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Influence of Awareness of Daily Payment on Uptake of Social Health Insurance among Bodaboda Operators In Eldoret Town, Kenya

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Abstract
Health financing is an important component of healthcare delivery. In Kenya, the universal health cover scheme has officially been adopted by the government and it is delivered through the National Health Insurance Fund (NHIF). The health insurer has since unbundled its subscription to include small daily subscription packages targeting low income workers in the country among them the motorcycle taxi operators (also known in Kenya as BodaBoda) aiming to reduce the costly out-of-pocket health financing. However, it is not known why low subscription of the daily package was still being reported among Bodaboda operators in Eldoret town in Uasin Gishu County, Kenya. The study, therefore, sought to find out how awareness of daily payment influenced uptake of social health insurance among Bodaboda operators in the town. The study adopted a cross-sectional descriptive design and used purposive sampling to select 263 respondents from 5000 Bodaboda operators including 26 officials affiliated to 26 registered cooperative organizations in the town. Data was collected from the respondents using both questionnaire and focus group discussions. Quantitative data from questionnaires was analyzed using descriptive and inferential statistics using Statistical Package for Social Sciences (SPSS) version 25.0 software. Qualitative data from focus group discussions was analyzed using conceptual content analysis. The study confirmed that majority (69.8%) of the Bodaboda operators were uninsured by NHIF. It also revealed that awareness plays a significant (OR.1.394, 95% CI = 0.559 – 3.478) role in the uptake of the daily health insurance package among Bodaboda operators. Further, the odds of uptake increased with the level of education of the Bodaboda operators. The study recommends that NHIF come up with targeted awareness strategies that reach out directly to the members of the bodaboda operators Saccos with current information about the products they have on offer and the subscriptions options.

Keywords*: Awareness, Daily payment, Uptake, Social health insurance, Bodaboda operators, Saccos*

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I. Introduction

1.1 Background of the Study

A good health financing system raises fund for health, in ways that ensure people can use needed services and are protected from financial catastrophe which are associated with having to pay for them (Etienne et al., 2010). This would mean that every citizen should have access to needed healthcare services that are effective and of acceptable quality and that no one should risk financial ruins as a result of illness. Health insurance is one of the ways in which healthcare can be financed to improve access to healthcare since the financial risk is spread among the insured, therefore, out of pocket payments by patients is avoided (Kimani et al.,2012). The uptake of health insurance across various nations worldwide significantly varies; it is estimated that one in six people in the United States are uninsured (Baicker, Congdon, & Mullainathan, 2012). In select European countries with statutory health insurance, the percentage of the population not covered differ slightly, such as, Belgium, less than 1% of the population lack health insurance cover, Germany 0.5%, Netherlands 0.2% and Switzerland 1.9% (Thomson et al., 2013). However, uptake of health insurance in Africa is significantly low (Nyagero et al., 2012); Tanzania 5%, Ghana 20% and Senegal 5% (Kagumire, 2009). In sub-Saharan Africa, only Rwanda has achieved 90% coverage levels through its community-based health insurance scheme (Lu et al., 2012). In Kenya, less than 25% of the population has either public or private health insurance cover (Were et al, 2019). The major constraint is the inability to pay for health care services by the poor (Wong et al, 2015).

Even in urban areas there are still glaring inequities in health insurance cover across socioeconomic strata with informal sector workers being largely disadvantaged. According to Kimani, Ettarh, Warren, and Bellows (2014) equity in health is a problem for a majority of people in Kenya, particularly the poor or those in the low income informal sector, such as, motorbike taxi operators commonly known as *Bodaboda*, who are highly vulnerable to economic changes.

