Karunafoundation

Determinants of membership

A study to investigate the most important determinants of membership of the Share & Care program in Mechchhe and Hansposha, Nepal

Iris Walraven

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Table of content

Preface

This thesis describes the results of the research project which I conducted in order of the Karuna Foundation.

I would like to thank everybody for their personal positive input during this study, for developing my technical research skills in International Public Health, writing this report and having a great experience in Nepal!

I would like to thank the participants of my research for their great help by sharing their opinions. Without them it was not possible to accomplish this study. Furthermore, I would like to thank the staff of the Karuna Foundation. Betteke de Gaay Fortman; thank you for giving me the opportunity to conduct this research at your organization and for being such a enthusiastic and warm person. Merel Schreurs; thank you for your valuable reflection and dedicating your time in reviewing my thesis. Deepak Raj Sapkota; thank you for welcoming us in your organization in Nepal. Archana Shrestra; thank you for your support during our stay in Nepal. Yogendra Yiri; thank you for giving us such a warm welcome in Hansposha. Furthermore, I would like to thank the rest of the staff of the Karuna Foundation in Kathmandu; I learned a lot during my stay in Nepal and you made my stay really comfortable despite all the differences between Nepal and The Netherlands.

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At last, I would like to thank my family and friends for their support during my Masters.

Amsterdam, August 2010

Iris Walraven

Summary

Context: Karuna Foundation Nepal (KFN) is an International Non Governmental Organization. One of the main aims of the KFN is scaling up essential community health services. For this aim, the KFN set up the Share & Care program. The Share & Care program sets up a health insurance system in which, ideally, the majority of the community participates. The Karuna Foundation decided to invest in the Share & Care program for two years. After this period, they longed the program to become sustainable. To reach sustainability, it is necessary to include at least 80% of the households of the community in the program. At this moment, the KFN managed to achieve a 40% membership rate. Therefore, it is important to gain insights on how to increase the number of members.

Objective: To find possible ways to increase the membership of the Share & Care program by investigating determinants of membership in the two pilot communities Mechchhe (Kavre) and Hansposha (Sunsari).

Design: Exploratory case-control study with a cross-sectional design.

Methods: The study was conducted in the two pilot communities of the Share & Care program, Mechchhe and Hansposha. Semi-structured questionnaires with open-ended and categorical questions were used to collect data. Analyses consisted of descriptive and qualitative analyses to describe differences between members and non-members. Furthermore, a multivariate logistic backward regression was performed to predict the most important determinants of membership.

Results & Conclusions: In Mechchhe, 72 members and 69 non-members were included in the study. In Hansposha, 108 members and 106 non-members were included. Knowledge of the Share & Care program and the benefits showed to be a determinant for membership in both communities. In Mechchhe, knowledge of the Share & Care program was significantly associated with membership (P 0,006). In Hansposha, knowledge of the benefits of the Share & Care program was significantly associated with membership (P 0,003). In Mechchhe, the ability to pay the membership fees (P 0,002), the willingness to pay the membership fees (P 0,004) and the perception of the membership fees (P 0,004) were all significantly related to membership. In Hansposha, being satisfied with the Sub Health Post was significantly related to membership (P 0,02). Non-members reported dissatisfaction with the quality of the health worker, a preference to be diagnosed by a qualified doctor emerged as well. These were important motives to refrain from membership.

Recommendations: The main recommendation for increasing the number of members of the Share & Care program is to improve promotional activities. Community members need to be provided with sufficient and correct knowledge and the highlights of the benefit package should be emphasized. Furthermore, a benefit package should be compiled which is the most attractive for that particular community. At last, research should be conducted on the level of membership fees which the majority of the community is able to pay.

List of abbreviations

BMVP	Behavioral Model for Vulnerable Populations
DHS	Department of Health Services
FGD	Focus Group Discussion
HBM	Health Belief Model
HFOMC	Health Facility Operation and Management Committee
HP	Health Post
IMR	Infant Mortality Rate
INGO	International Non-Governmental Organization
KFN	Karuna Foundation Nepal
NR	Nepali Roepia
OR	Odds Ratio
PHCT	Public Health Concern Trust
S & C	Share & Care
SES	Socio-Economic Status
SHP	Sub Health Post
UN	United Nations
VDC	Village Development Committee
WHO	World Health Organization

Chapter 1. Background information

In this chapter the contextual background of the study is described. First some general information about Nepal is outlined, including a brief description of the health system and the health situation. Then, some information is given about the Karuna Foundation, the Share & Care program and the two pilot communities Mechchhe and Hansposha.

1.1 General information Nepal

Nepal is a country located between China and India. Its mountains, lack of infrastructure, and land-locked status pose great barriers to development.[1] Geographically, the country is divided into three zones; the northern range (mountains), the mid range (hills) and the southern Terai range (flat land). Furthermore, the country is divided into five administrative development zones; eastern development region, central development region, western development region, mid-western development region and far-western development region. The country is further divided into 14 zones and 75 districts, which are divided into smaller units, called Village Development Committees (VDCs) and Municipalities. VDCs are rural areas whereas Municipalities are urban areas of the country. Furthermore, VDCs are divided into 9 wards.[1]

In 2006, the total population had reached 27,6 million, in which the proportion males and females were almost equally distributed. In the same year, the Gross National Income per capita was $1.[2] Nepal ranks 144 out of 182 on the Human Development Index and nearly one third of the population (30,8%) lives below poverty line.[3] The main caste in Nepal is Chhetri (15,8%) followed by Brahmin (12,7%). Other common castes are Magar, Tharu and Tamang. The main religions are Hindu (80,2%) and Buddhist (10,7%).[1] The literacy rate is showing an upward trend. It was 54% in 2001. The Ministry of Education indicated the latest percentage at 57%. Gender inequality in the rate of literacy is, however, noticeable. It was 42% for females and 65% for males.[4]

1.2 The health system in Nepal

The national health policy was adopted in 1991 and aims at improvement of the overall health status of the population of Nepal through extension of the primary health care system to the rural areas. In 1999, an analysis of this policy resulted in the development of a new strategy for a five-year health plan (2002-07). This included essential, affordable and accessible health care services, promoted a public-private NGO partnership and aimed at decentralising the health system.[5] As underlined by themselves, The Nepal government is committed to bring about substantial changes in the health-sector development process. Therefore, the proportion of the government budget allocated to health increased from 5% in 2005 to 6,5% in 2006 and 7% in 2009. Unfortunately, the allocated budget for the health sector has not been expended fully in recent years, with 68% of the total allocation spend in 2005.[5]

The health system in Nepal is structured by health facilities in a clear chain of command. The lowest level of formal health care starts from Sub-Health Posts (SHPs) at the VDC level to Health Posts (HPs), Primary Health Centres (PHCs) and hospitals at district, zonal, sub-regional, regional and central levels. Basically all PHC services provided at various levels in the public sector are initiated by the Department of Health Services

(DHS). This system can be seen in figure 1. This chain of command has been designed to ensure that the majority of the population receives health care and that treatment facilities are available in places accessible to them. This division aims at providing health care facilities to everyone, fulfilment of posts however remains a big problem. Many approved posts of health care workers are unfilled. For example, in whole Nepal, 13% of all deliveries are conducted by trained personnel; and for the poorest fifth of the population (mainly rural) this number is just 3%.[5]

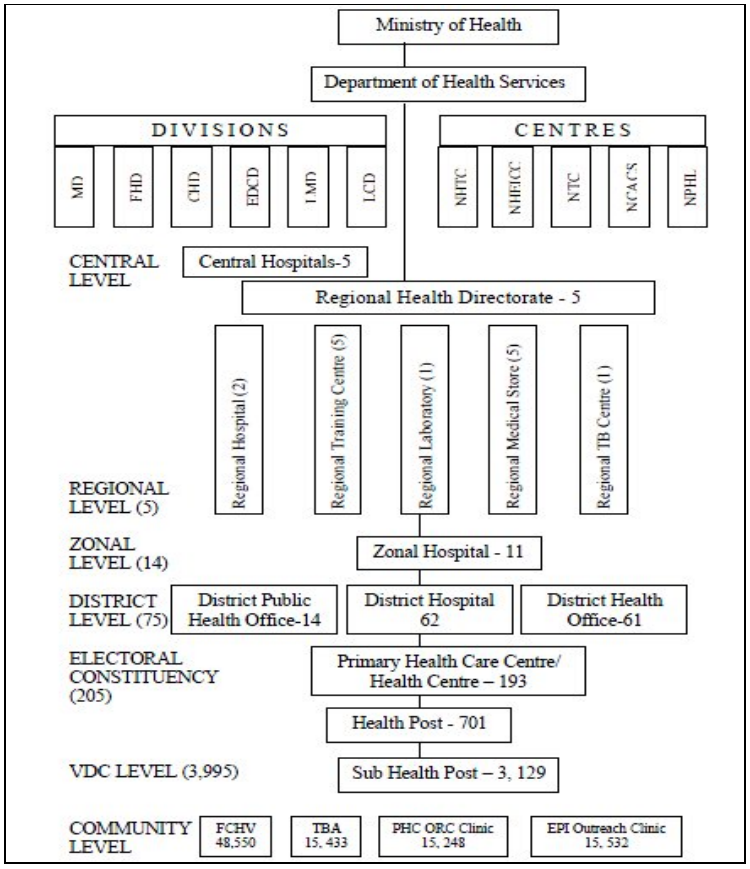

Figure 1: The health system in Nepal. Source of information: WHO, 2007 [5].

1.3 Health insurance schemes in Nepal

At this moment there is no adequate health insurance system in Nepal, therefore, there is a need for a proper health insurance system. However there are various types of alternative health care financing systems available. The types of health care financing systems include user charges, community financing schemes, community drug schemes of various types and community insurance schemes. Most of these schemes make use of direct payment by the users though there may be provision for the poor in some cases.

There exists a Community, health-post based insurance model, which is quite comparable to the Share & Care program. The insurance model was initiated in 1976 as the *Lalitpur Medical Insurance Scheme*[6]; this scheme has a coverage of 19 - 52 % of the rural population in six health posts. To obtain membership, people are required to pay a pre-defined contribution to the scheme. In return, they receive health services including essential medicines free of charge. Non-members can also derive services from the

scheme by paying required fees. The premium varies and is determined by the local management committee with the drug subsidy coming from the government. Free clinical service is provided in the clinic, and for the referred cases in Patan Hospital, the charges are discounted. It is observed that sustainability is a problem within this model, and the main reasons for declining membership were: coverage was limited to minimal package services; services were insufficiently promoted; and an increased availability of private clinics in the neighbourhood.[6]

Another existing health insurance scheme is called *the hospital based micro-social health insurance scheme*.[7] This insurance scheme was initiated in the year 2000 and offers services to rural and urban household members for the people of Dharan and neighbouring districts at the B.P. Koirala Institute of Health Sciences. The premium in urban areas is four times higher than in rural areas and the package includes free consultations by qualified doctors at the hospital for members, free hospital beds, medicines and surgery charges beyond a certain limit. The scheme is now marketed by more than 30 Village Development Committees, municipalities, schools and colleges, socio-cultural organizations and other local community groups. In 2004, the scheme had 18,000 members, and it had the largest membership of any insurance scheme in Nepal.[7] No literature was found on the current situation, however, inquiry about the current situation revealed that this insurance scheme failed to become sustainable (de Gaay Fortman B, written communication, 19th August 2010).

Again another existing health insurance scheme is the *Health Cooperative Model.*[8] This scheme was initiated by an NGO called Public Health Concern Trust (PHECT).[8] In 1992, a group of doctors wishing to offer their services to the poor established a small clinic in the village of Tikathali. It was an experiment to investigate the best way to provide health services. PHECT Nepal founded the 'Kathmandu Model Hospital' aiming to make it a referral centre and it offers health service through a cooperative society with the members maintaining daily savings of nominal amount to contribute for health, both in rural and urban areas. Subsidy is provided to the poor on referral cases. Membership is given to the household as a whole. In 2003, about 1,000 families were benefiting from the scheme and the membership had remained more or less stable since the beginning.[8] As with *the hospital based micro-social health insurance scheme*[7], again no literature was found on the current situation. However, it appeared that this scheme has failed to exist as well (de Gaay Fortman B, written communication, 19th August 2010).

1.4 The health situation in Nepal

Life expectancy at birth has been increasing for both males and females in Nepal. It has increased from 42 years for males and 40 years for females in 1971 to 62 years for males and 63 years for females in 2006.[9]

Infections and malnutrition accounts for two thirds of Nepal's illnesses, which are most common among pregnant women and children. The level of mortality and morbidity is high, especially in children with an Infant Mortality Rate (IMR) of 48/1000 life births and an under-five mortality rate of 61/1000 life births.[10] The reason for these high rates can largely be attributed to the high prevalence of malnutrition, parasitic- and infectious diseases. In children, stunting is present in nearly half (49%) of the children.[10] In contrast, overweight, with a percentage of 0.6%, is nearly absent in the Nepali population .[9]

1.5 The Karuna Foundation and the Share & Care program

Karuna Foundation Nepal (KFN) is an International Non Governmental Organization (INGO) working in Nepal with the main goals of decreasing birth defects and disabilities in the country. The main aims of the KFN are scaling up essential community health services, the development of a Community Based Disability Prevention and Rehabilitation Program and advocacy for the rights of people living with disabilities at national policy level.[11]

1.5.1 The Share & Care program

The KFN has developed a program named Share and Care, which is a comprehensive program for the prevention of avoidable disabilities and for the improvement of the lives of children with a disability and their families. It is focused at improving health systems by empowering communities in developing countries. It strengthens basic local structures and sets up a system of micro-insurance in which ideally the majority of the community participates. From the beginning the community is involved in and responsible for the planning, implementation and the monitoring, as well as the financial coverage by paying the Share & Care premium from their own pocket.[11] The program is led by a Health Facility Operation and Management Committee (HFOMC), which consists of at least one representative from every ward. The members of the HFOMC are trained with administrative and financial management skills, and organisational coordination skills.[11]

The Share & Care program consists of the following components:

1. Organisation development; which includes training of the HFOMC.
2. Upgrading of the health facilities; which includes renovation of the building, constructing new buildings and providing solar-powered lights.
3. Community based health insurance; each household contributes a certain amount to the program and gains membership, which provides them the benefit package. Different benefit packages have been developed for the different Share & Care VDCs.
4. Community Based Rehabilitation of children with disabilities; children with a disability receive medical, educational and social support in order to improve their lives.
5. Health promotion and disability prevention; which includes strengthening of Primary Health Care Outreach Clinics, supporting maternal health services and regular monitoring of the program.
6. Livelihood program; livelihood support is provided to poor families who can not afford to participate in the program. The families receive loans in order to increase their income. The repayment is collected weekly in additions to the savings.

To become a member of the Share & Care program, each household contributes a by the community predefined membership fee. This membership has to be renewed every year.

There is a set of free medicines (22 types), which are available to, ideally, all the people in Nepal. These medicines belong to the essential medicine list which is created by the Government of Nepal.[12] On top of these essential medicines, the Share & Care program adds extra medicines (on demand of the community). Members of the Share & Care program get these medicines for free and non-members have to pay for these extra medicines, however, consultation in the upgraded health post is free of charge for non-members as well.[11]

1.6 Baseline characteristics of Mechchhe and Hansposha

Mechchhe and Hansposha are two VDCs in which the Karuna Foundation piloted the Share & Care program since 2007. In order to implement the Share & Care program, a baseline assessment was made in which the main characteristics of the population of the communities were assessed. In this paragraph, a brief summary of the main findings per community will be given. Furthermore, as described earlier, the benefit packages of the Share & Care program differ per VDC, so the Share & Care package will be described as well.

1.6.1 Mechchhe

Mechchhe is a VDC which belongs to the Kabhre Palanchowk district. It is the furthest VDC of Kabhre Palanchowk and accessibility is not optimal. The 9 wards of Mechchhe are built on different altitudes and electricity is absent in this VDC.

