DETERMINANTS OF UPTAKE OF SOCIAL HEALTH INSURANCE DAILY PAYMENT STRATEGY AMONG MOTORCYCLE TAXISIN ELDORET TOWN, UASIN GISHU COUNTY, KENYA

REUBEN KIPRUTO MUTAI

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DECLARATION

"This thesis is my original workand has not been presented for a degree or any other award in any other university."

Signature: ……..Date: 20th September 2021

Reuben Kipruto Mutai

HSM-3-0315-1/2018

Supervisors

"We confirm that the work reported in this thesis was carried out by the candidate under our supervision''

Signature …….. Date …….

Dr. KeziaNjoroge

Department of Health Systems Management

Kenya Methodist University

Signature …….. Date …….

Dr. Eunice MuthoniMwangi

Department of Health Systems Management

Kenya Methodist University.

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DEDICATION

Thanks to the Lord Jesus Christ, for grace, mercy, and all wisdom throughout the journey. This thesis is dedicated to my wife and family for their unflinching help and support all through the process.

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ABSTRACT

A great health fund scheme creates funds for healthcare in such a way that customers can get crucial treatment and are defended from health-related money related catastrophes. The study's major objective was to find the variables that impact Bodaboda business people in Eldoret, Uasin Gishu District, to embrace a day by day installment approach for social wellbeing protections. The study's particular objectives were as follows: To determine the influence that demographic characteristics, awareness, socio-economic factors, and accessibility factors has on uptake of social insurance daily payment plan. The study adopted a cross-sectional descriptive design and targeted 5000 Bodaboda operators registered with Saccos in Eldoret town. The Saccos officials were also included in the population. A larger part of 263 people was picked as portion of the information set using the convenience sampling for the Bodaboda riders while purposive sampling was used for the Sacco officials and for forming the focus group discussions. To get information, the analysts utilized a survey and a focus group discourse layout. Conceptual substance examination was utilized to evaluate subjective information from focus group sessions. The study found out that an elevated extent (69.8%) of the number of the Bodaboda operators were not yet insured by NHIF. Demographic factors were not found to significantly (β = -0.055, t = -0.5833, p > 0.522) influence the uptake of social health insurance daily payment strategy among the respondents. The study revealed that awareness plays a significant (OR.1.394, 95% CI = 0.559 – 3.478) role in the uptake of social health insurance daily payment strategy among Bodaboda operators. Income level was found to be socioeconomic factor significantlypredicting (OR. 1.053, 95% CI = 0.746 – 1.486) the uptake of social health insurance daily payment strategy among Bodaboda operators. The findings also revealed that accessibility factors (OR. 2.222, 95% CI = 1.426 – 3.642) significantly influenced uptake of social health insurance daily payment strategy. The study, therefore, recommends that health insurance policy makers and strategists to reconsider differentiating their uptake strategies across demographic patterns when targeting informal sector workers. There is also need to enhance awareness of insurance service provider and accredited healthcare service provider so as to inculcate the positive impact of the uptake of the NHIF insurance scheme in the minds of the informal sector workers. Health insurance service providers need also to consider such issues as relative cash flows among income groups and introduce products along this like weekly subscriptions to cater for days with little or no cash flows. Finally, the social health insurers need to improve the visibility of their facilities online through their applications and websites so as to enable the informal sector subscribers know where to locate them conveniently from their locations. Advance inquire about into the effect of the improved NHIF rates on open conclusion and opinions toward its effect on benefit quality among the private and public wellbeing sectors in regard to NHIF ought to be conducted.

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LIST OF ABBREVIATIONS

CBHI	Community-Based Health Insurance
HMIS	Healthcare Management Information Systems
HRH	Human Resources for Healthcare
HSS	Healthcare system strengthening
HSS	Healthcare system strengthening
LMICs	Low and Middle Income Countries
MOPHS	Ministry of Public Health and Sanitation
NGOS	Non-Governmental Organizations
NHIF	National Hospital Insurance Fund
OOP	Out-of-Pocket
OR	Odds Ratio
SACCOs	Savings and Credit Cooperative Organizations
SHI	Social Health Insurance
SPSS	Statistical Package for Social Sciences
UHC	Universal Health Coverage
WHO	World Health Organization
WTP	Willingness to pay

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Healthcare system strengthening (HSS) is considered as a set of endeavors and approaches pointed at updating one or several viewpoints of the healthcare framework, resulting in improved care through expanded access, accessibility, unwavering quality, or effectiveness. According to World Health Organization (WHO, 2020) a viable wellbeing financing framework gives funds for wellbeing in such a way that people may get fundamental facilities whereas also being shielded from the money related catastrophe that comes with having to pay for them. This too suggest that each individual ought to have opportunity to satisfactory and desirable healing center arrangements, which no one should face monetary devastation as a result of malady. Wellbeing protections is one of the ways to fund healthcare to upgrade get to care since the monetary hazard is shared among the backup plan, maintaining a strategic distance from out-of-pocket expenditures for patients (Kimani et al.,2012).

Wellbeing protections scope changes broadly among nations; within the United States, one out of each six people is considered to be uninsured (Baickeret al., 2012). The rate of the populace without wellbeing protections changes marginally in European nations with statutory wellbeing protections, such as Belgium, where less than 1% of the populace is uninsured, Germany, where 0.5 percent of the populace is uninsured, the Netherlands, where 0.2 percent of the populace is uninsured, and Switzerland, where 1.9 percent of the populace is uninsured (Thomson et al., 2013). However, in Africa, wellbeing protections uptake is amazingly low (Nyagero et al., 2012). Tanzania has 5%, Ghana has 20%, and Senegal has 5% according to (Kagumire, 2009). Perhaps only Rwanda's community-based wellbeing protections program has accomplished 90 percent entrance in Sub-Saharan Africa (Lu et al., 2012). In Kenya, less than 25% of the population has either public or private health insurance

cover (Kazungu &Barasa, 2017). The poorest in society capacity to spend for wellbeing services may be a huge faltering block (Liu et al., 2015).

In Kenya, the National Hospital Insurance Fund is one of the key institutions tasked with the delivery of universal health coverage (UHC). Since it is Kenya's major provider of healthcare framework, the National Hospital Protections Fund encompasses an obligation to guarantee that all Residents have passage to raised, low-cost health care. The substitution of the National Clinic Protections Act (CAP 255) and the presentation of the National Hospital Protections Fund Act No. 9 in 1998 overhauled the procedure to fit the expanding treatment essentials of Kenya's wide masses, business, and the wellbeing sector's continuous change. With over 1200 authorized establishments around the region, incorporating state, faith-based, and privatized healthcare authorities, the NHIF is the foremost broadly usable optional social wellbeing protections within the state (National Health Insurance Fund [NHIF], 2012).Nationally, in 2015, NHIF covered approximately 19% of the population translating to 5.2 million principal members; the overwhelming individuals (3/4) live in metropolitan zone.

Even in urban areas there are still glaring inequities in health insurance cover across socioeconomic strata with informal sector workers being largely disadvantaged. Thus according to Kimani et al. (2014) medical reasonableness could be a concern for the masses of Kenyans, particularly the distraught or those in the low income informal sector such as *mama mboga* (vegetable vendors), shoe shiners, casual workers, *beba* (porters), cart pullers and motorbike taxi operators commonly known as *Bodaboda*, who are uncomfortable of monetary adjustments. Subsequently, a couple of medical services inclusion associations, particularly the public medical services inclusion asset especially NHIF, have made systems that consider relaxed agents for instance, NHIF introduced daily premiums in May 2018 targeting informal sector workers. The objective of the initiative was to encourage low income earners who earn their income daily by breaking the monthly subscriptions into

smaller daily packets that can be conveniently remitted daily through mobile money such as Mpesa. However, the response of the target subscribers to the new NHIFs daily subscription product has not been empirically investigated.

The Kenya Government introduced a policy of Universal Healthcare that seeks among other things to expand healthcare insurance to low income groups in order to achieve its policy objectives. Specifically, the study expected that one of the ways this could be achieved was through daily subscriptions to the country's main healthcare insurer the NHIF by the informal sector actors such as the Bodaboda operators. However, there have been challenges with the uptake of the payment scheme, hence, the ponders goal was to decide the components that impact uptake of social health-care scope daily payment strategy among Bodaboda operators in Eldoret town, Uasin Gishu County.

1.2 Statement of the Problem

Social protection mechanism such as health insurance provides financial protection that arises from high healthcare costs that usually arise from out-of-pocket payments. Health insurance, which is an acknowledged mechanism for meeting the healthcare costs in households, has in the past been mainly available to the population in the formal sector in Kenya who could afford it or who their employers were able to subscribe them to as an incentive (Barasa et al., 2017). However, NHIF since expanded its scope under the universal healthcare scheme to provide coverage to people in the informal sector. As part of its strategy, it has introduced the daily payment strategy to enhance enrolment by people in the informal sector among them being Bodaboda operators. NHIF introduced daily premiums in May 2018 targeting informal sector workers and there was sensitization of the daily payment when it was rolled (Barasa et al., 2018). However, despite these incentives, NHIF uptake in the informal sector still remain low at between 21-25% in most counties(Mwangi, 2020).

In Eldoret town, Uasin Gishu County, there is low uptake of social health insurance cover hence many Bodaboda operators easily resort to risky lifestyles such as self-medication, irrational use of over-the-counter antibiotics or use of unqualified medical practitioners including herbalists (traditional "doctors") (Kimani et al., 2012). Moreover, there is a general tendency of the operators resorting to fundraising or sale of family valuables included limited assets to cater for health care costs whenever accident occur to them, disease and sickness attacks uninsured families. Motorcycle related accidents account for 14% of reported traffic accidents, with an estimate of about 3000 per year. In Eldoret town, Uasin Gishu County, police data showed a significant increase in motorcycle related accidents from 22% to 36% over the past four years (Traffic Police Eldoret Central, 2018). Such accidents often result in high injury severity and fatalities. Consequently, medical and rehabilitation expenses relating to such injuries are often high, and when paid out of pocket, victims are pushed to into personal bankruptcy and eventually poverty. Lack of health insurance cover limits access to quality and appropriate health care among motorcycle taxi operators and their dependents. With the introduction of the daily health insurance subscription scheme, it was largely expected that the Bodaboda operators who form a substantial proportion of the informal sector would be among the primary beneficiaries. However, the determinants of uptake of social health insurance daily payment strategy among Bodaboda operators in Eldoret town, Uasin Gishu County are not documented. It is against this background that the study sought to find out the effect of daily payment strategy uptake on healthcare financing among Bodaboda operators in Eldoret town.

1.3 Research Objectives

1.3.1 Broad objective

The main objective of the study was to establish the determinants of uptake of social health insurance daily payment strategy among Bodaboda operators in Eldoret town, Uasin Gishu County.

1.3.2 Specific Objective

a) To assess the influence of demographic characteristics of Bodaboda operators on uptake of social health insurance daily payment strategy.
b) To determine the influence of awareness of daily payment on uptake of social health insurance among Bodaboda operators.
c) To examine the influence of socio-economic factors on uptake of social health insurance daily payment strategy among Bodaboda operators
d) To analyze the influence of accessibility factors on the uptake of social health insurance daily payment strategy among Bodaboda operators.

1.4 Hypothesis

a) Ho There is no significant relationship between demographic characteristics of Bodaboda operators and their uptake of social health insurance daily payment strategy.
b) Ho There is no significant relationship between awareness of daily subscription and their uptake of social health insurance daily payment strategy among Bodaboda operators in Eldoret town
c) Ho There is no significant relationship between socio-economic factors and their uptake of social health insurance daily payment strategy among Bodaboda operators in Eldoret town

d) Ho There is no significant relationship between accessibility factors and there the uptake of social health insurance daily payment strategy among Bodaboda operators in Eldoret town

1.5 Justification of the Study

Social protection mechanism such as health insurance provides financial protection that arises from medical related events. Despite the efforts to accelerate health insurance coverage and availability of various forms of health insurance, uptake largely remains low. Those in the informal sector such as Bodaboda operators mostly do not get competent healthcare attention when they are ill or get involved in accidents due to inability to pay monthly insurance premiums (Kimani et al., 2012). Bodaboda operators are 30 times more likely to be involved in a traffic accident than other road users. Bodaboda related accidents account for 14% of reported traffic accidents, with an estimate of about 3000 per year (Ministry of Public Health and Sanitation [MOPHS], 2011). Such accidents often result in high injury, morbidity and fatalities. Consequently, medical and rehabilitation expenses related to such injuries are often high and sometimes stay untreated for lack of money. Lack of health insurance cover limits access to quality and appropriate health care among Bodaboda operators and their dependents. Wellbeing protections plans can offer assistance to advance the accessibility of reasonable medical care by permitting individuals to pay for medical bills. In spite of incredible media campaigns and field visits to raise awareness approximately the need of wellbeing protections among Kenyans, the unregulated segment take-up of wellbeing protections remains insufficient. Eldoret town has been chosen in this study because it has a high Bodaboda population (over 5000) but a correspondingly low uptake of NHIF cover (14.7%) among persons who identify as the services group which also includes Bodaboda operators (Chomi et al., 2014). This means majority of the Bodaboda operators together with their families continue to function without a low-cost health cover and as such are vulnerable

to the financial implications of out-of-pocket healthcare finance. The study adds value to existing research by bringing out the health insurance uptake characteristics of one of the fastest growing sectors in the informal economy of the country. Based on this future research and social health insurance models can be developed

1.6 Limitations of the Study

The study's vital weak point was that the questioning as a data collection device might have a few investigator prejudice, in any case this was relieved by pre-testing the procedure earlier to introduction. Respondents were too reluctant to take part within the study since of individual information second thoughts, but each exertion was made to reassure them of the academic substance of the study and its worth to the pertinent parties to whom it was recognized. Another impediment was that a few respondents were as well active to keep their appointments amid the study.However, earlier agreements were made with interviewees who were eager but likely to be missing amid information collection to affirm that they joined within the study at a time that was pleasant for them, as well as confining information collection length to five minutes per member.

1.7 Delimitations of the Study

The study's essential objective was to decide the variables that impact the appropriation of social health insurance daily payment strategy among Bodaboda operators in Eldoret town, Uasin Gishuregions. The study exclusively looked at the effect of operator demographics, day by day membership awareness, socio-economic variables, and availability components on every day installment plot appropriation. The study focused on the Bodaboda operators operating within Eldoret town and the suburbs in well designated pick-up points within the areas. The demographic factors were limited to; household size, marital status, age and family size. The scope of awareness included; registration procedures, payment mechanism, benefits and access to information. Socio-economic factors under investigation in the study were

delimited to income and education, while the scope of accessibility factors included; access to NHIF offices, NHIF accredited hospitals and access to payment strategy.