Subsequently, several players in the health insurance industry, including the National Hospital Insurance Fund (NHIF) which is Kenya's largest social health insurance provider, have come up with strategies which accommodate informal sector workers. The NHIF is one of the key institutions tasked with the delivery of universal health coverage (UHC). The mandate of the National Hospital Insurance Fund (NHIF) is to enable all Kenyans access quality and affordable health services since it's the primary provider of health insurance in Kenya. The policy was restructured by the repeal of the National Hospital Insurance Act (CAP 255) and the enactment of the National Hospital Insurance Fund Act No. 9 in 1998 in order to accommodate the changing healthcare needs of the diverse Kenyan population, employment and the continuous restructuring in the health sector. To address the health coverage needs of the informal sector workers, NHIF introduced daily premiums in May 2018 targeting informal sector workers. This was done by breaking the monthly subscriptions into smaller daily packets that can be conveniently remitted daily through mobile money such as Safaricom's Mpesa (Barasa et al., 2018).

In Eldoret town, Uasin Gishu County, there is low uptake of social health insurance cover hence many Bodaboda operators easily resort to risky lifestyles such as self-medication, irrational use of over-the-counter antibiotics or use of unqualified medical practitioners including herbalists (traditional "doctors") (Kimani et al., 2012). Moreover, there is a general tendency of the operators fundraising or sale of family valuables included limited assets to cater for health care costs arising from accidents, diseases and sickness to them and uninsured families. Motorcycle related accidents account for 14% of reported traffic accidents, with an estimate of about 3000 per year. In Eldoret town, Uasin Gishu County, police data showed a significant increase in motorcycle related accidents from 22% to 36% over the past four years (Traffic Police Eldoret Central, 2018). Such accidents often result in high injury severity and fatalities. Consequently, medical and rehabilitation expenses relating to such injuries are often high, and when paid out of pocket, victims are pushed to into personal bankruptcy and eventually poverty. Lack of health insurance cover limits access to quality and appropriate health care among motorcycle taxi operators and their dependents. With the introduction of the daily health insurance subscription scheme, it was largely expected that the Bodaboda operators who form a substantial proportion of the informal sector would be among the primary beneficiaries. However, the low uptake of the daily subscription scheme suggests that there could be underlying factors among them awareness of the scheme that affects the level of subscription to the new health cover package. Therefore, the objective of this paper was to determine the influence of awareness of daily payment on uptake of social health insurance among Bodaboda operators in Eldoret Town, Uasin Gishu County, Kenya.

II. The Weberian Model of Social Stratification

This study adopted the Weberian Model of Social Stratification which views social stratification in three dimensions: economic class, social status, and political power. This three class system was developed by Max Weber who argues that there is interplay among wealth, prestige and power with each having a resultant effect and influence over the other areas (Ragnedda, 2017). The economic dimension of the Weberian Model of Stratification is represented by income and the goods and services which an individual possesses, while the social is represented by the prestige and honor one enjoys. Political power is represented by the power an individual exercises over others.In order to advance the arguments of this study, the economic and social dimensions were considered. Social stratification is a form of differentiation in which societal members are grouped into socioeconomic strata, based on occupation and income, wealth and social status, or derived power (Macionis & Linda, 2010). Stratification has structured inequalities among different groups of people. This means that people in a stratified society have been separated into unequal categories in as far as social evaluation is concerned (Giddens et al., 2009).

Due to unequal distribution of income, people on lower incomes are likely to buy goods and services that negatively affect their health (Marmot, 2017). When this view is applied, it means that lower income earners amongst informal sector workers are unlikely to purchase a health insurance cover and consequently opt for alternative health care services. As such, enrollment of informal sector workers would remain low. In addition, the economic dimension of the Weberian Model of Social Stratification was used to explain the second objective on awareness and knowledge of the benefits of having a health insurance cover. An individual's economic position greatly influences ability to access education and information through medium like television, radio, internet and newspaper. High levels of education can influence access to information, which in turn influences purchase of health insurance. Weber further argues that when stratification is perceived as social status, it applies to the positive and negative privilege to social prestige based on the mode of living, a formal

process of education and the prestige of birth or of an occupation (Lulu & Bin, 2017). In order to explain the effect of awareness on daily health insurance uptake, this study examined the information acquisition patterns across the levels of education, income and information outlets across the Bodaboda operators' substrata.

2.1 Awareness and Uptake of Health Insurance

Awareness comprises a general understanding of one's healthcare needs, but also more specific knowledge of risk and protective factors for healthcare.