According to the baseline survey[14], Mechchhe consists of 1,309 households. The most common caste is Tamang with a percentage of 74,6%. A total of 76,7% of the participants of the baseline survey were found to be illiterate. Twelve and a half percent (12,5%) of the participants were found to be destitute (owns no assets and has either none or only one basic need[13]), with the majority of destitute people living in ward 5 and 8. Moreover, 61,8% of the participants were grouped in the poor category, with equal distributions per ward. In case of health problems, 61,8% consulted a traditional healer first.[14]

Share & Care package

In Mechchhe, the membership fees of the Share & Care program were NRs 800 per household per year. A renewal system is established in which membership households have to renew their membership every year. The benefit package includes all services at the SHP and Sub Centre. In case of referral, a refund of NRs 5,000 per person is provided. A life insurance is included in the package which refunds NRs 20,000 in case of mortality if one person is insured, and NRs 10,000 per person if two persons are insured and so on. The livelihood program (see paragraph 1.5.1) has not yet been introduced in Mechchhe.[15] For this, people who cannot afford to participate in the program, have less options to be included in the program at this moment.

1.6.2 Hansposha

Hansposha is a VDC which belongs to the Sunsari district. Geographically it lies alongside a highway, therefore, the accessibility of Hansposha is good. Electricity is present is this VDC.

According to the baseline survey[16], Hansposha consists of 4,265 households. The main castes are Chhetri (26%), Tharu (20%) and Rai (15%). Forty-one percent (41%) of the participants never attended any form of formal education and 28,2% followed informal education. The mean family income per month is NRs 5,331 and the estimated amount of money spend on health service per year per household was NRs 12,934. The major source of income in Hansposha comes from agriculture.[16]

Share & Care package

In Hansposha, the membership fees of the Share & Care program comprise NRs 1,200 per household with a maximum of six members and NRs 150 extra for each additional family member. A renewal system exists in which membership households have to renew their

membership every year. The benefit package includes refund up to NRs 1,000 at the local health institution, up to NRs 5,000 for operation costs, up to NRs 1,000 for the cost of a bed in the hospital, up to NRs 3,500 for diagnostics, up to NRs 5,000 for Intensive Care use, up to NRs 600 for ambulance costs and up to NRs 5,000 for medicines. The life insurance amount comprises NRs 10,000 per person in case of mortality up to 2 members of the household. Furthermore, the livelihood program (see paragraph 1.5.1) has already been introduced in Hansposha.[16] Therefore, people who cannot afford to participate in the program, have increased options to join the program in comparison with Mechchhe.

Chapter 2. Research questions and objective

In this chapter, the problem definition, objective, main research question and the sub questions are described and the conceptual framework is presented.

2.1 Problem definition and objective

The KFN decided to invest in the Share & Care program for two years. After this period, they expect the program to become self-regulating and sustainable.[11] In order to reach sustainability, the program needs to become financial independent. To reach financial independency, it was calculated that it is necessary to have at least an 80% membership rate of the households of the community in the program. During this study, the KFN managed to achieve a 40% membership rate in the Share & Care program. It was unknown which factors influence a household on whether or not to become a member of the Share & Care program. To ultimately reach the goal of 80% membership, it is important to gain insights in the determinants which influence a persons decision making process on whether or not to become a member of the Share & Care program. It is also important to investigate whether these determinants are significantly associated with membership and in how far they could be a reason for refraining from membership of the Share & Care program. Another important reason for investigating these determinants is that they could give insight on how to accomplish a more sustainable program in other VDCs where the program is going to be implemented in the future.

Objective

The objective is to find possible ways to increase the membership of the Share & Care program by investigating determinants of membership, including predisposing characteristics, cues to action, consumer satisfaction, perceived health status, health behavior, financial resources and perceived needs, in the two pilot communities Mechchhe (Kavre) and Hansposha (Sunsari).

2.2 Central research question and sub questions

With the objective of increasing the number of members of the Share & Care program, the following main research question is formulated:

> "What are the most important determinants of membership of the Share & Care program in the two pilot communities Mechchhe (Kavre) and Hansposha (Sunsari)?"

In order to answer the main research question, the following sub questions are formulated:

1. What is the association between predisposing characteristics and membership of the Share & Care program?
2. What is the association between cues to action and membership of the Share & Care program?
    - *What is the association between discouraging cues to action and membership of the Share & Care program?*

    - *What is the association between encouraging cues to action and membership of the Share & Care program?*
3. What is the association between client satisfaction and membership of the Share & Care program?
4. What is the association between evaluated health status and membership of the Share & Care program?
    - *What is the association between perceived susceptibility and membership of the Share & Care program?*
    - *What is the association between prevalence of (perceived) chronic diseases, activity limitations and other health problems and membership of the Share & Care program?*
5. What is the association between health behavior and membership of the Share & Care program?
    - *What is the association between self-prescription and membership?*
    - *What is the association between use of health care services and membership?*
6. What is the association between financial resources and membership of the Share & Care program?
    - *What is the association between knowledge of the membership fees and membership of the Share & Care program?*
    - *What is the association between ability and willingness to pay the membership fees and membership of the Share & Care program?*
    - *What is the association between perception of the membership fees and membership of the Share & Care program?*
7. What are the perceived needs and additions of members and non-members towards the Share & Care program?

2.3 Conceptual framework

To answer the main research question and to gain a better framing of the research project, a research framework was designed. Since the reliability of the framework improves when grounded in theory, the framework was based on the Health Belief Model[17] (HBM), the Behavioral Model for Vulnerable Populations[21] (BMVP) and the earlier described information obtained from the baseline surveys from the KFN.

The used models are first presented and described, in order to gain a better understanding on the integration of these models in the research framework for this study. Furthermore, the different concepts of the models were used to interpret the results and are therefore referred to in the discussion chapter of this thesis.

2.3.1 The Health Belief model

The HBM[17] (see figure 2) was developed to explain participation in public health programs and it has been used for decades to explain health-related behaviors.[17] The HBM has been tested on a variety of health behaviors including alcohol use, dietary practice, health screening activities and visits to health professionals. Meta-analysis of these studies suggest that many health behaviors can be predicted by the components of the HBM.[18]

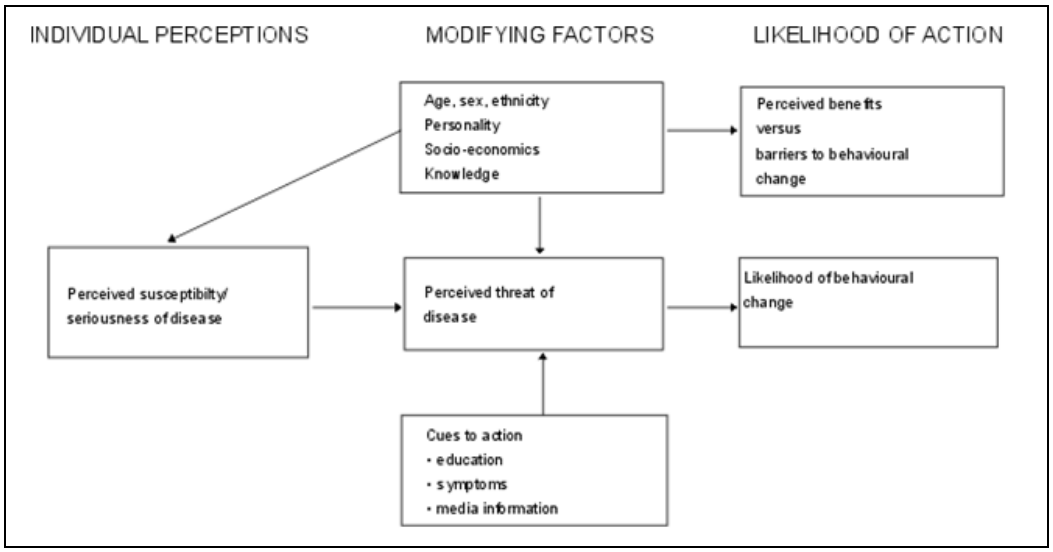

Figure 2: The health belief model. Source of information: Becker MH, 1974 [17].

The key components of the model are *perceived susceptibility, perceived benefits* and *barriers, personal factors (e.g. predisposing characteristics)* and *cues to action.*

Perceived susceptibility deals with individual perceptions about a specific condition or problem. If people believe that they are susceptible to a problem or health condition, and if they feel that the problem is serious, the chance that they will participate in a program will increase. Furthermore, predisposing characteristics such as age, ethnicity and Socio-Economic Status (SES) are considered to be modifying factors which can influence the *perceived benefits* and *perceived barriers* of health behavior, such as becoming member of a health insurance. Furthermore, they will also weigh the *perceived benefits* of the program against the *perceived barriers* of the program before deciding about participation.

A *cue to action* is something that can trigger an action, like educational level, information provided or sought, reminders by powerful others, persuasive communications, and personal experiences.[19]

2.3.2 The Behavioral Model for Vulnerable Populations

The Behavioral Model for Health Care Use[20] (see figure 3) was developed in the late 1960s to gain a better understanding why people use health services. The model suggests that health care use depends on factors that enable or hinder such use, and people's need for care.[20]

The revised and expanded BMVP[21] was designed because factors that make populations vulnerable might also affect their use of health services and their health status.[21] This model includes factors to consider when studying the use of health services and health outcomes of vulnerable populations. In case of this study, the investigation of factors related to health care use of vulnerable populations would be useful, since the hypothesis is that one of the most significant determinants of non-membership is poverty.

The key elements of this model are P*redisposing, Enabling* and N*eed* factors. These factors are all divided into traditional and vulnerable factors. The *Predisposing traditional domain* includes demographic characteristics, such as age, gender, and marital status, health beliefs and social structure. Social structure comprises characteristics such as

ethnicity, education, employment, and family size. The *Predisposing vulnerable domain* includes social structure characteristics, such as immigration status, literacy and living conditions (such as running water). The *Enabling traditional domain* includes personal/family resources, such as regular source of care and income. The *Enabling vulnerable domain* includes personal/family resources, such as receipt of public benefits and availability and use of information sources. The *Need traditional domain* includes self-perceptions (perceived need) and objective evaluations (evaluated need) of general population health conditions. The *Need vulnerable domain* includes perceptions and evaluated need regarding conditions of special relevance to vulnerable populations, such as tuberculosis and premature and low-birth weight infants. The *Outcomes* of this model include perceived and evaluated health status and satisfaction with health care.[21]

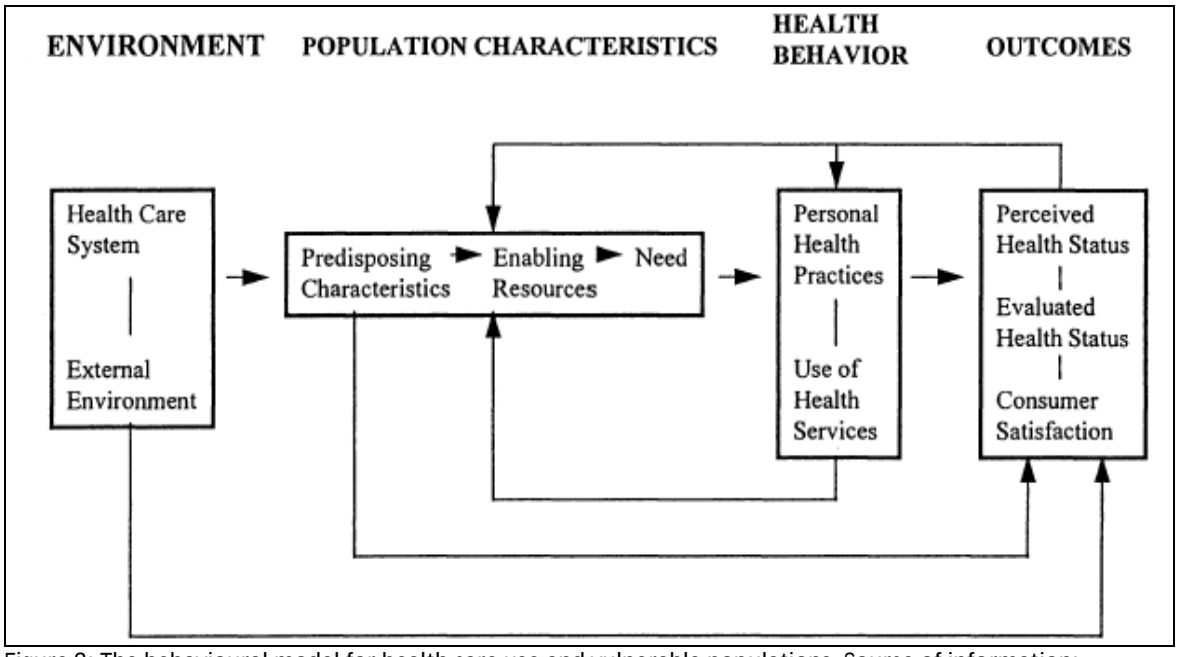

Figure 3: The behavioural model for health care use and vulnerable populations. Source of information: Gelberg L, Andersen RM, Leake BD, 2000 [21].

2.3.3 The research framework

The following framework has been designed for this study (see figure 4). The framework provides a better framing of the main research question and gives an understanding of how the sub questions were derived. Every determinant was based on either the HBM and/or the BMVP. Every determinant of the first part of the research framework was covered by a sub question and the content of these several determinants are described in the next chapter under paragraph 3.1. From every component of the first part of the framework, the associations with membership were researched. The results of these associations led to barriers and facilitators to increase the number of members. Discrepancies between these barriers and facilitators led to the likelihood on increasing the number of members of the Share & Care program.

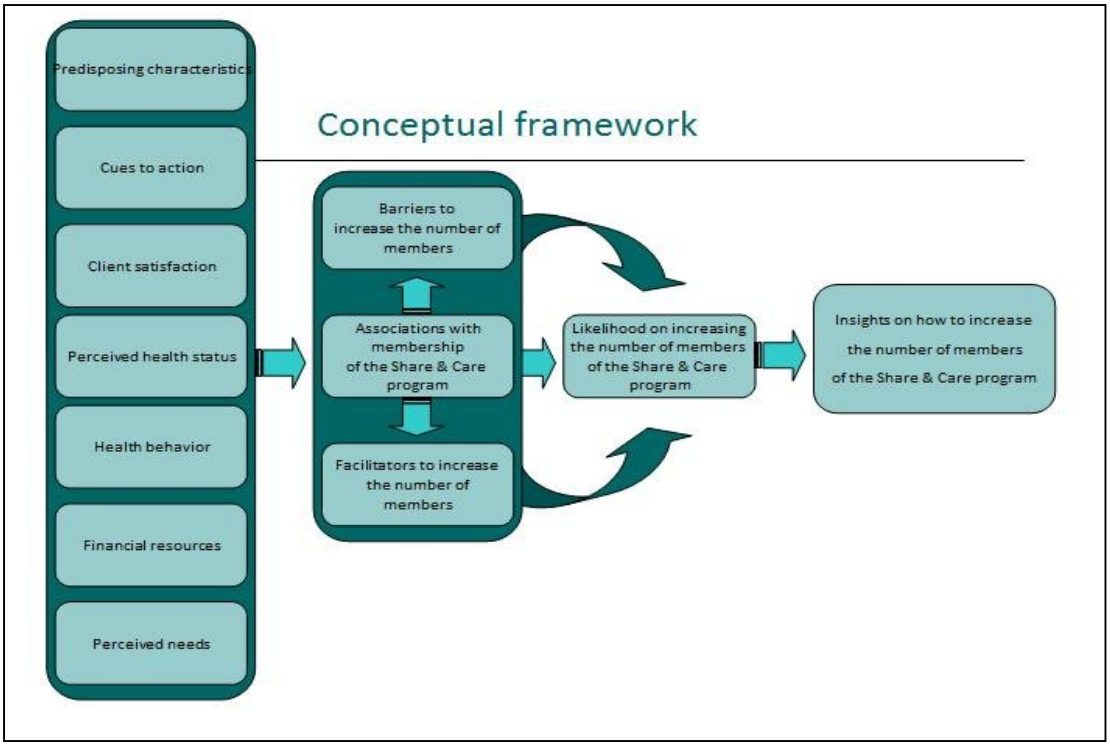

Figure 4: Conceptual framework

Chapter 3. Methodology

In this chapter, the methodology used for this study is described.

3.1 Study design

The study is a combination of an exploratory study with qualitative methods and a case-control study with quantitative methods.

The study has a cross-sectional design; this means that both determinants as the outcome (member/non-member) were measured at the same time. Cross-sectional analysis relates to how variables affect each other at the same time and period. The advantages of a cross-sectional study design are that it is usually quick and cheap, it is possible to study multiple exposures and it usually represents the general population.[22]

3.2 Method selection

Both quantitative and qualitative methods were used in order to answer the various sub questions. This paragraph briefly outlines the methods which were used to answer the different sub questions.