1.8 Significance of the Study

It was anticipated that the study's conclusions would be valuable to a variety of partners working on universal healthcare coverage programs, especially those that design and implement health financing programs, policies and projects in Kenya. Firstly, the results were meant to be of benefit to the NHIF as an organization and also to the respective Eldoret branch. The concerns give critical experiences into the basics of of the uptakes of their new products. Through the findings and recommendations, the NHIF decision making organs can strengthen their strategies to spur higher levels of uptake of health insurance among the laborers in the middle class. Understanding the variables of healthcare consumption strategies among the casual division laborers would be instrumental in helping overcome policy implementation challenges as the country gears up to the universal healthcare agenda under the Big Four Agenda. This class of stakeholders, especially those who are constantly exposed to health risks like Bodaboda riders, are meant to understand the implications of their presence and the significance of wellbeing protections need to subscribe to packages tailored for them. To the target group, that is the vulnerable rural households in Eldoret, the study will be instrumental in eliciting in them the need to acquire and regularly use social health insurance daily payment strategy in meeting the soaring cost of health care they are persistently facing and contending with. The findings were also meant to be significant to the policy makers at the national Ministry of Health Services and also the county governments. The findings will enable them to assess the permeation of social protection underwriting at the grassroots level among low cadre workers and, therefore, come up with additional policy interventions that improve subscription to the health insurance schemes and also their

utilization as intended in the National Health Policy Framework. The findings are also meant to add significant body of knowledge to other scholars conducting research in the field of health financing for the rural households, especially the informal sector and which are poor, vulnerable and marginalized populace.

1.9 Assumptions of the Study

In their reactions to the research instruments, the analyst expects that the interviewees would be genuine, agreeable, practical, objective, and reliable. This study shall be established on the presumption that the major partners recognize the value of great healthcare and the administration of high healthcare services, which they are working to achieve this noble objective. The test estimate is additionally expected to be genuine demonstrative of the target group within the study.

1.10Operational Definition of Terms

Bodaboda	Swahili slang name for a motorcycle taxi operator
Daily Payment Strategy	This is the payment model of as little as Kshs 16 daily towardscontributions for the NHIF cover paid through mobile money on a daily basis and meant for persons working in the informal sector.
East environs	In this proposal East Environs refers to the *Bodaboda operators* in eastern part of Eldoret town like Annex, Mediheal, Kapsoya, Moi girls and Elgon View.
Matatus	In Kenya this refers to minibuses that are used for transportation
Mpesa	This is a mobile money transfer service in kenya
National Hospital Insurance Fund (NHIF)	A Kenyan state-owned venture whose fundamental work is to provide heath scope to all of its endorsers and their stated beneficiaries.
North environs	In this proposal North and Environs refers the *Bodaboda operators* in northern part of Eldoret town like Railways, Kimumu and Action.
South environs	In this proposal South Environs refers the *Bodaboda operators* in southern part of Eldoret town like Kipkaren, Pioneer and Teleview.
Uptake	This is the adoption and enrollment to an insurance scheme individuals and households
West environs	In this proposal West Environs refers *Bodaboda operators* in western part of Eldoret town like West Indies, Kamukunji, Huruma and Mwanzo

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter covers the review of literature related to the determinants of uptake of social health insurance. The review and discussions are done along the variables of the study through conceptual and empirical perspectives. The chapter begins by introducing the concept of the Bodaboda taxis and their role in the Kenyan economy. It then discusses the study variables. The chapter also provides a theoretical framework to provide a theoretical understanding of the variables and finally a conceptual framework to show the theorized relationship between the independent variables and dependent variable.

2.2 Role of Bodaboda on the Economy and their Health Insurance Trends

Due to the collapse or absence of established open transportation frameworks, non-conventional modes of open transportation have surged in noticeable prominence, initially offered by transports and pooled commuter, preceded by business minicab services and motorcyclists (Sclar & Touber, 2011).In Africa, open transportation in Sub regions has changed significantly in consequent times as a combination of two parallel forms: the misfortune of gigantic state-owned firms and the unbalanced broadening of the unplanned fragment with its assorted operatives(Olvera et al., 2012).

Motorcycles, known in East Africa as Bodaboda, have developed in popularity as a commercial strategy of open transportation amid the final two decades (Kumar, 2011). A motorbike is characterized under the Kenyan Traffic Act as a vehicle with less than four wheels and an unladen weight of less than 400 kilograms. Motorcycles are made for an assortment of reasons and come in a variety of styles to fit their expecting utilize. Street motorcycles are designed for use on all-weather roads, while off-road motorcycles are

designed for utilize on irregular highways and difficult landforms. Sport motorcycles are lighter and more effective than off-road motorcycles (Porter, 2014). The development of motorbikes as a public form of transportation in Kenya has been extraordinary since the government of Kenya annulled the import duty on motorcycles in 2008.

One of the foremost fundamental modes of open transportation is the bodaboda. in urban and rural areas generally owing to the ease with which one may approach and leave the zone, as well as the speed with which one can move clogged and poor-quality roadways (Mbugua, 2011). The Bodaboda has predefined transportation benefits, such as simple flexibility, the potential to explore on bad roads, clamour attentiveness, and high intrusion, and as a result, they are effortlessly favored as a mode of transportation for brief ranges, particularly in zones where other modes of transportation are not accessible. In Kenya, the Bodaboda competes with conventional taxis and bicycles for short-distance transportation inside major cities. They moreover serve as feeders to low-density urban regions, tough landscape, and other non-attractive modes of transportation, as well as feeders to main roadways, competing with and increasing taxis and larger-capacity matatus (Mwobobia, 2011).

The motorcycle mode of transportation in the country has as a result created employment for thousands of youths who would otherwise be jobless and contributed approximately KES 200 billion annually to the economy (Kenya National Bureau of Statistics [KNBS], 2019). For a country in which youth unemployment is a perennial challenge, providing a source of employment that has low entry conditions such as the Bodaboda business is an important break. Unemployment could be a genuine a phenomenon that has an impact on Kenyans youthful generation. Each year, generally almost 1 million budding Kenyans enter the workforce each year, with youth unemployment at a record high detailed to be as tall as 35%, relative to a countrywide joblessness rate of 10%. Additionally, 80% of unemployed Kenyans are beneath the age of 35. Since it is the foremost predominant strategy of transportation

within the countryside, the assortment of Bodaboda operators is expanding on a daily premise, and the Bodaboda industry in Kenya has developed to be one of the country's major informal divisions, supporting thousands of youthful individuals (Owino, 2018).According to Mwaura (2013), since the presidency order empowering Bodaboda to be used as open transportation, they have become imposing contenders of major modes of transportation in cities, as well as commanding countryside transportation being finest remedy to run errands and penetration.

In spite of their developing popularity, Bodaboda has certain particular imperfections in terms of public safety; their extension has happened without compliance to safety directions set forward in various countries' portability enactment. In any case of the open transportation choices they grant, the advancement of the Bodaboda has finished in a comparable increment in street carnage and environmental harm (Kumar, 2011). Motorcycle redistribution has been actualized out with insufficient respect for satisfactory operator learning and permitting, safety precautions have been overlooked, and urban streets and highways are demonstrating greatly perilous as inexperienced and under informed bikers compete for clientele on the road. Motorcycle extension has brought a few unwelcome results, such as wrongdoing and health issues, in addition to security concerns (Kumar, 2011). According to insights, the rise of Bodaboda has contributed significantly to Kenya's road traffic mortality rate, which is calculated to be 34.4 deaths per 100,000 individuals (WHO, 2011; MOPHS, 2011). Motorcycle-related accidents often characterized by injury severity that is accompanied by enormous medical expenses associated with treatment and rehabilitation. The medical costs could easily bankrupt the operators returning them back to the vicious cycle of poverty. However, a customized health insurance scheme such as the NHIF’s daily subscription package that they can conveniently subscribed to can significantly improve their healthcare financing prospects.

Studies with respect to the utilize of wellbeing underwriting by Bodaboda drivers are scanty with most focusing on health insurance status among helmeted and un-helmeted cyclists Brownet al.(2011) revealed that un-helmeted Bodaboda operators received considerable accidents, had a longer hospital term, and were more likely to be uninsured in a study of 1738 Bodaboda operators hospitalized to a level 2 injury center in South Africa. Motorcycle mishap medical costs were secured by the government-run protections program or private health insurance, not by the casualty. Moreover, medical consumptions brought about by the uninsured who were incapable to pay their bills were part equitably between the healthcare supplier and the government.

In Uganda, analysts looked into the effect of wearing a motorbike head protector on bringing down mortality, morbidity, and health-care costs. When compared to those who wore head protectors, unhelmet Bodaboda operators had more prominent health-care costs, with costs up to 23 percent higher. Besides, 55 percent of those who did not wear protective caps and 45 percent of those who did were both uninsured (Bigelow, 2015). In Kenya, Mbugua (2011) study in Thika town Kenya established that 99% of Bodaboda operators were uninsured. Similarly, Grimm and Treibich (2014) study in India also established that 76% of motorcycle taxi operators lacked health insurance cover.

2.3 Demographic Factors on Uptake of NHIF Cover

The evaluation of masses predicated on criteria such as age, ethnic foundation, and sexuality is known as demographics. Statistic information could be a factual representation of socioeconomic data, such as work, education, wage, marriage rates, birth and death rates, and other perspectives. Statistic factors have a critical affect in a consumer's purchase or membership decision-making process, and they can lead to deviations from typical consumer decision-making patterns. As a result, strategists must intensive information on clients in

order to comprehend their activities and wants. In the present study, the demographic factors examined were; household size, marital status, age and family size.

2.3.1 Age on Uptake of Health Insurance

Age is an important demographic that can be used to assess decision making in a given population Because it is correlated with high verifiable susceptibility, higher medical utilization, and perhaps upgraded wealth stock, age may be a key figure of the propensity to safeguarded (Śliwiński & Borkowska, 2020). A study of the variables basic low- and middle-income people's participation in India's Kupra wellbeing protections program found that age was one of the foremost vital statistic characteristics driving inclination for wellbeing insurance. The age of the respondents was not significant within the lower age categories, whereas it was critical within the higher age groups.According to the study, typically due to the elderly being more mature and capable of understanding their threats, and thus utilizing health insurance to diminish their dangers and vulnerabilities (McGuire, 2011).

Whereas investigating non-enrolment in medical coverage plans within the Gweru metropolitan region of Zimbabwe's Midlands's area, analysts maintained that how old one was formed a significant variable for enlisting, recommending that as individuals grew more seasoned, they created a more prominent level of responsibility and awareness. In any case, as people's ages advanced, the probability of uptake diminished, suggesting that as they come to the conclusion of their profitable years, they became less concerned around their wellbeing and may have amassed sufficient income to cover their wellbeing requests. It's too conceivable that elderly parents had grown children who had assumed commitment for their elderly parents' health care (Mhere, 2013).

Aged agriculturists in Osun state had a diminished probability of subscribing in Nigeria's National Health Insurance Service (NHIS), according to a study (Oyekale, 2012). The elderly

was more likely to have huge families and a high number of spouses who were not secured by wellbeing insurance. Moreover, numerous elderly individuals without the financial capacity, education, and desire to enlist in a health-care plan.Female over 40 years old were detected to be very inclined to engage in wellbeing protections in a report by Duku et al. (2016) on accessibility of wellbeing insurance among ladies in Ghana, matched to those in more youthful generations. The reason being that as individuals get more seasoned, their healthcare stockpile is diminishing at a speedier regularity, inviting expanded endeavor in wellbeing, this might incorporate wellbeing security.

Besides, Chankova et al. (2010) revealed that adolescents and individuals over the range of 70 years were more inclined to be interested to take part in Ghana's national wellbeing protections benefit than those aged 18 to 49 years, based on household overviews in Nkoranza and Offinso areas. Enrollment was more likely if the individual was female, had a persistent illness, or was a part of a family headed by a woman who was also a part of a neighborhood affinity network. It was decided that the technique adapted at expanding cooperation within the arrange for people aged beneath 18 and those aged over 70 years had not been very impactful, as numerous within the disadvantaged had not however been enrolled due to lacking programme formulation.

In Kenya, all persons aged over 18 years and in possession of a national identify card can register in the National Hospital Insurance Fund, with the membership card covering the principal contributor, one spouse and all children in the family aged below 18 years. Children aged over 18 years and in a full-time educational institution are also eligible for coverage under the parents' cards. Unlike in private health insurance organizations, NHIF does not have an upper age limit, implying that aged in rural and urban areas can enroll irrespective of their health status as long as they can afford the monthly premiums (NHIF, 2012).

2.3.2 TheImpact of Marital Status and Family Level on Health InsuranceEnrollment

Several statistic examinations have found that spousal relationship and household size have an effect on decision-making. In Jamaica, for case, Bourne and Kerr-Campbell(2010) found that social positioning, earnings, spousal position, pension payments, housing environment, and the amount of males within the home all predicted health protections participation. People who were married were observed to be more inclined to buy wellbeing security. Mulupi et al. (2013) conducted a review on well-being securities in South Africa and found that companion status had a favorable effect on health-care scope possession. It was pointed out that a desire to protect their children, as well as concerns around high health uses and pooled reserves, may be driving people's expanded request. The family's appraisal incorporates a detrimental effect on the likelihood of owning well-being safeguards. The family's estimation may have a negative impact on profits. Yusuf and Leeder (2015) explored the significance of family structure in Australia, centring on dynamic women beneath the age of 30, as well as the pertinence of children on inclinations to enlist in medical security. Having numerous offspring expanded the probability of getting securities by 3% for those without recent children and closer to 5% for those who had had children. Families who arranged to have extra children within the future were 7.4% more likely to insure than women who had as of now completed their family plans, who were as it were 5.6 percent. Marital status, evaluated facility accessibility, and geographic area were all components that affected enrolment.

Fang (2012) found that families with less family numbers and higher salaries get stronger chance of having an expanded scope in both public and private wellbeing protections plans, according to a study on wellbeing protections scope and medical use in Taiwan. Families with long-term conditions, on the alternative extreme, more likely to have both individual and public livesand open health protections, which have been connected to expand out-of-pocket

investing. The study in general finding was that, whereas Taiwan has made critical advance in terms of enrollment, bringing down out-of-pocket investing remained a trouble.

Doyle et al. (2011) examined wellbeing protections acknowledgment in northern Indian families taking part in community-based wellbeing protections plans, centering on financial, statistic, family utilization, asset holdings, wellbeing status, and self-help group participation. The propensity of a few nuclear family units living together in single homes and so having different independent judgment entities was connected to the reality that bigger families were more likely to get wellbeing protections. In comparison to family heads over the age of 55, more youthful families were moreover more likely to select in wellbeing protections.

Thornton et al. (2010) found that family home members' wellbeing circumstance (particularly, whether the head of family domestic is genuinely sick) and the probability of potential wellbeing happenings (such as the number of children within the family) are both discernibly and emphatically connected with health protections take-up in Nicaragua. In a Rwandan investigative ponder subscription remained constant, notwithstanding of family estimate up to seven individuals, concurring to the justification (Jehu-Appiah et al., 2011). Micro insurance selection is related with family budget and participation. Usually adjusted with sensible family decision-making since the amount of commitment is unaffected by the size of the family (Bendig & Arun, 2011).

With the daily uptake scheme having been introduced by the NHIF in Kenya targeting low-income earners in the informal sectors such as Bodaboda operators, it was not known to what extent demographic factors influenced the uptake of the new package.

2.4 Awareness and Uptake of Health Insurance

A comprehensive insight of one's healthcare concerns, as well as more profound recognizing of risk and mitigating components for healthcare, is included in cognizance.

2.4.1 Registration Procedures

In a setting of healthcare assurance interest in low-income countries, it was found that the worldview of protection, which involves paying cash in exchange for an obscure future return, is generally modern in these nations. When no payout or claim happens, recently insured people may anticipate their premiums to be refunded, requiring comprehensive protections awareness instruction and the utilize of peers to disseminate data around protections services. A qualitative study in Kenya by Kazungu and Barasa (2017) found that wellbeing protections supplier workplaces were concentrated in urban regions, preventing countryside inhabitants from enlisting in health protections plans.

