FACTORS INFLUENCING UPTAKE OF NATIONAL HOSPITAL INSURANCE FUND COVER BY RURAL HOUSEHOLDS IN KASIPUL DIVISION, RACHUONYO SOUTH SUB COUNTY, HOMA BAY COUNTY

BY

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DECLARATION

This research project report is my own original work and has never been presented for a degree or any other award in any university.

Signature: ……. DATE…….

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L50/73535/2014

This research project report is submitted for examination with my approval as the University Supervisor.

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DEDICATION

The research project report is dedicated to my husband, Mr. Arnold Ochieng Orina for his inspirational, emotional and material support during the entire period for the study.

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CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATION

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LIST OF ABBREVIATIONS AND ACRONYMS

AGRA- Agricultural Revolution Africa

AIDS – Acquired Immune Deficiency Syndrome

ASAL – Arid and Semi-Arid Lands

CAS – Country Assistance Strategy

CBS – Central Bureau of Statistics

CDF – Constituency Development Fund

CSA – Country Social Analysis

DDC – District Development Committees

DFID- Department for International Development (UKAID)

ERP – Economic Recovery Paper

EU- European Union

FBO – Faith Based Organizations

FGD – Focus Group Discussions

FPE – Free Primary Education

GDP – Gross Domestic Product

GOK – Government of Kenya

HDI – Human Development Index

HH - Households

HIV – Human Immunodeficiency Virus

HPI – Human Poverty Index

IMF – International Monetary Fund

IP-ERS – Economic Recovery Strategy

IRA - Insurance Regulation Authority

KCBHFA - Kenya Community-Based Health Financing Association KDHS – Kenya Demographic and Health Survey

KNBS - Kenya National Bureau of Statistics

SHI - Social Health Insurance

LATF – Local Authority Transfer Fund

LDCs- Least Developed Countries

LSMS – Living Standards Monitoring Survey

MDGs – Millennium Development Goals

NHIS - National Health Insurance Scheme

NHIF - National Hospital Insurance Fund

OOP - Out-of-Pocket Payment

WTP - Willing – to – Pay

ABSTRACT

The purpose of the present study was to determine Factors Influencing Uptake of National Hospital Insurance Fund (NHIF) by Rural Households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County in Homa Bay County. The study was guided by the objectives: to determine the extent to which the demographic characteristics influence uptake of NHIF Cover by rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County; to establish the extent to which socio-economic factors influence NHIF uptake among rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County; to investigate the extent to which awareness influence NHIF uptake among rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County; and to establish the extent to which institutional factors influence NHIF uptake in rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County. The study findings was of significance to the Government of Kenya in formulating and implementing health insurance policy targeting rural households and in their current process of transforming NHIF into a universal health scheme for every Kenyan. The target population for this study was rural households drawn from Rachuonyo South District's Kasipul Division in Homa Bay County. Descriptive study design is adopted while stratified random sampling method was applied to select the respondents according to the different administrative locations they come from within Kasipul Division. In this study, the sample size was drawn using the Morgan Table basing the size of the actual population as per 2009 national population census report. The data collection tools for this study included questionnaires with both closed and open ended questions which shall be reviewed, cleaned and coded to minimize errors and enable easy entry and analysis. Statistical Package for Social Sciences (SPSS) version 20 aided by a computer was used to organize the data and carry out statistical analysis. At univariate level, descriptive analysis using frequencies and percentages was carried out while at bivariate level, multinomial logistic regression was carried out to determine the association between the dependent and independent variables at 5% level of significance. Besides, the study was valid and reliable in taking the desired measures to ensure data validity and reliability. The study was based on the basic assumptions that the data collection instruments was realistic and reliable in taking the desired reactions. In addition, the study was also assume that the respondents was willing to give information honestly and distinctively. The survey data revealed that 75% of the respondents or 315 households out of 420 households indicated not having NHIF Insurance Cover against a total of 105 households or 25% of the households who said they had NHIF Cover. In further interrogation of the respondents, the researcher established that those who are not covered by NHIF were mainly those aged between 18 and 35 and are in the informal sector, especially “Jua Kali” and “Boda Boda Riders”. Others who were not already covered were the small-scale traders, especially “mama mbogas” who argued that they are not in a position to meet the monthly NHIF subscription, especially now that the amount is increased. On the other hand, interaction, the frequency of interacting with NHIF staff was indicated to be very often and influenced uptake of NHIF significantly. The most effective and common product marketing and sales strategy was found out to be through local hospitals Finally, financial affordability was seen as being a major issue with NHIF with a majority of respondents saying that their inability to meet monthly NHIF subscriptions had incapacitated their ability to take up NHIF cover.

Key Words: National Hospital Insurance Fund, Social-Economic Status, Institutional Factors, Health Insurance Benefits Package, Education, Income and Occupation

CHAPTER ONE

INTRODUCTION

1.1. Background of the Study

Globally there is growing international consensus on the importance of extending social protection in health to the whole population in order to reduce financial barriers to health care services for the needy and to avoid catastrophic health expenditures (Carrin and Preker, 2004; WHA, 2005). The option of social health insurance as a financing mechanism generating additional resources in typically chronically underfinanced health systems is receiving increasing attention (Carrin and James, 2004), for the informal sector too (WHO, 2006). However, one of the major challenges to social health insurance in developing countries is integration of the expanding informal sector and inclusion of the poor. Various low-income countries (Ghana, Kenya, Kyrgyz Republic, the Philippines, Tanzania and Viet Nam) and mid-income countries (South Korea, Mexico), which have introduced or are in the process of expanding social health insurance, are being faced with this, (Carrin and James, 2004).

Health care financing, equity and access currently dominate policy agendas worldwide. Governments and international organizations are recognizing that equitable health systems are essential to achieving health related millennium development goals as well as National Socio-economic development goals for most of the developing and developed nations. [WHO, 2005). Consequently, many low income countries, including Kenya, are considering how to reform their health financing systems in a way that promotes high uptake of universal healthcare financing schemes, equity and efficiency, especially targeted at the rural households where the disease burden is at its peak.

In 2005, the 58th World Health Assembly called for health systems to move towards universal coverage, where all individuals have access to "key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost without compromising on quality, thereby achieving

equity in access to healthcare". It urged member states to ensure that health financing systems incorporate an element of pre-payment and risk pooling (WHO, 2005; WHO, 2006). Universal health systems seek to be equitable in terms of delivery and financing.

Recognition of NHIF as a mechanism for improving financial access to health care and for extending social protection to underserved population is gradually receiving political will and support and Ghana happens to be one of the countries to join the wagon having come out with its own unique health insurance strategy (Government of Ghana, 2004).

According to McIntyre (2007), equitable health financing requires that health care payments are on the basis of ability to pay; that there exists financial protection to ensure that everyone in need of health services is able to access and use the services without putting people at risk of a financial catastrophe and that there are risk and income cross-subsidies (i.e. from the healthy to the ill and from the wealthy to the poor). WHO (2010) held that equitable delivery of health services ensures that people benefit from health services according to need for care without necessarily being hindered by their socio-economic conditions and status.

Responding to the WHO call, the 56th session of the Regional Committee for Health in Africa urged member states to strengthen their national prepaid health financing systems, to develop comprehensive health financing policies and strategic plans and to build capacity for generating, disseminating and using evidence from health financing in decision making. They also called on the World Health Organization (WHO) to provide support to fair and sustainable financing and to identify financing approaches most suitable for the African region (WHO, 2006).

According to Wagstaff (2010), there has been a trend in the recent years for many developing countries to move towards a new or expanded role for various forms of social health insurance (SHI), including Nigeria and Ghana, in the pursuit of universal health care as championed by the World

Health Organization (WHO). The principal aim was to reduce the high dependency on out-of-pocket (OOP) payments in the form of user charges and co-payments, which are regressive as they disproportionately affect the poorest in society, and therefore challenge the underlying tenets of equity within healthcare systems (WHO, 2010).

Both the developed and developing countries have adopted social health insurance (SHI), a move aimed to modify their financing systems as a faster way towards achieving universal coverage (Nitayarumphong & Mills, 2005). Health Insurance, like other forms of insurances, is a form of collectivism by means of which people collectively pool their risk, in this case, the risk of incurring medical expenses when and if one becomes ill or hospitalized. The collectivity is usually publicly owned or else is organized on a non-profit basis for the members of the pool, though in some countries, health insurance pools may also be managed for profit companies (Arhin, 1996).

Shah (1999) observed that a widespread lack of insurance compounds the healthcare challenges that India faces. Although some form of health protection is provided by government and major private employers, the health insurance schemes available to the Indian public are generally basic and inaccessible to most people. India's first medical insurance scheme for the poor, especially vulnerable rural households was launched in 1996/1997 Fiscal Budget. The Janarogya Yojana Scheme is marketed by the four subsidiaries of General Insurance Company and covers people between the ages of five and seventy for pre and post hospitalization expenses for upto 30 and 60 days respectively. The insurance coverage costs around $122 per year. At the time of ill health, Vogel (1990) and Abel-Smith & Rawal (1994) notes that rural households in Africa do not have recourse to mechanisms that will protect the financial resources required for basic consumption needs such as transportation, education, food and health not produced by the households. As most functional health insurance schemes in Africa are associated with formal sector earning - the majority of individuals are not insured. Vogel and others therefore conclude that the forma sector schemes effectively cover only

members of the relatively small upper and middle classes, leaving out the majority in the lower-end cadre of the society.

Abel-Smith (1994) reported that the Nigerian Government established the National Health Insurance Scheme (NHIS) under the Act 35 of 1999 and aimed at providing easy access to health care for all Nigerians at an affordable cost through various prepayment systems. NHIS is a social security that guarantees the provision of needed health services to persons on the payment of token contributions at regular intervals. The beneficiaries are civil servants in Federal employment, 300,000 pregnant women and children under maternal and child health project.

In Rwanda, a mutual health insurance was established in 1999 across the country to ensure that the population of Rwanda particularly those in rural communities and the informal sector had equitable access to quality health services. Mutual health insurance is therefore intended to complete the existing social and private health system (Musau, 1999).

From the Kenyan perspective fifty-six per cent of the Kenyan population are poor by the World Bank definition, namely living on one dollar or less a day per capita (CBS, 2005). According to the national health accounts, more than a third of the poor who were ill did not seek care, compared with only 15% of the rich. Fifty-two per cent of poor households cited financial difficulties as the principal reason for not accessing health care (MoH, 2005a). Furthermore, 7.7% of poor households were faced with catastrophic health expenditure, i.e. out-of-pocket payments exceeding 40% of disposable household income (Xu et al., 2006). Expanding access to health care for the informal sector and the poor is therefore an important objective of the Kenyan health sector strategy (MoH, 2005). Household survey data show that the large majority of Kenyans (98% of the lowest, 96% of the 2nd and 95% of the 3rd quintile) have no health insurance, whereas 12% of the 4th and 25% of the highest quintile do have insurance (Xu et al., 2006). Private health insurance specifically is only

accessible to the higher-income segment (Vinard and Basaza, 2006). Community-based health insurance (CBHI) is not yet far developed in Kenya. Since its introduction in 1999, about 32 schemes has been set up so far with about 170 000 beneficiaries covered, as data from the Kenya Community-Based Health Financing Association of 2012 show. Under the current law of the 1998 NHIF Act, NHIF membership is mandatory for all civil servants and formal sector employees.