1. *What is the association between predisposing characteristics and membership of the Share & Care program?*
   Predisposing characteristics of the households include demographic variables such as ethnicity, religion, major source of income, family income, family type, family size, education, marital status, migration and SES.

   The predisposing characteristics were examined using a semi-structured questionnaire.

2. *What is the association between cues to action and membership of the Share & Care program?*
   With a cue to action, like in the HBM[17], is meant something that can trigger an action, like information provided or sought, reminders by powerful others, persuasive communications, and personal experiences. Cues to actions were divided into discouraging and encouraging cues to actions.

   Encouraging cues to action included knowledge of the Share & Care program and positive influences of others, like positive experiences of other members. Discouraging cues to action included negative influences of others, like negative experiences with the Share & Care program. Furthermore, another category of the discouraging cues to action were people who were in the precontemplation phase, which means they are not interested in becoming a member for no particular mentioned reason. Moreover, lack of knowledge and information regarding the Share & Care program and the benefits of it were considered as another discouraging cue to action as well.

   The cues to action were examined using both open-ended as categorical questions in the semi-structured questionnaire.

3. *What is the association between client satisfaction and membership of the Share & Care program?*

   Client satisfaction consisted of perceived quality of the Share & Care program and perceived health care quality of the SHP.

   Perceived quality of the Share & Care program consisted of perceived benefits and disadvantages of the Share & Care program, perceptions of the membership fees and perception of the quality and attitude of the staff of the Share & Care program.

   Perceived health care quality consisted of perceived benefits of the medical additions which were made by the Share & Care program. These were grouped into perceived benefits of the additions which were made to the medicine stock, treatment, medical facilities or other facilities. Furthermore, satisfaction and perceived overall quality of the SHP was measured.

   Client satisfaction was measured using both open-ended as categorical questions within the semi-structured questionnaire.

4. *What is the association between evaluated health status and membership of the Share & Care program?*

   Evaluated health status consisted of perceived susceptibility and the prevalence of perceived chronic diseases, activity limitations and other health problems than a chronic disease. Perceived health status was measured using the question '*How healthy do you consider yourself?'* in which the participants had the options *excellent, good, fair* and *poor.* Furthermore, the number of illnesses which a participant had suffered from in the last year was inquired.

   These variables were inquired with help of categorical questions in the semi-structured questionnaires. To validate each other and to draw more reliable conclusions, perceived health status was investigated with help of a Focus Group Discussion (FGD) as well.

5. *What is the association between health behavior and membership of the Share & Care program?*

   The determinant health behavior comprised use of self-medication and health care use. Health care use consisted of the use of health institutions other than the SHP, first consultation in case of a medical problem, perception of which health facility was closest by situated and the number of visits to the SHP in the last year.

   The relationship between health behavior and membership was examined using the semi-structured questionnaires.

6. *What is the association between financial resources and membership of the Share & Care program?*

   The component financial resources consisted of knowledge of the membership fees, ability and willingness to pay the membership fees and the perception of the membership fees.

   Financial resources were investigated with the help of the semi-structured questionnaire.

7. *What are the perceived needs and additions of members and non-members towards the Share & Care program?*
   The needs and expectation of members and non-members towards the Share & Care program were examined using the semi-structured questionnaire and focus groups.

3.3 Literature research

Literature research has been performed to investigate the optimal quantitative and qualitative research methods for this study and to cross-validate the results of this study in the discussion chapter. Furthermore, a literature study was done in order to investigate other existing health insurance systems in Nepal. Pubmed and Google Scholar were used and the following key words were searched after:
Health AND (1) *quality of life tools,* (2) *system Nepal,* (3) *Nepal population,*(4) *research frameworks. Nepal* AND (1) *self-medication,* (2) *insurance systems,* (3) *micro insurance,* (4) *Focus group design,* (5) *sustainability* AND *health insurance,* (6) *culture* AND *health,* (7) *poverty* AND *illiteracy,* (8) *perceived health status,* (9) *moral hazard. Model* AND (1) *Health belief,* (2) *Access to health care,* (3) *Health related behavior,* (4) *health. Characteristics* AND (1) *baseline assessment, (2) epidemiological studies,* (3) *research. Methodology* AND (1) *Focus Group Discussion,* (2) *interview training,* (3) *validation questionnaires,* (4) *sample size calculation. Focus Group* AND (1) *design,* (2) *visualization methods,* (3) *training. Behavioral model for vulnerable populations, Lalitpur Health Insurance scheme, BPKIHS, hospital based micro-social health insurance scheme*, *Health Cooperative Model.*

3.4 Quantitative methodology

In this section an overview of the epidemiological methodology with respect to this study is presented. First, the research design and the research population of the study are described. Lastly, more detailed information is provided concerning the followed procedure of the data collection.

3.4.1 Data collection method

All sub-questions were measured with the help of semi-structured questionnaires (see appendix I). The semi-structured questionnaires were conducted by trained interviewers (see 3.5.2. for more details about the training).

3.4.2 Sampling method

To better represent the whole VDC, the membership households per ward were selected by stratified random sampling. Stratification is the process of grouping members of the population into relatively homogeneous subgroups before sampling.[23] In this study, the number of members in each ward was calculated and from each ward, a proper percentage of membership households were selected. For the non-membership households, the neighboring households of the membership households were selected.

3.4.3 Research population

The study was conducted in the two pilot communities of the Share & Care program, Mechchhe and Hansposha. When the head of the household was present at the time of the interview, he/she was asked to participate in the research. When he/she was not present, another household member within the age category of 18-45 years was asked to participate. The household was excluded from the survey if the above mentioned criteria were not met.

The sample size was calculated with the help of the statistical program Epicalc 2000. Taken into account a 95% confidence level, a 5% confidence interval, an expected Odds Ratio (OR) of 3 with an expected 20% of the controls to be exposed and a 10% non response rate, the random sample in both VDCs consisted of at least 64 non-members and 64 members of the Share & Care program (Van Brakel W, written communication, 2010).

3.4.4 Measures

Semi-structured questionnaires were used to investigate the variables which are explained in paragraph 3.2. The questions were either categorical, numerical (continuous) or open ended. The questionnaires were validated by conducting pilot interviews in Narayansthan, another Share & Care VDC, and not belonging to the study population.

At the request of the KFN, the questionnaires for Mechchhe and Hansposha were slightly different, due to differences in caste distribution and differences in existence of cheap and expensive assets (Shrestra A, oral communication, 26th March 2010).

The questionnaires were designed in English and translated into Nepali. Since the interviewers could speak English properly and due to lack of time, the answers to the open-ended questions were directly written down in English.

3.4.5 Informed consent

Approval for interviewing the participants was obtained by asking those persons for their written consent. The participants were ensured of confidentiality and the voluntary character of participation in the project.

3.5 Qualitative methodology

In this section an overview of the qualitative methodology with respect to the study is presented.

3.5.1 Interview methodology

The semi-structured questionnaires were conducted by trained interviewers and not by self-completion. This method was chosen because of different reasons. By conducting a questionnaire, participants had the freedom to discuss their experiences and expectations in greater detail and at greater length compared to a questionnaire which they had to fill in their selves.[24] Another reason for conducting the questions with the help of interviewers was that a large percentage of the inhabitants of Mechchhe and Hansposha were expected to be illiterate.

3.5.2 Training of the interviewers

To ensure a more standardized application of the semi-structured questionnaires, the interviewers received a 5-day training. The training clarified the rationale of the study and study protocol, it motivated the interviewers to a certain extent, it provided practical suggestions and tools for interviewing and last but not least, it improved the overall quality of the collected data as much as possible. Moreover, the training probably led to a better intra and inter-observer reliability, since every interviewer received the same interview skills and thereby conducted the interview in the same way.[24]

The training consisted of theory, written exercises, role playing and real life exercises in the form of pilot interviewing. Furthermore, to be sure that every question was clear to everyone, the questions were reviewed and discussed. The schedule of the whole training can be found in appendix II.

3.5.3 Focus Group Discussion methodology

Since it was believed to be very important to investigate in-depth knowledge and the structure of values and beliefs, FGDs were held on several topics. FGDs are sites of social interaction where meaning and understanding are reconstructed.[24] The FGD was led by a facilitator, a note taker and an observer. Every FGD consisted of 5-12 participants and was held in the Nepali language, the notes were taken in English. Therefore, the FGD facilitator and the note taker both knew Nepali and English.

3.5.4 Focus Group Discussion designs

FGDs were held among members and non-members on different topics. One FGD was held to explore the differences in health care perception of members and non-members. Another FGD was conducted to explore the differences in perceived health status of members and non-members (see appendix III).

In each FGD, it was believed to be important to create a conversational environment in which the atmosphere was safe and non-threatening. In every FGD, it was desirable that the participants felt at ease to speak and express their opinions, but in such a way that the conversation was about the intended topic.[24] Every FGD followed the semi-structured method of circling in.[24] With this method, first different opinions about the intended subject were asked. After sharing these different opinions, the participants were asked more in-depth about their opinion. The different opinions were categorized and relations between the different categories were made by the participants themselves. At last, the participants were asked to prioritize these different categories.

3.7 Analysis

In this paragraph, the analyses methods used for this study are described. First, the methods used for the quantitative data analyses are presented. Second, the methods with regard to the qualitative data analyses are outlined.

3.7.1 Quantitative data analysis

Descriptive analysis was performed to describe the differences between members and non-members. The variables which were categorical and continuous were used for the

statistical analyses. The strength of association was investigated for the independent variables. These individual Odds Ratios (OR) are presented in Appendix IV

A multivariate backward logistic regression analysis was used to investigate which factors had an independent (statistical significant) association with membership. The dependent variable in this analysis is membership of the Share & Care program. This is a dichotomous variable. From the independent variables, only those variables with a p-value up to 0,1 in the univariate logistic regression were included in the model. A stepwise backward procedure was followed in which manually the least significant variables were excluded from the model. From the independent categorical variables, the category with the highest count was chosen as the reference category. From the variables with nominal values, the first category was chosen as the reference category. To conduct a reliable analysis, related categories were combined. Therefore, for some categories, combined ORs are given.

With multivariate logistic regression, the probability of confounding was eliminated (van Brakel W. 2010, oral communication, 4th August). Possible effect modifiers and correlation coefficients were argued and tested for. Furthermore, the Hosmer and Lemeshow test indicated the goodness of fit of the model and the Nagelkerke Rsquare was used to give indications on how well the variables within the final model predict membership.[23] A database was made in Epi-info and the analysis was performed in SPSS 16.0.

3.7.2 Qualitative data analysis

The open ended questions from the semi-structured questionnaire and the focus groups were analyzed using the grounded theory approach.[24] With this approach, the analytical concepts arose from the data during analysis and were further grouped into categories. Categories were created by the process of comparing similarities and differences between the different concepts.[24]

The process of analysis contains the following sequence of steps;

- The collected data from the questionnaires was explored and important themes and patterns were identified.
- The important themes and patterns were divided into different categories by comparing text fragments on similarities and differences.
- The different categories were refined and differentiated.
- Different patterns for the categories were researched and the categories were grouped into different determinants and a coding guide was developed (see appendix V).
- From the newly developed determinants, the research framework was revised and adapted.
- Hypotheses about relationships between the different concepts were developed and these were tested within the data and described in the discussion.
- The quality of the questions is evaluated in the discussion chapter and compared to concepts of other frameworks and other findings in the literature.

Furthermore, the different concepts of the conceptual frameworks described in paragraph 2.3 were kept in mind when defining the different concepts and categories. Using these models, the interpretability of the qualitative data was easier and believed to be more reliable.

Chapter 4. Results

In this chapter, the findings of this study are presented. First, the outcomes of the multivariate logistics regression analyses are given. Second, more specific results from Mechchhe and Hansposha are described in the same order as the determinants within the research framework. From the open-ended questions, only the most remarkable findings and answers are discussed and presented in combination with and in relation to the quantitative results. From the quantitative results, only the variables which were statistical significant in the multivariate logistic analysis are outlined.

4.1 Outcomes multivariate logistic regression

In this paragraph, the results of the multivariate logistic regression models are presented.

4.1.1 Mechchhe

In Mechchhe, the variables which were included in the model were *education, knowledge of the Share & Care program, knowledge of the benefits, satisfaction with the SHP, perceived health problems, number of illnesses in the last year, number of visits to the SHP in the last year, knowledge of the membership fees, perception of the membership fees, ability to pay the membership fees* and *willingness to pay the membership fees*. In table 1, the final model is presented.

Table 1: Final model of the multivariate logistic regression of Mechchhe.

	OR	95% CI	P-value
Knowledge of the Share & Care program	5,7	2,1 – 17,4	0,006
Perception of the membership fees Not expensive	6,7	3,2 – 19,3	0,004
Number of visits to the SHP	3,2	1,5 – 6,9	0,002
Ability to pay the membership fees	4,9	2,4 – 14,5	0,005
Willingness to pay the membership fees	5,2	1,8 – 15,6	0,002

As can be seen in table 1, *knowledge of the Share & Care program, perception of the membership fees, number of visits to the SHP, ability to pay the membership fees* and *willingness to pay the membership fees* showed to be significantly related to membership. None of the variables was significantly modified by another variable. The Hosmer and

Lemeshow P-value for this model was 0,35, so the model fits. The Nagelkerke Rsquare was of 0,66 which means that the model correctly predicts membership for 66% of the member participants of this study.

4.1.2 Hansposha

In Hansposha, the variables which were included in the model were *religion, family type, major source of income, SES, knowledge of the Share & Care program, knowledge of the benefits, knowledge of the membership fees, satisfaction with the SHP, perception of the overall quality of the SHP, perceived health problems, practice of self-medication, number of visits to the SHP in the last year, first consultation in case of a medical problem, perception of the health facility which is closest by, perception of the membership fees, ability to pay the membership fees* and *willingness to pay the membership fees*. In table 2, the final model is presented.

Table 2: Final model of the multivariate logistic regression of Hansposha.

	OR	95% CI	P-value
SES Middle income Rich	 3,0 8,8	 1,7 – 8,2 2,3 – 14,1	 0,04 0,001
Knowledge of the benefits	4,8	2,7 – 13,7	0,003
Satisfaction with the SHP Satisfied	 3,7	 1,8 – 10,6	 0,02
First consultation in case of a medical problem SHP	 7,4	 2,1 – 21,4	 0,003
Willingness to pay the membership fees	8,0	3,2 – 30,2	0,006

As can be seen in table 2, *SES, knowledge of the benefits, satisfaction with the SHP, first consultation in case of a medical problem* and *willingness to pay the membership fees showed to be significantly related to membership*. None of the variables showed to be significantly modified by another variable. The Hosmer and Lemeshow P-value for this model was 0,75, so the model fits. The Nagelkerke Rsquare was 0,64 which means that the model correctly predicts membership for 64% of the member participants of this study.

4.2 Predisposing characteristics

General

In Mechchhe, a total of one hundred and forty-one participants were included in the study, with a distribution of seventy-two members and sixty-nine non-members. In Hansposha, a total of two hundred and fourteen participants were included in the study, with a distribution of one hundred eight members and one hundred six non-members. Table 3 shows the general characteristics of the interviewed members and non-members in Mechchhe and Hansposha.

Table 3: General characteristics of Mechchhe and Hansposha.

