	19	50

Source: Generated from study data, 2013

The households strongly agreed that Ubudehe process has good categories that improve access to healthcare services in the community at a response rate of 57.9% and that the authority gives reasonable chance to the community to participate in the categorization at 50%. However they were not satisfied with the categorization of the entire household including the people under their responsibility at 42.1%. This implies that despite the fact that the Ubudehe process has good categories that improve access to health care services in the community and that the fact that the authorities give reasonable chances for community participation, the households are not happy with the categorization of members of their families. Table 4.14 below shows responses regarding the length of time the households would wish the categories to be change.

Table 4.14: Households responses on the Length of time for changes for the Ubudehe Categories

Length of time		Frequency	Percentage
Valid	After 2 years	15	39.5
	After 3 years	9	23.7
	After 1 year	12	31.6
	No reason to change	2	5.3
	Total	38	100.0

Source: Generated from study data, 2013

These data indicates that majority of the respondents (39.5%, n=15) are of the view indicated that categories of Ubudehe should be changed after every two years, 31.6% that they be changed after every one year, 9% of the respondent felt that they be changed after three years while 5.3% (n=2) indicated that there is no need to change the categories. This is an indication that the Ubudehe process should consider revision the categories after a given period preferably after every five years so that it takes into account the economic dynamics under which the households operate. Table 4.15 below provides the reasons for which the categories should be changed.

Table 4.15: Reasons for Change of Category

Reasons for Change of Category		Frequency	Percentage
Valid	Economic status changes	26	68.4
	To make it flexible	8	26.3
	Not well structured and implementation done wrongly	2	5.3
	Total	38	100.0

Source: Generated from study data, 2013

The study findings in table 4.15 shows the reasons as to why the community wants the categories reviewed occasionally. The results indicate that most of the respondents (68.4%, n=26) wants the categories changed to reflect the economic status of the population since it is dynamic while 26.3% (n=8) said it should be changed to make it flexible and 5.3% (n=2) indicated that it is not well structured and its implementation was done wrongly and hence should be changed. The researcher finalized this section by asking the respondents to comment of the Ubudehe process and indicate things that could be change/improve. The responses are presented in table 4.16 below.

Table 4.16: Household' comment on the categories and areas for improvement

Areas for improvement of the Ubudehe categorization of CBHI programme in Rwanda	Areas of change				Total	percentages
	Should improve on mobilization of the population	Should be clearly implemented and review done	It does not reflect the economic status of the population	Names used in categorization should be changed		
Complementation of categorization of population is not properly done	0	8	0	2	10	28
Mobilization is not done and they should improve	3	0	0	2	5	14
The policy is good for categorization	0	5	0	0	5	14
Category II is not suitable	5	2	3	2	12	33
Names of categorization are bad	0	2	0	2	4	11
Total	8	17	3	8	38	

Source: Generated from study data, 2013

Table 4.16 above indicates that majority of the community were not happy with category II as reported by 31.6% (n=12) of the respondents, and indicating that it should be clearly implemented and review done while 26.3% (n=10) of the respondents indicated that implementation of categorization of the population is not properly done and indicated that it should be clearly implemented and review done as well as names used in categorization should be changed. 8 (21.1%) indicated that the process should be clearly implemented and reviewed regularly with 0.07% (3) of the respondent feeling that it does not reflect the economic status of the population. The means that the households feel the current process of categorization has left out very key and important determinants which could have seen it formulated better than in its current state.

4.6: Community Perspective on Barries to access to healthcare using the Ubudehe categories as a basis for CBHI.

The third objective sought to measure the households' understanding on the barriers to the utilization of the CBHI under the Ubudehe categories. The researcher identified statements denoting perception about CBHI from a general perspective. The respondents were required to indicate their level of agreement with the statements. The response is presented in table 4.17 below.