Edna (2010) reported that Kenya adopted its own insurance for health in 1966 when the National Hospital Insurance Fund was first created through an Act of Parliament to provide a contributory health scheme to Kenyan residents. Since then, various changes have taken place in an effort to improve the delivery on its core mandate. For instance, in 1998, there was the National Hospital Insurance Fund Act, 1998 No. 9 which was assented on 31st December 1998.This Act provided for the contributions to and the payment of benefits out of the Fund. It also provided for the establishment of the NHIF Management Board.

Provision of health care services in Kenya has since evolved through many policy and legislative development. Currently, provision of health care services in Kenya is through the public and private sector, with the central government through the Ministry of Health Services being the largest provider (Kimalu et al, 2004). Kenya has had a predominantly tax-funded health system, which has gradually undergone a series of health financing policy changes. Like in most low-income countries, healthcare financing policies in Kenya have gone through three successive phases namely: In the first phase, the dominant approach was based on free access to healthcare with a focus on the necessity of providing primary care to all. The second policy phase, introduced user fees while emphazing accessibility to primary care and tried to incorporate healthcare programs into district-based healthcare structures through District Development Committees (DDCs). In the third phase concern has now been on the relationship between healthcare and development, one of the objectives of the Millennium Development Goals (MDGs). Most of these policies have negatively affected health care provision by

the state; the cost-sharing (user fees) programme introduced in 1989 being one of the most contentious policies that has widely been seen to take away the intended gains of the universal care policies. This is an indication that health financing in Kenya has faced numerous challenges, including inadequate funding (Deloitte, 2011).

Limited funding by the government means out-of-pocket spending remains a key source of funds for healthcare and ultimately this negatively affects acquisition of health care by the populace, mainly the poor and marginalized rural households. Likewise, high poverty levels among the rural population have also impacted negatively on health financing likewise low levels of education and high rates of joblessness with ever shrinking income generating opportunities in the rural areas as in urban slums in many developing countries (Deloitte, 2011). With 46% of Kenyans living on less than a dollar per day (Deloitte, 2011), there has been a reciprocal relationship between poverty and health status. On the one hand, poverty is a major driver of poor health status while at the same time poor health status drives the poor deeper into poverty. This implies that the poor in Kenya faces major financial barriers to accessing healthcare, not to mention their ability to raise premiums for health insurance. Deloitte (2011) further observe that the MDGs' objectives place strong emphasis on necessity of developing insurance schemes which have been touted as a means towards achieving universal health care. Health care reforms have shifted the burden of health care financing from government to patients and this has a negative impact on health care utilization. Even with the NHIF programme attempting to enroll informal sector workers, high unemployment rates in Kenya pose a major threat to this drive.

To enhance access to and uptake of health care, health insurance is emerging as the most preferred form of health financing mechanism in countries like in Kenya where private out-of-pocket expenditures on health care are significantly high and cost recovery strategies affect access to healthcare (WHO, 2000). It helps households to set aside financial resources to meet costs of medical care in the event of illness. The study by Carrin and James (2005) observed that the policies of NHIF

allow for formal sector, informal sector and non-employed citizens to be contributors and beneficiaries to the NHIF Cover. However, the reachability to the rural households in this context and the determination of their uptake levels of social health insurance scheme such as NHIF remains a viable research area that now needs a focus. Against such a background, it was critical to examine factors influencing uptake of National Hospital Insurance Fund (NHIF) in Kasipul Division of Rachuonyo Sub-County in Homa Bay County.

1.2. Statement of the Problem

In Kasipul Division, there is low uptake of NHIF Cover hence many poor and vulnerable households easily resort to risky lifestyles such self-medication, irrational use of over-the-counter antibiotics or use of unqualified medical practitioners including herbalists (traditional "doctors"). Moreover, there is a general tendency of poor and vulnerable rural households resorting to fundraising or sale of family valuables included limited assets to cater for health care costs whenever disease and sickness attacks uninsured families in Kasipul Division. Report from NHIF Office in Oyugis reveals that out of 4,710 households in Kasipul Division, only 801 households were covered by the NHIF cover, majority of whom (83.6%) are in formal employment and only a few (16.4%) are unemployment and or are in the informal sector. The secondary review of available data thus showed a huge discrepancy between rural households in so far as uptake of NHIF cover is concerned. Considering the aforementioned, a sound understanding of factors influencing the uptake of National Hospital Insurance Fund Cover by Rural Households in Kasipul Division is thus critical to this study and is the main purpose of this study.

1.3. Purpose of the Study

The purpose of the study was to determine the factors influencing uptake of NHIF cover by rural households in Kasipul Division, Rachuonyo Sub-County in Homa Bay County.

1.4. Objectives of the Study

The study was guided by the objectives:

1. To determine the extent to which the demographic characteristics influence uptake of NHIF cover by rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County;
2. To establish how socio-economic factors influence uptake of NHIF Cover among rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County;
3. To investigate the extent to which awareness influence uptake of NHIF Cover among rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County; and
4. To determine the extent to which accessibility factors influence uptake of NHIF Cover in rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County

1.5. Research Questions

1. To what extent does demographic characteristics influence uptake of NHIF Cover by rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County?
2. To what extent does socio-economic factors influence uptake of NHIF Cover among rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County?
3. How does awareness influence uptake of NHIF Cover among rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County?
4. To what extent do accessibility factors influence uptake of NHIF Cover by rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County?

1.6. Significance of the Study

It is hoped that the study findings will be significant to several individuals working on various organizations, especially those that design and implement health financing programs, policies and projects in Kenya. To begin with, the findings will be significant to the government of Kenya's Ministry of Health Services whose main task was to generate policy and programs at the national level on Health in Kenya. Besides, the findings of the study will be instrumental in informing the County Governments' policies, legislations and programs in matters related to universal access to healthcare programs and policies at the county level. Moreover, the findings of the study was useful

to the development partners who consider health financing options and models especially for the rural households and sustainability measures as a pre-condition for approving grant funding and support to the health sector and or healthcare programs in Kenya. The research will also add significant body of knowledge to other scholars conducting research in the field of Health Financing for the Rural Households, especially the poor, vulnerable and marginalized populace. To the target group, that is the poor and vulnerable rural households in Kasipul Division of Rachuonyo Sub-County in Homa Bay County, the study will be instrumental in eliciting in them the need to acquire and regularly use NHIF Cover in meeting the soaring cost of health care they are persistently facing and contending with.

1.7. Limitations of the Study

The study was limited by several factors such as weather issues. This limited the study in the sense that it was conducted in various rural settings in Kasipul Division of Rachuonyo Sub-County in Homa Bay County, Kenya. Most of this area is characterized by poor road network which are normally impassable during rainy season and extremely dusty during dry periods. This rendered data collection process difficult in some cases. The study was also be limited by resources inadequacy to be used in the development of data collection instruments and spending on other research related activities such as field data collection and report preparation among others. Moreover, other limitations arose from the respondents, either unwilling to give information or who gave inaccurate or false information deliberately.

However, the researcher overcame these limitations by scheduling field visits in areas with high rainfall during day time or slightly before noon and in most cases relied on the use of motor cycles to penetrate very remote parts of the study areas in the rural settings. Besides, the researcher wore clothes best suited for different weather conditions to avoid the adverse effect of weather and climatic conditions on the study. On resource constraints, the researcher was also to trade-off the sample size

with the available resources in such a manner that the sample size was not be too small to lack the representativeness of the target population, and neither too large to have constraints on the available resources. On the other hand, the respondents were informed that the purpose of this study was purely for academic purposes and not any other reasons or used, and that any information given was treated with utmost confidentiality.

1.8. Delimitations of the Study

The study was delimited to investigating the Factors Influencing Uptake of National Hospital Insurance Fund (NHIF) Cover by Rural Households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County. In this respect, the study targeted only rural households in the said division whose data were obtained from published National Census Survey Report (1999 and 2009). In this regard, residents in urban centers such as Kosele, Oyugis and Sikri were not considered in this descriptive survey study.

1.9. Basic Assumptions of the Study

The study was based on the basic assumption that the data collection instruments was valid and reliable in measuring the desired outcome of the study. Besides, the study was also be based on the assumption that the respondents was willing to give information honestly and objectively.

1.10. Definition of Significant Terms Used in the Study

Health Insurance: An agreement made between a company (insurer) and an individual or group of individuals (the insured) so that the insurer meets the costs of health care services born by the insured on regular basis provided the insured regularly meets his insurance premium obligations.

National Hospital Insurance Fund: A Government of Kenya entity established by an Act of Parliament in 1966 to mobilize funds from the public through subsidized contributions in order to receive health services in return.

Socio-Economic Factors: Refers to education, income and occupation levels of a society that determines and defines their social and economic status.

Premiums: A regular contribution to an Insurance scheme

Uptake: This is the adoption and enrollment to an insurance scheme individuals and households

1.11. Organization of the Study

The study comprised of five chapters. Chapter one presented background of the study, the statement of the problem, purpose of the study and study objectives. Moreover, the chapter also contained the research questions, significance of the study, limitations of the study and delimitation of the study. Besides, chapter one also highlighted basic assumptions of the study as well as definition of the key terms as used in this study.

Chapter two reviewed the literature related to the area of study as has been done by previous scholars and the reviewed is done against the backdrop of key study variable including the concept of Universal access (UC), health financing model, and influence socio-economic status on uptake of healthcare insurance.

Chapter three looked at the Study Design and Methodology that was used to answer the research questions and subsequently the research objectives. The chapter looked at the Research Design, Target Population, Sampling size that highlighted sampling collection and sample size. Also contained in the chapter is data collection instrument in which highlighted pre-testing and piloting of data collection instruments, instruments validity and instruments reliability. Chapter three also discussed procedures for data collection, methods of data analysis, operationalization of data variables and ethical issues in research.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This chapter reviewed literature related to the study based on the following thematic areas: Demographic Factors Influencing uptake of Health Insurance; Influence of Socio-Economic Factors on the Uptake of Health Insurance; Socio-cultural Factors and the uptake of Health Insurance; and the extent to which accessibility factors influence uptake of NHIF Cover in rural households. The chapter also presented a perceived conceptual framework for the study indicating independent, moderating and dependent variables guiding the study.