General	Mechchhe		Hansposha	
	Members	Non-members	Members	Non-members
	72	69	108	106
Sex Females	44 (61%)	41 (59%)	84 (77,8%)	86 (81,1%)
Mean age (yrs)	31 years	34 years	36 years	32 years
Caste Tamang Chattri Lama Brahmin Dalit Newar Magar Rai Tharu Limbu Gurung Mushar Other	 49(68,1%) 9 (12,5%) 3 (4,2%) 2 (2,8%) 3 (4,2%) 6 (8,3%) -- -- -- -- -- -- --	 50 (72,5%) 6 (8,6%) 5 (7,2%) 2 (2,9%) 2 (2,9%) -- 3 (4,3%) 2 (2,9%) -- -- -- -- --	 3 (2,8%) 17 (15,7%) -- 13 (12%) 8 (7,4%) 3 (2,8%) 5 (4,6%) 15 (13,9%) 10 (9,3%) 2 (1,9%) 4 (3,7%) 1 (0,9%) 27 (25%)	 2 (1,9%) 25 (24,0%) -- 13 (12,5%) 5 (4,8%) 3 (2,9%) 2 (1,9%) 24 (23,1%) 8 (7,7%) 7 (6,7%) 4 (3,8%) -- 11 (10,6%)
Religion Hindu Buddhist Other	 21 (29,2%) 51 (70,8%)	 13 (18,8%) 55 (79,7%) 1 (1,4%)	 87 (80,6%) 8 (7,4%) 12 (11,1%)	 95 (91,3%) 5 (4,8%) 4 (3,8%)
Marital status Married Unmarried Divorced Widower	 59 (81,9%) 10 (13,9%) 1 (1,4%) 2 (2,8%	 63 (91,3%) 2 (2,9%) 0 (0%) 4 (5,8%)	 96 (88,9%) 8 (7,4%) 0 (0%) 3 (2,8%	 90 (86,5%) 9 (8,7%) 2 (1,9%) 3 (2,9%)
Mean family size	7 members	5 members	6 members	5 members
Mean income per month	NRs 4000	NRs 4800	NRs 36,480	NRs 36,790

General	Mechchhe		Hansposha	
Major source of income				
Agriculture	62 (86,1%)	56 (81,2%)	36 (33,3%)	26 (25,0%)
Small trade	4 (5,6%)	1 (1,4%)	37 (34,3%)	24 (23,1%)
Service	3 (4,2%)	1 (1,4%)	12 (11,1%)	9 (8,7%)
Wage labor	1 (1,4%)	5 (7,2%)	2 (1,9%)	10 (9,6%)
No occupation	2 (2,8%)	6 (8,7%)	3 (2,8%)	6 (5,8%)
Foreign employment			18 (16,7%)	29 (27,9%)
Education				
Illiterate	31 (43,1%)	45 (65,2%)	17 (15,7%)	20 (19,2%)
Literate	22 (30,6%)	17 (24,6%)	39 (36,1%)	30 (28,8%)
Completed primary education	9 (12,5%)	4 (5,8%)	22 (20,4%)	29 (27,9%)
Completed secondary education	3 (4,2%)	2 (2,9%)	30 (27,8%)	25 (24%)
Going to school	7 (9,7%)	1 (1,4%)		
Socio-economic status				
Destitute	11 (15,3%)	8 (11,6%)	2 (1,9%)	1 (1,0%)
Poor	35 (48,6%)	36 (52,2%)	13 (12,0%)	30 (28,8%)
Middle income	15 (20,8%)	18 (26,1%)	62 (57,4%)	54 (51,9%)
Rich	10 (13,9%)	7 (10,1%)	31 (28,7%)	19 (18,3%)

In Mechchhe, illiteracy was found to be significantly related to the ability to pay the membership fees. Illiterate participants were 4,6 times more likely to not being able to pay the membership fees (P 0,03).

In Hansposha, SES was found to be significantly related to membership (Middle income; P 0,04, Rich; P 0,001, see table 2). The second largest group of members were categorized in the category rich, whereas the second most common group of non-members were grouped into the category poor (see table 3).

4.3 Cues to action

Both in Mechhche and Hansposha, almost all members had knowledge of the Share & Care program. Fewer non-members had heard of the program, although in both VDCs, still a majority of the non-members had heard of the program (see table 4). In Mechchhe, knowledge of the Share & Care program was significantly related to membership (P 0,006, see table 1).

Compared to knowledge of the Share & Care program, fewer members were able to mention some benefits of the Share & Care program, although still a large part of the members could list some of the benefits. Non-members had less knowledge of the

benefits compared to members. In Hansposha, knowledge of the benefits (P 0,003, see table 2) was found to be significantly related to membership.

Table 4: Knowledge of the Share & Care program and the benefits in Mechchhe and Hansposha.

	Mechchhe		Hansposha	
	Members	Non-members	Members	Non-members
Knowledge of the Share & Care program	69 (95,8%)	51 (59,4%)	107 (99,1%)	78 (75%)
Knowledge of the benefits	52 (72,2%)	23 (33,3%)	99 (91,7%)	51 (49%)

Encouraging cues to action

Both in Mechchhe and Hansposha, the majority of the members and non-members got their knowledge of the Share & Care program from the staff of the Share & Care program (see figure 6). In Mechchhe, twenty-four (33,3%) members got their knowledge from volunteers who were involved in the Share & Care program, whereas only five (7,2%) non-members got their knowledge from those volunteers. Another finding was that nineteen (27,5%) non-members who knew the program, got their knowledge mostly from mouth-to-mouth advertisement, like from neighbors or other villagers (see figure 6).

Both in Mechchhe and in Hansposha, non-members did not get positively influenced by others, whereas in Mechchhe five (7,4%) and in Hansposha sixteen (15,2%) of the members did became member because of positive influences;

'Everyone is a member and people are very enthusiastic, so we became member as well (Mechchhe)'
'All neighbors became member and they suggested us to become member as well (Hansposha)'.

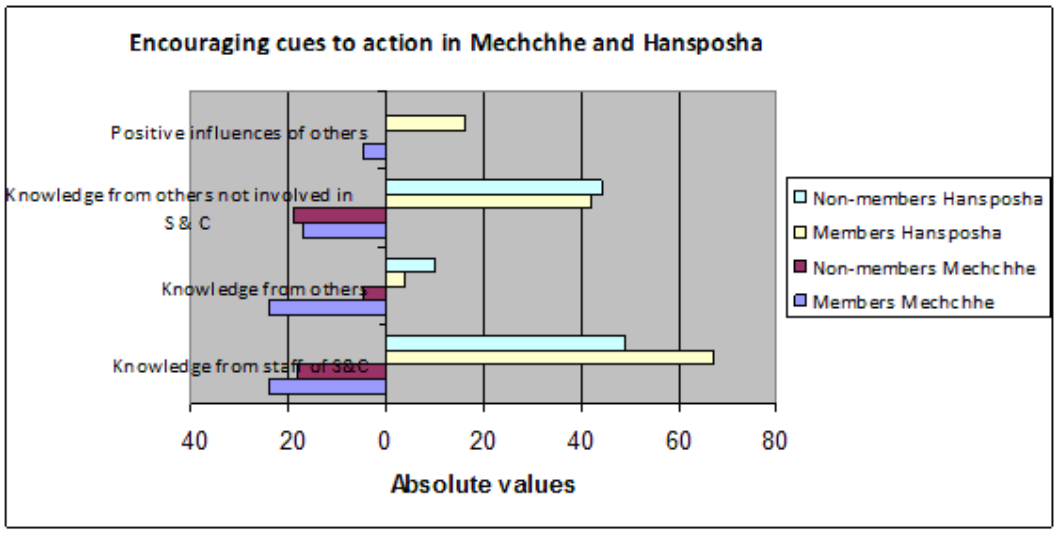

Figure 6: Encouraging cues to action in Mechchhe and Hansposha.

Discouraging cues to action

Both in Mechchhe and in Hansposha, the most discouraging cues to actions came from a lack of proper information (see figure 7). In Mechchhe, twenty (27,8%) members mentioned they did not know what the program was about;

> '*I am a member, but I don't know what the benefits of the program are'.*

In addition, twenty-seven (38,8%) non-members specifically mentioned that they did not became member, because of insufficient information;

> '*I did not get enough information about the program, so I don't know why the membership would be beneficial for me'.*

Discouraging cues to action coming from the precontemplation phase or negative influences of others were negligible (see figure 7).

In Hansposha, none of the members reported to be having discouraging cues to action coming from a lack of information, precontemplation phase or negative influences from others. Among non-members, almost one third (thirty-one, 29,2%) did not become member because of insufficient or incorrect information;

> '*A mobile team came and said that the program was meant for poor people and not for us, so I became disinterested in this program.'*

Compared to Mechchhe, a larger percentage (twenty-two, 20,7%) of the non-members did not become member because they were not interested in the program (precontemplation phase). Furthermore, nine (8,5%) non-members were discouraged to become member because they were negatively influenced by others (see figure 7).

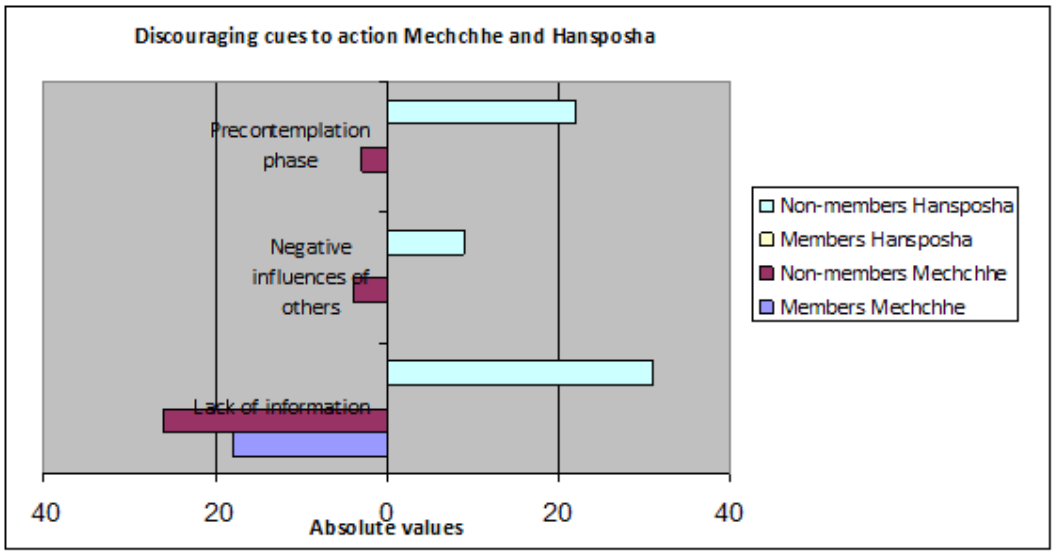

Figure 7: Discouraging cues to action in Mechchhe and Hansposha.

4.4 Client satisfaction

Evaluated quality of the Share & Care program

In Mechchhe, the most reported benefits by members were that the health post is nearby (mentioned by five members which is equal to 7,4%) and that the services had improved compared to the situation before the program was introduced (mentioned by four members, 5,9%). Four (6,1%) non-members noticed an improvement in service as well;

'Even for us, the service has improved significantly'.

In Hansposha, the most frequently reported benefits by members were that security was obtained about having access to health care (mentioned by fifteen members, 14%) and that the health post was nearby (also mentioned by fifteen members, 14%). Among non-members, certainty of having access to health care was perceived as a possible benefit by six (5,6%).

In Mechchhe and Hansposha, both members and non-members were satisfied with the SHP (see table 5). However, in Hansposha a large percentage (58,6%) of the non-members mentioned they didn't know what their opinion was of the SHP (see figure 13). The reason for this will become clear in paragraph 4.1.5 about health behavior of the participants.

Table 5: Satisfaction with the SHP in Mechchhe and Hansposha.

	Mechchhe		Hansposha	
	Members	Non-members	Members	Non-members
Very satisfied	4 (5,6%)	1 (1,4%)	6 (5,6%)	1 (1%)
Satisfied	63 (87,5%)	54 (78,3%)	86 (79,6%)	12 (11,5%)
Not satisfied	2 (2,8%)	6 (8,7%)	7 (6,5%)	5 (4,8%)
Don't know	3 (4,2%)	8 (11,6%)	9 (8,3%)	61 (58,7%)

In Mechchhe, satisfaction with the SHP and perceived overall quality of the SHP were not significantly related to membership (Satisfaction with the SHP; P 0,08, Overall quality of the SHP; P 0,27, see Appendix IV). This outcome is in contrast to Hansposha, where satisfaction with the SHP was found to be significantly related to membership (P 0,02).

In Mechchhe, none of the members perceived disadvantages with the Share & Care program, whereas six (8,7%) non-members did. Non-members were mostly (four, 5,8%) dissatisfied with the Share & Care renewal system, as some argued that they did not receive correct information about the renewal system. Others mentioned they were dissatisfied with the fact that they had to renew and thus had to pay the membership fees every year.

In Hansposha, three (2%) members mentioned perceived disadvantages with the Share & Care program, as they reported that their expectations remained unfulfilled. Unfortunately, it was not further defined which expectations remained unfulfilled. Among non-members, eighteen (17,9%) mentioned that they did not become member because of negative experiences they had with the program. These perceived disadvantages were grouped in two categories; perceived disadvantages of non-members with the Share & Care program (nine, 8,5%) and perceived disadvantages with the quality of the Share &

Care staff (ten, 10,4%). As in Mechchhe, dissatisfaction with the renewal system was reported (three non-members, 2,8%). Furthermore, uncertainty about the continuity of the program was mentioned (respectively three times, 2,8%). Dissatisfaction with the quality and attitude of the staff of the Share & Care program was mentioned by ten (10,4%) non-members. Most of them (seven, 6,6%) were dissatisfied with the quality and attitude of the health worker;

'*the health assistant cannot provide good service',*
'*the health workers makes bad diagnoses'*

The other three (3,8%) were not satisfied with the management of the Share & Care program, as they mentioned the management was bad and not transparent enough.

Perceived health care quality

Both in Mechchhe and Hansposha, members and non-members mentioned benefits about the provision of medicines most frequently. The improvement of the quality of medicines and the provision of free medicines were believed to be the most important benefits of the Share & Care program. Perceived benefits in relation to treatment (qualitative better and free treatment*)* and medical facilities *(*good referral facility*)* were the second and third most important benefits mentioned.

In Mechchhe, none of the members perceived disadvantages with the quality of health care. Nine (13%) non-members mentioned lack of quality of the health care as a reason for not becoming member of the Share & Care program;

'*It is not worth it because only simple cases are treated and for complicated cases we still need to go to Kathmandu'* (mentioned by six (8.6%) non-members).

In Hansposha, none of the members reported disadvantages related to the health care quality at the SHP. In contrast, thirteen (12,2%) non-members mentioned disadvantages according to the health care at the SHP. Perceived dissatisfaction with the SHP was brought up by ten (9,4%) non-members;

'*It is closed before 6PM',*
'Because the SHP is small, it does not meet all the required medical facilities'
'*It is too far'.*

Furthermore, half of the non-members (fifty-three, 51,2%) reported that there are better hospitals in the surrounding areas.

4.5 Perceived health status

Perceived health status

The question '*How healthy do you consider yourself?'* gave indications about the perceived health status of the study population. As can be seen in table 6, the perception on health of members and non-members was found to be more or less similar both in Mechchhe and Hansposha. Perceived health status was not significantly related to membership (Mechchhe; P0,34, Hansposha; P 0,54, see appendix IV).

In Mechchhe, seventeen (22,2%) members brought up reasons for becoming member of the Share & Care program which are categorized under perceived

susceptibility. Those members argued that membership would benefit their health and the health of their family. In Hansposha, perceived susceptibility was a reason for becoming member of the Share & Care program for twenty-eight (25,9%) members.

Table 6: Perceived health status of members and non-members in Mechchhe and Nepal.

	Mechchhe		Hansposha	
	Members	Non-members	Members	Non-members
Excellent	1 (1,4%)	0 (0%)	3 (2,8%)	2 (1,9%)
Very good	1 (1,4%)	2 (2,9%)	34 (31,5%)	5 (4,8%)
Good	29 (40,3%)	31 (44,9%)	58 (53,7%)	35 (33,7%)
Fair	38 (52,8%)	32 (46,4%)	4 (3,7%)	56 (53,8%)
Poor	3 (4,2%)	4 (5,8%)	9 (8,3%)	6 (5,8%)

Illnesses

Both in Mechchhe and Hansposha, perceived chronic diseases and perceived activity limitations were almost equally present among members and non-members (see table 7). These health problems showed no significant relation with membership (Mechchhe; P 0,75, Hansposha; P 0,11, see Appendix IV) In both VDCs, the presence of other health problems than chronic diseases was higher among members compared to non-members (see table 7). Unfortunately, which health problems were present was not further specified. No significant relationship between the presence of other health problems and membership was found in the multivariate logistic regression analysis of Mechchhe (P 0,28) and Hansposha (P 0,11).

Table 7: Presence of illnesses in Mechchhe and Hansposha.