Table 4.17: Community Perception

Statements	Modal choice	Frequency	Percent
Individuals are able to easily move between categories in the event of change in levels of income	Strongly disagree	32	84.2
Fear by the community to have quarrels with the hospital officials they had bad experience with in the previous days	Strongly disagree	31	81.6
Fear of being discriminated by the hospital officials based on their family or community where they come from	Strongly disagree	33	86.8
It is difficult for people with larger families to pay the required sum at once	Strongly agree	33	86.8
It is difficult for people who reside in a at different district to travel back and seek medical treatment at their district	Neutral	16	42.1
I was adequately informed of the time when categorization would take place	Strongly agree	31	81.6
I received adequate preparation/information on Ubudehe categories before the categorization and enrollment	Strongly agree	31	81.6

Source: Generated from study data, 2013

According to this study, the greatest barrier to accessing the Ubudehe based CBHI programmes are difficult for people with larger families to pay the required sum at once (86.8%). The other barrier is that individuals are not able to easily move between categories in the event of change in levels of income(84.2%).81.6 of the households also fear quarrels with the hospital officials they had bad experience with in the previous day.

Despite this there is no fear of discriminated by the hospital officials based on their family or community where they come from at 86.8% and they are adequately informed of the time when categorization would take place and receive adequate preparation/information on Ubudehe categories before the categorization and enrollment at 81.6 % in each case.

Therefore, the greatest barriers that the programme is unaffordable for people with large families and lack of flexibility where individuals cannot switch the categories at will. Table 4.18 below indicates the challenges facing the households in accessing Ubudehe progress in CBH.

Table 4.18: Comment on Challenges faced using Ubudehe in CBHI

Challenges		Frequency	Percent
Valid	Lack of power to get money to pay for health	19	50.0
	No problem since government covers the health insurance for the very poor	19	50.0
	Total	38	100.0

Source: Generated from study data, 2013

Table 4.18 indicates that 50% of the respondents said the lacked lack of power to get money to pay for health another 50% indicated that there is no problem since the government pays for the health insurance. This implies that the challenges associated with the sustainability of the programme are quite minimal and this can be attributed the support by the government on the poor households. Thus, it is important to fluid ways of improving access to Ubudehe categories in CBHI. The public or members of the community's suggestions are contained in table 4.19 below.

Table 4.19: Ways to improve access Ubudehe categories in CBHI

		Frequency	Percent
Valid	Reduce the cost of CBHI payment	3	7.9
	Mobilization should be done to involve the community	6	15.8
	Facilitation of big family to pay mutual	3	7.9
	Regular review of categorization of setting the population into category	9	23.7
	Careful assessment should be carried out before putting the population into categories	24	44.7
	Total	38	100.0

Source: Generated from study data, 2013

About 44.7% of the respondents suggested that careful assessment should be carried out before putting the public into the categories. 23.7% suggested that the categorization should be regularly reviewed based on the settings of the population while 15.8% said that there should be mobilization to involve the community on the process. Those who felt that the costs should be reduced and that large families should be facilitated were rated at 7.9%. This implies that programme requires a careful assessment on the stratification where reviews be carried out regularly to ensure that the categories match economic status of the community members. Information on the ways to enhance the programme is presented in the table below.

Table 4.20: what are the ways to improve the programme

	Responses	
	N	Percent
Change Ubudehe criterion of categorization	6	17.1
Proper editing and time allocation	3	8.6
Mobilize the population to know the benefits	18	51.4
Provide accurate information to members by the government	8	22.9
Total	35	100.0

Source: Generated from study data, 2013

Table 4.20 indicates that 51.4% (n=18) of the authority respondents proposed that there should be change in Ubudehe criterion of categorization to improve it and 22.9% (n=8) indicate that there should be provision of accurate information to members by the government to improve Ubudehe categorization process. Community mobilization was suggested to be the main strategy that can be used to improve on the performance of the programme.

4.7: Challenges facing the authorities relating to access healthcare using the Ubudehe categories

The fourth objective sought to assess the authorities understanding of the challenges facing the participation of the members of the public on the Ubudehe based CBHI programmes, the researcher posed statements and responses are below given in table 4.21 below.

Table 4.21: What are the challenges impeding access to CBHI by community members?

Statement	Modal choice	Frequency	Percent
We have adequate staff to administer Ubudehe process	Agree	18	62
Our staff members are well motivated to perform their duties	Agree	13	44.8
The government has provided us with adequate resources to discharge our duties	Agree	10	34.5
We have good working relationships with the community members	Strongly agree	18	62
We have good working relationship amongst ourselves	Strongly agree	16	55.2
We have good information about Ubudehe categories	Strongly agree	20	68.7

Source: Generated from study data, 2013

According to the authorities, there are no serious challenges to accessibility of the public to CBHI. The authorities felt member of the public that have provided good information about the programme 68.7%. They also felt that they have good working relationships with community members (62%), and have adequate staff to administer CBHI programme (62%). The authorities also felt that they have a good working relationship amongst themselves (55.2%). The staffsare well motivated to perform their duties(44.8%) with 34.5% who those who felt that the government has provided adequate resources to discharge their duties.