2.4.2 Payment Mechanism

Jahangir et al. (2013) examined the troubles of building up protections among the destitute and informal sector populaces in low-income nations, noticing that it is basic to pick up the believe of the target communities in order to influence them that health protections gives money related security. They observe that informal sector societies are by and large unacquainted with the system of wellbeing security and could be skeptical of coverage due to prior encounters of similar sorts of problems, as well as being disappointed paying cash in hand for administrations they may not require whereas getting no benefits themselves, requiring the need to collaborate with trusted community leaders and us.

When expanding wellbeing protections to the informal sector, community-based groups and microfinance organizations can be utilized as passage focuses. Ordinary communication systems may not be fruitful in drawing nearer the destitution stricken, rural, and informal sectors in developing nations, requiring the improvement of successful messages for depending founded around benefits of health-care coverage through social showcasing strategies such as the utilize of top teams on the grassroots talk to residents of the area about

the benefits of wellbeing security in India, the micro-insurance institute enrolls the administrations of trained health protections moderators to conduct programs for health protections instruction and group exercises.

2.4.3 Benefits

Insurance showcasing to the poor is troublesome since, indeed for those who have had get to insurance; their experiences are habitually unfavorable due to claims preparing delays and denied claims. According to Boateng and Awunyo-Vitor (2013), low-income people with low education who are living paycheck to paycheck may not get a handle on why they ought to contribute the restricted cash they have on future occasions that will or may not materialize. As a result, particular publicizing is required to raise awareness of health scope arrangements. To combat unfavorable anti-insurance reasons, special communications must underline principal concepts such as togetherness, inspiration, trust, and social security, whereas educating the needy that they are vulnerable and would be worse off in the event that risks were not overseen by protections. Straightforward and low-tech strategies such as Road Theater, film, pictorial, and video introduction can be utilized to progress information of insurance. Amid the social showcasing process, sales agents ought to help potential clients in coming to the conclusion that health emergencies are exorbitant by helping low-income family units in recognizing their dangers and how protections might offer assistance to them oversee those dangers

2.4.4 Access to Information

In order to better comprehend the variables that contribute to low health protections appropriation and membership costs, Maharashtra State in India performed a study to evaluate people's awareness of protections terms and their degree of insurance information (Platteau & Ontiveros, 2013). Low enrolment and renewal were driven by a need of information on how the plot worked and a poor comprehension of the insurance concept, with

the lion's share of respondents demonstrating a need of data on how to utilize the insurance enlisted clients were moreover less likely to reapply their insurance when the benefits obtained were less than the protections premiums paid. The study uncovered the need of ceaseless communication and the physical nearness of insurance operators within the field in order to provide data on insurance items through progressing awareness campaigns.

Jangati (2012) conducted a study on wellbeing insurance understanding among inhabitants of Hyderabad, Andhra Pradesh, and concluded that: - 65.5 percent had no thought what it was. It was found that 22% of males were aware of health protections, though 11.5 percent of females were. In terms of work status, it was found that self-employed individuals were less learned around health protections than those employed by the government or private businesses. Higher-educated individuals were more likely to be aware of health protections. To extend people's comprehension of protections, the analyst suggested growing successful data and communication activities.

The objective of a study conducted in Bangladesh that centered on informal sector employees was to see into the impact of giving education on health protections by holding week after week group dialogs on health use and protections. The study's primary objective was to see in case proficiency gaps and a need of information impacted informal sector workers' eagerness to pay. When comparing unplanned segment workers who participated in the durations to the few who did not, the concentration to remuneration after the rapid engagement interval was 33.8 percent higher. The test's overall result was that pedagogical approaches can be utilized to raise interest for healthcare security by delivering components that include wellness pooling, medical policy, payment packaging, and cohesion fortitude (Jahangir et al., 2013).

Evans and Etienne (2010) looked at the components that impact health protections request, centering on NHIF enrollment. Lack of awareness of enrolment strategies and essential

protections standards was distinguished to be a key impediment to enrollment within the study, which included interviews with individuals of taxi affiliations, farmers, and self-help groups from different segments of the country. Numerous of the interviewees had never heard of health protections and appeared to accept that on the off chance that they had not been sick for a long time, they would be reimbursed for their installments, illustrating their need of information of health protections as a means of amassing and spreading risks. It was decided that informal division specialists were unaware about the NHIF but were willing to enroll in the event that precise and well-packaged data was displayed to individuals of different educational levels. A past study by Evans and Etienne (2010) analyzing variables influencing request for health protections in Kenya found that numerous Kenyans, eminently those within the casual segment, have never heard of health protections.

Nevertheless, impressive breakthroughs in data and communications innovation, marked by a developing social media space as well as conventional media outlets, have happened within the final twelve years, and it was broadly anticipated that this would have an impact on health protections awareness, especially among informal division groups such as the Bodaboda industry. Existing research, however, have not looked into this perspective of health protections uptake, particularly in packages just like the NHIF day by day membership frameworks.

2.5 Social-Economic Factors and Uptake of Health Insurance

The financial level of an individual could be a pivotal pointer of a spectrum of health issues (Sehat et al., 2012). The challenges that health and welfare services must address are getting to be more advanced as a result of societal advancements. Physical and mental ailments have noteworthy social measurements, either as a cause or as a byproduct (or both) (Cameron et al., 2014). People's health suffers as they age as a result of financial imperatives such as anon-appearance of information and money related resources, high jobless and work

insecurity percentages, and working in occupations that don't give health protections. Women frequently have more occupational irregularity than males; they are less likely to work in occupations with retirement and, as a result, confront higher monetary hardships than men, especially afterward in life (Novignon et al., 2019).

In the social biological worldview, there are four levels of impacts of health behavior: individual, organization, community, and populace (Cramer &Kapusta 2017). At the specific scale, a person's conduct is decided by their understanding of the dangers of not having health protections as well as their individual salary (financial status and socioeconomics). At the organizational level, financial status is additionally a factor. In one's decision-making process, whether or not one is employed possibly plays a part. In addition, notwithstanding or not part-time work alternatives give for protections enrollment can be a concern. Social standards and convictions impact behavior at the community level (perceived need). At the populace level, perceived value is one factor that impacts who opts for health protections and who does not.

2.5.1 Income Levels

Income is the most noteworthy critical social and financial defining figure of health since it characterizes aggregate living criteria, mental working, and health-related behavior such as food security, housing, and interest in social and educational activities, all of which have negative health results and restrain one's capacity to live a satisfying life (Dorjdagva et al., 2015). One of the numerous obstacles to getting to health services is family health consumption paid as client fees, which may contribute to an increment in illness burden. In modern and past studies, family salary encompasses a positive relationship with the probability of acquiring health protections in both developed and developing countries, with income having a major effect on the sum of health protections obtained (Osei-Akoto & Adamba, 2011).

Budgetary limitations are one of the foremost critical obstacles to health care for marginalized groups in numerous countries. Roughly 1.3 billion impoverished individuals around the world don't have access to health services since they cannot bear to pay for them when they are required causing budgetary hardship and desperation for those who must utilize them (Tambor et al., 2014). Around 5% of Latin American family units spend 40% of their non-subsistence pay on medical care each year, whereas 40% of Indian family units paying for hospitalization drop into poverty as a result of their healthcare investing. The informal sector's operations are connected to deficiently income support and revenue-generating exercises, which compounds poverty (Zhang et al., 2017).

Sarpong et al. (2010) utilized gateway measures of well-being such as water accessibility, access to power, and sort of staying to classify families as low, middle, or high socio-economic status in Ghana. According to the measurements, as it were 21% of destitute family units were selected compared to 60% of those classed as having a high financial standing. The Ghanaian government, on the other hand, recognized the inconsistencies in health protections and healthcare and built up membership costs based on people's capacity to pay, as well as exempting women from paying premiums by repaying health suppliers for conveyance.

In contrast, an Indian survey conducted by McGuire (2011) on the inclination for private health protections among poorer and direct income groups found that families with protections had higher livelihoods than those who were not. Besides, families with higher healthcare investing as a rate of total family investing were more likely to purchase health protections.However, it was found that the relationship between salary and health protections was non-linear, in that as income expanded, health insurance expanded as well, but after a certain point, the relationship between pay and health protections got to be negative, inferring

that as earnings expanded, family units occupied their resources to other uses, obtained less health protections, and were willing to hold their health insurance.

Besides, Mulupi et al.(2013) showed that the percent of people with health protections developed as family income developed in an investigation on the connect between health protections enrolment and financial factors among women in South Africa. Those gaining less than 950 rand per month have 6.3 percent scope, whereas those earning more than 7600 rand per month have 90.75 percent scope, meaning that macroeconomic activity to extend expendable earnings in South Africa will increment health protections enrolment. Higher enrollment among those in higher pay categories is in line with consumer hypothesis, which treats health protections as a standard good with positive request flexibility. It has to be compelled to this assurance after taking note in a research in Ghana that wealthier families were more likely to enlist, with the poorest quintile accounting for 34% of the unregistered, compared to as it were 8% within the wealthiest quintile (Dalaba et al., 2012). In an isolated study in Ghana, high-income workers were 7 percent more likely than low-income workers to enlist in health insurance within the Kumasi city, which centered on both formal and informal segment, work (Boateng & Awunyo-Vitor, 2013). Information from the 2007 Kenya family spending study backs this up, uncovering that the wealthiest families (those within the top quintile of the riches record) spend more on healthcare.

Kimani et al. (2012) found that work profile is a fundamental marker of association within the NHIF scheme in an examination on the indicators of engagement in public health protections among tenants of Nairobi's urban ghettos. The formal and informal sectors have varied levels of association within the NHIF, which might have major repercussions for the increase of social prosperity protections in state. Poor people are moreover less likely to select within the National Health Insurance Fund program; this can be due to their failure to

create the NHIF's required obligations. Only 48% of people engaged within the formal segment were enrolled in the NHIF among respondents who dwelled in regions checked by extreme poverty. According to the discoveries, pay was a critical indicator of health protections scope.

In Kenya, private health protections participation is additionally very low, which is due to the high cost of premiums. As a result, the well-off individuals, especially those in metropolitan zones, have generally been left out, with Nairobi accounting for the bulk. In a study of the factors of health protections inclination in Kenya, Kiplagat et al. (2013) found that working individuals are more likely to be secured by public health protections than private health protections.

2.5.2 Educational Level

Concurring to several appraisals, health protections may be complicated money related product for clients (Tennyson, 2011) as a result of necessity of information and understanding of all-inclusive healthcare, customers with demonstrated wellness care with reduced premium proficiency confront challenges when acquiring health protections and they ought to be helped in understanding and utilizing health protections. According to factual prove, those with a prevalent foundation of literacy were more well-suited to enlist wellbeing protections plan. For example, Giwa et al. (2013) uncovered that educated people deemed prepared to pay larger sums for health protections within the Darjeeling region of India in a research on information and readiness to pay for health protections. The skilled had larger salaries and were able to reinvest in alternative sorts of assets that would yield superior benefits. In an examination on the use of local area based wellbeing securities plans in Northern India, Doyle et al. (2011) found that family units with educated heads who had gone to at slightest basic school those with a higher learning appeared twice certain to take an interest than people without one.

In Sri Lanka, a study on the relates of participation in micro finance (MFIs) and health protection, Bending and Arun (2011) found that family heads without a formal basic or secondary education were relatively less likely to subscribe in health protections. Individuals with less education were more likely to safeguard their families due to their lower salary and less cash making prospects. Consistent with Mhere (2013) who found that education level, as measured by extra years of schooling, improved the probability of inclusion in health protections frameworks in Zimbabwe.This was associated to educated individuals being more concerned about the well-being of their families, as well as the possibility that a few perspectives of healthcare and health insurance would be shielded as a result of the respondents' education. Researchers' explored utilization within the coastal, central, and northern zones of Ghana in a study on women's health protections proprietorship and uncovered socio-economic and geological disparities in protections enrollment. In comparison to the less educated and poorer Ghanaians, women with higher more learned and prosperous accomplices were especially inclined towards having obtained health protections (Kumi-Kyereme & Amo-Adjei, 2013). Concurring to a study conducted in Kenya by Kiplagat et al. (2013) that educated individuals have the potential to not only pick up skills and information, but too to form educated choices on health-related issues, such as the buy of health protections to avoid disastrous medical costs.

2.6 Health Assurance Arrangement and Uptake Cover

2.6.1 Access to NHIF Offices

Access is an important factor when considering service provision even despite the growing ICT capabilities to address a number of issues relating to service delivery. For instance, even after enrolling and remitting payment, subscribers have to visit the offices of the service providers from time to time to address queries that cannot be handled online. However, the key question remains is whether they are sufficient and readily accessible to all their clients.

In Kenya, there are 31 totally computerized NHIF facilities and an additional 82 care areas in hospitals and community centers where policyholders can pay charges, update participation information, and get other client benefit services (NHIF, 2012). The NHIF has been chastised for giving the lion's share of its services through private offices, suggesting that the larger part of its benefactors, salaried workers, lean toward to look for services from private suppliers instead of open institutions (Barasa et al., 2017).

According to the Social Health Protections Plan Report, the components to extend get to distribution centers for others within the informal segment include compilation by different organizations near to the inhabitants, such as agreeable societies, welfare organizations, trade affiliations, and churches, as they can more viably collect contributions. These businesses have been contracted and identified to supply these administrations, whereas others have been allowed to issue or stamp social health protections cards. Adequate mechanisms were meant to be put in place to ensure that the contributions collected by these organizations are transferred regularly to the NHIF (Deloitte, 2011).

According to the WHO (2010), the Kenyan community is getting to be more mindful of the NHIF, as prove by a later survey, but the trouble is the preposterously high cost of people traveling to NHIF workplaces for enrolment. Kazungu and Barasa (2017) found that health protections supplier workplaces were concentrated in metropolitan locales, making it troublesome for people living in rural regions to enlist in health protections plans. In contrast, a research by Lu et al. (2010) within the United States uncovered no critical contrasts in health protections status between people living in urban and rural Kentucky.

2.6.2 NHIF Accredited Hospitals

The medical structure of the NHIF is partitioned into three categories. NHIF clients have broad scope in “Contract A” institutions, which are overwhelmingly state facilities, with no

total limitation on the sum of benefits given. The National Hospital Insurance Fund has contracts with over 600 wellbeing offices in Kenya's eight territories, which are worked by both the public and private sectors. Almost 150 of these clinics are run by the state, whereas the others are run by private and mission groups. Butsubsequently reserved wellbeing benefit suppliers account for a huge section of the medical space in these states and regularly fill setbacks in amenities for low communities (Suchman, 2018).SHI's extension of entry to these experts has the guarantee to advantage LMICs get advance to accomplishing UHC.

According to the 2005 Family Wellbeing Cost and Utilization Study, health-care utilize rates for those with protections rose from 77.2 percent of sick people looking for healthcare in 1990 to 77.2 percent in 2003, whereas the national utilization rate rose to 1.92 sessions per individual annually. Besides, out-of-pocket prosperity utilization has diminished from generally 51% of financing in 2001 to 36% in 2008. The anticipated value of outpatient visit(s) for each individual is Kshs 328. Besides, metropolitan dwellers' normal out-of-pocket (OOP) spending (Kshs 699) was uniquely bigger than that of rural poor (Kshs 236). Larger part inpatients selected physical payments, which summed for 67 percent of all endorsements. On normal, per-capita out-of-pocket investing on confirmation was Kshs 245 per year (Ministry of Medical Services [MOMS], 2007; Onwujekwe et al., 2011).