	Mechchhe		Hansposha	
	Members	Non-members	Members	Non-members
Chronic disease	8 (11,1%)	6 (8,7%)	23 (21,3%)	18 (17,3%)
Other health problems	30 (41,7%)	17 (24,6%)	33 (30,6%)	17 (16,3%)
Activity limitations	5 (6,9%)	5 (7,2%)	12 (11,1%)	6 (5,8%)
Mean incidence of illnesses	5	3	3	3

In Mechchhe, the mean incidence of illnesses in the last year was higher among members compared to non-members (see table 7). In Hansposha, the mean incidence of illnesses in the last year was similar among members and non-members (see table 7). The mean incidence of illnesses in the last year was not found to be significantly related to membership in the multivariate logistic regression analysis both in Mechchhe (P 0,08) as in Hansposha (P 0,33)

4.6 Health behavior

In Mechchhe, the practice of self-medication was slightly lower among members (eight, 11,1%) compared to non-members (eleven, 15,9%). Self-medication was not found to be significantly related to membership (P 0,40, see appendix IV). In Hansposha, the use of self-medication was less frequently present among members (thirty-six, 33,3%) compared to non-members (fifty-three, 50%). However, practice of self-medication was not found to be significantly related to membership within the multivariate analysis.

In Mechchhe, for both members and non-members, the SHP was the first place where they went in case of a medical problem and they perceived the SHP as the health facility which was closest by situated (see table 8).

In Hansposha, a difference can be seen between members and non-members when looking at the health institution which was consulted first in case of a medical problem. As can be seen in table 8, eighty-five (78,6%) members consulted the SHP or the sub centre first, while only eighteen (18,3%) non-members consulted these institutions first. Fifty-three (51%) of the non-members consulted a private clinic first, and twenty-three (22,1%) went to the hospital in case of a medical problem. There was a significant relationship between the facility which was consulted first in case of a medical problem and membership in the multivariate logistic regression (P 0,003, see table 2). This difference was also found in the perception of the health facility which was closest to their home (see table 8). However, the relationship between the perception which health facility was closest by and membership was not found to be significantly related in the multivariate logistic regression analysis (P 0,09).

Table 8: The health facility which was consulted first in case of a medical problem.

	Mechchhe		Hansposha	
	Members	Non-members	Members	Non-members
SHP	70 (97,4%)	59 (84,4%)	85 (78,7%)	18 (17,3%)
Hospital	1 (1,4%)	6 (8,7%)	8 (7,4%)	23 (22,1%)
Private clinic	1 (1,4%)	2 (2,9%)	13 (12%)	53 (51,0%)
Traditional Healer	0 (0%)	1 (1,4%)	2 (1,9%)	6 (5,8%)
Other	0 (0%)	1 (1,4%)	0 (0%)	4 (3,8%)

In Mechchhe, the average number of SHP visits in the last year was four times for members. The average number of SHP visits for non-members visited was two times. The number of visits was significantly related to membership (P 0,002, see table 1). In Hansposha, members visited the SHP three times and non-members 0,5 times in the last year. However, this relationship was not found to be significantly related to membership in the multivariate logistic regression analysis (P 0,11).

4.7 Financial resources

In Mechchhe, when reviewing the ability and willingness to pay the membership fees, a difference can be seen. Whereas sixty-one (70,8%) members reported to be able to pay the membership fees, only fourteen (20,2%) non-members reported to be able to pay the membership fees. Both the ability and the willingness to pay the membership fees showed to be significantly related to membership in the multivariate logistic regression analysis (Ability to pay; P 0,002, Willingness to pay; P 0,004, see table 1). In addition, upon the question '*What is the most important reason for not being a member of the Share & Care program?'* twenty-two (31,8%) non-members specifically mentioned lack of money as the most important reason for refraining from membership;

'*I can pay NRs. 500 per year but I cannot pay NRs. 1,000 per year'.*

A difference in the perception of the membership fees between members and non-members was found (see table 9). Most members (thirty-four, 47,2%) perceived the membership fees as not expensive, whereas the majority (twenty, 29,0%) of the non-members considered the membership fees as expensive. The perception of the membership fees was significantly related to membership (P 0,004, see table 1). This corresponds with the finding from the open-ended question where twenty-two non-members refrained from membership because they were unable to pay the membership fees.

Table 9: Perception of the membership fees of the Share & Care program.

	Mechchhe		Hansposha	
	Members	Non-members	Members	Non-members
Too expensive	1 (1,4%)	6 (8,7%)	1 (0,9%)	0 (0,0%)
Expensive	4 (5,6%)	20 (29%)	5 (4,6%)	8 (7,7%)
Not expensive	34 (47,2%)	13 (18,8%)	58 (53,7%)	45 (43,3%)
Cheap	20 (27,8%)	3 (4,3%)	37 (34,3%)	21 (20,2%)
No opinion	13 (18,1%)	27 (39,1%)	7 (6,5%)	27 (26%)

In Hansposha, ninety-eight (90,7%) members and fifty-nine (56,7%) non-members responded that they were able to pay the membership fees. Furthermore, almost all (ninety-five, 88%) members were willing to pay the membership fees while far less non-members (thirty-seven, 35,6%) were willing to pay these costs. Willingness to pay the membership fees was significantly related to membership in the multivariate logistic regression analysis (P 0,006, see table 2).

As can be seen in table 9, both members and non-members did not perceive the membership fees as too expensive. Perception of the membership fees was not found to be significantly related to membership in the multivariate analysis (P 0,12).

4.8 Perceived needs

Medicines

In Mechchhe, recommendations about the stock of medicines were made by twelve members (18%). Five (6,9%) members suggested to obtain qualitatively better medicines compared to those that are now kept in stock. Five (6,9%) members recommended to expand the medicine stock in order to be able to treat a larger variety of diseases. Eight (11,6%) non-members made recommendations about the stock of medicines. Expansion of the stock of medicines was mentioned by four (5,8%) non-members and improvement of the quality of the medicines was suggested by three (4,3%) non-members.

In Hansposha, expansion of the medicine stock was suggested by three (2,7%) members and two (1,9%) non-members. The provision of more and expensive medicines were the only suggestions which came up.

Treatment

In Mechchhe, suggestions to broaden the different types of treatment were mentioned by seven (9,7%) members, of whom four (5,6%) emphasized that the SHP should be able to treat chronic diseases. Six (8,7%) non-members came up with suggestions to broaden to the treatment facilities, of whom three (4,3%) recommended an expansion of the different sorts of treatment, and the other three (4,3%) desired that the SHP had the capacity to treat chronic diseases.

In Hansposha, eleven (10,2%) members suggested to broaden the different sorts of treatment in order to be able to treat more complicated cases. Two (1,8%) members pointed out that clients should be treated on time. One (0,9%) non-member recommended qualitative better treatments, as he was dissatisfied with the quality of the treatment at this moment.

Medical facilities

Recommendations about the medical facilities were forming the main suggestions mentioned by members in both Mechchhe and Hansposha.

In Mechchhe, forty-eight (66,7%) members made recommendations about the facilities. Additions of several medical facilities, such as a laboratory, an x-ray department, maternity and ambulance facilities were mentioned most frequently (forty-two times, 58,3%). Furthermore, employment of a qualified doctor was mentioned by six (8,3%) members. Non-members came up with recommendations about the medical facilities less frequently compared to members, respectively twelve (17,4%) times. Expansion of the medical facilities was mentioned eight (11,6%) times, and the employment of a qualified doctor six (8,7%) times.

In Hansposha, eighty-eight (81,5%) members and eighteen (17,0%) non-members suggested to extend the available medical facilities. The largest group of the members recommended to employ a qualified doctor (mentioned by twenty-two, 20,4%). In contrast to the earlier described dissatisfaction about the unavailability of a qualified doctor, none of the non-members suggested to employ a qualified doctor.

The remaining members advised to broaden the variety of available medical facilities. The largest group (fourteen, 13%) suggested to provide a 24-hour health facility. Eighteen (16,9%) non-members made recommendation about the medical facilities. Non-

members mentioned the same suggestions as members about extending the medical facilities.

Other facilities

In Mechchhe, recommendations about other facilities than medical ones were mentioned by eight (11,2%) members and three (4,3%) non-members. The most suggested addition was the provision of clean drinking water, mentioned four (5,6%) times by members and two (2,9%) times by non-members. Furthermore, three (4,3%) members suggested that electricity should be made available.

In Hansposha, eight (7,4%) members and three (2,8%) non-members made recommendations which move beyond the medical facilities. Seven (6,5%) members suggested that the access to health care should be improved, by improving the building itself. The three (2,8%) non-members all came up with different additions, which were that tap water should be provided, better facilities for disabled people should come and the health post should be in a fixed place.

The Share & Care Program

In Mechchhe, additions to the Share & Care program were mentioned by four (5,6%) members and four (5,8%) non-members. Removal of the renewal system (or the fact that you have to pay the membership fees every year) was pointed out by one (1,4%) member and three (4,3%) non-members. The other three (4,3%) members suggested to continue the Share & Care program. One (1,4%) non-member suggested to improve the information provision.

In Hansposha, a considerable proportion of the members (twenty-four, 22,2%) suggested to make additions to the Share & Care program itself. These additions varied from 'community participation' to 'awareness about sanitation'. Furthermore, from the answers itself, a sense of dissatisfaction was felt;

'*Share & Care should give satisfaction to members'*
'*Share & Care should at least provide the facilities which they promised'*

Six (5,7%) non-members suggested to improve the Share & Care program itself. These answers were completely different compared to members, as they came up with more 'neutral' changes. The main suggestions were that the renewal system should be removed and that it should be easier to become a members of the Share & Care program.

Membership fees

In Mechchhe, amendments to the membership fees were recommended by four (5,6%) members and eighteen (26,1%) non-members. Among members, three (4,3%) suggested to reduce the membership charges and one (1,4%) recommended free membership. Among non-members, fourteen (20,2%) suggested to reduce the membership fees. The other four (5,8%) recommended to make the membership free of costs.

In Hansposha, recommendations to change the membership fees of the program were made by four (3,7%) members and six (5,6%) non-members. In both groups, the main suggestions were that the membership should cover all fees and that the membership fees should be reduced.

Share & Care staff

In Mechchhe, none of the participants made recommendations to change the staff of the Share & Care program.

In Hansposha, a large number of members (nineteen, 17,6%) and non-members (fourteen, 13,2%) mentioned that changes related to the Share & Care staff should be made. Among members, eleven (10,2%) suggested that the management of the Share & Care program should be improved, because they were dissatisfied with the present management team. They advised to make the management team more transparent and to improve the financial management. The other eight (7,4%) members recommended to employ better qualified health workers. Seven (6,6%) non-members suggested to improve to skills of the health workers, or to employ another (better) health worker;

'*Share & Care should change the staff; good and co-operative staff should come'.*

Seven (6,6%) non-members were dissatisfied with the present management team. Non-members recommended a more transparent management as well.

Summary

The figure below (figure 8) shows a summary of the recommendations which members and non-members made in Mechchhe and Hansposha in order to increase the number of members.

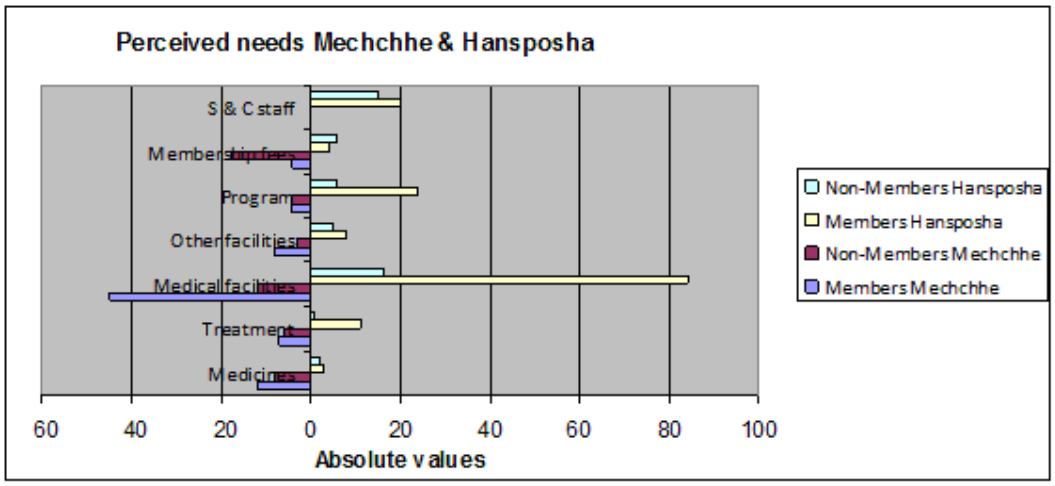

Figure 8: Perceived needs towards the Share & Care program.

Chapter 5. Discussion

In this section, the results are discussed and compared with other literature. Moreover, the designed research framework is used to interpret the results.
Furthermore, a methodological discussion is included in which the strengths and weaknesses of this study are considered.

5.1 Interpreting the results & comparison with literature

5.1.1 Predisposing characteristics

With regard to the predisposing characteristics in Mechchhe, participants who were not able to pay the membership fees, were more frequently found to be illiterate (P 0,03). It is not surprising that this was found as there is a strong association between poverty and illiteracy.[25] Furthermore, as described in paragraph 2.3.1 about the HBM[19], a good educational level is believed to be a cue to action which can trigger an action, in this case becoming member of the program. These results might indicate that people who are poor (and illiterate) are less reached by the program.

In Hansposha, a significant relationship between SES and membership was found (Middle income; P 0,04, Rich; 0,001). An explanation could be that people who are poor are less able to pay the membership fees and therefore, are less likely to become a member. In Hansposha, these results might indicate that people with a lower SES are not being reached by the program. A study of Hotchkiss[26] found that people who are wealthier are more likely to make use of health care services or health insurance than people who are less wealthy, this corresponds with the results in this study. Furthermore, as described in paragraph 2.3.1 about the HBM[19], SES is believed to be a modifying factor which can influence the perceived benefits and barriers of the program.

5.1.2 Cues to action

In Mechchhe, a significant relation between knowledge of the Share & Care program and membership was found (P 0,006). Lack of knowledge or information about the Share & Care program appears to be a barrier to become a member of the program. Therefore, it is important to make sure that more inhabitants get to know the program.

Both in Mechchhe and Hansposha, it showed that lack of providing correct and sufficient information (e.g. proper information about the benefits of the Share & Care program) is a barrier to increase the number of members. As indicated by the HBM[19], proper information is regarded as an important cue to action which can trigger an action, and thus, in case of the Share & Care program, increase the number of members. Lack of proper information is probably related to insufficient Public Relations (PR) of the Share & Care program.

In Hansposha, knowledge of the benefits was significantly related to membership (P 0,003). This is also believed to be a barrier to increase the number of members, since members could positively influence non-members to become a member. Furthermore, when members are not familiar with the benefits of the Share & Care program, it is expected that they will not extend their membership. These findings are comparable with

the earlier described Lalitpur health insurance scheme[6] (paragraph 1.4), where people refrained from membership because of insufficient promotion of the program.

In Mechchhe, a remarkable difference was that members were mostly informed by the staff of the Share & Care program, while non-members got their knowledge mostly from mouth-to-mouth advertisement. With this finding, it could be argued that getting information about the Share & Care program from the staff itself is more convincing than getting information from others. However, this contradicts with a study of Bartholomew[27] on role modeling, where mouth-to-mouth advertisement is seen as a strong way when trying to increase the number of members. Where the findings of Mechchhe were conflicting with the existing literature[27], the findings of Hansposha do correspond with the study of Bartholomew[27] on role modeling. In Hansposha, a noteworthy proportion of the members did became member because of positive influences of other members. The difference between Mechchhe and Hansposha could possibly be dedicated to the fact that Mechchhe is a rural area and Hansposha is more urban. The possibility exists that inhabitants of rural areas are more likely to belief experts where inhabitants of urban areas are more vulnerable to become influenced by relatives. However, no literature was found on this topic.

Another remarkable finding and barrier to increase the number of members in Hansposha, was that one-fifth of the non-members pointed out they did not become member because they were just not interested in the program (precontemplation phase). As described in the literature[28], in order to get non-members who are in the precontemplation phase to become a member of the program, the most important step is to build rapport and trust. Furthermore, as described in the results, there is a lot of dissatisfaction with the Share & Care program and the staff of Share & Care program in Hansposha. For this reason, it is believed that building rapport will be difficult to accomplish in this VDC.

5.1.3 Client satisfaction

Regarding dissatisfaction with the Share & Care program in both VDCs, merely dissatisfaction with the renewal system was reported; both members and non-members mentioned they were not properly informed about the annual renewal system. Furthermore, both members and non-members mentioned they were dissatisfied with the renewal system itself, i.e. with the annual membership fees. A study of Dror and Radermacher[29] showed that inhabitants of Nepal are not familiar with health insurance schemes and therefore, are not familiar with renewal systems. This study[29] also mentioned that 'insurance education' is believed to be important in order to develop a sustainable program in which a renewal system is perceived as 'normal'.