2.1.1 Registration procedures and payment mechanisms

In a review of demand for health insurance in low-income countries it was observed that the concept of insurance which involves spending money in return for an uncertain payout in future is fairly new in low income countries (De Bock & Gelade, 2012). Newly insured people may expect to receive their premiums back when no payout or claim occurs, hence the need for intensive insurance literacy training and use of peers in spreading information on insurance products. A qualitative study in Kenya by Chomi *et al.,* (2014) revealed that health insurance providers offices were located in urban areas thus hindered registration into health insurance schemes for those who lived in rural areas.

Gina and Sapna (2008) explored the challenges of introducing insurance among the poor and informal sector populations in low income countries and noted that it is important to build trust in the target communities to convince them that health insurance offers financial protection. On awareness, they observe that informal sector populations are generally unfamiliar with the concept of health insurance and may be suspicious of insurance because of past experience of others with other types of insurance and are also uncomfortable paying upfront for services they may not need while not getting any benefits themselves, hence the need to work with trusted community leaders and use appropriate communication mechanisms to build knowledge and trust in the organization providing the proposed health insurance product.

At the community level, community-based organizations, microfinance organizations may be used as entry- points when introducing health insurance in the informal sector (Witter, 2012). Traditional channels of communication may not be effective in reaching the poor, rural and informal sectors in the developing world, hence the need to device effective messages for relying the benefits of health insurance using social marketing techniques including, use of local champions to speak to villages on benefits of health insurance. In India the micro-insurance academy uses local leaders to organize activities for health insurance education and group exercises with the help of educated health insurance facilitators (Ertekin & Navarrete-Moreno, 2017).

2.1.2 Benefits of health insurance subscriptions

Marketing of insurance to the poor presents challenges because even for those who have had access to insurance, their experiences is often negative due to delays in claims processing, and rejected claims (Rom et al., 2012). According to Churchill et al., (2005), low income people with low literacy and living from day – to- day may not understand why they should spend the little cash available to cover future events that may never occur. Therefore, there is need to create awareness of the health insurance products through targeted campaigns. To counter the negative anti-insurance arguments, the marketing messages should emphasize the key areas of solidarity, optimism, trust and social protection while reminding the poor that they are vulnerable and would be worse off without managing risks through insurance. To improve understanding of insurance, simple and low tech techniques, street theatre, video, pictorial and video presentation can be used. In the social marketing process, the sales agents should assist potential clients towards concluding that health emergencies are expensive by helping low income households recognize their risks and how insurance would assist in managing the risks.

2.1.3 Access to health insurance subscription information

In an attempt to understand the factors underlying low uptake and renewal rates of health insurance, Maharashtra State in India conducted a study understanding of insurance concepts and the level of information that people had on insurance (Panda et al., 2016). The findings of the study where: low enrolment and renewal was influenced by deficient information on the functioning of the scheme and poor understanding of insurance concept with most respondents citing lack of information on how to use the insurance. Also when enrolled members received benefits that were lower than the insurance premiums paid, they were less inclined to renew their insurance. The study demonstrated the need for continuous communication and the importance of the physical presence of insurance agents in the field to provide information on Insurance products through sustained awareness campaigns.

A study carried out by Jangati (2012) on awareness of health Insurance among residents of Hyderabad city in Andra Pradesh and found that: 65.5 percent had no idea about it. It was established 22 percent of males were aware while 11.5 percent of females were aware about health insurance. On employment status, it was found that self-employed people were less aware about health insurance compared to government and private

companies. Those with higher levels of education were more likely to be aware of health insurance. The researcher called for extending effective information and communication activities to improve peoples' understanding about insurance. In a study carried out in Bangladesh focusing on informal sector workers, was to investigate the impact of offering education on health insurance using weekly group discussion on health expenditure and health insurance. The key focus of the study was to know whether literacy gaps and lack of knowledge influenced the willingness of informal sector workers, the willingness to pay (WTP) after the educational intervention period was 33.8 percent higher among the informal sector workers who joined the education sessions compared to those who had not joined the session. The general conclusion of the study was that educational interventions can be used to increase demand for health insurance by offering modules that are comprehensive and covering health pooling, health insurance, benefits packages and the strength of solidarity (Khan & Ahmed, 2013).