Getting the desired budgetary capacity to attain decent medical necessities besides that rising masses Whereas Kenya looks for to achieve all of the millennium policy activities relating to wellness, all things considered still could be a bounty of effort to be performed and an enormous hurdle to overcome across the state. Kenya has set up a different restorative fund framework that comprises endowments from the authorities, commercial workplace plans, non-governmental organizations (NGOs), society programs, and individual and family out-of-pocket investing. Be that as it may, the exorbitant OOP and excessive dependence on

contributors are two huge stresses. As per the National Health Accounts (NHA) for the year, householders bolstered 29.1% in general wellbeing costs, charities 18.2%, the authority's 39%, corporate wellbeing protections frameworks 5.4 percent, and the National Health Insurance Finance (NHIF) as it were 3.7 percent.

The Kenyan government has been essentially attempting to return to investment strategies in order to diminish riches crevice in section to the impeded categories of community with the objective of satisfying all-inclusive healthcare and adjusting to Article 43 of the governing body, which states that each Kenyan has an authority to unwavering quality and budget - inviting Medicare. One of the suggested choices is to rename the National Health Insurance Fund (NHIF) to the National Social Insurance Finance (NSHIF) and utilize it as a conduit for growing enrollment citizens. The proposal in sessional paper no. 7 on universal wellbeing scope from 2004 was to move away from the current OOP and taxpayer support and instep utilize paid ahead of time programs (protections). The administration was assumed to pay deposits for the impoverished while at the same time reorganizing the Fund's authority. The objective of disposing of disparities in healthcare scope is prioritized in Vision 2030's social procedure, with one of the major ventures beneath the social column being the creation of a National Wellbeing Protections Scheme to improve value in Kenya's wellbeing care financing.

In Kenya, more than four out of every ten individuals (46.6 percent) live in desperation (Kiplagat et al., 2013). Agreeing to figures from the national health statistics, more than a third of the destitute who were sick did not look for treatment. Besides, as per to the 2005/06 national wellbeing records, families contributed 36 percent of cash to the wellbeing segment, with out-of-pocket spending accounting for more than 29 percent of this.These perceptions highlight concerns with respect to decency and financial arrangement to wellbeing care

among Kenyans, outstandingly the underprivileged, who are greatly helpless to economical upheavals caused by destroying out-of-pocket health investing. According to existing research, the destitute are more likely to end up sick, are less likely to look for preventative health and restorative treatment, and so have more regrettable casualty rates. Based on later discoveries, one of the factors contributing to these challenges is excessive out-of-pocket health-care costs (Mwenge, 2010).

2.6.3 Access to Payment Strategy

Following these developments, the NHIF introduced daily premiums in May 2018 targeting workforce in the informal domain. The ultimate goal of the initiative was to encourage low income earners who earn their income daily to conveniently subscribe to health-care insurer plan. The overall goal of the daily payment strategy might guarantee disparity, efficiency, astuteness, and openness in monetary mobilization, designation, and utilization to realize this goal. This will require endeavors to set up a long legislative, institutional, and open commitment to accomplishing all-inclusive wellbeing scope employing a more different inner fund technique. Subscribers of the National Hospital Insurance Finance (NHIF) can utilize their insurance at any of the NHIF-affiliated establishments, whatever environmental zone. In-patient healthcare repayment terms have been agreed between the National Hospital Insurance Fund (NHIF) and private insurers. The sum of cash fluctuates depending on the degree of specialist, the affliction, and the sort of benefit required. Specific occurrence or fee-for-service source payouts are commonly utilized to reimburse "Contract A" and "Contract B" services. A per individual per night incentive component is utilized to reimburse "Contract C" suppliers. Institutions present demands expeditiously to the National Hospital Insurance Finance (NHIF), which pays hospitals for services and repays clients. The lion's share of claims is repaid inside 14 days of receipt. This is often a computerized handle that's intended to be straightforward to the providers.

2.7 Uptake of Daily Payment Strategy

Adopting universal health coverage guarantees equitable affordable and appropriate health care quality services to all. Health insurance provides a medium through which out of pocket expenditure can be reduced. Additionally, least and average economic performing states are striving to accelerate uptake of wellbeing security of health insurance among its citizen with a view to provide financial protection from out of pocket expenditure (Spaan et al., 2012). However, achieving universal health coverage in most of world countries remains a mirage (Spaan et al., 2012). Africa bares a significant proportion of countries without universal health coverage to its citizens. Despite the availability of different forms of health-care premium, an insignificant a ratio of individuals in Africa own health insurance (Onwujekwe, 2009; Kimani et al., 2012). Weak tax collection mechanisms in most African countries have translated to inadequate allocation to health sector. This situation is further exacerbated by presence of large informal sectors whose regulation remains a headache to policy makers (Kimani et al., 2014).

2.7.1Enrolment in NHIF

Autonomous operators make up a major percentage of the showcase in Kenya, a society with a small and reasonable wealthleveraging a social wellbeing insurance plan that has as it were steadily emerged reasonable to the common public. They outnumber faith-based and NGO-backed players in general. Customers in Kenya can get health protections by private insurance companies and, to a lesser degree, well-being security granted by the group organizations, in addition to the NHIF.The National Health Insurance Finance (NHIF) is in charge of enrolling and authorizing all qualified endorsers from both the official and informal segments. Hospitalization confirmations uses are paid as portion of the healthcare plan, with the rate of spending repaid generally dependent by the brand of medical office. In 2010, the

NHIF program enrolled at around 2 million dynamic contributors and almost 8 million dependents across the country, with the larger part (approximately 74 percent) living in urban regions (NHIF, 2012).

Kimani et al. (2012) conducted a cross-sectional audit of drivers of inclusion in a state healthcare scheme among tenants of metropolitan settlements in Nairobi, Kenya, and found a significant connect between work within the formal segment and NHIF enrollment. Only 3% of respondents within the informal division were enrolled within the NHIF program, whereas about half of those within the official segment (48%) were. The NHIF program was specified by a significant lion's share (81%) of those who took part within the NSSF.The NHIF plan was subscribed by a much greater rate of candidate's clients of savings and credit cooperative organizations (SACCOs) and community-based ventures, 90 percent and 21 percent, deferentially. In terms of income, the poor (as it were 2% of the populace) were enrolled within the NHIF at a considerably lower rate (as it were 2%) than the non-poor (24%) group. Men (16%), those who were as of now in a union (16%), and those with a secondary school education or higher (16%) were all more likely to take an interest within the NHIF program (20 percent).

A study conducted by Ndung'u (2015) on variables affecting the execution of National Wellbeing Protections within the small ventures in Ithanga Division, Murang'a District, Kenya, demonstrated that the overwhelming of family units (66.57 percent) had not taken part with NHIF, whereas 33.43 percent did. The limited uptake of NHIF within the informal segment is demonstrated by these perceptions. In addition, 18.90 percent of girls and 14.53 percent of males were engaged within the study. On the other hand, 124(36.05 percent) of those not enlisted were males and 30.52 percent were females. Further study of the information uncovers that females make up nearly half of the entire enrollment was higher at 56.52% compared to 43.48% for males. Ochieng (2015), indeed in spite of the fact that the

NHIF venture is looking for to select work force from the informal division, Kenya's high joblessness figures constitute a genuine threat to this effort. According to a more modern study, over 36% of Kenya's populace lives in destitution, and less than 20% of the populace is secured by health protections, in spite of the reality that over 88 percent of those secured are enlisted within the SHI framework (Barasa et al., 2017)

2.7.2 Utilizations of Healthcare in Accredited Facilities

Regarding utilization of the health insurance cover, according to the 2005 Family Wellbeing Consumption and Use Appraisal, medical utilization designs for those with cover climbed from 1990 to 2003 to 77.2 percent of sick people getting treatment, whereas the across the country selection rate climbed to 1.92 check - ups per person per year. Besides, out-of-pocket health-care spending has plummeted by nearly 51% of fund in 2001 to 36% in 2008.Ndung'u (2015) inspected data on hospitalized patients in Ithanga Division, Murang'a District, Kenya, over a five-year term (2010–2015) and found that 40.4 percent of families had people taken to hospitals. As it were 37.4 percent utilized the NHIF card to pay their hospital expenses, according to the report, whereas 1.44 percent had other sorts of wellbeing protections. The implication of this finding was that the majority (61.2%) were relying on other out-of-pocket methods including sale of family assets, family savings, fundraisings and borrowing.

Overreliance on out-of-pocket payments may appear sustainable in the short term, but for poor households with low incomes, sale of household assets may lead to families falling further into a cycle of poverty. Such families may also tend to postpone urgent medical attention, hence the need for an affordable health insurance. The findings were generally in agreement with the observation of Buigut et al. (2015) that households' out-of-pocket healthcare expenditure in Kenya was 44.8% and the households were not protected from health shocks. However, subscribers of the NHIF can use their privileges at all of those

NHIF-affiliated establishments, notwithstanding of where they are placed.The rate of installment ranges depending on the greatness of specialist, the determination, and the sort of benefit required. Situation or fee-for-service operator pays are commonly utilized to reimburse "Contract A" and "Contract B"providers are Commitments to suppliers are ordinarily made on a case-by-case premise or on a fee-for-service premise. A per diem payout instrument is utilized to repay "Contract C" suppliers. Institutions make solicitations solely to the NHIF which pays facilities for services and reimburses subscribers. The larger part of claims is refunded inside 14 days of receipt (Mbogori et al., 2015). Usually programmed process that is aiming to be clear to the providers.

2.8 Theoretical Framework

2.8.1 The Weberian Model of Social Stratification

This study will adopt theWeberian Show of Social Stratification considers three components of social course division: economical course, social standing, and political control. Max Weber formulated this three-class structure, contending that success, status, and dominance are all intertwined, with each having an impact and result on the others. The financial angle of the Weberian Demonstrate of Stratification is communicated by each one's riches and products and services, whereas the social measurement is spoken to by one's distinction and honor. The impact that one individual uses over others is alluded to as political control.

The financial and social components were examined in addition to create the study's claims. Societal participants are partitioned into financial categories dependent on their work and income, riches and social standing, or obtained control (Frank et al., 2010). Contrasts between unmistakable groups of people have been shaped by division. This shows that, in terms of social judgment, individuals in a stratified society have been isolated into unequal categories.

Individuals with lower earnings are more likely to buy things and services that are harmful to their wellbeing as a result of lopsided income dispersion. When this perspective is taken underconsideration, it indicates that lower-income laborers within the informal division are less likely to get medical scope and will instead look for out alternative health care choices. As a result, informal economic individuals' enrolment would drop significantly. In specific, the Weberian Demonstrate of Social Stratification's financial measurement was utilized to clarify the moment objective, which included mindfulness and information of the benefits of having health insurance coverage. The capacity to get schooling and information from media such as TV news, radios, the web, and daily papers is intensely impacted by a person's money related situation.

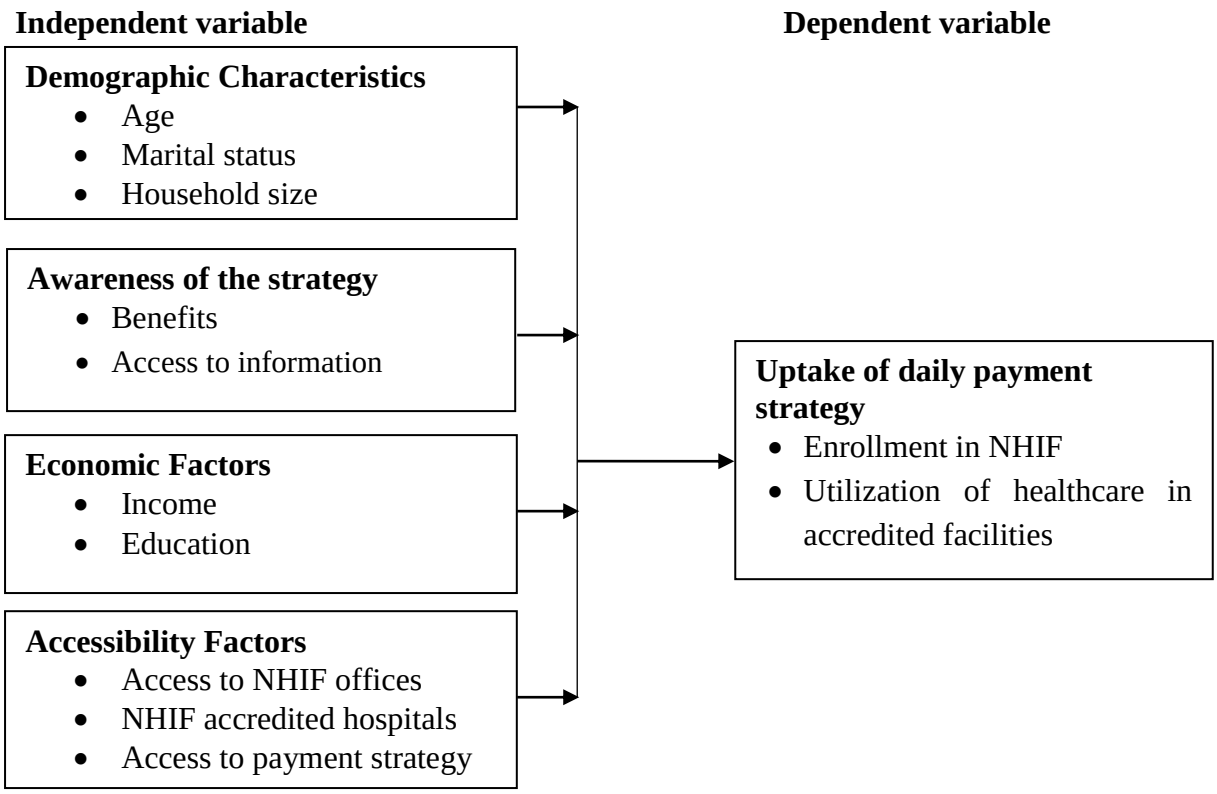
Exposure to information, which impacts the buying of medical coverage, can be impacted by a high degree of literacy. Weber goes on to say that when division is alluded to as social status, it refers to the good and unfavorable privileges related with social distinction based on way of life, formal education, and the distinction of birth or employment (John et al., 2017). To clarify the moment purpose, this study utilized social standing as a premise for the formal educational process. Consumers with more grounded ranges of literacy are more cognizant of healthcare coverage and get it its merits than those with lower ranges of schooling or nothing at all.

2.9 Conceptual Framework

In this study, an intellectual underpinning helped in characterizing the different factors being inspected, their connections, and how they relate to the research question and issue explanation.

Figure 2.1

Conceptual Framework



In this study, the independent variables are determinants which are measured through demographic characteristics (household size, marital status, age and family size)

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

This area clarifies the strategies that will be taken after to carry out the research. It covers the study's research plan, demographic, inspecting procedure and test measure, information collection instruments, information collection protocols, and information processing, as well as findings presentation and ethical contemplations.

3.2 Research Design

The examination was accordingly employing a cross-sectional expressive research plan. In any case according Rao et al. (2011), expressive research is utilized to accumulate data on the phenomenon's current state. It moreover encourages the utilize of various analytical approaches to research the interplay between autonomous and completely reliant variables The clear inquire about plan was chosen because of the information it gives for the portrayal, recording, investigation, and detailing of existing circumstances (Ondigi & Mugenda, 2011).