In Mechchhe, 12% of the non-members reported inadequate quality of the health services as a reason for not becoming a member of the Share & Care program.

In Hansposha, satisfaction with the SHP showed to be significantly related to membership (P 0,02). This indicates that a significant part of the non-members were not satisfied with the SHP. Nineteen percent of the non-members reported negative experiences with the quality of the Share & Care program. These negative experiences included both dissatisfaction with the attitude and quality of the staff of the Share & Care program and with the program itself. As these were mainly the reasons for refraining from membership, negative experiences are forming a barrier to increase the number of members in the two communities studied. As described in the BMVP[21], being satisfied with a health care

program influences people in making decisions on whether or not to become a member of a health insurance program. Therefore, it seems that those non-members who are dissatisfied with the program will not become a member until this dissatisfaction is eliminated.

In Hansposha, almost 15% of the members became member because they wanted to have certainty of having access to health facilities. Therefore, being sure of having access to health facilities is believed to be a facilitator to increase the number of members. As described in the BMVP[21] (paragraph 2.3.2), use of health services and enabling resources such as having access to health facilities, influences people in making decisions about becoming member of a health insurance program.

5.1.4 Perceived health status

In both villages, a large part of the members became member of the program because they expected that the program would benefit their health or the health of their family (perceived susceptibility). As the HBM[19] describes, perceived susceptibility is believed to be a facilitator for increasing the number of members.

5.1.5 Health behavior

In Mechchhe, almost all members and non-members went to the SHP in case of a medical problem. They perceived the SHP as the health facility which was physically most accessible.

In Hansposha, most members went to the SHP whereas most non-members went to private clinics or hospitals first (P 0,003). A study of Rous[29] reported that, compared to people living in the Terai (such as a village like Hansposha), people living in the mountain and hilly areas (such as Mechchhe) are more likely to make use of HP and SHP instead of private clinics. The main explanation given was that private clinics are not readily available in rural areas. This corresponds with the findings of this study, where almost no use was made of private clinics or hospitals in Mechchhe (hilly area), while, in Hansposha (Terai area), hospitals and private clinics were consulted a lot by non-members. The availability of private clinics and hospitals in the neighbourhood of Hansposha are believed to be a barrier to increase the number of Share & Care members, because of the reported desire to be diagnosed and treated by a qualified doctor.

In Mechchhe, the number of visits to the SHP was significantly related to membership (P 0,002). However, this could also be an outcome of membership instead of a determinant; due to membership, people are more likely to visit the SHP.

5.1.6 Financial resources

In Mechchhe, both the ability and willingness to pay the membership fees showed to be significantly related to membership (ability to pay; P 0,005, willingness to pay; 0,002). The answers to the open ended questions also revealed that 35% of the non-members were not able to pay the membership fees. This correspond with the earlier stated quantitative findings. As described in the BMVP[21], enabling resources such as being able to pay the membership fees relate to use of health services or to become a member or not. The inability to pay the membership fees by non-members is assumed to be a barrier to increase the number of members. As the livelihood program has not yet been implemented in Mechchhe, there are few options for poor non-members to become a member. Some non-members mentioned that, if they wanted to become a member, they

had to sell their buffalo. As the buffalo provides for daily living, they preferred to keep their buffalo instead of becoming member.

Perception of the levels of membership fees showed to be significantly related to membership (P 0,004). Whereas most members perceived the membership fees as cheap or not expensive, most non-members perceived the membership fees as expensive. There is an obvious clarification; when people are not able to pay the membership fees, subsequently they will perceive these costs as expensive.

A study of Dror and Radermaker[30] revealed that the population did not understand the concept of health insurance; they found it odd that their membership fees would not be returned when they did not make use of health care. In this study, both members and non-members suggested that the membership fees should be returned when one did not make use of health care. This indicates a lack of understanding of the health insurance system.

In Hansposha, more than half of the non-members mentioned not to be willing to pay the membership fees. Willingness to pay showed to be significantly in (P 0,006). As the ability to pay the membership fees and the perception of the membership fees were not significantly related to membership, other reasons for this lack of willingness to pay should be researched. Unwillingness to pay the membership fees by non-members is believed to be a barrier to increase the number of members. Compared to a study of Hotchkiss[26] which showed that inhabitants of urban areas in Nepal on average spent NRs 595 annually on health care. This is less than the annual membership fee of the Share & Care program. When the health care expenditures are less than the membership fees, it is unlikely that non-members will become a member. Furthermore, perceived dissatisfaction with the Share & Care program and the fact that there are private clinics and hospitals in the neighborhood could influence this unwillingness to pay the membership fees as well.

5.1.7 Perceived needs to the Share & Care program

Both in Mechchhe and Hansposha, members mostly suggested to expand the variety of medical facilities. As described in the BMVP[21], consumer or client satisfaction is an important factor which influences whether or not a person continues a health insurance.

In Mechchhe, non-members mostly suggested that the membership fees should be lowered; this cross-validates the earlier stated findings in which that non-members were able to pay the membership fees.

In Hansposha, a remarkable finding was that the second and third most mentioned additions, reported among members, were additions to the Share & Care program in general and more specifically to the staff (i.e. employing new staff). These findings may indicate that a sense of dissatisfaction prevails among members. As indicated in the BMVP [21], dissatisfaction is believed to be a barrier when trying to increase the number of members. When members are not satisfied with the program, they may less likely to renew their membership. Furthermor, they may not likely promote the program to non-members. In contrast, they will more likely influence non-members in refraining from membership.

Non-members mentioned far less additional activities and/or facilities to the Share & Care program than members. However, suggestions to employ better qualified health workers and a more transparent management team of the Share & Care program were made a lot among non-members as well. This corresponds with the earlier findings of the dissatisfaction with the reported inadequate quality and attitude of the health worker. Furthermore, in the study of Dror and Radermachers[30], different benefit packages were

presented to the different villages and it showed that in each village, other preferences existed. Referring to this study it could be that the benefit package which is offered is not attractive to non-members.

5.2 Methodological discussion

5.2.1 General strengths and weaknesses

To assess the differences between members and non-members in order to gain insights on how to increase the membership percentage, the relationship between several determinants and membership were investigated. The different determinants were extensive in terms of categories which were investigated. Therefore, a lot of mutual relationships could be analyzed. These relationships provide an indication of the possible existing barriers and facilitators that can lead to an increase in membership. These indications can be useful in order to strengthen the Share & Care program as well in ensuring the development of a sustainable insurance scheme.

The inability of this study to gather more in-depth information about decision making processes can be seen as a weakness. This research focused merely on behavioral change (i.e. increasing membership) and not on decision making processes, which is important to investigate as well, since decision making processes differ per culture. As research of Adam, Beck and van Loon[31] suggests, not just people's reasons for not seeking health care (or not becoming member) need to be explored, but also their view on existing health risks and how they translate this into their own risks and make decision related to seeking health care or not. Nonetheless, this study reveals a number of important and unexpected findings (e.g. dissatisfaction with the program in Hansposha), which would not have been reported when this study was not performed.

The researcher is Dutch, therefore cultural differences are present and this could have caused incorrect interpretations of the qualitative data. Furthermore, the interviewers directly translated the answers in English. Since the English language skills of the interviewers and the Dutch researcher are not flawless, this could have caused interpretation problems by the researcher.[22] On the other hand, both quantitative and qualitative methods were used. These methods triangulated each other and the outcomes are therefore believed to be more reliable.[24] During the pilot interviews and in between data collection, the questionnaire was adapted, this probably led to an improved and more valid questionnaire. However, when analysing, some additional questions evolved which could have been usefull in this study. For example, in Hansposha it showed that there was dissatisfaction with the Share & Care program itself. However, this view emerged from answers to the open-ended questions. If a question such as '*How satisfied are you with the Share & Care program?'* would have been included, it would most probably resulted in more obvious reasons about dissatisfaction with the program.

The interpretability of the results improved since the investigated determinants from this study were based on two well-known and tested models, namely the HBM[19] and BMVP[21] (see paragraph 2.3.1 and 2.3.2). Furthermore, although not every result could be underpinned by supporting literature, a lot of findings could be compared and related to other studies and were validated using the available literature. This probably led to improved interpretability of the results.

5.2.2 Bias and validity issues

With cross-sectional research, the possibility of recall bias and selection bias exists. Recall bias occurs when the information solicited is associated with the likelihood of remembering the information in one of the comparison groups, either among the cases or among the controls. (van Brakel W. Written communication, 2010) As questions like '*How many times were you ill in the last year?'* mostly relies on remembrance, the chance that recall bias occurred is high. However, since the number of participants is high, it is likely that this form of bias was equally spread over members and non-members.

During the interviews, participants could have given socially desirable answers, which could lead to information bias.[22] Some questions (for example '*How satisfied are you with the SHP?' & 'What is your mean income?'*) are straight to the point. Therefore, it could be that the participants gave socially desirable questions. This could have caused less strong relations. This could have been decreased when no names were asked and the questionnaires thus would have been completely anonymous.

Selection bias occurs if the probability of selection in one of the groups is associated with the outcome or with a significant determinant (independent factor) (van Brakel W. written communication, 2010). Selection bias can occur when the study population is too homogenous.[22] In Mechchhe, it is likely that selection bias occurred. Only half of the interviewers were able to walk to the different wards to conduct the interviews. Fir this reason, the other half of the interviews had to be conducted at the SHP. The number of interviews was still equally spread over the different wards. However, it is likely that another type of people visit the SHP than interviewed members and non-members from the door-to-door visits. For example, non-members who visit the SHP are probably more likely to know the Share & Care program. Knowledge of the Share & Care program was already found to be significantly related to membership, and this relationship could even be stronger when exclusively door-to-door visits would have been accomplished. In Hansposha, members did get randomly selected , and therefore the chance of selection bias is lower. Both in Mechchhe and Hansposha, non-members were selected as those living in the neighboring house of members, therefore selection bias definitely occurred and some findings (again for example knowledge of the Share & Care program) could be biased and could in reality thus be even more arduous.[22]

Both in Mechchhe and in Hansposha, the needed minimal sample size was interviewed. Therefore the study sample taken is likely to represent the total study population of the VDC.[22]

To obtain a probably higher inter- and intra-interviewer reliability, the interviewers were trained and the interviews were piloted in Narayansthan. The interview methods were discussed and answers to some questions were made clear. Furthermore, with piloting the questionnaires, a better validity of the questionnaire was obtained.[24] Although the interviewers received a proper training, it was hard for them to ask in-depth questions and get the best quality of answers. As such the answers remain possibly superficial.

For this study, FGDs were used. Since the use of FGDs is a qualitative method, reliable and reproducible conclusions could not be drawn.[24] Furthermore, even though the interviewers received a training in methods to conduct FGDs, it was hard for them to accomplish the FGDs in a proper way. Taken into account that it was hard to find suitable participants, the content validity of the focus groups is believed to be insufficient. For these reasons, the focus groups were only used to triangulate the results from the questionnaires. The findings of the focus groups can be found in appendix VI.

Chapter 6. Conclusions

In this chapter, based on the results and discussion, conclusions are formulated. These will answer the main research question:

'What are the most important determinants of membership of the Share & Care program in the two pilot communities Mechchhe (Kavre) and Hansposha (Sunsari)?'

First, general determinants will be given which were found to have a relationship with membership of the Share & Care program in both VDCs, than specific determinants are highlighted for both Mechchhe and Hansposha.

General

1. Knowledge of the Share & Care program and its benefits are important determinants for membership in both Mechchhe and Hansposha.
2. Related to knowledge, the provision of proper information was found to be an important determinant for membership. Examples of aspects which were lacking in the information provision were proper information about the renewal system and information about the benefit package.
3. Another determinant of membership in both VDCs is formed by perceived susceptibility. Perceived susceptibility is believed to be related to proper information provision of health insurance systems.

Mechchhe

1. Perception of the membership fees showed to be a determinant for membership. Whereas more members perceived the membership fees as cheap or not expensive, most non-members perceived them as expensive.
2. The ability to pay the membership fees showed to be a determinant for membership. When people cannot afford to pay the membership fees, they will most probably refrain from becoming a member.
3. Willingness to pay the membership fees is a determinant for membership as well. When people perceive the membership fees as expensive and they presume themselves as not being able to pay the membership fees, they may automatically be not willing to pay them.

Hansposha

1. SES is a determinant of membership. A higher percentage of the members belonged to the middle income or rich category in comparison with non-members.
2. Satisfaction with the SHP and the Share & Care program showed to be a determinant of membership.
3. Another determinant of membership was the health facility where members and non-members went to in case of a medical problem. Where most members went to the SHP, most non-members went to private clinics or hospitals which are readily available in this area.
4. Willingness to pay the membership fees showed to be a determinant for membership as well. This unwillingness to pay the membership fees probably relates to the dissatisfaction with the SHP and the Share & Care program and the preference to consult a qualified doctor instead of a health worker.

Chapter 7. Recommendations

In this chapter, recommendations are given to the Karuna Foundation with the aim to increase the number of members in the two pilot VDCs Mechchhe and Hansposha. First, general recommendations are given, followed by more specific recommendations for Mechchhe and Hansposha. These recommendations could also be useful when implementing the Share & Care program in other VDCs in Nepal.

General

1. The first recommendation is that information about the Share & Care program and about health insurance systems in general within the VDCs should be improved.
   With ongoing PR, the knowledge of the content, possibilities and benefits of the Share & Care program will be increased. The awareness about the Share & Care program and the benefits may improve, and thereby, the number of members may increase.
   Within the PR, the following items are believed to be useful to include;
   - Proper information of the benefits of a health insurance should be provided. Many participants mentioned they became member to be sure of having access to medical facilities and to benefit their health (perceived susceptibility). When these items could be highlighted within these promotional activities, non-members may probably be more eager to become a member.
   - The benefits of the Share & Care program itself should be highlighted. A lot of members and non-members mentioned, the advantage of receiving free medicines in case of a medical problem was considered to be an important benefit of the program. The advantage of free medicines could be emphasized, however care should be taken since promotion of the use of medicines is a bit controversial.
   - The concept of the renewal system should be explained in greater detail. Many members and non-members mentioned they were dissatisfied with the renewal system, because they did not know they had to pay the membership fees every year or that they were just dissatisfied with the fact that they had to pay them every year. When proper information about the renewal system would be provided, this dissatisfaction may reduce.

2. The second recommendation is to take a closer look at the benefit package and in what way it can become more attractive to non-members within these VDCs. The following aspects of the benefit package could be useful to take a look at;
   - The membership fees should be adapted to the minimum amount what inhabitants of a VDC are able and willing to pay. At this moment, the membership committee of each VDC decides what the membership fees are going to be. However, as shown in Mechchhe, a lot of non-members mentioned not to be able to pay the contribution costs. Therefore, more research should be conducted on the level of the membership fees per VDC.
   - As a lot of members ad non-members reported dissatisfaction with the renewal system, and with the fact that you have to pay the membership fees every year, it could be valuable to adapt this system to a certain extent. A system known as the 'no-claim rebate rule' which was introduced in The Netherlands,

could probably be useful. Within this system, a rebate was given if no claim was made during the preceding year.[32] With this rule, becoming member of the Share & Care program could possible become more attractive.

- Before implementing the Share & Care program in a VDC, it could be useful to research which benefit package is most likely to succeed in increasing the number of members. A possible option is to conduct a focus group among inhabitants of a village and to research of which elements the benefit package of the Share & Care program should consist, as in the study of Dror and Radermacher.[30]

Mechchhe

1. It could be wise to implement the livelihood program in Mechchhe in order to be able to include those parts of the population who cannot afford to become a member.

Hansposha

1. The relationship between SES and membership indicated that people with a lower SES are less reached by the program. Therefore, it is wise to focus more on the livelihood program and keep close eyes on the implementation.
2. As mentioned before, members and non-members reported dissatisfaction with the SHP, the quality and attitude of the health workers and the Share & Care program. It is highly recommended to further research this dissatisfaction in order to reduce this. Otherwise, it is believed to be very difficult to increase the number of members.
3. As described before, private clinics and hospitals are readily available in the neighborhood. As there exists a preference to go to these health facilities[29], this is believed to be a barrier to increase the number of members. A possible solution could be to employ a qualified doctor, with this, non-members may be more eager to become a member. However, with the existing dissatisfaction and the fact that private clinics and hospitals are readily available, most probably it would be very difficult to increase the number of members in Hansposha.
4. In choosing VDCs to implement the Share & Care program, it could be wise to look at the availability of health care in that area and chose these VDCs where access to health care is not optimal.