The study wound up by seeking the finding out on the challenges facing the categories of the programme and opinions on what should be done to enhance its performance. The response is presented in table 4.22 below.

Table 4.22 How would you rate the categories by number of challenges?

	Responses	
	N	**Percent**
Category 1	0	0 %
Category 2	20	52.6%
Category 3	18	47.4%
Total	38	100.0%

Source: Generated from study data, 2013

The study findings in table 4.22 indicates that the category with the most challenges is category two as reported by 52.6% (n=20) of the respondents. This was followed by category 3 at 47.4% (n=18) of the respondents while category 1 are the ones sponsored by the government. This is because most of the household are categorized in category 2 based on the economic capabilities and therefore they feel they have been unfairly categorized.

CHAPTER FIVE:

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of findings, conclusions and recommendations of the study. The major objective of this study was to determine household perception to the community based health insurance based on Ubudehe categories. It has been observed that the policy is well received by the community by the implementation has challenges.

5.2 Summary

The study has established that there is a varied perception of respondents on the Ubudehe categories used by the government of Rwanda on community based health insurance scheme. The study has established that most of those in the authority are in the category two of the Ubudehe. The study has also established that those who are in the authority are comfortable with the categories where they belong for it reflects their economic status and covers them in terms of health insurance scheme.

This indicates that the Ubudehe insurance scheme is designed to benefit all the people in the community and the household irrespective of their economic status thereby confirming the study done initially by Mupenzi, (2010), in which he indicated that at the community level, individual poverty profiles are drawn with the help of facilitators and trainers based on individual evaluation of one's lifestyle and also establish the causes and consequences affiliated with individual poverty levels which is followed by drawing of the village social map that includes names of heads of households and development infrastructure of the region. However, the study has established that there are complaints that are usually lodged with the authorities by the households with regards to the insurance scheme of Ubudehe.

The study indicates that lack of participation of the population and their unhappiness is the major problem with the categorization.In addition there is poor involvement of the community and households in the in categorisation process. However, this is against the study conducted by Shimeles(2010) who indicated that the communities at village level go through a process of collectively mapping their community facilitated by trained community volunteers. Niringiye's (2012) findings indicated that Ubudehe program involves the local community members themselves identify development issues and deciding on priority actions to fight poverty in their neighborhoods and therefore the governments participation.

The process collectively defines and analyses the nature of poverty in their community, look at local categories of poverty, characteristics of each category, and mobility between categories, the causes and impact of poverty, and so on. The study has established that majority of the respondents were not sure if the healthcare provision using Ubudehe categories is fair and not biased to a selected few individuals. This indicates that the authority cannot determine on behalf of the household and community if the scheme is fair or not.

The study has also established that the authorities share information amongst themselves regarding the Ubudehe scheme. The study found that households with greater and recurring health risks are not given priority in health coverage. Thus, the risk of health is disregarded than others indicating that sometimes the risk of health is disregarded and people categorized into the various groups according to the determination of the government. The study has also established that the government is persistent with the mobilization programme on the Ubudehe program thereby indicating that the government takes into account the health of its citizens.

On the perception of the community and the household on the Ubudehe based health insurance scheme, the study has established that the households cannot easily move between categories as indicated by majority of the respondents. The study has reveals that Ubudehe based categories are acceptable as the best strategy for paying for health care services. This indicates that the citizens' health is insured and they have the obligation to accept and be in the categories in which they are placed. The study has established that the community and the household have a positive perception of the Ubudehe health scheme since it takes into account their health matters.

On the barriers to access healthcare using the Ubudehe based categories, the study has established that there is no shortage of staffing in the implementation of the CBHI. The study has also established that government provides adequate resources towards the CBHI. This indicates that the government takes into account the poverty of the people and has the desire to keep the health of its citizens irrespective of their status. The findings further show that the program is not flexible to incorporate the rise or decline in the economic status. The study has established that there is also difficulty for people with large families to pay the required sum at once.