2.2. Demographical Factors influencing uptake of NHIF cover

It is apparent that universal health insurance schemes are viewed by many as a promising new tool for health system improvement for rural populations in low-income countries, particularly in Sub-Saharan Africa (Creese and Bennett, 1997). It was a means of providing financing coverage for rural communities unlikely to benefit immediately from either a social or private health financing scheme (Asenso-Okyere et al., 1997). Hence, the schemes have the advantage of dissociating the time of payment from the time of use of services, which is clearly better adapted than user fees to the seasonal fluctuations of revenue and expenditure flows of the households.

According to economic theory the maximum amount of money an individual is willing to pay for a commodity or service is an indicator of the utility or satisfaction to her of that commodity. This help in circumventing the absence of actual markets by presenting consumers with hypothetical markets in which they have the opportunity to buy the good or service. A number of studies of willing – to – pay (WTP) for health benefits to others have been undertaken. Viscusi et al. (1987) compared WTP to

reduce pesticide risks to oneself and to one's children. Agee and Crocker (1996) estimated parental WTP to reduce the risk of neurological impairment in their children. Liu et al. (2000) asked a sample of 700 mothers in Taiwan how much they were willing to pay for preventive medicine to protect themselves and their children from suffering a cold.

Although two studies have previously asked household heads about their WTP for health financing for the whole household, neither study compared the WTP of the household head for financing for themselves with their WTP for financing for the entire household and the influence of age and gender on uptake of universal health Financing scheme (Asenso-Okyere et al. 1997; Mathiyazhagan 1998). Such a comparison is important because it can provide information relevant to the choice of whether the enrolment unit should be individual or household, and to setting the premium and whether biological factors do have any influence.

According to a study by Dong and Cairns (2004) on differential willingness of household heads to pay community-based health financing premium for themselves and other household members, age of household head had a negative coefficient and significantly influenced individual WTP and WTP per capita. Male gender and years of schooling had the expected positive associations. Male gender significantly influenced WTP per capita, and education significantly influenced both individual WTP and WTP per capita. Single marital state had a positive association and significantly influenced WTP per capita. Residing in Nouna town, religion and episodes of disease did not have a statistically significant impact In addition, household income and expenditure in the past 6 months both had a positive impact on WTP, but it was only statistically significant in the case of individual WTP. The size of the household had a significantly negative impact on both individual WTP and WTP per capita. Greater distance to the health facility had the expected negative association, reducing individual WTP and WTP per capita, although it was only statistically significant in the latter case.

The starting bid had the expected positive impact on individual WTP and WTP per capita. The impact was particularly marked in the case of individual WTP (Dong, Kouyate, Cairns and Sauerborn, 2004).

Also suggested is that medical expenditure is significantly associated with both higher individual WTP and higher WTP per capita, and age is significantly associated with both lower individual WTP and lower WTP per capita. Medical expenditure can be taken as an indicator of economic status like income and total expenditure. These findings imply that the poor and the aged are vulnerable groups that need to be taken into consideration when determining the arrangements for Community Based Insurance (CBI) (also known as micro-health insurance). This study aimed at investigating influence of factors such as age, education level, marital status, family size, and sex on uptake of universal health insurance schemes other interview questions relied upon to determine factors influencing uptake of NHIF Cover also included: socio-economic factors, awareness and accessibility factors.

2.3. Influence of Socio-Economic Factors on the uptake of NHIF Cover

Financial constraint is one of the major barriers of access to healthcare for marginalized sections of society in many countries, especially in the rural areas in the developing world (Garg and Karan 2009). In a simple setting, Giné et al. (2008) considered a model of insurance participation with symmetric information, which predicts that a household's willingness to pay for an insurance contract: increases if the household is more risk averse; increases with the expected insurance payout; increases with the size of the insured risks; and decreases with basis risk. However, it was obvious that many households remain uninsured against significant income risks due to various reasons.

Deviating from the above described full-information simple model, adverse selection and moral hazard are largely considered as potential explanations for barriers to insurance participation.

Providing insurance has all the incentive problems related to the provision of credit (Rothschild and Stiglitz, 2006; Pauly, 2004). Private health insurance is also considered to be a luxury good in

countries with national health insurance schemes and therefore sensitive to fiscal incentives. Models of adverse selection and moral hazard are applicable to the life and health insurance contracts. In the case of micro life insurances, the insurance providing institution cannot fully observe if an individual is at high or low risk of death. Though, the national life expectancy and health status is public information in most countries that publishes quarterly and annual Human Health and Demographic Survey Reports, but to observe these individually required a high and not efficient effort of time, costs and human resources. Therefore, adverse selection may be a problem in the insurance market. It was evident that this leads to problems in the insurance participation practice (Pauly, 2004).

Moral hazard may exist as well in a setting of insurance markets, if the household can live with less caution and risk more after contracting insurance, which is a major problem especially for health, but also for life insurances. In the case of micro health insurance, there is evidence for the existence of adverse selection, as households having a higher ratio of sick members are more likely to purchase micro health insurance (Ito and Kono, 2010). Incentive structures such as solidarity enhancing rules seem to keep individual interests restrained by the group interests, whereas co-payment rules may be a strong deterrent to very poor households (Hamid, et al, 2010).

The organizational efforts of the rural households themselves are the principal means whereby social and community development workers was able to bring about social changes in their social-economic conditions. While protective approaches cannot significantly change the social-economic situation of the rural households, they can dramatically reduce its pernicious effects on living conditions allowing them to perform safer tasks under healthy and protected conditions through cost-effective and sustainable measures at the community level (Jütting, 2004).

There have been limited attempts to deal with the informal sector in the area of health promotion and protection, although, never with a comprehensive strategy. However, evidence suggests, that with the

appropriate support, informal sector workers can move from a situation of mere survival to a stronger economic position enhancing their contribution to economic growth and social integration, as well as participating in the improvement of their own working and living conditions (Francis, 2005).

The level of a person's education may determine his/her ability to understand the benefits of risk management and savings. A higher level of education might therefore increase an individual's level of risk aversion. Education may also increase the demand for pure death protection by lengthening the period of dependency, as well as increasing the human capital of, and so the value to be protected in, the primary wage earned (Halawani et al, 2000) find a positive relationship between life insurance penetration and the level of education.

Health insurance penetration should rise with the level of income, for several reasons. First, an individual's consumption and human capital typically increase along with income. This can create a greater demand for insurance (mortality coverage) to safeguard the income potential of the insured and the expected consumption of his/her dependents. Second, life insurance may be a superior good, inasmuch as increasing income may explain an increasing ability to direct a higher share of income towards retirement and investment-related life insurance products. Finally, the overhead costs associated with administrating and marketing insurance make larger size policies less expensive per Shilling of insurance in force, which lowers the price of life insurance policies. Höfter (2006) has shown that the demand for life insurance is positively related to income, using both aggregate national account data and individual household data.

Vladescu et al, (2000) study revealed that the marketing of assurance policies revolved around the company activities. It also revealed that most of the life assurance products were made for family members in regards to spouses and children.

In Kenya, observed insurer behavior also suggests that this market may be characterized by pricing problems. For example, consumers offer evidence that similar life insurance policies are sold at significantly different prices across insurers. Statistical analysis revealed that income and age had significant influences on the sum assured. The higher an individual's income the greater the amount of insurance he can afford. Age is considered in premium determination hence has a bearing on the size of policy that can be afforded. Most policyholders (63.5%) were of the view that the cover on their lives was just enough while 33.3% felt it was inadequate. On the other hand, most insurance companies (75%) were of the view that most of their clients were inadequately covered with 25% of them being of the opinion that they were covered adequately. No case of over insurance was noted (IRA Report, 2008).

Maina (2003) conducted a research on factors that determine perceived quality of service in the Insurance Industry in Kenya. In this study the data was collected by use of questionnaires, which were dropped and picked later. A sample of 150 policyholders was selected for the study and stratified random sampling was used. The study established that the factors that customers consider some factors important when judging quality of service in the insurance industry. These are: - efficiency, fast action on complaints and prompt service. On the other hand, the factors considered unimportant are confidentiality, communicating at least once a year and employee discretion in solving customer problems.

In 2002, the Ministry of Health Services with the support of donor partners initiated a number of countrywide programs to combat priority problem in preventive health care and promotes awareness in health issues. Since then a modest increase in the number of institutions and facilities in Kenya has been witnessed. This is illustrated by the growth of the number of private health facilities with access to NHIF services standing at 7.1% of the entire health care sector in 2002, compared to 2.5% in the

previous year (2001) and currently standing at 12% as at 2008 (IRA, 2008) . There were 481 hospitals, 601 health centers and 3273 dispensaries in the country (IRA Report, 2008).

A health work environment facilitates optimal physical and mental health in relation to work and adaptation of work to the capabilities of workers in light of their state of physical and mental health. Educators, managers, employers, learners, parents and stakeholders have a duty of ensuring that the rights and dignity of all affected or infected persons are respected (Jack, 2000).

After setting the promotional objectives, an organization must decide on how much to spend. Determining the ideal amount for the budget is difficult because there is no precise method to measure the exact results of spending promotional dollars (Barrientos, 2000). With promotional pricing, companies will temporally price their product below list price and sometimes even below cost to create buying excitement and urgency. Promotional activities forms part of marketing which becomes handy in finding out the factors influencing poor uptake of health insurance in informal sector into NHIF. In Uganda most policy holders did not know how much they were paying, what was covered or how to make claims. The insurance agent MFI staff pension also knew little and therefore would be of no much help according to Höfter (2006).

2.4. Influence of Awareness Factors on the Uptake of NHIF Cover

There are a number of marketing tools that can be used to reach potential members. These included a few traditional methods like brochures, Newsletters, the occasional exhibition and aggressive public relations effort. Witter and Garshong (2009) go on to say that the techniques available have largely been ignored by public organizations because of their distaste for marketing. These organizations that have taken marketing enthusiastically provide excellent examples of just what marketing can achieve by the sensitive tools available. NHIF has engaged in promotion activities according to their

marketing department. These activities included show stands in agricultural shows in Kenya, they also distributes brochures and magazines on their products through local radio stations.

The prevailing concepts of illness and risk are relevant to the decision of households whether to purchase health insurance or not. If people see illness as a somewhat random event that can hit anyone, they are surely more willing to purchase Health Financing than if they perceive it as punishment for misbehavior by magic powers or superstitious phenomena. Cultural habits in dealing with the risk of illness can influence the demand for Health Insurance: for example, in rural Benin, people were used to put money aside for unpredictable events like marriages and funerals, but they believed that saving money for eventual health care costs meant “wishing oneself the disease”. Fortunately, this attitude changed after a Community Based Health Financing (CBHF) had come into existence (Garba and Cyr, 1998).