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Appendix I : Questionnaires

Official questionnaire Mechchhe

QUESTIONNAIRE NUMBER:

INTERVIEWER'S NAME (INITIALS) :_____

DATE: ___/___/_____

I am a Nepali student and I would like to conduct this interview for a student from the Netherlands. She wants to investigate what the differences are between members and non members of the Share & Care program.
The interview will take about 20 minutes. First I will ask you some general background questions, then I will ask you some questions about your health and health seeking behaviour and finally, I will ask you some questions about the Share & Care program. All the information we obtain will remain strictly confidential. The research is an independent project, so it is very important that you give your honest opinion. There are no right or wrong answers, the most important thing is that with your help, we can achieve insights in the differences of members and non members of the Share & Care program in Mechchhe VDC. You are not obliged to answer any question you don't want to, and you may withdraw from the interview at any time. Do you want to cooperate in this interview?

RESPONDENT AGREES TO BE INTERVIEWED 1
RESPONDENT DOES NOT AGREE TO BE INTERVIEWED 2 → END
NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT IN HOUSEHOLD AT TIME OF VISIT 3

1. Ward no……	*2. VDC Mechchhe*
3. Name respondent……M / F	
4. Name Head of household……	Telephone number:

Demographic Background		
5.	Membership	1. Yes 2. No
6.	Ethnicity	1. Tamang 2. Tharu 3. Newar 4. Brahmin 5. Magar 6. Rai 7. Limbu 8. Chattri 9. Dalit 10. Gurung 11. Mushar 12. Lama 13. Sherpa 14. Yanajati 15. Other,…….
7.	Religion	1. Hindu 2. Buddhist 3. Other
8.	Major source of income of family	1. Agriculture 2. Wage labor 3. Small Trade/Business 4. Service 5. No occupation 6. Foreign employment 7. Other……
9.	What is your occupation?	1. Agriculture 2. Wage labor 3. Small Trade/Business 4. Service 5. Artist 6. Tailor 7. Homemaker 8. No occupation 9. Foreign employment 10. Other……
10.	Your family cash income last month	……

11.	Family Type	1. Nuclear 2. Joint 3. Other……
12.	Of how many members does your household consist?	…….
13.	Education	1. Illiterate 2. literate 3. Completed primary education 4. Completed secondary education 5. Going to school
14.	Marital status	1. Married 2. Unmarried 3. Divorced 4. Widower
15.	Did any member of your family migrate to other places?	1. Yes 2. No
16.	If yes, do you request medicines for this person at the SHP?	1. Yes 2. No

Socio-economic status		
17.	Composition of the roof	1. Tin 2. Tile 3. Stone 4. Thatch 5. Cemented
18.	Toilet facility	1. No toilet 2. Pit whole (only whole) 3. Improved pit
19.	Main source drinking water	1. Tap 2. Tube well 3. Well 4. River 5. Stream 6. Other…
20.	Treatment of the water	1. No treatment 2. Boil

		3. Add chlorine 4. Filter
21.	Ownership cheap assets	1. Radio 2. Mobile 3. Watch 4. Television 5. Computer 6. Bicycle 7. Goat
22.	Ownership expensive assets	1. Tube well 2. Motorcycle/scooter 3. Car/Truck/Bus 4. Buffalo

Health behavior		
23.	How many times were you ill in the last year?	
24.	Chronic disease	1. Yes 2. No
25.	Other health problem	1. Yes 2. No
26.	Activity limitations	1. Yes 2. No
27.	Perceived health	1. Excellent 2. Very good 3. Good 4. Fair 5. Poor 6. Don't know
28.	How many times did you visit the SHP last year?	
29.	How many times did your family visited the SHP in the last year?	
30.	First consultation in case of a medical problem	1. SHP (go to 32) 2. Sub centre (go to 32) 3. Hospital (go to 32) 4. Private clinic (go to 32) 5. Traditional healer 6. Other (friend/relative/nobody…)
31.	Reason for not consulting health facility	1. No permission 2. No money 3. Health facility too far 4. Does not want to go alone 5. No female health worker 6. Other…
32.	Health facility closest by	1. SHP 2. Sub centre 3. Hospital 4. Health post of other VDC 5. Private clinic 6. Other

33.	Practice self-medication	1. Yes 2. No
34.	Satisfaction SHP	1. Very satisfied 2. Satisfied 3. Not satisfied 4. Don't know
35.	Overall quality SHP	1. Very good quality 2. Good quality 3. Average 4. Bad quality 5. Don't know

Questions concerning Share & Care program

We are almost finished, the last part of the interview are some questions about the Share & Care program. Some of them are open questions without answers to choose from, so I would like to ask you to give your honest opinion. The reasons you come up with will be very worthy for this study.

36. Have you heard about the Share & Care program?

1. Yes
2. No
3. Not sure

37. If yes, how did you hear from the Share & Care program?

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38. Do you know what benefits it provides?

1. Yes
2. No
3. Not sure

39. If yes, can you tell me what benefits it provides?

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40. Do you know what the membership fees of the Share & Care program are?

1. Yes
2. No
3. Not sure

41. If yes, what do you think of the membership fees?

1. Too expensive
2. Expensive
3. Not expensive
4. Cheap
5. No opinion

42. Is your family able to pay the membership fees?

1. Yes
2. No
3. Not sure
4. Don't know

43. Is your family willing to pay the membership fees?

1. Yes
2. No
3. Not sure
4. Don't know

44. For non members, what are the most important reasons for your family not being a member of the program?

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45. *For members, what are the most important reasons why your family became member of the program?*

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46. For members, how satisfied are you with the Share & Care program?

1. Very satisfied
2. Satisfied
3. Not satisfied
4. Don't know

47. What expectations do you have of the Share & Care program?

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48. What do you think the Share & Care program needs to add/change?

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With this question, we came to the end of the interview, I would like to thank you for your cooperation! Furthermore, I want to emphasize again that your answers will be strictly confidential and will be handled with care. Do you have any more questions before we end this session

Official questionnaire Hansposa

QUESTIONNAIRE NUMBER:

INTERVIEWER'S NAME (INITIALS) :_____

DATE: ___/___/_____

I am a Nepali student and I would like to conduct this interview for a student from the Netherlands. She wants to investigate what the differences are between members and non members of the Share & Care program.
The interview will take about 20 minutes. First I will ask you some general background questions, then I will ask you some questions about your health and health seeking behaviour and finally, I will ask you some questions about the Share & Care program. All the information we obtain will remain strictly confidential. The research is an independent project, so it is very important that you give your honest opinion. There are no right or wrong answers, the most important thing is that with your help, we can achieve insights in the differences of members and non members of the Share & Care program in Mechchhe VDC. You are not obliged to answer any question you don't want to, and you may withdraw from the interview at any time. Do you want to cooperate in this interview?

RESPONDENT AGREES TO BE INTERVIEWED 1
RESPONDENT DOES NOT AGREE TO BE INTERVIEWED 2 → END
NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT IN HOUSEHOLD AT TIME OF VISIT 3

1. Ward no……	*2. VDC Hansposa*
3. Name respondent……M / F Age:	
4. Name Head of household……	Telephone number:

Demographic Background		
5.	Membership	1. Yes 2. No
6.	Ethnicity	0. Tamang 1. Tharu 2. Newar 3. Brahmin 4. Magar 5. Rai 6. Limbu 7. Chattri 8. Dalit 9. Gurung 10. Mushar 11. Lama 12. Other,……
7.	Religion	1. Hindu 2. Buddhist 3. Other
8.	Major source of income of family	1. Agriculture 2. Wage labor 3. Small Trade/Business 4. Service 5. No occupation 6. Other……
9.	What is your occupation?	1. Agriculture 2. Wage labor 3. Small Trade/Business 4. Service 5. Artist 6. Tailor 7. Homemaker 8. No occupation 9. Other……
10.	Your family cash income last month	……
11.	Family Type	1. Nuclear 2. Joint 3. Other……
12.	Of how many members	…….

	does your household consist?	
13.	Education	1. Illiterate 2. literate 3. Completed primary education 4. Completed secondary education 5. Going to school
14.	Marital status	1. Married 2. Unmarried 3. Divorced 4. Widower
15.	Did any member of your family migrate to other places?	1. Yes 2. No
16.	If yes, do you request medicines for this person at the SHP?	1. Yes 2. No

Socio-economic status		
17.	Composition of the roof	1. Tin 2. Tile 3. Stone 4. Thatch
18.	Toilet facility	1. No toilet 2. Pit whole (only whole) 3. Improved pit
19.	Main source drinking water	1. Tap 2. Tube well 3. Well 4. River 5. Stream 6. Other…
20.	Treatment of the water	1. No treatment 2. Boil 3. Add chlorine 4. Filter
21.	Ownership cheap assets	1. Radio 2. Mobile 3. Watch

		4. Television 5. Computer 6. Bicycle 7. Goat
22.	Ownership expensive assets	1. Rikshaw 2. Tube well 3. Motorcycle/scooter 4. Car/Truck/Bus 5. Buffalo

Health behavior		
23.	How many times were you ill in the last year?	
24.	Chronic disease	1. Yes 2. No
25.	Other health problem	1. Yes 2. No
26.	Activity limitations	1. Yes 2. No
27.	Perceived health	1. Excellent 2. Very good 3. Good 4. Fair 5. Poor 6. Don't know
28.	How many times did you visit the SHP last year?	
29.	How many times did your family visited the SHP in the last year?	
30.	First consultation in case of a medical problem	1. SHP 2. Sub centre 3. Hospital 4. Private clinic 5. Traditional healer 6. Other (friend/relative/nobody…)
31.	Reason for not consulting health facility	1. No permission 2. No money 3. Health facility too far

		4. Does not want to go alone 5. No female health worker 6. Other…
32.	Health facility closest by	1. SHP 2. Sub centre 3. Hospital 4. Health post of other VDC 5. Private clinic 6. Other
33.	Practice self-medication	1. Yes 2. No
34.	Satisfaction SHP	1. Very satisfied 2. Satisfied 3. Not satisfied 4. Don't know
35.	Overall quality SHP	1. Very good quality 2. Good quality 3. Average 4. Bad quality 5. Don't know

Questions concerning Share & Care program

We are almost finished, the last part of the interview are some questions about the Share & Care program. Some of them are open questions without answers to choose from, so I would like to ask you to give your honest opinion. The reasons you come up with will be very worthy for this study.

36. Have you heard about the Share & Care program?

4. Yes
5. No
6. Not sure

37. If yes, how did you hear from the Share & Care program?

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……
……

38. Do you know what benefits it provides?

1. Yes
2. No
3. Not sure

39. If yes, can you tell me what benefits it provides?

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40. Do you know what the membership fees of the Share & Care program are?

1. Yes
2. No
3. Not sure

41. If yes, what do you think of the membership fees?

1. Too expensive
2. Expensive
3. Not expensive
4. Cheap
5. No opinion

42. Is your family able to pay the membership fees?

1. Yes
2. No
3. Not sure
4. Don't know

43. Is your family willing to pay the membership fees?

1. Yes
2. No
3. Not sure
4. Don't know

44. For non members, what are the most important reasons for your family not being a member of the program?

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45. *For members, what are the most important reasons why your family became member of the program?*

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46. What expectations do you have of the Share & Care program?

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47. What do you think the Share & Care program needs to add/change in order to increase the number of members?

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With this question, we came to the end of the interview, I would like to thank you for your cooperation! Furthermore, I want to emphasize again that your answers will be strictly confidential and will be handled with care. Do you have any more questions before we end this session

Appendix II: Training schedule of interviewers

Day	Activities
Day 1	9.00-9.30 Introduction round 9.30-10.00 Presentation about research projects, goal of questionnaires and focus groups and expectations 10.00-10.30 Discussion 10.30-11.30 Presentation about rapport, culture, geography and guidelines 11.30-12.00 Tea break 12.00-13.00 Questionnaires (in English and Nepali) 13.00-14.00 Lunch break 14.00-16.00 Questionnaires (in English and Nepali) 16.00-16.30 Feedback day 1 (homework)
Day 2	9.00-9.30 Review and questions from day 1 9.30-11.00 Discuss problems in the questionnaires and questions about questionnaires 11.00-11.30 Tea break 11.30-13.00 Explain questionnaire techniques, followed by role-play 13.00-14.00 Lunch break 14.00-16.00 Role-play 16.00-16.30 Feedback day 2
Day 3	9.00-9.30 Review and questions from day 2 9.30-10.00 Discussion 10.00-11.00 Discuss schedule 11.00-11.30 Tea break

	11.30-13.00 Explain focus group techniques and methods, focus group questions 13.00-14.00 Lunch break 14.00-16.00 Focus group training 16.00-16.30 Feedback day 3
Day 4	Travel to Narayansthan
Day 5	Pilot questionnaires and pilot focus groups in Narayansthan
Day 6	Travel back to Kathmandu

Appendix III: Outline for focus group discussions

The following steps will guide and structure the focus groups.

Focus group to explore the needs and expectation of members and non-members towards the Share & Care program

Aim: To explore the needs and expectations of members and non-members towards the Share & Care program

Anticipated outcomes: To gain more insights in additions the Share & Care program need to make according to non-members in order for them to let them become member

Participant selection: Two focus groups will be held, one among members and one among non-members. The focus group will consist of 5-12 members. The focus group will be held among women and men in the age category of 18-45 years. During the earlier conducted questionnaires, the participants who were very willing to participate, are going to be asked to join the focus group. For this reason, the participants will be likely to give reliable answers.

Focus group outline for members

- *Introduction (5 minutes)*
  The focus group facilitator will briefly introduce himself and the other focus group leaders and explain the aim of the focus group. He/she will explain the process and the duration and confidentiality will be ensured.
- *First explorative question (10 minutes)*
  The focus group leader will ask the participants what the most important reasons were to become member of the Share & Care program. Every participant will be given the opportunity to give an answer and all answers are written/drawn on post its by the focus group leader and they will be put on a large white paper.
- *Categorize (10 minutes)*
  The focus group leader will now ask the participants to group the different expectations towards the Share & Care program in expectations which have been met and which expectations have not been met and have a short discussion on it.
- *Additions which should be made to the Share & Care program (10 minutes)*
  The focus group leader will now ask the participants what they want to be added/changed to the Share & Care program. Every answer will be written down on post-its by the focus group leader as well.
- *Categorize/prioritize (5 minutes)*
  The focus group leader will ask the participants to group the answers and prioritize them to the most important additions which should be made according to them.
- *Rounding off (5 minutes)*
  The focus group leader will thank the participants for their input and will ensure them again of the confidentiality.

Focus group outline for non-members

- *Introduction (5 minutes)*
  The focus group facilitator will briefly introduce himself and the other focus group leaders and explain the aim of the focus group. He/she will explain the process and the duration and confidentiality will be ensured.
- *First explorative question (10 minutes)*

The focus group leader will ask the participants whether they know the Share & Care program, if they don't know the program. He/she will explain what's the program about. Then the focus group leader will ask the participants what the most important reasons are for not being member of the Share & Care program. Every participant will be given the opportunity to give an answer and all answers are written/drawn on post its and they will be put on a large white paper.

- *Categorize (10 minutes)*
  The focus group leader will now ask the participants to prioritize the different reasons and have a short discussion on it.
- *Additions which should be made to the Share & Care program (10 minutes)*
  The focus group leader will now ask the participants what they want to be added/changed to the Share & Care program. Every answer will be written down on post-its as well.
- *Categorize/prioritize (5 minutes)*
  The focus group leader will ask the participants to group the answers and prioritize them to the most important additions which should be made according to them.
- *Rounding off (5 minutes)*
  The focus group leader will thank the participants for their input and will ensure them again of the confidentiality.

<u>Focus group to explore the differences in perceived health status of members and non-members.</u>

Aim: To explore the differences in perceived health status of members and non-members of the Share & Care program.

Anticipated outcomes: To gain more insights in whether differences in perceived health status influence the likelihood of becoming member of the Share & Care program.

Participant selection: Two focus groups will be held, one among members and one among non-members. The focus group will consist of 5-12 members. The focus group will be held among women and men in the age category of 18-45 years. During the earlier conducted questionnaires, the participants who were very willing to participate, are going to be asked to join the focus group. For this reason, the participants will be likely to give reliable answers.