Mathauer, Schmidt and Wenyaa (2008) assessed the factors affecting the demand for health insurance, focusing on enrolment into NHIF. In the study using discussions with members of taxis associations, farmers, self- help groups from different parts of the country, it was found that lack of knowledge about enrolment procedures and the basic principles of insurance was a major barrier to enrollment. Many of the participants had not heard of the health insurance and appeared to expect to be paid back the premiums of they had not fallen sick for a long period, reflecting their poor understanding of health insurance as a way of pooling and sharing risks. It was concluded that informal sector workers did not know about NHIF but were ready to enroll when correct and well packaged information was provided for persons at different levels of education. Another earlier study by Mathaur, Schmidt and Wenyaa (2008) assessing factors affecting demand for health insurance in Kenya found out that many Kenyans particularly those in the informal sector have not heard about the concept of health insurance.

However, in the last twelve years there has been significant developments in information and communications technology characterized by an expanding social media space and also traditional media outlets, therefore, it was largely expected that this could affect the levels of awareness of health insurance especially among informal sector groups like the Bodaboda industry. Nevertheless, existing studies have not explored this aspect in health insurance uptake and, particularly, on packages such as NHIF daily subscription schemes.

III. Materials and Methods

The study used cross sectional descriptive research design. This research design was considered as the appropriate research design since it is a more appropriate strategy for answering research questions which the researcher has no control over the events (Rahi, 2017). It also allowed the use of the mixed method approach using both quantitative and qualitative methods to make an in-depth inquiry of the study problem. The study was carried out in Eldoret town. Eldoret is a principal city in Rift Valley region and the fifth largest in the country and serves as the capital of Uasin Gishu County with a population of 475,716 persons according to the 2019 Population and Housing Census (KNBS, 2019). Of these, the working age population, that is, those aged between 18 and 60 years were 47.46%. The main economic activities in the town which is at the heart of a large agricultural belt is industry and services. The town has an extensive suburban area with over 32 estates where majority of its residents live. However, the town and its estates are not served by a well-developed public transport system to serve its large population. This, therefore, creates the right conditions for a thriving Bodaboda business who already number more than 5000 in the town and are registered in 26 Bodaboda Saccos (Department of Traffic and Road Safety, UasinGishu County, 2018).

The study targeted 5000the Sacco officials and Bodaboda operators due to occupational risk associated with group. From these, a sample size of 263 respondents were obtained using the formula proposed by Nassiuma (2000) to calculate the required sample size from the target population of, thus;

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

Where n = sample size, N = population size, c = coefficient of variation (≤ 50%), and e = error margin (≤ 3 %). Owing to the busy and highly mobile nature of the target population, the study adopted purposive sampling for the Bodaboda riders while purposive sampling was used for the Sacco officials and for forming the focus group discussions. Purposive sampling was also used to select members of the focus group discussions from the Bodaboda riders and their officials. The study used both the questionnaire and focus group discussion guide to collect data. Two focus groups discussions, one with 7 members and the other with 8 members were also conducted to gain more in-depth understanding on uptake of health insurance among Bodaboda operators. The FGDs comprised of Bodaboda riders and their Sacco officials and were held at a convenient location agreed to by all members and was moderated by the researcher.

A pilot study was conducted to test the validity of the questionnaires and focus group guides. Piloting of the instruments was done among Bodaboda operators in one of the estates in Eldoret town known as Kimumu who did not participate in the actual study. The study used content validity which drew from the expert opinion of the researcher's supervisors from the university to ascertain the representativeness and suitability of instrument items and give suggestions of corrections to be made to the structure of the research tools. The questionnaire was also subjected to the internal consistency method to check its reliability. The study established a Cronbach Coefficient instrument reliability $\alpha = 0.895$ which was deemed admissible for the study as it was above the $\alpha = 0.7$ recommended by Cronbach (Tavakol & Dennick, 2011). Data was analyzed using both descriptive and inferential statistics with the aid of Statistical Package for Social Scientists (SPSS). Descriptive analysis involved the use of frequency distribution and percentages while regression analysis was undertaken between the variables with a view of understanding the association levels between them (Orodho, 2009). In this respect, bivariate regression was undertaken which enabled the computation of the correlation coefficient, R, and the Odds Ratio (OR). Qualitative data from focus group discussions was analyzed using conceptual content analysis.