The appropriate survey method was decided to be a clear research strategy since it may be a way better strategy for tackling inquiring about issues in which the investigator has no influence over the circumstances. The method that was embraced was a computable one. The numerical approach entailed gathering data and putting it through an intensive investigation in a structured and disciplined presentation.

The current study utilized a blended strategy paradigm, which, according to Fetters et al. (2013)is based on a more noteworthy information of research challenges than either methodology alone. Since the two strategies were utilized to broaden the scope, intensity, and degree of investigation, resulting in mixed conclusions, this study utilized a blended strategy approach combining both quantitative and qualitative methodologies.

3.3 Location of Study

The request was performed out at the district of Eldoret. Eldoret is the fifth busiest city in Kenya, and the governmental hub of the Uasin Gishu Township. It is found within the Rift Valley zone. It encompasses a total area of 3,345.2 square kilometers. Eldoret town contains a total populace of 475,716 individuals, according to the 2019 Populace and Housing Census. Working-age individuals, those between the ages of 18 and 60, accounted for 47.46% of the overall. Industry and services are the most financial exercises within the town, which is found within the middle of a wide agrarian zone. The town has an extensive suburban area with over 32 estates where majority of its residents live. However, the town and its estates are not served by a well-developed public transport system to serve its large population. This, therefore, creates the right conditions for a thriving Bodaboda business.

3.4 Target Population

According to the department of Traffic and Road Safety, Uasin Gishu County 2018, there are about 5000 Bodaboda operators in Eldoret town and who are registered in 26 Bodaboda Saccos. The target population in the study were the Sacco officials and Bodaboda operators. The target population was chosen due to occupational risk associated with group. Only registered Bodaboda operators with valid registration stickers from the County council participated in the study. The study excluded Bodaboda operators who did not consent to participate in the survey as well as those who are not registered as Bodaboda operators.

3.5 Sampling Techniques and Sample Size

3.5.1 Sampling Techniques

Owing to the busy and highly mobile nature of the target population, the study adopted convenience sampling for the Bodaboda riders while purposive sampling was used for the Sacco officials and for forming the focus group discussions. Convenience examining is a research procedure in which research scientist found market study data from a populace of

participants who are effortlessly accessible. It is the foremost regularly used test strategy since it is extremely fast, simple, and cost-effective. Individuals who are effortlessly reachable are regularly included within the survey (John et al., 2017). Using convenience sampling, the researcher approached groups of Bodaboda operators parked in their stations (including specially constructed sheds) across different areas of Eldoret town and struck a rapport with them after which he administered the questionnaires to them and required them to fill in less than 10 minutes so as not to inconvenience their work. From the Bodaboda operators, he was also able to identify their Sacco officials some of who were riders (and who were the key informants) and purposively select them for the study. According to Rao et al. (2011), an analyst uses a purposive testing technique when they select a representative dependent on their understanding of the issue and demographic. Purposive choice was moreover utilized to choose the people members of the focus group discussions from the Bodaboda riders and their officials.

3.5.2 Sample Size Determination

The overview utilized Nassiuma's (2000) algorithm to compute the imperative reference amount from the objective community of 5000 individuals, per indication below:

$$n = \frac{Nc^2}{c^2 + (N-1)e^2}$$

Where n is the test estimate, N is the populace measure, c is the coefficient of variety (50%) and e is the error gap (3%). The investigators can utilize this algorithm to diminish mistake and progress the consistency of their results (Nassiuma, 2000). Getting to substitute the following:

$$n = \frac{5000 * (0.5)^2}{(0.5)^2 + (5000-1) * (0.03)^2} = 263.208 \approx 263$$

As a result of the aforementioned equation, a test estimate of 263 people was determined.

3.6 Instrumentation

The study used both the questionnaire (Appendix II) to collect data. The questionnaires were structured as per research objectives. The questionnaire was semi-structured and was developed along the variables of the study to gain more in-depth understanding on uptake of health insurance among Bodaboda operators. Moreover, questionnaires are suitable for studies that are constrained by time. Kumar (2018) opined that questionnaires are good for primary data collection, thus fitted the current study. The reasons of choosing a questionnaire were because it was going to be affordable and easy to administer, data that was obtained by use of a questionnaire was easily arranged and analyzed. Also the researcher did not need to be physically present when the respondents were filling the questionnaires hence provided a more conducive atmosphere to the respondents to better answer to the questions. This also assumedly enhanced better extraction of information from respondents.

3.6.1 Pre-test

Kumar (2018) stated that pilot testing refers to putting of the research questions into test to a different study population but with similar characteristics as the study population to be studied. A pretest study was conducted to test the validity of the questionnaires. This enabled the researcher to test whether questions being posed gave the required responses and gauge on the choice of design of questions asked, finding out whether they are logical, clear and easy to understand. This allowed one to check if the variables can easily be processed and analyzed. Pretest of the instruments was done to Bodaboda operators in Kimumu who did not participate in the study. Kimumu is one of the estates in Eldoret. After the pretest, the instruments were subjected to validity and reliability tests.

3.6.2 Validity

Validity is the accuracy and convenience of inferences drawn from study discoveries (Salehi & Golafshani, 2010). The study depended on substance validity, which includes extrapolating

test comes about to a wide set of things that are comparable to those on the exam. The representativeness of the test populace is an issue for substance legitimacy. The data and abilities represented by the test items ought to, according to Almanasreh et al. (2019) be characteristic of the more prominent scope of data and capabilities. The university analysts were inquired for their master input on the proportionality and pertinence of the questions, as well as recommendations for changes to the system of the research apparatus.

3.6.3 Reliability

The consistency of the results from the gadget checks is evaluated by unwavering quality (Mohajan, 2017). It's a metric for how well a study device produces regular results or information after sequential sessions. The examiner checked the study tools' unwavering quality utilizing the inner consistency approach. The Cronbach's alpha coefficient for all components of the inquiry was calculated utilizing the conclusions of the preparatory test. A value of 0.7 and above is usually taken as acceptable for most studies in social sciences and the instrument can be used for the study after some minor adjustments for language, clarity and layout (Taber, 2018). The Cronbach Coefficient instrument constancy was found to be 0.895, which was pronounced worthy for the study. As a result, any imperfections or issues with clarity found within the questions at this step were fittingly addressed, corrected, or disposed of as required.

3.7 Methods of Data Analysis

The data accumulated was at first altered and labeled to dispose of ambiguities, unimportant data, and exclusions. After that, the information was imported into excel spreadsheets and analyzed with the Statistical Package for Social Science (SPSS) 25.0 program. Utilizing SPSS factual computer program, the information was changed to numerical images reflecting properties of measured factors and assessed utilizing graphic measurements (Ott & Longnecker, 2015). The quantitative information was counted and analyzed utilizing

recurrence charts and percentages, and the results were shown in recurrence tables and bar charts.

A regression assessment was performed between the factors in order to decide the values of relationship between them (Kleinbaum et al., 2013). In this respect, bivariate correlation was undertaken which enabled the computation of the correlation coefficient, R, and the Odds Ratio (OR). The bivariate regressions were supposed to be able to withstand the model;

$Y = \beta_0+\beta_i X_i+\varepsilon$

Whereby;

Y= Uptake of daily health insurance payment plan

i= are the independent variables; Demographic factors, Awareness, Socio-Economic Factors and accessibility

β_0 = the intercept

β_i = Models coefficients

ε = Error term

Tables were utilized for the reasons behind information revealing due to the ease of them utilize as well as adaptability in information uncovering.

3.8 Logistical and Ethical considerations

Moral standards address scholastically pertinent address and has an effect on the researcher's engagement as well as those who take part within the study. It too must do with the processes that will be utilized to shield/protect people who are taking portion within the research if suitable (Ponterotto, 2010). TheMinistry of Higher Education Science and Technology and National Commission for Science, Technologyand Innovation (Appendix IV), KEMU SERC (Appendix V), and County Director of Education and faculty in charge were reached the concerned who takes part within the study pursuing license to execute the inquiry (Appendix VI). The analyst altogether clarified the nature of the study's discoveries and repercussions to

the respondents. The members having been requested to commitment statement (Appendix I), and it was focused that cooperation was totally deliberate. The respondents were guaranteed of namelessness and secrecy, as well as the truth that their individual data would not be utilized in any way amid the research.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

In this chapter, the results arising from the data analysis are presented, interpreted and discussed. The results are presented as per the objectives of the study and discussed. Each objective is presented in terms of descriptive and inferential statistics.

4.1.1 Response Rate

The study sought to determine the response rate and the findings were as shown in table 4.1.

Table 4.1

Response Rate

	Frequency	**Percentage** (%)
Total Issued	263	100
Returned	239	91
Not returned	24	9

Table 4.1 shows that 239 of the 263 application form apportioned to interviewees were submitted completely by the interviewees. This translated to a 91 percent response recurrence. The reaction rate was more often than not satisfactory, as expressed by Babbie (2020), who expressed that a reaction rate of 50% is suitable for examination and recording, a rate of 60% is good, and a rate of 70% or more is extraordinary. The reaction rate accomplished from this overview was excellent and appropriately representational of the specified demographics in this circumstance.

4.1.2 Reliability Results

Cronbach's Alpha, basically surveys inbuilt consistency by deciding in case multiple components on a spectrum demonstrate the comparable construct, was at that point utilized to conduct a unwavering quality examination. The Alpha value criterion was set at 0.7 by

Frankfort-Nachmias et al. (2015), which served as the study's pattern. As appeared in Table 4.2, Cronbach Alpha was calculated for each target.

Table 4.2

Reliability Results

Variable	Cronbach's Alpha	Number of Items
Demographic characteristics	0.761	5
Awareness	0.898	11
Socio-economic factors	0.784	4
Accessibility factors	0.777	3
Uptake of social health insurance daily payment strategy	0.717	4
Overall	0.7874	27

Values in Table 4.2 suggest that the total of 27 items in the questionnaire had an overall instrument reliability of 0.7874 which was higher than the recommended threshold of 0.7 for instrument reliability. Imperatively, all the variables had high levels of reliability exceeding the Cronbach 0.70 value; demographic characteristics $\alpha = 0.761$, awareness $\alpha = 0.898$, socio-economic factors $\alpha = 0.784$, accessibility factors $\alpha = 0.777$ and uptake of social health insurance daily payment strategy $\alpha = 0.784$, are sufficient confirmation of data reliability for the four independent variables. This clarifies that all five aspects validated tried and true, as was the study instrumented, which no alterations were justified.

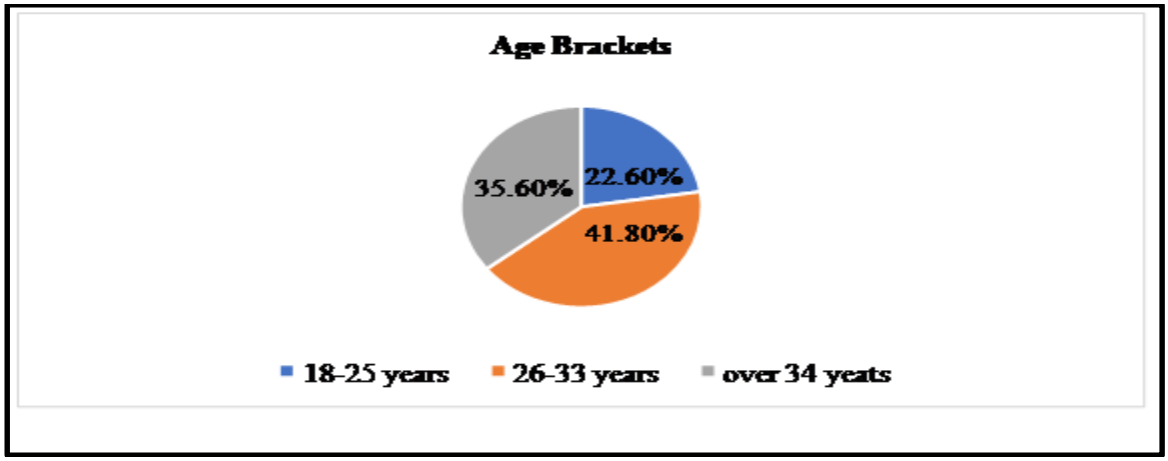
4.2 Demographics Factors

4.2.1 Distribution of the Respondents by Age

The participants were prompted to indicate their age, and the results are depicted underneath. in Figure 4.1.

Figure 4.1

Respondents' Age Brackets



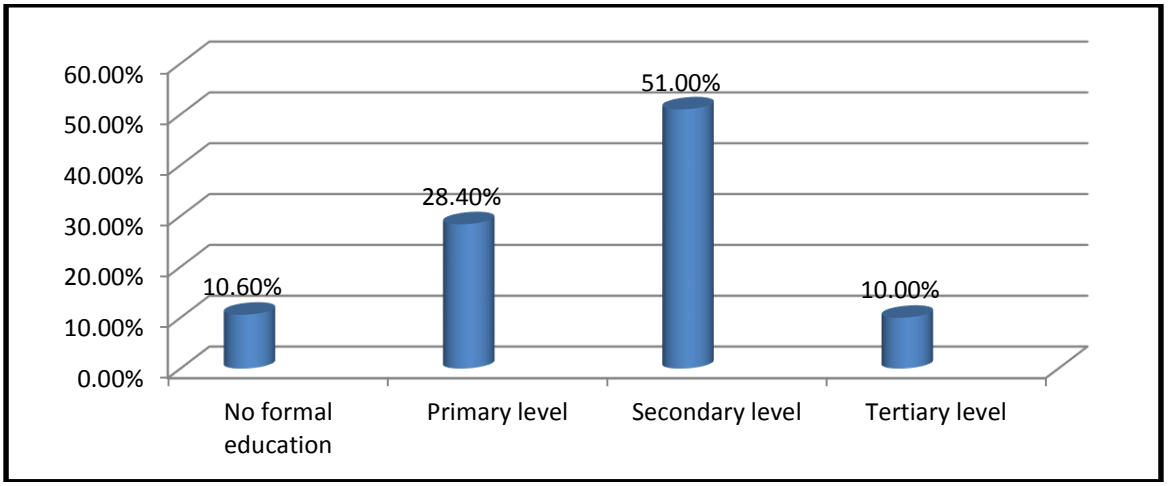
From Figure 4.1, it was clear that majority 100 (41.8%) of the respondents fall in the age brackets of between 26 and 33 years followed by 85(35.6%) in the age bracket of between 18 and 25 years and the remaining 54 (22.6%) are in34 years and above the age brackets. This implied that the Bodaboda sector in Eldoret town was largely comprised of young people in their late twenties and early thirties.

4.2.2 Level of Education of Respondents

In addition, the study sought to ascertain the level of education of the respondents. Education level is a determinant of unemployment rate in the economy based on job opportunities; which is a factor of level of income. The results are presented in Figure 4.2.