<u>Focus group outline for members and non-members</u>

- *Introduction (5 minutes)*
  The focus group facilitator will briefly introduce himself and the other focus group leaders and explain the aim of the focus group. He/she will explain the process and the duration and confidentiality will be ensured.
- *First explorative question (10 minutes)*
  The focus group leader will ask the participants what they consider as being healthy. (*When is a person healthy?)* Every participant will be given the opportunity to give an answer and all answers are written/drawn on post its by the focus group leader and they will be put on a large white paper.
- *Categorize (10 minutes)*
  The focus group leader will now ask the participants to group the different answers in different aspects of health and asks more in-depth why they consider the mentioned health aspects as important issues for being healthy.

- *Perceived health (15 minutes)*
  The focus group leader will now ask the participants how healthy the participants consider themselves according to the earlier mentioned health aspects.
- *Rounding off*
  The focus group leader will thank the participants for their input and will ensure them again of confidentiality.

Appendix IV: Univariate analysis tables

Table 10: Univariate analysis of sexe with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Sexe	1,1	0,55 – 2,1	0,84	0,73	0,37 - 1,5	0,37

Table 11: Univariate analysis of mean age with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Mean age	0,9	0,43	0,87 – 3,4	1,5	0,88 – 2,6	0,13

Table 12: Univariate analysis of caste with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Caste	1,2	0,58	0,6 – 2,5	1,2	0,98 – 1,4	0,8

Table 13: Univariate analysis of religion with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Religion	0,56	0,15	0,26 – 1,2	1,9	0,95- 3,1	0,07

Table 14: Univariate analysis of marital status with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Marital status	2,3	0,11	0,83 – 6,5	0,73	0,32 – 1,7	0,46

Table 15: Univariate analysis of family type with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Family type	0,74	0,37	0,38 – 1,4	1,7	0,99 – 2,9	0,06

Table 16: Univariate analysis of the mean family size with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Mean family size	1,4	0,12	0,91 – 2,2	1,2	0,78 – 1,9	0,38

Table 17: Univariate analysis of mean income with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Mean income	0,86	0,56	0,51 – 1,4	1,1	0,86 – 1,3	0,55

Table 18: Univariate analysis of the major source of income with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Major source of income	0,87	0,61	0,51 – 1,4	0,83	0,66 – 1	0,11

Table 19: Univariate analysis of migration with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Migration	0,58	0,23	0,24 – 1,4	1,1	0,56 – 1,9	0,86

Table 20: Univariate analysis of educational level with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Education	Literate: 1,9	0,1	0,86 – 4,1	1,5	0,67 – 3,4	0,3
	Completed Education: 3,9	0,00	1,5 – 10,5	1,4	0,61 – 3,2	0,42

Table 21: Univariate analysis of SES with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Socio-economic status	1,01	0,92	0,7 – 1,5	Middle income: 2,4	1.1 – 4,9	0,02
				Rich: 3,4	1,5 – 7,8	0,005

Table 22: Univariate analysis of knowledge of the Share & Care program with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Knowledge Share & Care	6,3	2,5 – 15,8	0,001	2,7	1,3 – 5,6	0,01

Table 23: Univariate analysis of knowledge of the benefits of the Share & Care program with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Knowledge of the benefits	5,2	2,5 – 10,7	0,004	8,3	4,3 – 16,9	0,005

Table 24: Univariate analysis of satisfaction with the SHP with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Satisfaction with the SHP	3,2	0,82 – 12,8	0,09	16,4	7,4 – 36,4	0,0001

Table 25: Univariate analysis of the perceived overall quality of the SHP and membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Overall quality SHP						
Average	2,5	0,12	0,8 – 7,4	20,9	7,9 – 55,4	0,0001
Good	2,2	0,15	0,8 – 6,5	17,8	7,4 – 42,4	0,0002

Table 26: Univariate analysis of perceived health status and membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Perceived health status						
Good	0,94	0,54 – 7,4	0,80	0,45	0,16 – 1,3	0,14
Fair	1,21	0,64 – 6,4	0,57	0,62	0,23 – 1,6	0,34
Poor				0,97	0,25 – 3,8	0,97

Table 27: Univariate analysis of chronic disease and membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Chronic disease	1,3	0,43 – 6,0	0,63	1,3	0,65 – 2,6	0,46

Table 28: Univariate analysis of other health problems and membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Other health problems	2,2	1,1 – 4,5	0,03	2,3	1,2 – 4,4	0,02

Table 29: Univariate analysis of activity limitations and membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Activity limitations	0,96	0,26 – 3,4	0,94	2	0,74 – 5,4	0,17

Table 30: Univariate analysis of the mean incidence of illnesses and membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Mean incidence of illnesses						
1–4 illnesses	2,2	0,93 – 5,4	0,07	0,87	0,56 – 2,5	0,7
≥ 5 illnesses	4,1	1,7 – 9,7	0,004	1,2	0,5 – 2,3	0,67

Table 31: Univariate analysis of knowledge of the membership fees and membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Knowledge of the membership fees	3,7	1,7 – 7,9	0,002	8,3	2,6 – 11,1	0,0001

Table 32: Univariate analysis of the perception of the membership fees and membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Perception membership fees						
Cheap	3,1	2,1 – 11,1	0,01	7,6	2,8 – 20,2	0,003
Expensive	7	3,1 – 16,7	0,005	5,1	2,1 – 12,9	0,001

Table 33: Univariate analysis of the ability to pay with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Ability to pay	8,3	3,5 – 19,7	0,0001	5,3	2 – 13,9	0,003

Table 34: Univariate analysis of willingness to pay with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Willingness to pay	12	5,2 – 27,8	0,0003	10	4,5 – 22,1	0,004

Table 35: Univariate analysis of the practice of self-medication with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Practice of self-medication	0,66	0,25 – 1,8	0,4	0,49	0,28 – 0,86	0,01

Table 36: Univariate analysis of the number of visits to the SHP with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Number visits SHP						
1 visit	2,1	1,5 – 6,7	0,001	2,1	0,85 - 5,1	0,11
2 visits	3,9	1,7 – 8,8	0,005	9	2,9 – 28,3	0,005
≥ 3 visits	8,3	3,0 – 23,1	0,005	7,4	3,3 – 16,9	0,002

Table 37: Univariate analysis of first consultation in case of a medical problem with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
First consultation medical problem SHP	5,9	1,25 – 28,2	0,03	23,6	4,8 – 53,8	0,000

Table 38: Univariate analysis of the health facility which is closest by situated with membership in Mechchhe and Hansposha.

	Mechchhe			Hansposha		
	OR	95% CI	P-value	OR	95% CI	P-value
Health facility closest by						
SHP	4,4	0,48 – 40,1	0,19	3,9	1.2 – 12,6	0,02
Other	0,23	0,03 – 2,1	0,19	0,73	0,22 – 2,4	0,61

Appendix V: Coding guide

Predisposing characteristics

- Demographic variables
  - Ethnicity
  - Religion
  - Major source of income
  - Family income
  - Family type
  - Family size
  - Education
  - Marital status
  - Migration
  - Socio-economic status

Cues to action

- Discouraging cues to action
  - Influence of others
  - Advertising
  - Knowledge
    - Precontemplation fase
    - Lack of information
    - Lack of knowledge
    - Share & Care
    - Others involved in Share & Care
    - None Share & Care

- Encouraging cues to action
  - Influence of others
    - Share & Care
    - Others involved in Share & Care
    - None Share & Care
  - Knowledge
    - Share & Care
    - Others involved in Share & Care
    - None Share & Care

Client satisfaction

- Perceived quality of the Share & Care program
  - Expected benefits Share & Care program
    - Program costs
    - Program
    - Share & Care staff

- Perceived benefits Share & Care program
  - Program costs
  - Program
  - Share & Care staff
- Perceived disadvantages Share & Care program
  - Program costs
  - Program
  - Share & Care staff

- Evaluated health care quality
  - Expected benefits health care quality
    - Medicines
    - Treatment
    - Medical facilities
    - Other facilities
  - Perceived benefits health care quality
    - Medicines
    - Treatment
    - Medical facilities
    - Other facilities
  - Perceived disadvantages health care quality
    - Medicines
    - Treatment
    - Medical facilities
    - Other facilities
    - Satisfaction SHP

  - Satisfaction SHP
  - Perception overall quality SHP

Evaluated health status

- Evaluated health status
  - Perceived susceptibility
  - Perceived health status > Quantitative analysis
    - Chronic disease
    - Other illnesses
    - Activity limitations
  - # illnesses last year > Quantitative analysis

Health behavior

- Personal health practices
  - Use of self-medication
- Health care use
  - Use of other health institutions

- First consultation in case of a medical problem
- Perception health facility closest by
- # visits health post

Financial resources

- Financial barriers
  - Knowledge membership fees
  - Ability to pay
  - Perceived disadvantages membership fees
  - Perception membership fees
  - Willingness to pay
  - Ability to pay

Perceived Needs

- Additions to the Share & Care program
  - Medicines
  - Treatment
  - Medical facilities
  - Other facilities
  - Program
  - Program costs
  - Share & Care staff
  - Knowledge

Appendix VI: FGD results

FGD results Mechchhe

Needs and expectations of the Share & Care program

Members

The expectations of members towards the Share & Care program before the implementation mentioned were;

- More medicines for members (II)
- Qualitative better medicines (III)
- Wider variety of medicines
- Ability to treat all kinds of diseases
- The capacity to treat serious cases in the SHP as well
- Ability of permanent treatment of chronic diseases for members (II)
- Getting treatment more easily then before
- No need to go to the Health Post in Narayansthan but the ability to get treatment in Mechchhe itself
- Qualitative better facilities then before the implementation of Share & Care (II)
- High service at less costs
- The availability of stretchers for members
- Good treatment at a health post nearby
- Emergency treatment

Expectations met and expectations which have not been met;

Expectations met

- Qualitative better medicines
- Increased service
- High service at less costs
- Qualitative better service
- Emergency treatment
- Ability to get treatment in Mechchhe itself
- Treatment nearby

Expectations which have not been met

- Treatment of chronic diseases
- Wider variety of medicines
- More medicines for members
- Availability of stretchers
- The capacity to treat serious cases at the SHP
- The ability to treat all kinds of diseases

Members feel the following additions should be made to the Share & Care program;

- Ambulance service
- X-ray facility

- Operation facility
- Lab service
- Share & Care should increase the financial support, now they only support for 30%
- Membership costs should be reduced
- Service for women should be improved

After prioritizing, the most important additions which should be made to the Share & Care program according to members are;

1. Lab service
2. Ambulance service
3. X-ray facility
4. Improvement of service for women
5. Reducing the membership costs
6. Operation facility
7. Increase financial support of Share & Care

Non-members

All participants of the focus group knew the Share & Care program.
The most important reasons for the non-members of not being member of the program in the sequence of most importance are;

1. Lack of money (III)
2. There isn't a good doctor available
3. Membership costs are too expensive
4. Medicines are believed to be ineffective
5. Does not have illnesses very often

Non-members feel the following additions should be made to the Share & Care program;

- Qualitative good doctor
- X-ray facility
- More facilities
- Reduction of membership costs
- Family planning service
- More medicines
- Qualitative better medicines

After prioritizing, the most important additions which should be made to the Share & Care program are;

1. Qualitative good doctor
2. Reduction of membership costs
3. Qualitative better medicines
4. More medicines
5. More facilities
6. X-ray facility
7. Family planning service

Perceived health status of members and non-members

Members

The aspects which are considered as being healthy according to members are;

- When I can stay quietly (because there is no tension when I am quiet, I don't have to work)
- When you are in a good physical state, free from pain and healthy
- No pain in any part of the body when I have medicine
- If I get medicines I get healthy
- When I can exercise
- When my joints are all ok
- Balanced diet, when I can get all the necessary vitamins
- When I can be busy in my work
- When I can complete my work
- When I am satisfied with my work

After prioritizing, the most important aspects of being healthy are;

1. When you are in a good physical state, free from pain and healthy
2. When I am satisfied with my work
3. Balanced diet, when I can get all the necessary vitamins
4. When my joints are all ok
5. When I can complete my work
6. When I can stay quietly (because there is no tension when I am quiet, I don't have to work)
7. When I can exercise
8. If I get medicines I get healthy
9. When I can exercise
10. When I can be busy with my work

Non-members

The aspects which were considered as begin health by non-members were;

- While being healthy
- Being free of disease
- Being happy
- Being free of injuries and wounds
- Being in a good physical state

After prioritizing, the order of sequence was;

1. Being free of disease
2. Being in a good physical state
3. Being healthy
4. Being free of injuries and wounds
5. Being happy

Health care perception of members and non-members

Members

The ideal SHP according to members should consist of;

- Strong medicines
- Ability to cure illnesses
- Correct diagnoses
- Qualitative good medicines
- Qualified & experienced doctor
- Lab facility
- Availability of a stretcher

In order of importance;

1. Qualified & experienced doctor
2. Qualitative good medicines
3. Correct diagnoses
4. Strong medicines
5. Ability to cure illnesses
6. Lab facility
7. Availability of a stretcher

Non-members

The ideal SHP according to non-members should consist of;

- Immediate treatment
- Qualitative good medicines
- Free from disease
- Easy treatment
- Ability to treat all diseases
- Good service

In order of importance;

1. Qualitative good medicines
2. Ability to treat all diseases
3. Immediate treatment
4. Good service
5. Easy treatment
6. Free from disease

Focus group results Hansposha

Needs and expectations of the Share & Care program

Members

The expectations of members towards the Share & Care program before the implementation mentioned were;

- Easy way to get service
- Get treatment nearby
- 24-hour service
- Good doctors
- Many diseases should be treated
- Good health
- More health facilities
- Delivery service
- Emergency service
- Treatment for every member of the household
- High service
- Good service
- Quick service
- Good hospital

Expectations met and expectations which have not been met;

Expectations met

- Treatment on time
- Treatment for every member of the household
- Cheap
- Good service
- High service
- Quick service
- Easy way to get service
- Get treatment nearby

Expectations which have not been met

- 24-hour service
- Good doctors
- Delivery service
- Emergency service
- Good hospital
- More health facilities

Members feel the following additions should be made to the Share & Care program;

- A good doctor should be available at least once a week
- Good referral
- Good service
- 24-hour service

- More facilities, like x-ray, lab

After prioritizing, the most important additions which should be made to the Share & Care program according to members are;

- Availability of a good doctor
- 24-hour service
- More facilities

Non-members

All participants of the focus group knew the Share & Care program.

The most important reasons for the non-members of not being member of the program in the sequence of most importance are;

- No money
- There are better private clinics (III)
- There isn't a good doctor
- The management of the Share & Care program is not good
- There is no 24-hour service

Non-members feel the following additions should be made to the Share & Care program;

- Help & support to the villagers
- Hospital
- More facilities, like ambulance and good medicines
- 24-hour service
- Laboratory facility
- Good service
- X-ray facility
- Better staff
- Availability of a good doctor
- Free treatment in other hospitals

After prioritizing, the most important additions which should be made to the Share & Care program are;

1. Availability of a good doctor
2. X-ray facility
3. Lab facility
4. More facilities
5. Hospital
6. Good service
7. 24-hour facility
8. Better staff
9. Free treatment in other hospitals
10. Help & support to the villagers

Perceived health status of members and non-members

Members

The aspects which are considered as being healthy according to members are;

- Being open minded
- No psychological problem
- Having a good and healthy diet
- Being fresh and clean
- I am healthy when I feel like eating
- Being happy
- Being able to concentrate in my work
- Being energetic

100% of the participants considers themselves as being healthy
(*I can do my work and fulfill my responsibilities)*

After prioritizing, the most important aspects of being healthy are;

1. Being energetic
2. Being able to concentrate in my work
3. Having a good and healthy diet
4. Being happy
5. When I feel like eating
6. Being open minded
7. No psychological problem
8. Being fresh and clean

Non-members

The aspects which were considered as begin health by non-members were;

- Being able to accomplish my daily activities
- Being able to eat
- Feeling young
- When I can do my work enthusiastically (II)
- Being able to work and walk everywhere
- While not being old
- Feeling fresh and clean
- While being happy
- At early morning
- Being energetic

After prioritizing, the order of sequence was;

1. Being able to accomplish my daily activities
2. When I can do my work enthusiastically
3. Being able to work and walk everywhere
4. Feeling fresh and clean
5. At early morning
6. Being able to eat
7. While being happy

8. Feeling young
9. While not being old
10. Being energetic