If solidarity is strong, people will not worry so much if the benefits of the premiums they paid will accrue to themselves or other community members. For example, members of the Bwamanda scheme in Zaire expressed the opinion that if they would not need health care themselves, at least they had done something good for the community by contributing to the financing fund (Criel, 1998b). The degree of solidarity and mutual trust is probably higher in homogeneous, close-knit communities than in scattered and diverse populations comprising people of different ethnic origin, religion and culture (Creese and Bennett, 1997).

Existing, “traditional” institutions of risk-sharing and mutual help can on the one hand facilitate CBHF implementation, because health financing may be built upon these groups, as has been one with the Engozi societies in Uganda by the Kisiizi Hospital Health Society (Musau, 1999). On the other hand, the different logic of traditional networks sometimes induces misperceptions of financing and disappointment, because people have expectations based on their experience with traditional

institutions that are not fulfilled by CBHF, e.g. that the money paid into the common fund accumulates over time and that the benefits will correspond to the contributions made (Batusa, 1999). A lot of community sensitization may be necessary in this respect. In any case, initiators and managers of health financing schemes should pay more attention to consumer satisfaction and to people's preferences and perceptions, because these are crucial factors for successful implementation of CBHF.

2.5. Influence of Accessibility Factors on the Uptake of NHIF Cover

In a study conducted by Mwikali (2011), the researcher pinpointed that the universal health care systems vary according to the extent of government involvement in providing care and health insurance. While citing Tara (2010), Mwikali argued that in some countries such as the United Kingdom (UK), Spain and Italy, the government has a high degree of involvement in the commissioning or delivery of health care services and access is based on residence rights not on the purchase of insurance. Others have a much more pluralistic delivery system based on obligatory health with contributory insurance rates related to salaries or income, and usually funded by the employers and beneficiaries jointly. These insurance based system, according to Mwikali (2011) tend to reimburse private or public medical providers often at heavily regulated rates through mutual or publicly owned medical insurers.

Many of these regulatory initiatives particularly in the aspect of health insurance underwriting are designed to achieve specific policy goals, such as controlling escalating health care costs or expanding the availability of health coverage, particularly for the most at-risk or vulnerable members of the society. Achieving these vital goals invariably requires trade-offs, but policy makers rarely make this trade-offs as explicit as should be the case. For instance, in the United States, the Patient Protection and Affordable Care Act (2010) mainly addresses the access to health insurance coverage and assures all Americans who need coverage of health insurance. It was however not clear how the

legislation will impact the cost of health insurance, especially premiums and out-of-pocket expenses borne by the individual Americans. It was likely that the costs will continue to sky-rocket for the unforeseeable future. How much health insurance will cost and individual American will depend on among other parameters, the age, the condition of one's health, where in the country one lives in, his/her income levels and job status (Biheri, 2010).

In Kenya, KIPPRA (2012) indicate that The National Hospital Insurance Fund (NHIF) is the primary provider of health insurance in Kenya with a mandate to enable all Kenyans to access quality and affordable health services. The NHIF was established in 1966 under CAP 255 of the Laws of Kenya to be run by an Advisory Council appointed by the Minister of Health. At the initial stages, NHIF catered for salaried employees earning Kshs.1,000 and above per month, making a monthly contribution of Kshs.20/=. In 1972 an amendment was made to incorporate voluntary members (self-employed) at a monthly contribution of Kshs.60/=

NHIF was restructured by the repeal of the National Hospital Insurance Act (CAP 255) of 1966 and the enactment of the National Hospital Insurance Fund Act No. 9 in 1998. This new law made the NHIF an autonomous parastatal, separating it from the direct control of the Ministry of Health. The Fund was today governed by a Board of Directors with representatives from civil society, employers, and local governments. Members of NHIF Board of Directors included the following: -Permanent Secretary – Ministry of Health Services, Workers' Union Representative from Central Organization of Trade Unions (COTU), Directorate of Personnel Management Representative from Kenya National Union of Teachers (KNUT), Director of Medical Services, Representatives of the Kenya National Farmers Union, Federation of Kenya Employers, Association Kenya Insurers, Christian Association of Kenya, NGOs and the Kenya Medical Association.

The Health Insurance Act of 1998 makes no distinction between formal and informal sector, and indicates that membership shall be mandatory for all Kenyans at least 18 years of age. In practice, however, while Kenya has achieved high levels of coverage of the formal sector, coverage of the informal sector has proved more challenging. The National Hospital Insurance Fund (NHIF) requires compulsory membership for all salaried employees with premium contributions automatically deducted through payroll. Contributions are calculated on a graduated scale based on income, with a majority contributing between KES 30 to KES 320 per month. For the self-employed and others in the informal sector, membership is contributory and is available for a fixed premium of Kshs. 160 per month. To be a member of the National Hospital Insurance Fund (NHIF), one must simply be a Kenyan resident age 18 or older. This payment trend is likely to change if the new NHIF premium rates reported in the Daily Nation, Tuesday February 17, 2015 was to be effected. In which case, the least paid Kenya earning Kshs. 5,999 shall be required to pay a monthly premium of Kshs. 150 with those earning over Kshs. 100,000 paying a monthly premium of Kshs. 1,700.

NHIF covers certain dependents of the primary policy holder automatically, including spouse, children under the age of 18, students (even if over the age of 18), and disabled dependents. Other adult family members require separate premium contributions to be covered. NHIF is responsible for enrolling and registering all eligible members from the formal and informal sectors. The benefits package includes coverage of inpatient expenses with the share of expenses covered determined largely by the type of hospital. The NHIF's hospital network is broken into three tiers of hospitals. At "Contract A" hospitals, which included primarily government hospitals, NHIF beneficiaries receive comprehensive cover with no overall limit on the amount of benefits received. National Hospital Insurance Fund contracts with about 600 health facilities that are managed by both the public and private sector throughout Kenya's 8 provinces. About 150 of these facilities are state-run, while the remaining hospitals are managed by private and mission organizations. Individuals who are members

of NHIF are able to access their benefits at any of the hospitals affiliated with NHIF regardless of locations.

The National Hospital Insurance Fund (NHIF) and private insurers have negotiated fixed reimbursement rates for in-patient care. The reimbursement amount varies slightly with the level of provider, the diagnosis, and the type of care required. “Contract A” and “Contract B” providers are typically reimbursed through case based or fee-for-service provider payments. “Contract C” providers are reimbursed through a per diem rebate system. Claims are submitted by hospitals directly to the National Hospital Insurance Fund (NHIF), and then hospitals are paid for procedures and users are reimbursed. Most claims are reimbursed within 14 days of the claim received. This process is computerized and is designed to be transparent to the providers. The Household Health Expenditure and Utilization survey of 2005 found utilization rates of health care for those with insurance increased between 1990 and 2003 to 77.2% of ill people seeking healthcare, while the national utilization rate increased to 1.92 visits per person annually. In addition, out of pocket expenditure on health care has decreased from about 51% of the funding in 2001 to 36% in 2008. Few substantial results have been seen with regards to disease levels (NHIF, 1999).

In recent years, interest has grown in providing health insurance programs to the poor and vulnerable households throughout the world as a means of increasing access to priority, health services and protecting families from catastrophic health care costs that sometimes lead to loss of meager family assets and sources of livelihoods. In South East Asia, a study conducted by Behrman & Knowles (1999) on Poverty Levels among the population in South East Asia suggest that uptake of voluntary medical health insurance among 70% of the poor is typically low. Besides, collecting premiums from the poor population who are generally living in the country side (rural areas) and mainly employed in the informal sector is so challenging (Abel-Smith, 1992).

In a special gazette notice dated February 6, 2015, the proposed NHIF premiums will see those in employment and earning a gross income of up to Sh5,999 contribute Sh150 per month, the lowest contribution according to the proposed rates published by the fund. The self-employed will contribute Sh500 monthly. The highest monthly contribution is Sh1,700 for those earning Sh100,000 and above. Those earning between Sh8,000 and Sh11,999 will contribute Sh400 while those earning between 12,000 and Sh14,999 will contribute a monthly premium of Sh500. Those earning between Sh15,000 and 19,999 will contribute Sh600 while those earning between Sh20,000 and Sh24,999 will have Sh750 deducted from their monthly pay slips. Accordingly those expected to be hit most was low income earners who will now be required to dig deeper into their pockets to make contributions to the National Hospital Insurance Fund pool. It was yet to be determined how this incremental changes in NHIF Cover premiums was received by low-income earners as well as those in the jua kali sector, further making this study not only timely but of utmost necessity at this time when these far-reaching changes are being introduced.

In conclusion, Mwikali (2011) argued that Legislation and Policy environment is helpful as it protects the contributors, controls contribution rates in regard to income levels and guarantees protection of the funds in the central pool.

This study therefore looked into factors influencing of the uptake of NHIF by rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County.

2.6. Theoretical Framework of the Study

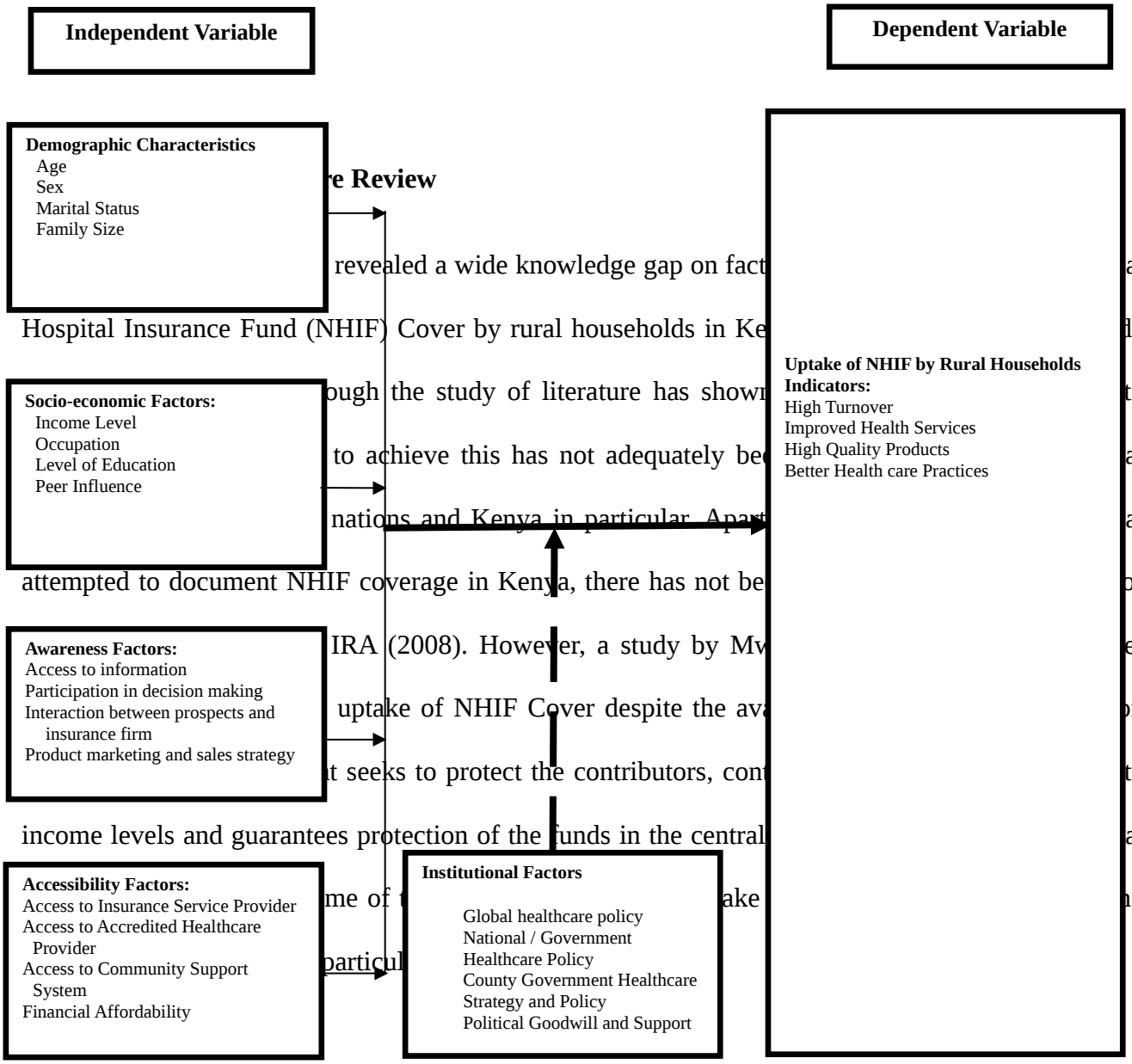
Consumer Behavior Theory introduced in 1870 by a British Economist, William Stanley Jerons shall be adopted in this study. The major theories of consumer behavior adopted in this study can be grouped with (a) economic theories, (b) psychological theories (c) psycho-analytical theories and (d) socio-cultural theories. All the consumer behavioral theories are based on the basic law of