On the ways of improvement, the study has established that both the authorities and community would wish that there is mobilization and adequate sensitization to involve all people in the community and in the determination of categories for assistance to large families as well as reduction in the cost of CBHI payment or facilitation of large family to pay the required fees. The study has established that Ubudehe criteria and names should be changed because the households feel that they are shameful. For instance category I means is for the people who live in abject poverty begging and soliciting to help from others in the society and therefore perceived better of they are dead. Therefore the naming of categorization ought to be improved and there should be provision of accurate information to members by the government to improve Ubudehe categorization process to enhance the provision of the healthcare services to the society.

5.3 Conclusions

Based on the above findings, the study concludes that the perception of the households on the CBHI based on the Ubudehe categories is positive. This is because the process helps to improve accessibility to health services and takes into consideration their economic well being. Local government charged with the implementation of the programme give adequate chances for community participation.

However the households feel that the programmes does not take into account some of their plights in the society particularly some elements of their economic status and therefore a review of the programmes would make it more acceptable to them. For the authorities, they are happy with categorization of the programme because they have stable sources of income which

supports them in sustaining the programme and the same time they are the ones in charge of the process of implementing the programmes. Further members of the community feel that the programme is not flexible and therefore they cannot easily switch between the available categories.

The study established that there are no major barriers to accessing the Ubudehe based CBHI. The study also found that the staffing of the authorities is adequate and are well motivated. The first barrier to the Ubudehe based BHI is lack of movement from one category to the next with respect to the change in economic status. It is also difficult for people with larger families to pay the required sum at once. This is due to poverty that has bedeviled Rwanda for long and most of the population who reside in different districts to travel back and seek medical attention at their districts.

According to the study findings there is need to make improvements in the categorization of the Ubudehe programmes in order to improve its performance and realization of the initial objectives. The suggested changes include change of the Ubudehe criteria of categorization, the names (in Kinyarwanda) and the description of the categories. The changes should further involve proper editing and time allocation for the community to participate in the categorization process, mobilization and sensitization of the population to know the benefits of the Ubudehe based CBHI. It is suggested that government provide adequate and accurate information to the community and the households of the Ubudehe categorization. The study suggests that there is need for change on reduction of the CBHI payments to make it affordable to all and ensure regular review of categorization and assisting the large families to pay the required fees.

5.4 Recommendations

Based on the study findings, this study has a number of recommendations for government and the stakeholders as well as for the community.

1. The government and the stakeholders in the heath sector need to make the Ubudehe program flexible to allow free movement and registration of people into various categories and its benefits.

2. The government and the stakeholders in the health sector should do proper sensitization, mobilization and education of the community on their involvement in the categorization into the Ubudehe category and its benefits to the community and the households.

3. The government and the stakeholders in the health sector should subsidize the payment for the larger families in order for them to access the CBHI program, alleviate poverty and create infrastructure to increase their capacity to pay.

4. The government and the policy makers in the health sector need to change name, description and criteria of categorization process, proper editing and time allocation for the community to participate in the categorization and provision of adequate and accurate information by the government to the community and the household on the Ubudehe categorization to enhance full participation of the community.

5.5 Suggestion for Further Studies

Based on the findings the researcher recommends further studies in the following areas,

1. The factors influencing affective participation of households in the Ubudehe based CBHI in Rwanda

2. The benefits of the Ubudehe based CBHI on households in Rwanda

3. Possible areas of review in the Ubudehe based CBHI in Rwanda to enhance its performance.

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APPENDICES

APPENDIX I: QUESTIONNAIRE FOR AUTHORITY

Perception of Household Members on Ubudehe based Community Health Insurance in Rwanda: The case study of Huye district.

Introduction

My name is Veneranda Uwamariya. As part of my studies in Kenya, I am conducting a study on perceptions of Household members on Ubudehe categories based community health insurance in Rwanda. Please provide the information requested for this questionnaire which will help in better understanding issues related to community health insurance in our country. Your response will be confidential, only be seen by the researcher. The response given could be used in improving community based health insurance policy in Rwanda.