Figure 4.2

Respondents' Top Educational Qualifications



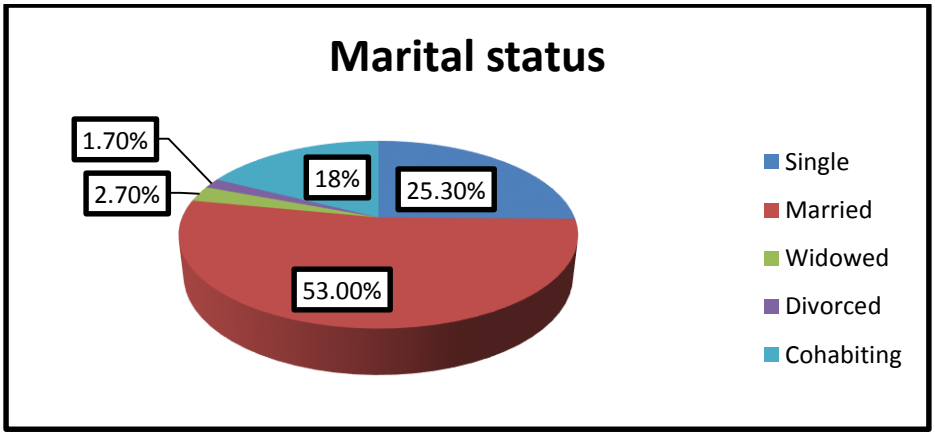
The vast large number of those who voted had acquired schooling particularly at the upper point as represented by 51%, as 28.4% had only primary school education, 10.6% had no formal education while only 10% who had acquired education up to tertiary level. This implies that majority of Bodaboda operators in Uasin Gishu County had achieved education level of up to secondary school.

4.1.3Respondents' Marital Status

Polled people were asked to indicate their marital status. Figure 4.3 shows the findings of this item.

Figure 4.3

Marital Status of the Respondents



The percent of the individuals who responded had spouses as represented by 53%, as 25.3% were single, 17.3% were cohabiting, 2.7% were widowed while 1.7% were divorced. This implies that majority of the Bodaboda operators in Uasin Gishu County were in a family set up and the cases of divorce were minimal. These results are comparable to those of Muiya and Kamau (2013), who looked at the characteristics that contribute to Kenya's low insurance infiltration. According to the study, statistic variables such as marital status are components that can depict Kenya's display low protections appropriation since they have a solid negative effect on insurance uptake. The married respondents are more likely to be benefiting from combined incomes from the spouses, hence their ability to afford the premiums. They are also more likely to have children who need the health insurance cover to enable them access health care in accredited health facilities. Mulupi et al. (2013) also reported the positive influence of marital status on health insurance enrollment in South Africa.

4.2.4 Residents with Minors below the Age of Majority

The respondents were requested to indicate the number of children under 18 years old in household. The feedback is as shown in Figure 4.4

Figure 4.4

Residents with minors below the age of majority

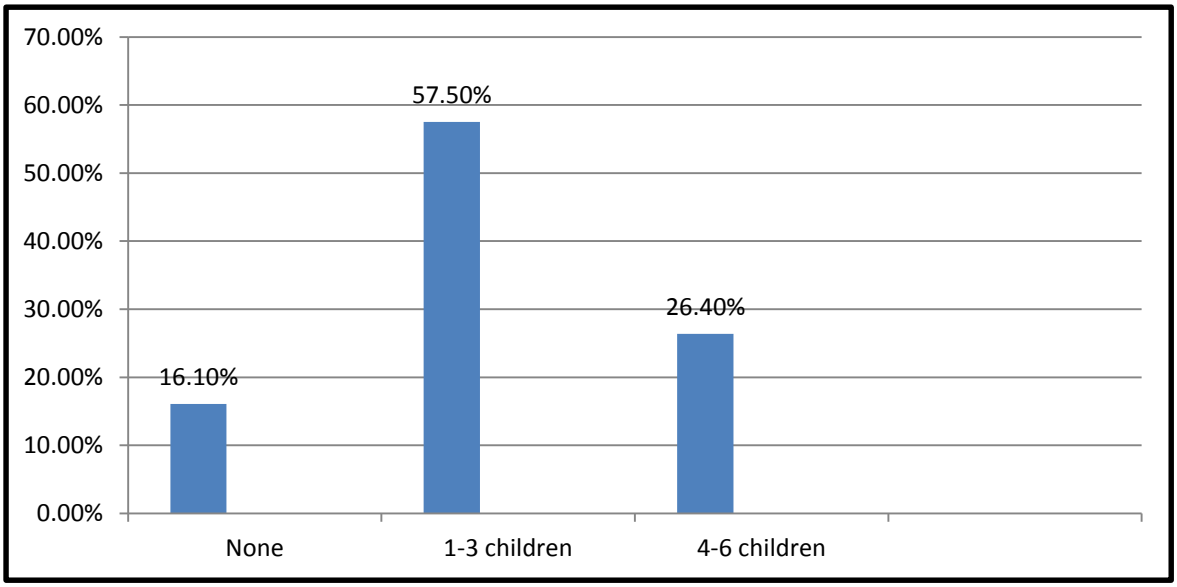


Figure 4.4 Shows that 57.5% had between 1 and 3 children under age of 18 years, 26.4% had between4-6 children and 16.1% did not have any child. This implies that the households would be expected to require some form of health insurance to cater for the health needs of young children. The findings agree with those of Thornton et al. (2010) who observed a positive relationship between the sum of children in a residence and the likelihood of enrolling in well-being schemes.

4.2.5 Uptake of Social Health Insurance across Demographic Patterns

The study also sought to establish the uptake of social health insurance across the demographic patterns and to establish whether the uptake was significant. The results are given in Table 4.3.

Table 4.3

Uptake of social health insurance across demographic patterns

		With Health Insurance		Without Health Insurance	
		F	%	F	%
Age Brackets	18-25 years	21	8.9	64	26.7
	26-33 years	26	11	74	30.8
	Over 34 years	25	10.3	29	12.3
Educational Level	No formal education	4	1.7	21	8.9
	Primary level	17	7.2	51	21.2
	Secondary level	40	16.7	82	34.3
	Tertiary level	11	4.6	13	5.4
Marital Status	Single	18	7.5	43	18
	Married	37	15.5	89	36.9
	Widowed	2	1	4	1.7
	Divorced	2	1	2	1
	Cohabiting	13	5.2	29	12
Number of Children	None	11	4.6	34	14.4
	1 - 3.	41	17.2	89	36.9
	4 - 6.	20	8.4	44	18.5
	Overall Total	**72**	**30.2**	**167**	**69.8**

Table 4.3 shows that majority 167(69.8%) of the respondents did not have health insurance while 72 (30.2%) had subscribed to social health insurance. Across the age brackets, most of those who had subscribed to health insurance 26 (11.0%) were aged between 26 and 33 years of age. The findings also indicate there was variation in uptake of social health insurance and concur with Mhere (2013) whose study on non-participation in health Insurance schemes in Gweru urban area in Midlandsprovince, Zimbabwe found that enrollment in health insurance increased with age. The findings in this study also concur with those of Kumi-Kyereme and Amo-Adjei (2013) who found that likelihood of being insured increased with the age of respondents.

The findings on education levels and enrolment into daily payment strategy for NHIF cover indicate that 16.7% of the respondents who had enrolled into the daily payment strategy had secondary level of education, 7.2% had primary school level of education and 4.6% were holders of tertiary level of education and 1.7% did not have formal education. As for those

who had not enrolled into the daily payment strategy, 34.3% had schooled up to secondary school level, 21.2% had schooled to primary level, 8.9% did not have formal education, and 5.2% were holders of tertiary level of education. The findings agree with Mhere (2013) in Zimbabwe, Kumi-Kyereme and Amo-Adjei (2013) in Ghana as well as Mulupi et al. (2013) in South Africa who concluded that the uptake of social health insurance increased with education levels. The results of this study further disagree with those of Oyekale (2012) who found that older farmers in Osun state in Nigeria, who lacked education and financial backing, also had lower probability of enrolling in health schemes.

Marital status formed part of demographic characteristics assessed. The findings in Table 4.3 indicated that of those who had enrolled on daily payment strategy for NHIF cover, 15.5% were married, followed by 7.5% who were single, then 5.2% were cohabiting, 1% were widowed and 1% were divorced or separated. The findings support those of Bourne and Kerr-Campbell (2010) in Jamaica who found that enrollment in health insurance was influenced by social standing, income, marital status, retirement benefits, living conditions and the number of males in the household. Married respondents were found to be more likely to purchase health insurance. The findings also support those of Mulupi et al. (2013) who similarly concluded that ownership of health insurance was high among married couples in South Africa.

A cross tabulation between extent of minors beneath the threshold of the age of majority in the residence and enrolment into daily payment strategy was carried out. The results suggest that out of the 30.2% of respondents who have enrolled into daily payment NHIF cover, that those who had 1-3 children had the highest uptake (17.2%), followed by 8.4% who had 4-6 children and 4.6% who had no children. These findings agree with Fang (2012) detailed that residents with lesser family populace extents and more noteworthy incomes were more anticipated to secure bigger assurance in both state and corporate well-being security

activities in Taiwan. The findings also agree with Thornton et al. (2010) in Nicaragua established that both the Appropriation of wellbeing assurance is heightening and considerably coupled with the chances of upcoming wellbeing incidents (such as the extent of descendant within the staying). Similarly, the findings disagree with by Saksena et al. (2011) in Rwanda who established that considerable inhabitants with as much slightest five human beings were most well-suited than peers to enlist in wellbeing endorsing assurance arrangements.

4.3 Awareness of Daily Subscription Scheme as well as the Utilize of Communal Wellness Security

The survey's auxiliary focus was to see how literacy moved forward the usage of communal wellness security in our discourse daily payment strategy among Bodaboda operators. This objective was measured in terms of; registration procedures, payment mechanism, benefits and access to information. The experiment connected a 5-point Likert rating to measure reactions on this subject, with 1 signifying noteworthy difference and 5 communicating extraordinary support. The better the median number were, the more concurrence there was on the proposition. A score around 2.5 would indicate uncertainty while scores significantly below 3.45 would suggest disagreement regarding the statement posed. The findings are presented in Table 4.4.

Table 4.4

Awareness of Daily Subscription Scheme on Uptake of Health Insurance

Statement	Disagree (%)	Agree (%)	Mean	Std. Dev
I am aware of NHIF's daily payment strategy for healthcare financing	60.3	39.7	2.79	0.906
I am aware that the daily payment is paid to NHIF scheme	63.3	36.7	3.04	0.969
I am aware The amount is paid through a mobile money	34.3	65.7	3.73	0.867
I am aware of other modes of payment of NHIF apart from going to their offices	42.1	57.9	3.99	0.712
I am aware Late payment of monthly contributions attracts penalty	10.3	89.7	4.24	0.512
I am aware all Kenyans over 18 years can join NHIF scheme	38	62	3.91	0.676
I am aware the one can register at any NHIF offices	0	100	4.56	0.44
I am aware NHIF covers admissions and Outpatient services on registered hospitals	40.2	59.8	3.52	0.942
I am aware up to 6 family members can benefit from one principal member	43	57	3.63	0.874

The findings in Table 4.4 indicate that majority the respondents (60.3%) were not aware of daily payment strategy uptake on health care financing. The findings also indicate that majority of the respondents (63.3%) were not aware that the daily payment was paid to NHIF scheme, however, most of them seemed to be familiar with paying their subscription fees to NHIF using mobile money (65.7%). Further, the findings suggest that most of the respondents (57.9%) were aware that there were other modes of payment of NHIF apart from going to their offices. Also, most of the respondents were aware that late payment of monthly contributions attracted penalty (89.7). These findings generally imply that the level of awareness of the NHIF daily payment strategy uptake on health care financing was considerably low among Bodaboda operators.

Regarding the awareness of registration procedures, most of the respondents (62%) of the respondents were aware that all Kenyans over 18 years can join NHIF scheme. All

respondents (100%) were aware that one can register at any NHIF offices. Most were also aware that NHIF covers admissions and outpatient services on registered hospitals (59.8%) and that up to 6 family members can benefit from one principal member (57%). To encourage potential members to register, it is imperative that they be made aware of the insurance contract they are entering into. From the results of the study, it is clear that there are major insurance knowledge gaps that should be filled through mass campaigns to educate the respondents on the role of insurance in health financing.

These findings on low awareness level of health insurance in the informal sector appear to agree with Jangati (2012) who observed that low enrollment in informal sector was influenced by deficient information, and poor understanding of functioning of insurance schemes. Boateng and Awunyo-Vitor (2013) also found that in Ghana, knowledge of basic insurance concepts was lacking, and potential clients were unable to answer questions related to insurance products and premium, with insurance knowledge gaps being more evident among women with low education and among rural dwellers. It is very clear from the study that there is need for simple and clear messages on health insurance, delivered using the most used communication media. Lack of knowledge on health insurance is common in many other parts of the globe. Frank et al. (2014) conducted a study on public understanding of basic health insurance concepts and established that knowledge was particularly low among the currently uninsured. Even among the insured, only 40 per cent were somewhat confident that they understood all the insurance terms that the survey asked them about.

Low levels of knowledge were noted in Indonesia (Setyonaluri & Radjiman, 2016) where only about 38 per cent of the informal workers were aware of the enrolment procedures into a health protection programme. Even members of health protection programmes showed significant knowledge gaps regarding the benefit packages (outpatient services, inpatient care) that they were entitled to. The low enrolment rates mirror the wider global picture more

so in low income countries. Van de Poelet al. (2012) argued that in Philippines the informal sector accounted for more of the uninsured than any other group. In their study on challenges to extending universal health cover, only 33 per cent of eligible persons in the informal sector were covered by 2012 under the Individually Paying Programme (IPP).

4.3.1 Source of Information on Uptake of Daily Payment Strategy

Those who were aware of the strategy were asked to indicate the source of information on daily payment strategy uptake on health care financing. Table 4.5 presents the findings of this item.

Table 4.5

Source of Information on Uptake of Daily Payment Strategy

Source of information	Frequency	Percentage
Radio	30	12.3%
Newspaper	17	7.2%
Family friend	26	11.0%
Others	22	9.2%
Not Applicable	144	60.3%

Agreeing to the discoveries, 12.3% of those polled were cognizant of the situation of daily payment strategy uptake on healthcare financing through radio, 11% cited they heard it on friends, 9.2% indicated other source like posters and *chamas* and 7.2% read in newspapers. Media contributes to higher percentage of information dissemination that is useful in overcoming information gaps in healthcare service delivery. Mulupi et al. (2013) established that there was very limited understanding of health insurance among community members, particularly related to the concept of risk pooling. The media can be instrumental in overcoming these information gaps.

4.4 Socio-Economic Factors

The third objective of the study was to establish the influence socio-economic factors on uptake of social health insurance daily payment strategy among Bodaboda operators. This objective was measured in terms of; income and education. The study used a 5 point Likert scale to rate responses of this variable and it ranged from; 1 = strongly disagree to 5 = strongly agree. The closer the mean score was to 5, the more the agreement concerning the statement. A score around 3.45 would indicate uncertainty while scores significantly below 3.45 would suggest disagreement regarding the statement posed. The findings are presented in Table 4.6.