IV. Results and Discussion

4.1 Awareness of Daily Subscription Scheme and Uptake of Social Health Insurance

The objective of the study was to assess the influence of awareness on uptake of social health insurance daily payment strategy among Bodaboda operators. This objective was measured in terms of; registration procedures, payment mechanism, benefits and means of accessing information. The findings are presented in Table 1.

Table 1: Awareness of Daily Subscription Scheme onUptake of Health Insurance

Statement	SD (%)	D (%)	N (%)	A (%)	SA (%)	Mean	Std. Dev
I am aware of NHIF's daily payment strategy for healthcare financing	15.1	35.2	10	27.2	12.5	2.79	0.906
I am aware that the daily payment is paid to NHIF scheme	18.8	38.4	6.1	25.5	11.2	3.04	0.969
I am aware the amount is paid through a mobile money	11.6	17.8	4.9	51.2	14.5	3.73	0.867
I am aware of other modes of payment of NHIF apart from going to their offices	9	29.1	4	49.2	8.7	3.99	0.712
I am aware Late payment of monthly contributions attracts penalty	2	8.3	0	71.5	18.2	4.24	0.512
I am aware all Kenyans over 18 years can join NHIF scheme	5.3	27.6	5.1	48	14	3.91	0.676
I am aware the one can register at any NHIF offices	0	0	0	50	50	4.56	0.44
I am aware NHIF covers admissions and Outpatient services on registered hospitals	13.2	20	7	52.8	7	3.52	0.942
I am aware up to 6 family members can benefit from one principal member	11.6	27.4	4	47	10	3.63	0.874

The findings in Table 1 indicate that the respondents (mean = 2.79, SD = 0.906) were not aware of daily payment strategy uptake on health care financing. Most of them(mean = 3.04, SD = 0.969) were also not aware that the daily payment was paid to NHIF scheme, however, most of them seemed to be familiar with paying their subscription fees to NHIF using mobile money (mean = 3.73, SD = 0.867). Further, the findings suggest that the respondents (mean = 3.99, SD = 0.712) were aware that there were other modes of payment of NHIF apart from going to their offices. Also, most of the respondents were aware that late payment of monthly contributions attracted penalty (mean = 4.24, SD = 0.512). These findings generally imply that the level of awareness of the NHIF daily payment strategy uptake on health care financing was considerably low among Bodaboda operators.

Regarding the awareness of registration procedures, the respondents (mean = 3.91, SD = 0.676) of the respondents were aware that all Kenyans over 18 years can join NHIF scheme. All respondents (mean = 4.56, SD = 0.44) were aware that one can register at any NHIF offices. Most were also aware that NHIF covers

admissions and outpatient services on registered hospitals (mean = 3.52, SD = 0.942) and that up to 6 family members can benefit from one principal member (mean = 3.63, SD = 0.874). To encourage potential members to register, it is imperative that they be made aware of the insurance contract they are entering into. From the results of the study, it is clear that there are major insurance knowledge gaps that should be filled through mass campaigns to educate the respondents on the role of insurance in health financing.

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

Low levels of knowledge were noted in Indonesia (Setyonaluri & Radjiman, 2016) where only about 38 per cent of the informal workers were aware of the enrolment procedures into a health protection programme. Even members of health protection programmes showed significant knowledge gaps regarding the benefit packages (outpatient services, inpatient care) that they were entitled to. The low enrolment rates mirror the wider global picture more so in low income countries. Bredenkamp and Buisman (2016) argued that in Philippines the informal sector accounted for more of the uninsured than any other group. In their study on challenges to extending universal health cover, only 33 per cent of eligible persons in the informal sector were covered by 2012 under the Individually Paying Programme (IPP).