consumption i.e. when aggregate income increases, consumption also increases by somewhat smaller amount and is based on the assumptions like spending habits remain the same, political conditions, remaining normal and economy is free and perfect (Gupta, 1994). The economic theories on consumer behavior will in this study focus on how consumers allocate their income and how this determines the demands of various goods and services, particular health care services. The traditional theory of demand starts with the examination of the behavior of the consumer, since the market demand is assumed to be the summation of the demand of individual consumers. In the traditional theory it was assumed that the consumer has full knowledge about all available commodities their prices and income. In order to attain the objective the consumer must be able to compare the utility (satisfaction) of various baskets of goods, which he can buy with his income. The basic economic theories included marginal utility theory, psychological law of consumption, absolute, relative and permanent income hypothesis etc (Gandhi, 1991).

2.7. Conceptual Framework of the Study:

This section describes the perceived conceptual framework that will guide this study.

Figure 2.1 conceptual Framework



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revealed a wide knowledge gap on fact al Hospital Insurance Fund (NHIF) Cover by rural households in Ke ly ough the study of literature has show to to achieve this has not adequately be al nations and Kenya in particular. Apar at attempted to document NHIF coverage in Kenya, there has not be or IRA (2008). However, a study by Mw er uptake of NHIF Cover despite the ava on t seeks to protect the contributors, con to income levels and guarantees protection of the funds in the central al me of ake nd particul

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter focused on the research methodology used in this study. These methodological aspects included research design, target population, sample size and sample selection. Besides, it also highlighted data collection instruments, instruments pre-testing, instrument validity as well as instruments reliability. Moreover, it also presented procedure of data collection, methods of data analysis, operationalization of study variables and ethical consideration in research.

3.2 Research Design

This study adopted a descriptive research design. Kothari (2006) asserts that descriptive research included survey and fact finding enquiries of different kinds. This research design is considered appropriate because variables involved do not involve any manipulation and will establish the current status of the phenomena (Borg and Gail, 1983).The design enables the researcher to determine the current status of factors affecting uptake of voluntary social health insurance in the rural areas especially within a heterogeneous set. This study used a mixed research approach as it consists of both the qualitative and Quantitative techniques. Kombo and Tromp (2006) affirmed that research can be regarded as an arrangement of conditions which combine relevance with research purpose. Consequently, qualitative approach is used to gather information which cannot be quantified numerically but connected to the theme. Mugenda and Mugenda (2003) suggested that unlike the quantitative approach, the qualitative approach recognizes methods through which the disadvantaged or minority groups can disclose information with authority in a given field of study. The quantitative techniques are used because the expected information from the field involved factual elements which were analyzed using descriptive statistics.

3.3 Target Population

According to Kothari, C.K. (2005), a target population describes the accessible population from where a study sample is drawn and upon which the findings are generalized. In this study, the target population was the entire number of households of Kasipul Division as per the official records in the 2009 National Population Census report as published by the Kenya National Bureau of Statistics (KNBS, 2009). The number of households in Kasipul Division, according to KNBS (2009) is 4,170.

3.3.1 Sample Size and Sample Selection

This section discussed the sample size and the sampling selection for this study. It was guided by the number of households in Kasipul Division, Rachuonyo Sub-county as was reported in the KNBS (2009) that gave an indication that Kasipul Division had a total of 4,170 households.

3.3.2 Sample Size

According to Tromp and Kombo (2002), a sample is a subset of a population. Polansky (1995) defines a sample as a group of subjects selected from a larger group and including less than all the subjects in that larger group. In this study, simple random sampling augmented with purposive sampling was used to determine the sample size. However, the study relied on the Sample Size Determination Table (Morgan Table) provided by Stoker in Strydom and De Vos (1998) that gives indicative sample sizes in a survey research like the one proposed herein.

Table 3.1: Sample Size (Stoker in Stydom and De Vos, 1998:192)

Target Population Size	Percentage Suggested	Number of Respondents
20	100	20
30	80	24
50	64	32
100	45	45
200	32	64
500	20	100
1,000	14	140
10,000	4.5	450
50,000	2.5	1,250
100,000	2	2,000
200,000	1	2,000

For the purpose of this study, and given the multiplicity and homogeneity of the target population, the preferred target sample size was 4,170 households for Kasipul Division according to the 2009 National Population Census Report. This according to Morgan table above gives a sample population of 450 (that is 4.5% of the target population).

3.3.3 Sample Procedure

A *stratified random sample* that partitioned the population into subsets called *strata* was considered so that the study can take into account all the various segments of the population under study, i.e. sex, age, education level, level of income, household size and actual location of the respondent. The latter was done to exclude any respondent residing in an urban center.

3.4 Data collection instruments

In this study, the researcher developed questionnaire as the main data collection instrument. This was selected because the questionnaires allow researchers in social and educational studies to describe things as they occur and is a reliable tool to be used with a large population (Okombo and Orodho, 2002).

The questionnaire items adopted a mixed question methods with most items being open-ended and others contingency open ended and matrix to allow for collection of maximum information. The questionnaire was structured into the following sections: (a) Section 1: Identification Section that required the respondents to indicate the date of the interview, their names (which was optional), location and sub-location. Location was required to help in data cleaning just in-case there was questionnaire pilferage to urban areas not targeted in this study; (b) Section 2: Demographic Factors which sought to determine the age, sex, marital status, and size of household; (c) Section 3: Socio-economic factors that was concerned with determining the income levels, occupation, level of education, and peer relationships and influence of peers in decision making; (d) Section 4: Awareness factors that sought to determine the respondents' access to information about NHIF, whether or not they had NHIF cover, respondent's participation in decision making, respondents' interaction with the insurance firm (NHIF) and product marketing strategy that were used and that they were aware about; (e) Section 5: Accessibility Factors that included determination of such factors as access to insurance service provider, access to an accredited healthcare provider, access to community support system, and financial affordability; (f) Section 6: Institutional factors such as global health policy, national/county government health strategy and policy, marketing of the insurance scheme; and other general questions aimed at validating items captured earlier.

3.4.1 Instruments pre-testing/piloting

Pre-testing/piloting is a preliminary mini-study conducted with a small sample in order to establish the effectiveness of data collection instruments (Mugenda and Mugenda, 2003). In the views of Gay

in Mugenda and Mugenda (2003), a pre-test sample should be between 1% and 10% of the actual sample size. In the light of this, the researcher used 5% of the sample size, i.e. 5% x 2,000 = 100 respondents.

3.4.2 Validity of the Instruments

Validity of a research instruments refers to the extent to which a research tool measures what it was supposed to measure (Kothari, C. R., 2005). In this study, the researcher ascertained the validity of the research instruments by ensuring that there is adequate coverage of research objectives. Moreover, the data collection instruments were also be exposed to peers for review and experts for judgment.

3.4.3 Reliability of the Instruments

According to Tromp and Combo (2002), reliability is a measure of the consistency with which a measuring instrument yields consistent data with repeated trials. In this study, the researcher sought to use split half reliability of the questionnaire split half method to ascertain the reliability of the questionnaire. Split-half method was chosen thereby taking care of factors influencing internal validity of the instruments. Split half method was used by dividing the questionnaire into 2 halves on the basis of odd and even appearances. By comparing the results using Pearson's Product Moment Correlation of Co-efficient and obtaining a co-efficient value of 0.6 and above, the instrument was deemed reliable.

3.5 Procedure of Data Collection

Wisemen (1980) says that this indicates the steps and sequencing of these steps in the process of data collection. Having prepared the research proposal, presented for assessment and made the necessary corrections, the researcher applied for research permit from the National council for science and technology. Upon the receipt of the research permit, the researcher hit the ground for data collection, presenting the research permit to the relevant persons for authorization. The data were collected by

two well trained and motivated research assistants who self-administered the questionnaires to the respondents.

3.6 Data Analysis Techniques

Data analysis begun with aspects of data coding, editing, organizing and cleaning before applying subsequent statistical measures (Aurela, 2010). The study being descriptive in its major characteristics adopted descriptive statistics in data analysis. These features of descriptive statistics used included: frequencies and percentages whereas analyzed data were presented using frequency distribution table. The tool for data analysis was a Statistical Package for Social Scientists (SPSS) aided by a computer.

3.7 Operationalization of Study Variables

According to Tromp and Kombo (2000), operational definition of the variable describes how each variable in a study was measured. In this study, the extent to which the demographic characteristics influence uptake of NHIF cover by rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County was measured on the basis of age, sex, marital status and family size. Social-cultural factors was measured on the basis of income levels, education levels, occupation and Peer influence. Awareness factors on the other hand were measured on the basis of access to information, participation in decision making, interaction between prospects and the insurance firm (NHIF), and product marketing and sales strategy (ies). Accessibility factors were measured on the basis of access to insurance service provider, access to accredited healthcare service provider (s), access to community support system, and Financial affordability. The operationalization of the variables is indicated in Table 3.2.