Table 4.6

Socio-economic factors on uptake of health insurance daily payment strategy

Statement	Disagree (%)	Agree (%)	**Mean**	**Std. Dev**
I have other sources of income apart from my Bodaboda Riding/Business	42.1	57.9	3.83	0.917
I prefer daily payment strategy of NHIF premiums over the monthly payment strategy	28.6	71.4	4.06	0.74
I am a member of a Social Welfare Association	26.4	73.6	3.99	0.612
Average			3.96	0.756

The comes in Table 4.6 uncovers that majority of the respondents (57.9%) were engaged in other source of income generating activities apart from their Bodaboda occupations. Of those who claimed to have other sources of income apart from Bodaboda majority were involved in small scale farming while others were engaged in small scale business. This shows that some Bodaboda operators may be able to get extra cash to enroll into daily payment strategy. Improving income earning opportunities through improved agricultural practices, business co-operatives and merry-go-round groups may be a better and practical way of improving the socio-economic well-being of residents and improve their ability to pay health insurance premiums. The findings also indicate that majority (71.4%) of the respondents would prefer a

daily payment of premium over the monthly payment strategy and 19.2% disagreed. Those who were willing to enroll into daily payment strategy indicated that they can easily get daily cash while those who were unwilling indicated that some days, they can go home without money due to inability to make money daily/cannot be guaranteed motorcycle because they are given by owners daily or they could spend the whole day in the garage repairing the motorcycles.

Other findings show that most of the Bodaboda operators (73.6%) were members of social welfare/*chamas*, that is, cooperative or merry-go-round. This suggests that the Bodaboda operators were active in welfare planning and this would increase their savings prospects. As a way of accumulating additional money that can be used in making contribution to NHIF cover, people get into social welfare. Bendig and Arun (2011) also noted that persons who were participating in micro finance schemes and social welfare groups in communities were more likely to be enrolled in health insurance schemes, demonstrating the crucial role played by social welfare groups in resource mobilization and improving the social-economic conditions of their members and their ability to pay insurance premiums. The influence of formal associations was also noted by Oriakhi and Onemolease (2012) in Nigeria, where those who were members of town unions and associations were three times more likely to be enrolled in community-based insurance schemes. It is also possible that the group provide an opportunity for residents to exchange development-related ideas, including ways of improving health conditions and health financing in the community. These findings tend to agree with those of Sarpong et al. (2010) and Mulupi et al. (2013) who found that enrollment into health insurance schemes is generally higher among persons of higher social economic groups.

In line with these findings, the respondents were asked to indicate their daily income and the results are presented in Table 4.7.

Table 4.7

Respondents' Daily Income

Daily Income (Kshs)	Frequency	Percentage
Below 1,000	168	70.2
1,001 to 2,000	49	20.5
Above 2,000	22	9.3
Total	**239**	**100.0**

Majority of the respondents, 70.2%, indicated that their daily income level is below Kshs 1,000, 20.5% reported that their daily income levels is between Kshs 1,001 and 2,000 while 9.3% of the respondents cited that they earn above Kshs 2,000 on a daily basis. The findings imply that most of the Bodaboda operators were not high income earners; however, most of them had daily access to cash making it possible for them to make daily contributions towards NHIF cover. Higher incomes enable families to meet basic household expenses, including food and clothing and have some extra disposable income for payment of premiums The findings agree with Boateng and Awunyo-Vitor (2013) who found that higher income earners were seven percent more likely to enroll in Ghana's national health insurance fund compared to those with lower incomes.

4.5 Accessibility Factors and Uptake of Social Health Insurance Daily Payment

The fourth objective of the study was to find out the influence of accessibility factors on the uptake of social health insurance daily payment strategy among Bodaboda operators. This objective was measured in terms of; access to NHIF offices, NHIF accredited hospitals and access to payment strategy. The study used a 5 point Likert scale to rate responses of this variable and it ranged from; 1 = strongly disagree to 5 = strongly agree. The closer the mean score was to 5, the more the agreement concerning the statement. A score around 3.45 would

indicate uncertainty while scores significantly below 3.45 would suggest disagreement regarding the statement posed. The findings are presented in Table 4.8.

Table 4.8

Accessibility to NHIF Accredited Hospitals when needing Medical Care

Statement	SD (%)	D (%)	N (%)	A (%)	SA (%)	Mean	Std. Dev
Accessibility to NHIF Accredited Hospitals when needing Medical Care	0	0	0	50	50	4.27	0.589
Accessibility to the NHIF offices	0	0	0	50	50	4.27	0.589
Other Means of Contributing to NHIF other than visit Offices	6.2	10.2	9	63.6	11	3.94	0.634

The results in Table 4.8 regarding the accessibility to NHIF accredited hospitals when respondents need medical care indicate that all of the respondents had access to the accredited hospitals (100%). The findings imply that there was high healthcare facility coverage by NHIF in the area that enabled the subscribers to conveniently access them. According to Deloitte (2011) in the National Social Health Insurance Strategy Report, the mechanisms to increase accessibility to collection points for those in the informal sector to include collection by various organizations that are close to the population which include; cooperative societies, welfare organizations, trade associations and churches as they may collect the contributions more effectively than NHIF branch offices.

The findings on whether the Bodaboda operators were aware of the location of NHIF offices indicate that they all were aware of NHIF offices (100%). This implies that the respondents could prefer to make NHIF contributions directly to NHIF offices than using other means. It also implies that the Bodaboda operators could conveniently access the NHIF officers to address issues concerning the status of their subscription. In relation to whether the Bodaboda operators had other means they know and use to make contributing to NHIF other than visiting the offices, majority (74.6%) indicated that they knew other means of contributing to

NHIF other visiting offices. Those who know or use other means to make their NHIF payments use mobile money transfer platform (Mpesa, Airtel money, Telkom).

4.6Regression Analysis

4.6.1 Multivariate Logistic Regression Analysis

Multivariate logistic regression analysis was used to determine whether the variables identified in the study had a significant influence on the uptake of the daily payment health insurance plan among the Boda boda operators. It was also used to determine which were the more influential variables. The results are summarized in Table 4.9.

Table 4.9

Multivariate Logistic Regression Analysis

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B)	
							Lower	Upper
Age	-0.632	0.65	0.943	1	0.331	0.532	0.149	1.903
Education	-0.133	0.174	0.584	1	0.445	0.875	0.622	1.232
Marital status	-0.331	0.305	1.174	1	0.279	0.719	0.395	1.307
No. of children	-0.574	0.311	3.401	1	0.065	0.563	0.306	1.037
Awareness	0.332	0.466	0.508	1	0.476	1.394	0.559	3.478
Socio-Economics	0.052	0.176	0.087	1	0.768	1.053	0.746	1.486
Accessibility	0.798	0.226	12.439	1	0	2.222	1.426	3.462
Constant	0.735	2.586	0.081	1	0.776	2.086		

The first regression was done to determine whether demographic characteristics of Bodaboda operators significantly influenced their uptake of social health insurance daily payment strategy. The results in Table 4.9 shows that the odds ratios (ORs) for all the predictors of demographic factors were not significant; Age (OR.0.532, 95% CI = 0.149 - 1.903), Education Levels (OR.0.875, 95% CI = 0.622 - 1.232), Marital status (OR.0.719, 95% CI = 0.395 - 1.307) and Number of Children (OR.0.563, 95% CI = 0.306 - 1.037). Therefore,

overall demographic factors did not significantly influence the uptake of NHIF's daily payment strategy. This means that the Bodaboda operators' backgrounds were not important determinants of their uptake of daily uptake of health insurance. The results disagree with Atun et al. (2013) also found that consumers with documented low-to-moderate levels of health insurance literacy are challenged in making health insurance purchases due to little knowledge and understanding of universal healthcare and they should be helped understand and use health insurance.The findings, however, agree with Boateng and Awunyo-Vitor (2013) who found that education level had no significant influence ($p = 0.635 > 0.05$) in enrollment in Ghana's national health scheme. The study by Boateng and Awunyo-Vitor (2013) used respondents from general household survey from a rural community drawn from different professions. Atun et al. (2013) also used a general household survey. However, both studies were carried out among low income populations. However, in Atun et al. (2013) study, the context was Turkey in Europe where the concept of health insurance is already well known. In contrast, the context of Boateng and Awunyo-Vitorstudy was rural Ghana where the subject of health insurance has not been well canvassed.

The study also sought to determine whether awareness of Bodaboda operators significantly influenced their uptake of social health insurance daily payment strategy. The regression results in Table 4.9 indicates that a significant relationship (OR.1.394, 95% CI = 0.559 – 3.478) existed between the variables. The significant relationship between the variables implies that making information available would increase the likelihood of uptake of the daily subscription of social health insurance among the Bodaboda operators. The findings agree with Jahangir et al. (2013) who found that informal sector populations are generally unfamiliar with the concept of health insurance and may be suspicious of insurance because of past experience of others with other types of insurance and are also uncomfortable paying upfront for services they may not need while not getting any benefits themselves. The

findings also agree with Jangati (2012) who found that self-employed people were less aware about health insurance compared to government and private companies.

It was also important to determine whether socio-economic factors of Bodaboda operators significantly influenced their uptake of social health insurance daily payment strategy. The regression analysis in Table 4.9 indicates that there was indeed a significant relationship (OR. 1.053, 95% CI = 0.746 – 1.486) between the variables. The result suggests that there was a significant and relationship between the variables suggesting that there were odds that socio-economic factors and especially higher income could increase uptake of health insurance. The results agree with those of Boateng and Awunyo-Vitor (2013) who found that the demand for health insurance in Kumasi metropolis among formal and informal sector employees found that high income earners were 7% more likely to be enrolled compared to those with low incomes. The results were also mirrored by Sarpong et al. (2010) who found that only 21% of poor households were enrolled in health insurance as compared to 60% who were classified as belonging to high socio-economic status.

Finally, the study sought to determine whether accessibility of Bodaboda operators significantly influenced their uptake of social health insurance daily payment strategy. The correlation analysis in Table 4.9 indicates that there was indeed higher likelihood (OR.2.222, 95% CI = 1.426 – 3.642) that increasing access to the NHIF facilities including the accredited hospitals would significantly result in higher uptakes of the daily payment strategy among the operators. This finding suggests that the relationship between the variables was moderate implying that the convenient location of the NHIF offices and the availability of technology enabled options made it possible for the Bodaboda operators to subscribe to the daily uptake option. This finding is in agreement with Platteau and Ontiveros (2013) who concluded that

flexible payment modalities including technology applications made health insurance accessible especially to the low income group, hence, were important in healthcare insurance subscription.

It can further be deduced from the findings in Table 4.9 that the most influential determinant of uptake of social health insurance daily payment was Accessibility (OR.2.222, 95% CI = 1.426 – 3.642). This was followed by the and Awareness (OR.1.394, 95% CI = 0.559 – 3.478) andSocio-Economic Factors (OR. 1.053, 95% CI = 0.746 – 1.486) respectively. However, the Demographics was not found to be significant to the as all predictors had ORs of less than 1. The study therefore establishes that Awareness, Socio-economic factors, Accessibility were all factors influencing uptake of social health insurance daily payment strategy among Bodaboda operators in Eldoret town, Uasin Gishu County. According to the multiple regression model, only three out of the four independent variables were found to be significant, that is; Awareness, Socio-economic factors, Accessibility while demographic factors was not found to be significant.

These findings underscore the importance of understanding the dynamics of universal health coverage which needs to be taken into account for further decision making on this policy. For instance, demographic factors have been known to influence the uptake of health insurance. For example, age was one of the key demographic factors influencing demand for health insurance (Atun et al., 2013). Consumers with documented low-to-moderate levels of health insurance literacy are challenged in making health insurance purchases due to little knowledge and understanding of universal healthcare and they should be helped understand and use health insurance (McGuire, 2011). However, in the context of the present study this was not the case as the demographic variations within the income group was small.

Awareness was, however, found to be an important factor in the uptake of health insurance consistent with previous studies such as Bourne and Kerr-Campbell(2010) who found that awareness affected willingness to pay for health insurance. Lack of knowledge about enrolment procedures and the basic principles of insurance was a major barrier to enrollment. Majority of informal sector workers did not know about health insurance but were ready to enroll when correct and well packaged information was provided for persons at different levels of education (Kutzin, 2013). The low level of significance of the awareness variable in the model shows that there is still lack of awareness on health insurance in Kenya.

The findings also showed that socio-economic factors significantly influenced uptake of social health insurance daily payment strategy among Bodaboda riders in Eldoret town, Uasin Gishu County. This was in line with previous studies that underscored the importance of socio-economic factors in health insurance uptake. For instance, Kiplagat et al. (2013) found that employed people are more likely to be covered with public health insurance as compared to private health insurance. Essentially, socioeconomic disadvantages, such as having limited education and economic resources, high rates of unemployment and under-employment, and working at jobs that lack access to health insurance negatively impact people's health as they age. However, the findings disagree with Lu et al. (2010) who found no significant difference in health insurance status among adults living in urban and rural Kentucky.

Accessibility was found to be an influential variable in the model suggesting that more needs to be done to increase the accessibility of the health insurance services either through a physical office or through technology. This was consistent with Boateng and Awunyo-Vitor (2013) who found that increased accessibility especially among low income groups significantly determined their uptake of health insurance.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This segment expresses the considerable results and attestations that were extracted from the disclosure and proposition gathered from the analysis of the data. It is divided in various sections that incorporate an outline of your confirmations, attestations, and guidelines for improvement.

5.2 Summary of the Findings

5.2.1 Demographics Factors and Uptake of Health Insurance

All study participants were male. Agreeing to the findings, the vast almost all of individuals surveyed within the survey were in the 26-33 years old age bracket. The study revealed that majority of those who were insured aged between the ages of 26- 33 years old. This study has established that over 71% of the respondents in the study were married or cohabiting. Additionally, married respondents represented a significant proportion i.e. 15.5% among those were medically insured. Results from this study show that 51% motorcycle operators in this survey had secondary school education; very few had college or university level education. The logistic regression results revealed that the odds ratios (ORs) for all the predictors of demographic factors were not significant; Age (OR.0.532, 95% CI = 0.149 - 1.903), Education Levels (OR.0.875, 95% CI = 0.622 - 1.232), Marital status (OR.0.719, 95% CI = 0.395 - 1.307) and Number of Children (OR.0.563, 95% CI = 0.306 - 1.037). Therefore, overall demographic factors did not significantly influence the uptake of NHIF's daily payment strategy.

5.2.2 Awareness and Uptake of Health Insurance

The findings demonstrated that lion's share of the people polled were not aware of daily payment strategy uptake on health care financing. However, those who awareness of daily payment strategy uptake on health care financing got the information through friends heard it on radio, and other source like posters and chamas. Regarding the awareness of registration procedures, 60.3% of the respondents were not aware of daily payment strategy of NHIF, 67.1% indicated that they were aware of the fact that every citizen attaining age of majority may enlist with NHIF scheme and all the respondents were aware that one can register at any NHIF offices. On awareness of payment mechanism, the respondents were aware that there are other modes of payments of NHIIF apart from going to their offices; almost all individuals polled reported that they had a clue that daily payment is paid to NHIF scheme, others were aware that the amount is paid through mobile money and that late payment of monthly contributions attracts penalty. The respondents were aware that NHIF incorporates both hospice and palliative care in registered hospitals and that up to 6 family members can benefit from one principal member. Results from the logistic regression revealed that that a significant relationship (OR.1.394, 95% CI = 0.559 – 3.478) existed between awareness and uptake of social health insurance daily payment strategy.