From the FGDs, it emerged that some participants did not understand the concept of health insurance in general. This was so because some of them had expectations of getting a refund of the contributions they have made at the end of a year in the event that they did not seek for health care services:

Health insurance is good since when members of my family or I fall sick, I am assured of healthcare services. At times one has no money to spend when they fall sick. However, what happens when I do not get sick within a year? I should be paid back the money I have contributed at the end of the year whenever I do not fall sick)

If I have been contributing as self-employed and I happen to get a job (meaning formal employment), should I be submitting my contribution through my employer. What would happen to my earlier contributions? Can I request for a refund?

Those who were aware of the strategy were asked to indicate the source of information on daily payment strategy uptake on health care financing. Table 2 presents the findings of this item.

Table 2: Source of Information on Uptake of Daily Payment Strategy

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

The study showed that 12.3% of the respondents were made aware of daily payment strategy uptake on healthcare financing through radio, 11% cited they heard it on friends, 9.2% indicated other source like posters and *chamas* and 7.2% read in newspapers. Media contributes to higher percentage of information dissemination that is useful in overcoming information gaps in healthcare service delivery. Munge *et al*., (2015) established that there was very limited understanding of health insurance among community members, particularly related to the concept of risk pooling. The media can be instrumental in overcoming these information gaps.

4.2 Uptake of social health insurance across the BodaBoda Riders

The study also sought to establish the uptake of social health insurance across the BodaBoda Riders. The results are given in Table 3.

Table 3: Uptake of social health insurance across the BodaBoda Riders

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

Table 3 shows that, overall, majority 167(69.8%) of the respondents did not have health insurance while 72 (30.2%) had subscribed to social health insurance. Across the age brackets, most of those who had subscribed to health insurance 26 (11.0%) were aged between 26 and 33 years of age. The findings also indicate there was variation in uptake of social health insurance and concur with Mhere (2013)whose study on non-participation in health Insurance schemes in Gweru urban area in Midlands province, Zimbabwe found that enrollment in health insurance increased with age. The findings in this study also concur with those of Kumi-Kyereme and Amo-Adjei (2013) who found that likelihood of being insured increased with the age of respondents.

The findings on education levels and enrolment into daily payment strategy for NHIF cover indicate that 16.7% of the respondents who had enrolled into the daily payment strategy had secondary level of education, 7.2% had primary school level of education and 4.6% were holders of tertiary level of education and 1.7% did not have formal education. As for those who had not enrolled into the daily payment strategy, 34.3% had schooled up to secondary school level, 21.2% had schooled to primary level, 8.9% did not have formal education, and 5.4% were holders of tertiary level of education. The findings agree with Mhere (2013) in Zimbabwe Kumi-Kyereme and Amo-Adjei (2013) in Ghana, Kirigia *et al* (2005) in South Africa who concluded that the uptake of social health insurance increased with education levels. The results of this study further disagree with those of Oyekale (2012) who found that older farmers in Osun state in Nigeria, who lacked education and financial backing, also had lower probability of enrolling in health schemes.

Marital status formed part of demographic characteristics assessed. The findings in Table 4.3 indicated that of those who had enrolled on daily payment strategy for NHIF cover, 15.5% were married, followed by 7.5% who were single, then 5.2% were cohabiting, 1% were widowed and 1% were divorced or separated. The findings support those of Bourne and Kerr-Campbell (2010) in Jamaica who found that enrollment in health insurance was influenced by social standing, income, marital status, retirement benefits, living conditions and the number of males in the household. Married respondents were found to be more likely to purchase health insurance. The findings also support those of Kirigia *et al* (2005) who similarly concluded that ownership of health insurance was high among married couples in South Africa.