Table 3.2: Operational Table

OBJECTIVE	VARIABLE	INDICATORS	MEASURES	SCALE
To determine the extent to which the demographic characteristics influence uptake of NHIF Cover by rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County;	Independent Variable: Demographic characteristics	Age Sex Marital Status Size of the Family	Observation Direct Interviews National ID cards Observation	Nominal Scale Nominal Scale Nominal Scale Ordinal Scale
To establish how socio-economic factors influence NHIF uptake among rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County	Independent Variable: Socio-economic factors	Income Level Occupation Level of Education Peer Influence	Premium Rates Location of Offices Health Care Needs Peer Influence	Nominal Scale Nominal Scale Nominal Scale Ordinal Scale
To investigate the extent to which awareness influence NHIF uptake among rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County	Independent Variable: Awareness Factors	Access to information Participation in decision making Interaction between prospects and insurance firm Product marketing and sales strategy	Field Activities Reports Observation Health Reports and Records Field Reports	Ordinal Scale Nominal Scale Nominal Scale Ordinal Scale

To determine the extent to which access factors influence uptake of NHIF Cover in rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County	Independent Variable: Access Factors	Access to Insurance Service Provider Access to accredited service providers Access to community support system Financial Affordability	Observations Health Records Observations Observation	Nominal Scale Nominal Scale Nominal Scale Nominal Scale
Uptake of NHIF by Rural Households	Dependent Variable	High Turnover Improved Health Services High Quality Products Better Health care Practices	NHIF Records at various outlets within the study area	Nominal Scale Ordinal Scale Ordinal Scale Ordinal Scale

3.8 Ethical Issues in Research

These are aspects of conduct or behavior to be exhibited by the researcher to deliver a credible study. Aspects included observing plagiarism through textual citation and reference (acknowledgement); data forgery where one person completes several copies of questionnaire or give data more than once; authorization, that was to avoid using minors without the authority from the guardians and always collect data with permission. Authorization also relates to theft of data. Moreover, other ethical issues to consider included: enticement that is offering favors/money in exchange of data; physical/psychological harm (use of force to get information) and confidentiality.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1 Introduction

The purpose of the study was to find out Factors Influencing Uptake of National Hospital Insurance Fund (NHIF) Cover by Rural Households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County. In order to achieve the goal of the study, the chapter is organized under variables based on the objectives of the study. The variables include: demographic characteristics, socio-economic factors, awareness factors, access factors and institutional factors. The study targeted a total of 450 households in Kasipul Division of Rachuonyo South Sub-County. Out of the 450 households, a total of 420 questionnaires were returned. This was 93.3% return rate which is very good in conducting a survey study and generating valid conclusions. This return rate was good according to Mugenda and Mugenda (1999), who says that a questionnaire return rate of 60% is good and 70% and above very good.

Table 4.1: Questionnaire return rate

LOCATION	SUB-LOCATION	QUESTIONNAIRE RETURNED BY HOUSEHOLDS	TOTAL QUESTIONNAIRES DISTRIBUTED TO HOUSEHOLDS
EAST KAMAGAK	SINO KAGOLA	20	
	KACHIENG’	22	52
WEST KAMAGAK	OBISA	26	
	KAMUMA	30	56
NORTH KAMAGAK	NYALENDA	15	
	KAWERE EAST	15	56
	KAWERE WEST	26	
KODERA	KODERA KARABACH	20	
	KODERA KAMIYAWA	20	52
	KADEL KAMIDIGO	10	
KOWIDI	KOKAL	28	
	KANYANGO	12	58
KACHIEN	NORTH KACHIEN	55	60
KONUONGA	KOTIENO KONUONGA	55	60
KOKECH	KAWINO	30	56
	KASIMBA	16	
TOTALS		**420**	**450**

The table 4.1 shows that the majority of the respondents hailed from North Kachien, Kotiemo Konuonga and West Kamagak respectively.

4.2 Demographic Characteristics on the uptake of NHIF Cover

This variable sought to know among other factors, how the following variables influenced the uptake of NHIF: age, sex, marital status and family size. The findings were captured by the study questionnaires and are presented in the following sections.

4.2.1 Age of respondents

The respondents were asked to indicate their age, and the responses obtained are summarized in table 4.2.

Table 4.2: Age of respondents

AGE OF RESPONDENTS	NO. OF HOUSEHOLDS	PERCENTAGE (%)
18 – 28	197	47
29 – 39	98	21
40 – 49	69	16
50 – 59	51	12
Over 60	5	04
TOTALS	**420**	**100**

From table 4.2, it was clear that majority of the households' respondents interviewed (197) or 47% fall in the age group of 18 – 28 followed by 98 or 21% in the age bracket of 29 – 39 and then age bracket of 40 – 49 with 69 respondents equivalent to 16%. This was followed by those in the age bracket of 50 – 59 with 51 respondents or 12% and the least number of respondents was recorded in the age bracket of those above the age of 60 who had a paltry 5 households' respondents or 4%. This reveal that the majority of the respondents were in the age bracket of the youths who also form the

largest population segment in the study area. When asked whether they had had NHIF card, those in the age bracket of 18 – 28 indicated a converse status with the least number in this age cohort (15%) saying they had NHIF Card. On the other hand, those in the age bracket 29-39 indicated a significant number having NHIF card (47%). Those aged between 40-49 had 28% having NHIF card while those aged between 50 – 59 had 8% with NHIF card and the group with the least NHIF coverage were those aged above 60 years.

4.2.2 Sex of the respondents

The respondents were asked to indicate their sex, and the responses obtained are summarized in table 4.3.

Table 4.3: Sex of Respondents

SEX OF RESPONDENTS	FREQUENCY	PERCENTAGE (%)
MALE	193	45.95
FEMALE	227	54.05
TOTALS	**420**	**100.00**

The above figure shows the distribution of respondents by sex. It indicates that 45.95% (n=193) were male while 54.05% (n=227) were female. This implies a wide discrepancy in the proportion of male and female respondents per household, indicating that sex of respondents was not evenly represented in the sample which tallies with the findings of Ouma et al., (2007) which showed that approximately 50% of those living in the rural areas and operate in the informal sector were women. Further analysis of respondents in terms of whether or not they had NHIF card, the study found out that a total of 108 women out of the total respondents of 227 or just 47.58% had NHIF cards while 52.42% did not have NHIF cards. On the other hand, the number of male with NHIF cards almost tallied the number of

women with 46.82% of male reporting having NHIF card while 53.18% of the male respondents reported not having NHIF cards.

4.2.3 Marital Status of Respondents

The study further sought to determine the marital status of the respondents. The findings were recorded as follows:

Table 4.4: Marital Status of Respondents

Marital Status	FREQUENCY	PERCENTAGE (%)
Never married	12	2.86
Single	39	9.29
Married	217	51.67
Divorced	3	0.71
Separated	25	5.95
Widow/Widowed	124	29.52
TOTALS	**420**	**100.00**

The study findings above revealed that a total of 217 respondents in the sampled households or 51.67 were married while 29.52% or 124 of the total respondents in the sampled households were widows/widowers. Further analysis of the questionnaires revealed that of the 124 respondents who indicated that they were either widows/widowers, a total of 104 were female while only 20 were male. This trend is worrying given the KNBS (2010) Health and Demographic Survey Report for the same area that shows a higher percentage of female to male. Of the sampled households, those in stable marriages also had a high percentage (78%) having NHIF Card as compared to those that never married, single or divorced/separated with only 22% reporting having NHIF card.

4.2.4 Size of the family

The study sought to determine the family sizes within the study area. The findings were tabulated as follows:

Table 4.5: Family Size

Family Size	FREQUENCY	PERCENTAGE
1-2	76	18.10
3-5	40	9.52
6-8	240	57.14
8-10	42	10.00
Over 10	22	5.24
TOTALS	**420**	**100.00**

From the above findings, it was revealed that majority of households had a family size of 6-8 with a total respondents of 240 (equivalent to 57.14%) were in this category. This was followed by a family size of 1 – 2 who had a total of 76 respondents or 18.10%. The least family size were those with over 10 members per households who were only 22 households out of the total 420 households surveyed or 5.24%. Given the family structure in the rural areas of Kasipul Division, where polygamy was still a common practice, the high number of household size was attributed to the polygamy status in some households while the high number of household size was common among those low-income bracket households with high incidence of semi-illiteracy rates. Uptake of NHIF was however high among households with a family size of 1-2 with 100% NHIF coverage unlike households with family size of 6-8 with only 44% NHIF coverage.

4.3. Socio-Economic Factors on the uptake of NHIF cover

These factors sought to determine how income levels, occupation, level of education and peer influence affected or influenced the uptake of NHIF by the rural households in Kasipul Division of Rachuonyo South Sub-County in Homa Bay County. The findings were captured by the study questionnaire and are presented as follows:

4.3.1 Income level

The study further sought to determine the income levels of the households within the study area. The findings of the study were documented and tabulated as follows:

Table 4.6: Income Levels

MONTHLY INCOME	FREQUENCY	PERCENTAGE (%)
Below 3000	88	20.95
3,000 - 5000	99	23.57
5,000 – 8,000	58	13.81
8,000 – 11,000	63	15.00
11,000 – 14,000	57	13.57
14,000 – 17,000	33	7.86
17,000 – 20, 000	17	4.05
Over 20,000 but below 50,000	5	1.19
TOTALS	**20**	**100.00**

The responses from the above study indicated that the study area is generally inhabited by low-income earners with a total of 308 respondents or 73.71% saying they earned less than Kshs. 11,000 per month. However, the majority of this fell in the category of those whose monthly earnings were between Kshs. 3,000 and Kshs. 5,000 with total respondents of 99 households or 23.57% being in this category. This was followed by those earning a monthly income of between Kshs. 0 and Kshs. 3,000 with a total of 20.95% being in this category. This shows that the area under study is relatively poor with less than 2% of the respondents having a monthly income of over Kshs. 20,000 and but below Kshs. 50,000.

4.3.2 Occupation of Respondents

One of the major concerns of the study was to establish the influence of occupation on uptake of National Hospital Insurance Fund Cover (NHIF). It was therefore very important to establish whether occupation had any influence on an individual's choice to take or not to take the NHIF cover. Among the things that the study questionnaire looked at were the type of occupation, whether formal or informal and nature of employment contract, whether permanent or contract. The study establish that those employed in the formal sectors had no choice but to ascribe to the NHIF cover as a legal requirement while those in the informal sector had this as a personal choice which they either made to insure or not.