5.2.3 Socioeconomic Factors and Uptake of Health Insurance

Socioeconomic level was one of the components inspected in this study, quality of literacy, proximity from residence to metropolis, and earlier work position are all variables to consider. Findings reveal that the median daily income was Kshs 500 ($5). When grouped, the majority of respondents in the survey earned a daily income level of cash K.sh. below 1000. Most were engaged in other source of income generating activities apart from their Bodaboda occupations. Of those who claimed to have other sources of income apart from

Bodaboda, majority were involved in small scale farming while were engaged in small scale business. This shows that some Bodaboda operators may be able to get extra cash to enroll into daily payment strategy. Improving income earning opportunities through improved agricultural practices, business co-operatives and merry-go-round groups may be a better and practical way of improving the well-being of inhabitants and move forward their capacity to pay wellbeing protections subscription. Membership of self-help groups *(chamas)* aids in supplementing income levels. Such groups would be beneficial if utilized to pool financial resource for health care. Results from the logistic regression models further revealed that there was a significant relationship (OR. 1.053, 95% CI = 0.746 – 1.486) between socio-economic factors of Bodaboda riders and uptake of social health insurance daily payment strategy.

5.2.4 Accessibility Factors and Uptake of Health Insurance

Concerning the accessibility construct, the findings revealed that majority of the respondents prefer to make NHIF contributions directly to NHIF offices than using other means. Regarding the accessibility to NHIF accredited hospitals when respondents need medical care, all of them agreed. The findings indicated there exist strong relationship between access to NHIF accredited health facility and the uptake of daily payment strategy NHIF cover. The pathways to expand convenience to information gathering sites for those within the unorganized workforce, according to Delloite in the National Social Wellbeing Protections Methodology Report, involve gathering by different organizations associated to the inhabitants, such as agreeable societies, social security entities, trade groups, and religious affiliations, as they may be able to gather contributions more successfully. There comes about of the calculated relapse appeared that there's a bigger possibility of victory. (OR.2.222, 95% CI = 1.426 – 3.642) that increasing access to the NHIF facilities including the accredited

hospitals would significantly result in higher uptakes of the daily payment strategy among the operators among the Bodaboda operators.

5.3 Conclusion

The study first endeavored to furnish a clarification to the subject of impact of demographic characteristics of Bodaboda operators on consideration in widespread healthcare underwriting daily payment strategy in Eldoret town. The findings revealed that the likelihood of subscribing to the NHIF's daily payment strategy was not significant as per the odds ratios (ORs) for each of the demographic factors examined. Overall demographic factors did not significantly influence the uptake of NHIF's daily payment strategy. This meant that the Bodaboda operators' backgrounds were not important determinants of their uptake of daily uptake of health insurance. Therefore, the study concluded that demographic factors did not significantly influence the uptake of NHIF's daily payment strategy.

Regarding the question on the influence of awareness of daily subscription on uptake of social health insurance daily payment strategy among Bodaboda operators in Eldoret town, the study revealed that the odds were high that increased awareness would lead to inclusion of the NHIF's daily payment strategy. This led to the conclusion that awareness plays a very important role in the inclusion wellbeing protection daily payment strategy among Bodaboda operators.

In relation to the question on the influence of socio-economic factors on uptake of social health insurance daily payment strategy among Bodaboda operators in Eldoret town, the study found that socioeconomic factors such as income levels and other source of income were significant predictors to the inclusion of communal wellness services and indeed increased the likelihood of the uptake of daily payment strategy among Bodaboda operators.

As such, the study concluded that socioeconomic factors needed to be considered when making strategy decisions on inclusion of wellness protection.

Finally, concerning the answer pertaining to the influence of accessibility factors on the inclusion of wellness daily payment strategy among Bodaboda operators in Eldoret town, the findings revealed that there was a higher likelihood that increasing access to the NHIF facilities including the accredited hospitals would significantly result in higher uptakes of the daily payment strategy among the operators among the Bodaboda operators. Consequently, the study concluded that accessibility was an important factor in the uptake of daily payment strategy among Bodaboda operators.

5.4 Recommendations

The following are some of the conclusions made in relation to the findings and conclusions of the study.

Regarding the first objective relating to demographic patterns, there is need for health insurance policy makers and strategists to reconsider differentiating their product packages across demographic patterns when targeting informal sector workers. This could be done along spousal relationships and also apply to those with children as direct dependents. This may encourage those with children and not in formalized spousal relationships to subscribe to the daily health insurance payment scheme.

Concerning the second objective relating to awareness, there is need to enhance awareness of insurance service provider and accredited healthcare service provider among bodaboda operators and the informal sector at large in order to inculcate the positive impact of the uptake of the NHIF insurance scheme. Since bodaboda operators are already affiliated to Saccos, the NHIF could come up with targeted awareness strategies that reach out directly to the members of the Saccos letting them know about the products they have on offer and the

subscriptions options. Furthermore, to encourage potential members to register, it is imperative that they are made aware of the details of the insurance contract they are entering into.

In relation to the third objective on socioeconomic patterns, the NHIF and other health insurance providers need to tailor packages along the income and savings trends of the bodaboda riders in order to help cater for days with little or no cash flows and ensure continuity in subscriptions. In this regard, weekly subscriptions also should be developed by the service provider sat the convenient for the bodaboda operators as well as those who work within the unregulated space.

Lastly, in relation to the fourth objective on accessibility, the social health insurers need to improve the visibility of their premisesinorder to enable the informal sector subscribers to locate them conveniently. The insurer also needs to ensure that the bodaboda operators have information on the physical addresses of their partnering health facilities where they can obtain both in-patient and out-patient healthcare services.

5.5 Extra Investigating Recommendations

It is vital to do proportionate examination in other Kenyan townships in order to assess and evaluate if the results are solid. A ponder on the effect of the modern NHIF rates on public impression and suppositions around the commercial and open wellbeing sectors' impact on benefit quality in connection to NHIF is additionally required.

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APPENDICES

APPENDIX I: INFORMED CONSENT FORM

Kenya Methodist University
P. 0 Box 267-60200
MERU, Kenya

SUBJECT: INFORMED CONSENT

Dear Respondent,

My name is **Reuben K. Mutai**. I am an Msc student from Kenya Methodist University. I am conducting a study titled: DETERMINANTS OF UPTAKE OF SOCIAL HEALTH INSURANCE DAILY PAYMENT STRATEGY AMONG BODABODAOPERATORS IN ELDORET TOWN**.**

The findings will be utilized to strengthen the health systems in Kenya and other Low-income countries in Africa. As a result, countries, communities and individuals will benefit from improved quality of healthcare services. This research proposal is critical to strengthening health systems as it will generate new knowledge in this area that will inform decision makers to make decisions that are research based.

Procedure to be followed

Participation in this study will require that I ask you some questions to address the six pillars of the health system. I will record the information from you in a questionnaire check list.

You have the right to refuse participation in this study. You will not be penalized nor victimized for not joining the study and your decision will not be used against you nor affect you at your place of employment.

Please remember that participation in the study is voluntary. You may ask questions related to the study at any time. You may refuse to respond to any questions and you may stop an interview at any time. You may also stop being in the study at any time without any consequences to the services you are rendering.

Discomforts and risks.

Some of the questions you will be asked are on intimate subject and may be embarrassing or make you uncomfortable. If this happens; you may refuse to answer if you choose. You may also stop the interview at any time. The interview may take about 40 minutes to complete.

Benefits

If you participate in this study you will help us to strengthen the health systems in Kenya and other Low-in- come countries in Africa. As a result, countries, communities and individuals will benefit from improved quality of healthcare services. This field attachment is critical to strengthening the health systems as it will generate new knowledge in this area that will inform decision makers to make decisions that are research based.

Rewards

There is no reward for anyone who chooses to participate in the study.

Confidentiality

The interviews will be conducted in a private setting within the region. Your name will not be recorded on the questionnaire and the questionnaires will be kept in a safe place at the University.

Contact Information

If you have any questions you may contact the following supervisors:

1. Dr. Kezia Njoroge, Department of Health Systems Management Kenya Methodist University, Nairobi campus.

2. Dr. Eunice Muthoni Mwangi, Department of Health Systems Management Kenya Methodist University

Participant's Statement

The above statement regarding my participation in the study is clear to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time. I understand that I will not be victimized at my place of work whether I decide to leave the study or not and my decision will not affect the way I am treated at my work place.

Name of Participant…REUBEN KIPRUTO MUTAI.....Date: 20th September 2021

Signature……

Investigator's Statement

I, the undersigned, have explained to the volunteer in a language s/he understands the procedures to be followed in the study and the risks and the benefits involved.

Name of Interviewer……Date…….

Interviewer Signature……

APPENDIX II: QUESTIONNAIRE

DEMOGRAPHIC CHARACTERISTICS AND UPTAKE OF SOCIAL HEALTH INSURANCE DAILY PAYMENT STRATEGY

Kindly fill the following section as accurate as possible:

1. What is your age?
   a) 18-25 years
   b) 26-33 years
   c) 34 years and above

2. What is your highest level of education?
   a) Primary level [ ]
   b) Secondary level [ ]
   c) Tertiary level. [ ]

3. What is your marital status?
   a) Single [ ]
   b) Married [ ]
   c) Widowed [ ]
   d) Divorced [ ]
   e) Cohabiting [ ]

4. How many children under 18 years old live in your household?
   a) None [ ]
   b) 1 to 3 [ ]
   c) 4 to 6 [ ]
   d) 7 and Above [ ]

5. Where do you live?
   a) West and its environs [ ]
   b) South and its environs [ ]
   c) East and its environs [ ]
   d) North and its environs [ ]

AWARENESS OF DAILY PAYMENT STRATEGY UPTAKE ON HEALTHCARE FINANCING

1. Are you aware of daily payment strategy uptake on health care financing?

a) Yes [ ]

b) No [ ]

2. What is the source of information on daily payment strategy uptake on health care financing?

a) Radio [ ]

b) Television [ ]

c) Newspaper [ ]

d) Family/Friends [ ]

e) Others, specify) [ ]

3. The following are statements about the daily payment strategy uptake on health care financing. Please tick appropriately. SD(Strongly disagree), D(Disagree), N(undecided), A(Agree) and SA(Strongly Agree)

STATEMENT	**SD**	**D**	**N**	**A**	**SA**
Awareness of Registration Procedures					
Daily payment is a strategy of NHIF					
All Kenyans over 18 years can join NHIF scheme					
One can register at any NHIF offices					
Awareness of Payment Mechanism					
There are other mode of payment of NHIF apart from going to their offices					
Daily payment is paid to NHIF scheme					
The amount is paid through a mobile money					
Late payment of monthly contributions attracts penalty					
Awareness of NHIF Benefits					
NHIF covers admissions and Outpatient services on registered hospitals					
Up to 6 family members can benefit from one principal member					

ECONOMIC FACTORS AND UPTAKE OF SOCIAL HEALTH INSURANCE DAILY PAYMENT STRATEGY

The following are statements on economic factors on the daily payment strategy uptake on health care financing. Please tick appropriately. SD (Strongly disagree), D (Disagree), N (undecided), A (Agree) and SA (Strongly Agree)

	Statement	**SD**	**D**	**N**	**A**	**SA**
1.	I have other sources of income apart from my Bodaboda Riding/Business					
2.	I prefer daily payment strategy of NHIF premiums over the monthly payment strategy					
3.	I am a member of a Social Welfare Association					

2. What is your daily income in Kenya?
   a) Below 1,000 [ ]
   b) 1,001 to 2000 [ ]
   c) Above 2,000 [ ]

ACCESSIBILITY AND UPTAKE OF SOCIAL HEALTH INSURANCE DAILY PAYMENT STRATEGY

The following are statements about accessibility to the daily payment strategy uptake on health care financing. Please tick appropriately. SD (Strongly disagree), D (Disagree), N (undecided), A (Agree) and SA (Strongly Agree)

	Statement	**SD**	**D**	**N**	**A**	**SA**
4.	Accessibility to NHIF Accredited Hospitals when needing Medical Care					
5.	Accessibility to the NHIF offices					
6.	Other Means of Contributing to NHIF other than visit Offices					
7.	Do you access NHIF accredited hospitals when you need medical attention?					
8.	Do you access to payment strategy?					

6. If yes, through which means?

1. Mobile phone paybill number [ ]
2. Physical payment to NHIF offices [ ]

7. What other challenges do you experience if you want to enroll with daily payment strategy?

_____

_____

APPENDIX III: NACOSTI RESEARCH LICENSE

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **433089**

Date of Issue: **11/June/2020**

RESEARCH LICENSE

This is to Certify that Mr.. REUBEN KIPRUTO MUTAI of Kenya Methodist University, has been licensed to conduct research in Uasin-Gishu on the topic: DETERMINANTS OF UPTAKE OF SOCIAL HEALTH INSURANCE DAILY PAYMENT STRATEGY AMONG BODABODA RIDERS IN ELDORET, UASIN GISHU COUNTY for the period ending : 11/June/2021.

License No: **NACOSTI/P/20/5252**

433089

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

APPENDIX IV: ETHICAL CLEARANCE LETTER

KENYA METHODIST UNIVERSITY
P. O. BOX 267 MERU - 60200, KENYA FAX: 254-64-30162
TEL: 254-064-30301/31229/30367/31171 EMAIL: INFO@KEMU.AC.KE

March 16, 2020 KeMU/SERC/HSM/7/2020

Reuben Kipruto Mutai
HSM-3-0315-1/2018
Kenya Methodist University

Dear Reuben,

SUBJECT: ***DETERMINANTS OF UPTAKE OF SOCIAL HEALTH INSURANCE DAILY PAYMENT STRATEGY AMONG BODABODA RIDERS IN ELDORET, USASIN GISHU COUNTY.***

This is to inform you that Kenya Methodist University Scientific Ethics and Review Committee has reviewed and approved your above research proposal. Your application approval number is KeMU/SERC/HSM/7/2020. The approval period is 16th March 2020 – 16th March 2021.

This approval is subject to compliance with the following requirements

I. Only approved documents including (informed consents, study instruments, MTA) will be used.

II. All changes including (amendments, deviations, and violations) are submitted for review and approval by Kenya Methodist University Scientific Ethics and Review committee.

III. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to KeMU SERC within 72 hours of notification.

IV. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to KeMU SERC within 72 hours.

V. Clearance for export of biological specimens must be obtained from relevant institutions.

VI. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal

VII. Submission of an executive summary report within 90 days upon completion of the study to KeMU SERC.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and also obtain other clearances needed.

Yours sincerely,

KENYA METHODIST UNIVERSITY
KEMU SERC
10 MAR 2020
P.O. Box 267 - 60200, MERU

Dr. A. WAMACHI
Chair, SERC

APPENDIX V: RESEARCH LETTER OF AUTHORIZATION

REPUBLIC OF KENYA

MINISTRY OF EDUCATION

State Department for Early Learning and Basic Education

Telegrams: **"EDUCATION"**, Eldoret
Telephone: **053-2063342** or **2031421/2**
Mobile : **0719 12 72 12/0732 260 280**
Email: cdeuasingishucounty@yahoo.com
: cdeuasingishucounty@gmail.com
When replying please quote:

County Director of Education,
Uasin Gishu County,
P.O. Box 9843-30100,
ELDORET.

Ref: No. MOE/UGC/ACT/9/VOLL. III/169

18th June , 2020

Reuben Kipruto Mutai
P.O BOX 363
NANDI HILLS

RE: RESEARCH AUTHORIZATION.

In reference to your licence Ref no. 433089 dated 11th June, 2020 from National Commission for Science, Technology and Innovation (NACOSTI), and your request letter dated 17th June,2020, you are hereby granted the authority to carry out research on ***"Determinats of uptake of social health insurance daily payment strategy among bodaboda riders in Eldoret, Ending 11th June,2021,"***within Uasin Gishu County.

We take this opportunity to wish you well during this data collection.

DR. S.G MBAKA
County Director of Education
UASIN GISHU.