A cross tabulation between number of children under 18 years old in household and enrolment into daily payment strategy was carried out. The results suggest that out of the 30.2% of respondents who have enrolled into daily payment NHIF cover, that those who had 1-3 children had the highest uptake (17.2%), followed by 8.4% who had 4-6 children and 4.6% who had no children. These findings agree with Fang et al., (2012) whose study on health insurance coverage and medical expenditure in Taiwan observed that households with smaller family sizes and higher incomes were more likely to have higher coverage in both public and private health insurance schemes. The findings also agree with Thornton et al., (2010) in Nicaragua established that both the probability of future health events occurring (such as the number of children in the household) are significantly and positively associated with uptake of health insurance. Similarly, the findings disagree with by Dhillon et al., (2012) in Rwanda who established that large households with more than five members had a greater probability to enroll in the health insurance cover schemes than others.

4.3 Regression Analysis

Bivariate logistic regression analysis was used to determine whether the variables identified in the study had a significant influence on the uptake of the daily payment health insurance plan among the Boda boda operators. The results are summarized in Table 4.

Table 4: Regression of professional-related factors influencing inter-professional collaboration

Chi-square	df	Sig.	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
47.172	27	0.009	47.050a	0.49	0.663

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
Awareness	0.332	0.466	0.508	1	0.036	1.394	0.559	3.478
Age	-0.632	0.65	0.943	1	0.331	0.532	0.149	1.903
Education	-0.574	0.311	3.401	1	0.045	0.875	0.622	1.232
Marital status	-0.331	0.305	1.174	1	0.279	0.719	0.395	1.307
No. of children	-0.133	0.174	0.584	1	0.445	0.563	0.306	1.037
Constant	0.735	2.586	0.081	1	0.776	2.086		

The logistic regression was performed to ascertain the influence of awareness, age, education levels, marital status and number of children on the likelihood of the Bodaboda operators to uptake the daily health insurance subscription plan. The logistic regression model was statistically significant, $\chi^2(27) = 47.050$, $p < .009$. The model explained 66.3% (NagelkerkeR^2) of the variance in uptake the daily health insurance subscription plan. Awareness (OR.1.394, 95% CI = 0.559 – 3.478) and education Levels (OR.0.875, 95% CI = 0.622 - 1.232) were found to significantly increase the likelihood of the Bodaboda operators in the area subscribing to the uptake the daily health insurance subscription plan. Bodaboda riders with higher levels of education were more likely to subscribe to the daily health insurance subscription plan. These findings, therefore, show that education improved levels of awareness with more educated operators showing increased likelihood of being aware of the health insurance schemes and actively subscribing to them. The results agree with Atun et al., (2013)who found that consumers with documented low-to-moderate levels of health insurance literacy are challenged in making health insurance purchases due to little knowledge and understanding of universal healthcare and they should be helped understand and use health insurance. The findings, however, disagree with Boaeng and Awunyor-Victor (2013) who found that education level had no significant influence ($p = 0.635 > 0.05$) in enrollment in Ghana's national health scheme.

V. Conclusions

The study sought to examine the influence of awareness of daily subscription on uptake of social health insurance daily payment strategy among Bodaboda operators in Eldoret town. These was examined through several constructs, such as, registration procedures, payment mechanism, benefits and means of accessing information.Through the regression analysis the study revealed that the odds were high that increased awareness would lead to higher uptakes of the NHIF's daily payment strategy. This led to the conclusion that awareness plays a very important role in the uptake of social health insurance daily payment strategy among Bodaboda operators. However, as things stand currently, the level of awareness of the NHIF daily payment strategy uptake on health care financing was considerably low among Bodaboda operators. This suggests that there are major insurance knowledge gaps that should be filled through well targeted campaigns to educate the members of the informal sector such as Bodaboda on the benefits of healthcare insurance and the convenient packages and modes of subscription especially the daily subscription package.

VI. Recommendations

The study, therefore, recommends that there is need to enhance awareness of insurance service provider and accredited healthcare service provider so as to inculcate the positive impact of the uptake of the NHIF insurance scheme in the minds of the informal sector workers. As Bodaboda operators are already affiliated to Saccos, the NHIF could come up with targeted awareness strategies that reach out directly to the members of the Saccos letting them know about the products they have on offer and the subscriptions options. Further, to encourage potential members to register, it is imperative that they be made aware of the details of the insurance contract they are entering into.

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