SECTION A: DEMOGRAPHIC INFORMATION

1. What is your age? (in years).

    18 – 29   [   ]   30 – 39   [   ]

    40 – 49   [   ]   50 and above [   ]

2. Gender

    Male[   ]   Female[   ]

3. How many year of formal education have you attained?

    a) Primary   [   ]
    b) Secondary   [   ]
    c) College certificate   [   ]
    d) College diploma   [   ]
    e) University degree   [   ]
    f) Post graduate   [   ]

g) Others (specify)   [   ]

_____

4. How long have you participated in the implementation of CBHI policy in Rwanda?

      a) Less than 1 year [   ]

      b) 1 -3 years [   ]

      c) 4 -6 years[   ]

      d) 7 years and above[   ]

SECTION B: MEASURING PERCEPTION OF HOUSEHOLDS ON COMMUNITY BASED HEALTH INSURANCE BASED ON UBUDEHE CATEGORIES

1. Which category do you belong?

      a) Category 1   [   ]

      b) Category 2   [   ]

      c) Category 3   [   ]

2. Are you satisfied with the Ubudehe category you belong?

      a) Yes [   ]

      b) No[   ]

Comment on your response above? --

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3. In your opinion, are members of the public comfortable with specific categories?

      a) Yes [   ]

      b) No [   ]

Comment on your response above?--

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4. How often do you receive complaints on Ubudehe categories?

      a) Daily [   ]

      b) weekly [   ]

      c) monthly[   ]

      d) yearly [   ]

      e) never[   ]

5. What is the problem with the categorization from authority view?

      ----

6. In your view, do you think the mode of categorization need to be changed?

    a) Yes [   ]

    b) No [   ]

    If yes, what should be changed? --

SECTION B: MEASURING PERCEPTION OF HOUSEHOLDS ON CBHI BASED ON UBUDEHE CATEGORIES

7. On a scale of 1-5, where 1-strongly disagree, 2-disagree, , 3-agree, 4-strongly agree 5-not sure state the extent to which you agree with the following regarding Ubudehe categories

Description		Response				
		1	2	3	4	5
a.	Healthcare provision using Ubudehe categories is fair and not biased to a selected few individuals					
b.	There is a sharing of information between authority					
c.	There is no form of discrimination against any category in health care service provision					

d.	The authority fairly judges each member level of wealth and livelihood to allow categorization of households.					
e.	Households with greater and recurring health risks are given more priority in health insurance coverage than others					
f.	Strategies developed for effective continuity of health care in the categories are best suited to the needs of its members					
g.	The government is persistent with the mobilization of the community on Ubudehe categories					

8. In your opinion, what should be done to improve or change the perception of the community about Ubudehe categorization?

SECTION C: BARRIERS TO ACCESS HEALTHCARE USING THE UBUDEHE CATEGORIES AS A BASIS FOR CBHI

9. On a scale of 1-5, where 1-strongly disagree, 2-disagree, 3-not sure, 4-agree, 5-strongly agree state the extent to which you agree with the following regarding Ubudehe categories

Description		Response				
		1	2	3	4	5
a.	We have adequate staff to administer Ubudehe process					
b.	Our staff members are well motivated to perform their duties					

c.	The government has provided us with adequate resources to discharge our duties					
d.	We have good working relationships with the community members					
e.	We have good working relationship amongst ourselves					
f.	We have good information about Ubudehe categories					

10. In your opinion, which category faces the most challenges and why?

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11. What should be done to improve Ubudehe categorization process?----------------------------

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Thank you for your participation!

APPENDIX II: QUESTIONNAIRE FOR THE COMMUNITY

Perception of Household Members on Ubudehe based Community Health Insurance in Rwanda: The case study of Huye district.

Introduction.

My name is Veneranda Uwamariya. As part of my studies in Kenya, I am conducting a study on perceptions of Household members on Ubudehe categories based community health insurance in Rwanda. Please provide the information requested for this questionnaire which will help in better understanding issues related to community health insurance in our country. Your response will be confidential, only be seen by the researcher. The response given could be used in improving community based health insurance policy in Rwanda.