4.3.3 Level of Education of Respondents

In addition, the study sought to ascertain the level of education of the respondents. The results from this study item were recorded via frequency distribution table as follows:

Table 4.7: Level of education

Level of Education	NO. OF RESPONDENTS	PERCENTAGE (%)
Never attended school	37	8.81
Primary	193	45.95
Secondary	125	29.76
College Certificate/Diploma	37	8.81
University Degree	28	6.67
TOTALS	**420**	**100.00**

According to table 4.7, the concentration of the respondents (45.95%) equivalent to 193 respondents were primary school leavers. These were followed by secondary school leavers who tallied 125 of the 420 respondents' surveyed equivalent to 29.76%. Those who never attended school equated those with college certificates and diplomas at 37 respondents respectively out of the 420 total respondents, or equivalent to 8.81%. Those with university degrees were the least tallying only 82 of the respondents or 6.67%. The questionnaire analysis further revealed that the majority of those who never attended school were young girls aged between 15 and 25 and already in marriage and further analysis of the questionnaires showed a sharp relationship with one's level of education and his/her access to NHIF with a total of 88.52% of respondents with either primary or secondary education reporting never having been registered with nor have NHIF card. The study questionnaires further revealed that those whose level of education was primary had not even completed the 7 or 8 years in primary education (for KCE or KCPE respectively). These findings concurs with those of Transmara District Development Plan (2008 – 2012), which established and reported that the illiteracy level in the District is high and stood at 60%. Mwangi (2005) observe that this high illiteracy rate may disadvantage the community as one's education level is likely to influence his or her involvement in critical life decisions including access to and utilization of medical insurance schemes.

4.3.4 Influence of Peers

The researcher had a keen interest in knowing whether the respondents were also influenced by their peers in their decision making process with regard to ascribing to NHIF Cover. This particular research variable was considered vital due to the trend today in society where community members tend to group themselves either as support or welfare groups or as workmates socio-economic groupings (SACCOs or investment groups). They were asked the following two questions: (a) how well do you relate with your peers? And (b) Does your peers influence your decision to take up or not take up NHIF cover? The outcome of this study were captured and recorded as follows:

Table 4.8: Relationship with Peers

Relationship with Peers	FREQUENCY	PERCENTAGE (%)
Not at all	13	3.10
Rarely	87	20.71
Often	111	26.43
Very Often	209	49.76
TOTALS	420	**100.00**

Peer relationship among members of the households was reported to be quite cordial with a majority of respondents report very often relationship with peers with a 49.76% or 209 of the total 420 respondents giving a response to this effect.

Table 4.9: Peer Influence on uptake of NHIF Cover

Peer Influence on Uptake of NHIF Cover	FREQUENCY	PERCENTAGE (%)
YES	321	76.43
		23.57
TOTALS	**420**	**100.00**

From the above study tables 4.8 and 4.9, it was revealed that there is a very strong tendency for community members to relate with their peers with a total of 321 respondents or 76.43% saying they very often related with their peers and that through this peer relationship, they had been significantly influenced to take up NHIF Cover.

4.4 Awareness Factors on the uptake of NHIF cover

Under these variables, the researcher wanted to understand how awareness of the insurance cover affected uptake. These were determined through study variables including respondents' access to information, participation in decision making, interaction with the insurance firm and product marketing and sales strategy. The findings were documented and presented as follows:-

4.4.1 Access to Information about NHIF

The researcher had a keen interest in knowing whether respondents had an access to information about NHIF and from which sources they accessed this information. They were asked: "have you heard about NHIF? If YES. How did you get to hear about NHIF? The results were as follows in table 4.10

Table 4.10: Access to information about NHIF

Have you heard about NHIF Cover	FREQUENCY	PERCENTAGE
YES	382	90.95
NO	38	9.05
TOTALS	**420**	**100.00**

From the above data analysis, it was evident that a majority of respondents (90.95%) had had access to information about NHIF except 9.05% who had not had access to information about NHIF as at the time of conducting this study. The table 4.11 sought to determine the source of information about NHIF and findings were captured and presented as follows:

Table 4.11: Source of Information about NHIF

Source of Information	FREQUENCY	PERCENTAGE
Newspaper	17	4.05
Radio	81	19.29
TV	51	12.14
Local Hospital	129	30.00
Community Support Group	97	23.10
NGOs/CBOs Program	27	6.43
Local Church	18	4.29
TOTALS	**420**	**100.00**

From the above study findings it was established that at least every household had access to information regarding NHIF. However, majority of the respondents in each of the household interviewed said that they got information about NHIF from local hospitals, meaning that hospitals played an important role in disseminating NHIF information in the rural households. It was therefore

established through this study that community support groups were a vital means through which NHIF could be marketed to the prospects.

4.4.2 Number of respondents insured by NHIF

The study sought to determine the number of respondents with NHIF Insurance Cover. With an answer of “YES” or “NO”, the responses were captured as follows:

Table 4.12: Number of Respondents insured by NHIF

NHIF Insurance Covered	FREQUENCY	PERCENTAGE
YES	105	25
NO	315	75
TOTALS	**420**	**100.00**

The survey data revealed that 75% of the respondents or 315 households out of 420 households indicated not having NHIF Insurance Cover against a total of 105 households or 25% of the households who said they had NHIF Cover. In further interrogation of the respondents, the researcher established that those who are not covered by NHIF were mainly those aged between 18 and 35 and are in the informal sector, especially “Jua Kali” and “Boda Boda Riders”. Others who were not already covered were the small-scale traders, especially “mama mbogas” who argued that they are not in a position to meet the monthly NHIF subscription, especially now that the amount is increased.

4.4.3 Participation in Decision Making

The study also sought to know if participation in decision making influenced or not influenced the uptake of NHIF by the respondents. Of particular concern to this study was whether the respondent was consulted or involved in making a decision to ascribe to an insurance policy, especially NHIF Cover. The findings of this study were captured and recorded in table 4.14 as follows: -

Table 4.13: Participation in Decision Making

Do you take part in decision making process?	FREQUENCY	PERCENTAGE
YES	341	81.31
NO	79	18.69
TOTALS	**420**	**100.00**

It was established that 81.31% or a total of 341 of the respondents were actively involved in a decision to take an insurance cover, mainly through family meetings and discussion sessions.

Interaction between prospects (Clients) and insurance firm

The study sought to know and determine whether interaction between prospects and the insurance firm influenced the uptake of NHIF insurance cover. They were asked: (a) “How often do you interact with NHIF staff?” and (b) “How did this interaction influence your decision to register with NHIF?”

On the above items, the study results were recorded in the following table 4.15 and 4.16 as follows: -

Table 4.14: Interaction with NHIF Staff

How often do you interact with NHIF staff	FREQUENCY	PERCENTAGE (%)
Not at all	37	8.81
Rarely	66	15.71
Often	240	57.14
Very Often	77	18.33

TOTALS	**420**	**100.00**

From the above table it was evident that interaction with NHIF staff was quite often, especially through the local hospitals, and hence the need to harness their role in promoting uptake of NHIF cover is of significance and a study on how to do this could prove important in the short-run.

Table 4.15: How interaction with NHIF Staff influence decision to register with NHIF

How did this interaction influence your decision to register with NHIF	**FREQUENCY**	**PERCENTAGE (%)**
Not at all	60	14.29
Somehow	41	9.76
Very Much	319	75.95
TOTALS	**420**	**100.00**

From the above table, it was established that regular interaction with NHIF personnel had a string influence on the decision to take up or register with NHIF cover, a total of 319 households (75.95%) of the respondents indicated that their interaction with NHIF staff influenced their decision to register with NHIF. On the other hand, another 41 respondents or 9.76% said that the interaction with NHIF somehow influenced their decision to register with NHIF. Only 14.29% answered to the contrary. It is therefore established that interaction between the prospects (clients) and the insurer is vital in aiding decision making process to uptake the services of the insurance provider.

4.4.4 Product marketing and sales strategy

The researcher was also interested in knowing which products marketing and sales strategies were used by NHIF to reach the potential customers. The following strategies were recorded in table 4.17.

Table 4.16: Product Marketing and Sales Strategies

Source of Information	FREQUENCY	PERCENTAGE (%)
Newspaper	17	4.05
Radio	81	19.29
TV	51	12.14
Local Hospital	129	30.00
Community Support Group	97	23.10
NGOs/CBOs Program	27	6.43
Local Church	18	4.29
TOTALS	**420**	**100.00**

From the above result analysis, it was established that a majority of 129 respondents or 30% indicated that the main product marketing and sales strategy applied by NHIF has been through local hospitals and that it is through this strategy that their decision to register with NHIF had been influenced as the NHIF staff keep on asking which method they will use to pay their hospital bills. This was followed with 97 respondents or 23.10% who indicated that they had come to know about NHIF through their community support groups, this mainly applied to Persons Living with HIV/AIDs.

4.5 Accessibility Factors on the uptake of NHIF Cover

This variable sought to know among other factors, how the following variables influenced the uptake of NHIF: Access to Insurance Service provider, Access to accredited Health care provider, Access to Community support System, Financial Affordability. The findings were captured by the study questionnaires and are presented in the following sections

4.5.1 Access to insurance service provider

The researcher was also keen to know whether access to NHIF had influence on the uptake of the service. The respondents were asked to state whether access to insurance service provider influenced their decision to register with the services offered by the service provider. The result showed the following as captured and presented in table 4.17:

Table 4.17: Influence of access to insurance service provider on uptake of insurance service

Does access to insurance service provider influence your decision to take up an insurance cover?	**FREQUENCY**	**PERCENTAGE (%)**
YES	320	76.19
NO	100	23.81
TOTALS	**420**	**100.00**

The findings in the above table indicates a strong relationship between access to an insurance provider and uptake of an insurance service by the respondent with a total of 320 (or 76.19%) saying that access to an insurance service provider influences their decision to take up the service.

4.5.2 Access to accredited service provider

The researcher was also keen to know whether access to NHIF accredited facility influenced uptake of NHIF Insurance cover. The findings were presented as follows:

Table 4.18: Influence of access to NHIF accredited facility on uptake of NHIF cover

Does access to NHIF accredited facility influence your decision to take up an NHIF cover?	**FREQUENCY**	**PERCENTAGE**
YES	355	84.52

NO	65	15.48
TOTALS	**420**	**100.00**

The above data analysis indicates a strong relationship between the existence of or access to NHIF accredited health facility and the uptake of NHIF insurance with a total of 355 respondents (or 84.52%) saying that the existence of accredited facilities within their reach strongly influence their decision to register with NHIF.

4.5.3 Access to community support system

The respondents were also asked: “Does access to community support system influence your decision to register with NHIF?” the result from this study finding were reported in the table 4.20: -

Table 4.19: Influence of access to community support system on uptake of NHIF cover

Does access to community support system influence your decision to take up an NHIF cover?	**FREQUENCY**	**PERCENTAGE (%)**
YES	329	78.33
NO	91	21.67
TOTALS	**420**	**100.00**

The researcher established that there is a strong relationship between the access to community support system and uptake of NHIF cover with 329 respondents (or 78.33%) saying that the existence of community support system such as NGOs, CBOs, Faith Organizations, Self-help groups to mention but a few had had a very strong influence on their decision to take up NHIF cover.