SECTION A: **DEMOGRAPHIC INFORMATION**

1. What is your age?

     a) 18 – 29 [   ]

     b) 30 – 39 [   ]

     c) 40 – 49 [   ]

     d) 50 and above [   ]

2. Gender

     a) Male   [   ]

     b) Female [   ]

3. How many year of formal education have you attained?

     a) Primary   [   ]

     b) Secondary   [   ]

     c) College certificate   [   ]

     d) College diploma   [   ]

     e) University degree   [   ]

     f) Post graduate   [   ]

          Others   [   ] _____

3. What is your major source of income?
   a. Farmer   [ ]
   b. Business trading   [ ]
   c. Employed in private sector   [ ]
   d. Government Worker   [ ]
   e. Others [   ]
      Please, specify: _____

4. What is your status in your household?
   a) Female head of household   [ ]
   b) Male head of household   [ ]
   c) Wife   [ ]
   d) Grandmother/grandfather; [   ]
   e) Representative of household [   ]

5. How many people live in this household, including youself? [   ]
6. How many adults (18 years and above) live here? [   ]
7. How many children (less than 18 years) live here? [   ]
8. Are you the main income earner in your household?
   a) Yes [   ]
   b) No   [   ]

9. Do you consider yourself to be the main decision-maker in your household about what your household spends money on?
   a) Yes [   ]
   b) No   [   ]

SECTION B: PERCEPTION OF HOUSEHOLDS ON CBHI BASED ON UBUDEHE CATEGORIES

10. On a scale of 1-5, where 1-strongly disagree, 2-disagree, , 3-agree, 4-not sure,5-strongly agree, state the extent to which you agree with the following regarding Ubudehe categories

Description		Response				
		1	2	3	4	5
a.	Individuals are able to easily move between categories in the event of change in levels of income generation					
b.	Ubudehe category acceptable to me as the best strategy for paying for health care services					
c.	The categories of Ubudehe process is the best and meet my income level with the services I receive					
d.	I am happy with the Ubudehe category that I belong to					
e.	If given a new chance to register I would enroll for the same category I am currently enrolled for					
f.	Ubudehe process has good categories that improve our access to healthcare services in the community					
g.	I am satisfied with the categorization of the entire household including people under my responsibility					
h.	The authority gives reasonable chance to the community to participate in the categorization					

11. After what period of time in terms of years would you wish for the categories to be changed?

Explain ---

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12. Based on your experience with Ubudehe process, comment on the categories and state things you wish to be changed or improved?

SECTION C: BARRIERS TO ACCESS HEALTHCARE USING THE UBUDEHE CATEGORIES AS A BASIS FOR CBHI

13. On a scale of 1-5, where 1-strongly disagree, 2-disagree, 3-not sure, 4-agree, 5-strongly agree state the extent to which you agree with the following regarding Ubudehe categories

Description		Response				
		1	2	3	4	5
1	Individuals are able to easily move between categories in the event of change in levels of income					
2	Fear by the community to have quarrels with the hospital officials they had bad experience with in the previous days					
3	Fear of being discriminated by the hospital officials based on their family or community where they come from					

4	It is difficult for people with larger families to pay the required sum at once					
5	It is difficult for people who reside in a at different district to travel back and seek medical treatment at their district					
6	I was adequately informed of the time when categorization would take place					
7	I received adequate preparation/information on Ubudehe categories before the categorization and enrollment					

14. Comment on the challenges you have faced while using the Ubudehe categories?

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15. What should be done to improve access to health?

Thank you for your participation!

APPENDIX III: RESEARCH PERMIT

University of Nairobi
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
Department of Political Science & Public Administration

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Nairobi

September 27th 2013.

The Mayor,
Huye District,
Southern Province,
Rwanda

Veneranda Uwamariya
Registration Number C50/72920/2012.

I am pleased to write to introduce and, to confirm that the above named is a student in the Department of Political Science and Public Administration. Ms Uwamariya has successfully completed her class work and is currently preparing to go to the field to collect data towards the completion of her MA Project on *"Perception of Household Members on Ubudehe Based Community Health Insurance in Rwanda: The Case Study of Huye District"*.

I further wish to affirm that Ms Uwamariya will be undertaking her research under the supervision of one lecturer in the department, namely: Dr. Richard Bosire. My office is informed that she intends to go for data collection during the month of October, 2013, and it is for this reason that she is applying for the Research Permit to enable her undertake the exercise.
I further wish to appeal for any help that can be accorded to the student towards getting the permit, and to assure you that the information she will be seeking is for academic purposes, and that the department is appreciative of your assistance.

Thank you for your cooperation in this matter.

Yours truly,

Dr. Adams Oloo
Chairman
Department of Political Science & Public Administration
University of Nairobi.

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