4.5.4 Financial Affordability

The study further wanted to find out whether financial affordability was a factor in deciding whether or not to take up NHIF cover. The respondents: “in your opinion, do you think that the proposed new NHIF rates are affordable?” They were required to answer with a “YES” or “NO” answer. This came in the advent of the introduction of new NHIF rates. The result was reported as follows: -

Table 4.20: Financial Affordability of the Proposed New NHIF Rates

In your opinion, do you think that the proposed new NHIF rates are affordable?	FREQUENCY	PERCENTAGE (%)
YES	299	71.19
NO	121	28.81
TOTALS	**420**	**100.00**

The survey indicated that a total of 299 or 71.19% of the respondents agreed that the proposed new NHIF rates were affordable while a total of 121 or 28.81% said to the contrary.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATION

5.1 Introduction

The chapter gives a summary of the study, draws conclusion and makes recommendations and suggestion for further research.

5.2 Summary

When a large proportion of the population is without health insurance, it results in high out of pocket expenditure on health services which is catastrophic to the household with resultant negative impact on health indicators. The main issue was the attainment of the highest possible level of health which according to World Health Organization constitution is a fundamental human right and the impact of health insurance scheme on the household and individual include good health which enable the supply of labour and reduction in catastrophic expenditure on health. This situation is magnified in the rural households where sources of income and livelihood is unpredictable and poverty incidence quite high.

The purpose of the study was to find out the factors that influence NHIF Cover uptake by the rural households in Kasipul Division of Rachuonyo Sub-County in Homa Bay County. The study was guided by the objectives: To determine the extent to which the demographic characteristics influence uptake of NHIF Cover by rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County; To establish the extent to which socio-economic factors influence NHIF uptake among rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County; To investigate the extent to which awareness influence NHIF uptake among rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County; and To establish the extent to which institutional factors influence NHIF uptake in rural households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County.

The research was carried out in Kasipul Division which had approximately 2,000 targeted respondents but due to limitations of this study, only 420 respondents returned their duly completed questionnaires. This gave over 70% which according to Mugenda and Mugenda (2003) is a good rate of return.

Descriptive research design was used while stratified random sampling was applied to select the respondent or participants to be included in the survey sample frame.

The survey data revealed that 75% of the respondents or 315 households out of 420 households indicated not having NHIF Insurance Cover against a total of 105 households or 25% of the households who said they had NHIF Cover. In further interrogation of the respondents, the researcher established that those who are not covered by NHIF were mainly those aged between 18 and 35 and are in the informal sector, especially “Jua Kali” and “Boda Boda Riders”. Others who were not already covered were the small-scale traders, especially “mama mbogas” who argued that they are not in a position to meet the monthly NHIF subscription, especially now that the amount is increased. On the other hand, interaction, the frequency of interacting with NHIF staff was indicated to be very often and influenced uptake of NHIF significantly. The most effective and common product marketing and sales strategy was found out to be through local hospitals Finally, financial affordability was seen as being a major issue with NHIF with a majority of respondents saying that their inability to meet monthly NHIF subscriptions had incapacitated their ability to take up NHIF cover.

5.3 Conclusion

The study revealed that awareness and access plays a very important role in the uptake of NHIF cover and therefore efforts to enhance awareness creation and promote access to insurance service provider and accredited health care service provider will have positive impact on the uptake of the NHIF

insurance scheme. The study further found out that a higher percentage of the population of reproductive age are not yet insured by NHIF, majority of whom are in the informal sectors including jua kali sector, boda boda operators and small-scale traders. The study therefore recommends that a strategy should be developed by NHIF to target this lot of respondents.

5.4 Recommendations

After the research findings it's important for the government to fully incorporate the poor and vulnerable rural households and residents in the rural areas working in the informal sector when designing the Universal Health Insurance Scheme, especially when calculating premiums payable since less than half of them are enrolled in NHIF Cover yet due to their living standards and the kind of environment they operate in they are at high risk of developing health problems and due to high poverty incidence in the rural areas, they are likely to delay access to competent medical care. The activities in the rural areas are associated with low inadequate income which reinforces poverty and the transitory nature of the households presents a challenge in incorporating them as stakeholders in NHIF Cover and requires innovative approaches which will carter for their specific needs including simplified means of paying their monthly contributions. This calls for a lot of baseline survey and long term planning. The peasant farmers and self-employed rural folks should have easy access to sources of financing which include Small and Medium Enterprises (SMEs) which like Women Enterprise Fund, Youth Enterprise Development Fund and Uwezo Fund which give subsidized loans to help boost their business at the same time mechanisms should be put in place to increase their knowledge and skills in running their enterprises. This will boost and ensure sustainability of their income enabling them to enroll in NHIF Cover and sustain the required premiums.

There are different mechanisms that the government can employ to sensitize and raise awareness about the NHIF Cover and its inherent benefits through mass media and public forums like public meeting places, road shows, churches and hospitals during health talks and community health

workers outreach. Since most of the rural dwellers are enrolled in a social welfare societies like SACCO, Chama or Merry go Round, this can also be used as avenues for raising awareness about NHIF Cover and collecting premiums.

5.5 Suggestions for Further Research

There is a need for related research to be carried out in other Counties in Kenya so as to compare and assess whether the findings are consistent. There is also need to conduct a study on the effect of the new NHIF Rates on public perception and attitudes for or against its influence on service quality between private and public health sectors in relation to NHIF.

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APPENDICES

APPENDIX A: LETTER OF TRANSMITTAL

THE UNIVERSITY OF NAIROBI

P.O BOX 30197,

NAIROBI.

11TH MARCH 2015.

Dear Respondent,

RE: REQUEST FOR QUESTIONNAIRE COMPLETION

I am a student of Master of Arts in Project Planning and Management at the University of Nairobi,
I am conducting a research on Factors Influencing Uptake of National Hospital Insurance Fund Cover by Rural Households in Kasipul Division, Rachuonyo Sub-County, Homa Bay County in Homa Bay County".
As part of the requirements for the award of the Degree of Master of Arts in Project Planning and Management, I am required to undertake a research project that involves collecting data directly from the respondents using a questionnaire.
It was in this regard that I write to humbly request you to assist me by answering the questions in the study questionnaires as objectively and accurately as possible. Your response and participation in the study is voluntary and any response given was treated with utmost level of confidentiality as possible.
Take note that the responses provided will not be used for any other purpose other than for the academic work stated only.
Please complete the questionnaire provided to the best of your ability following instruction and return your completed questionnaire to the researcher. Your cooperation shall be highly appreciated,
Thanks in advance for your cooperation

Yours faithfully,

Ochieng Dorothy Lencer.

APPENDIX B: QUESTIONNAIRE FOR UPTAKE OF NATIONAL HOSPTAL INSURANCE FUND COVER BY RURAL HOUSEHOLDS IN KASIPUL DIVISION.

Instruction: Indicate the following information about. Please tick ( ) the appropriate choice or fill in the blanks accordingly.

Section one

1.1 Date of interview-----/--------/2015

Name (Optional):----------

Location: ----------

Sub-Location: …….

Section 2: Demographic factors

Please tick appropriately in the shaded regions:

Age	18- 28	29 – 39	40 – 49	50 – 59	60+
Sex	Male				
	Female				
Marital Status	Never Married				
	Single				
	Married				
	Divorced				
	Separated				
	Widow				
Size of the Family	1 – 2				
	3 – 5				
	6 – 8				
	8 – 10				
	Over 10				

Section 2: Socio-Economic Factors

Please indicate your income level by ticking the shaded box that is applicable to you

Income Level	Below Kshs. 3000 pm	Kshs. 3000 – 5000 pm	Kshs. 5000 – 8,000 pm	Kshs. 8,000 – 11,000 pm	Kshs. 11,000 – 14,000 pm	Kshs. 14,000 – 17,000 pm	Kshs. 17,000 – 20,000 pm	Over Kshs. 20,000 but below 50,000

Please indicate your occupation (source of livelihood)

Occupation	House Wife	House Help	Shamba Boy	Peasant Farmer	Small Trader	Large Scale Trader	Self Employed	Civil Servant

Please indicate your level of education

Level of Education	Never attended school	Attended school upto	Never finished	O'Level Certificate	Vocational Trade Test	College Certific	College Diploma	University Degree

		Class 8	Form Four	(KCSE)	Qualification	ate		

How well do you related with your Peers?

(1 – Not at all; 2 – Rarely; 3 – Occasionally; 4 – Frequently; 4 – Very Frequently

Peer Influence	1	2	3	4	5

To what extent do the peers influence your decision regarding your health and choice of health care services available?

(1 – Not at all; 2 – Rarely; 3 – Occasionally; 4 – Frequently; 4 – Very Frequently

Peer Influence	1	2	3	4	5

Section 3: Awareness Factors:

Tick “YES” or “NO” to the following factors and briefly explain your answer

Factor Influencing Uptake of NHIF Cover	YES	NO
Access to information		
Participation in decision making		
Interaction between prospects and insurance firm		
Product marketing and sales strategy		

Explanation of your answer indicate your choice for a “YES” or “NO” answer.:

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Section 4: Accessibility Factors

Tick “YES” or “NO” to the following factors and briefly explain your answer

Factor Influencing Uptake of NHIF Cover	YES	NO
Access to insurance service provider		
Access to accredited healthcare provider		
Access to community support system		
Financial affordability		

Explanation of your answer indicate your choice for a “YES” or “NO” answer.:

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Do you have a NHIF Insurance Cover? Yes…… / No……..

Section 5: Institutional Factors

Which of the following factors influence your choice for a health insurance scheme?

FACTOR INFLUENCING CHOICE OF HEALTH INSURANCE SCHEME	TICK ALL THAT APPLIES
Global health policy	
National/Government Health Policy	
County Government Health care strategy and policy	
Marketing of the Insurance Scheme	
All of the above factors	
Others (State factor or the factors other than the above that influence your choice for a health insurance cover): …… …… …… ……	

In your opinion, what other factors prevent you from enlisting and benefiting from NHIF Cover?

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Suggest solutions for the above factors that affect your uptake for NHIF Cover.

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Thank you.

APPENDIX C: TABLE FOR DETERMINING SAMPLE SIZE FROM AGIVEN POPULATION

Sample Size (Stoker in Stydom and De Vos, 1998:192)

Target Population Size	Percentage Suggested	Number of Respondents
20	100	20
30	80	24
50	64	32
100	45	45
200	32	64
500	20	100
1,000	14	140
10,000	4.5	450
50,000	2.5	1,250
100,000	2	2,000
200,000	1	2,000

APPENDIX D: RESEARCH PERMIT