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DETERMINANTS OF DROPOUT FROM COMMUNITY BASED HEALTH INSURANCE AMONG HOUSEHOLDS IN SODO ZURIA WOREDA, SOUTHERN ETHIOPIA.

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A THESIS SUBMITTED TO THE COLLEGE OF HEALTH SCIENCES, SCHOOL OF NURSING AND MIDWIFERY, ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR MASTERS SCIENCE DEGREE IN ADULT HEALTH NURSING.

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ABBREVIATIONS

AAU	Addis Ababa University
CBHI	Community Based Health Insurance
CI	Confidence interval
CL	Confidence Level
ERC	Ethical Review Committee
E.C	Ethiopian Calendar
HF	Health facility
HHs	Households
HHH	Household heads
HP	Health professionals
LMIC	Low and Middle Income Countries
OOP	Out Of Pocket
PCA	Principal Commponent Analysis
SHI	Social Health Insurance
SNNPR	South Nations Nationalities and People Region
SPSS	Statistical Package for Social Science
SRS	Simple Random Sampling
UHC	Universal Health Coverage

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ABSTRACT

Background: Ideally, large adoption and renewal rates for the schemes were expected. However, practically, the uptake rates are low, and due to different factors, the dropout rate could threaten its achievement and sustainability. This later on brought the community back to paying from their pockets for healthcare expenses. Therefore, this study evaluated the reasons why households dropout from community-based health insurance in Sodo Zuria Woreda, Southern Ethiopia.

Methods: A cross-sectional community-based study was conducted by mixing quantitative and qualitative data collection methods. For the purpose of selecting samples, a multistage sampling procedure was used, which were then proportionally allotted to the number of study households. Factors with a P-value of 0.05 or less were deemed to have a statistically significant association with the dropout of the program after descriptive statistics and logistic regression analyses had been carried out. Thematic analysis, however, is employed to analyze qualitative data.

Results: Overall, out of 591 households, 34.45% dropped out of the CBHI scheme. Young age-adjusted odds ratio (AOR (95% CI) = 0.498 (0.263–0.944)), uneducation/illiterate (AOR (95% CI) = 0.377 (0.212–0.671)), unaffording the premium [AOR (95% CI) = 1.52 (1.04–2.03)], and underutilizing the health service (AOR (95% CI) = 2.16 (1.46–3.18)) were statistically significant determinants associated with dropout.

Conclusions: Drop out of CBHI is most commonly associated with young age of households, uneduced households, poor knowledge toward the scheme, poor perceived health service quality, and low trust in scheme mangers. By reasons they had to decide to discontinue their membership, and these factors were likewise linked to community-based health insurance dropout.

Recommendations: It was discovered that a considerable number of the respondents were unfamiliar with the scheme's premise. This implies that the concerned groups must continue to raise knowledge and develop concepts for the scheme and insurance.

Keywords: Informal Workers; Community based Health Insurance; dropout

1. INRODUCTION

1.1 Background of the study

Community-based health insurance (CBHI) refers to a voluntary and not-for-profitable health insurance defined by community members that are purposely organized at the community level, mainly targeting informal sector workers and the rural population. CBHI is a kind of micro health insurance, and it's one of the types of health insurance focused at people with lower incomes (1).

The CBHI scheme has been implemented as a mechanism of financial security by lowering out-of-pocket (OOPs) medical care expenses (2, 3). In industrialized countries, such as China, several systems were put in place to achieve UHC. Similarly, the CBHI scheme was established in several nations as a strategy or means to attain universal health coverage (UHC), and it is becoming priorities in low-income nations (4, 5). In South Asia the CBHI scheme is used as an alternative to fee-for-service and user fees as a means of financing healthcare. As a result, CBHI schemes are created to make sure that members have access to sufficient funds to receive proper care. (3). The CBHI scheme has high significance when compared to the uninsured, OOPs expenses in Bangladesh were significantly lower by 6.40% for CBHI members (6).

Aside from its significance, CBHI is currently experiencing challenges due to dropouts and low uptake. In addition, health insurance does not cover a big part of Africa, which greatly contributes to the CBHI scheme's low level of engagement (7). In addition, it is still not thoroughly examined, and such circumstance might provide a durability issue for the CBHI system in various LMICs (8, 9) Dropping out also makes it more challenging to share risks and affecting sustainability in the long run. According to Asian research conducted in rural India, 80% of the enrolled individuals discontinued their CBHI subscriptions (10). The dropout rate rises from 58% to 83% in Senegal(8) and 38% in Ethiopia (11).

Copious studies showed that different factors contributes to the drop out, such as the socioeconomic and demographic factors, affordability of the Premium, low education level,

understanding of the CBHI program, drug and medical supply limited availability, attitudes of healthcare professionals toward CBHI members, and prolonged waits for services were indicated as a factor influences CBHI members to dropout (12-16).

Ethiopia began the CBHI program in 2011 (17), and the health insurance coverage is about 28%, which is very low in comparison to others (18). The fact that not everyone is able to get a wide-ranging health insurance scheme in Ethiopia, Personal expenses OOP covered 37% of the overall health care costs (19) and another study in Northeastern Ethiopia reported as catastrophic health expenditure is 20% which indicated the significance of CBHI for the community in order to reduce OOPs and improve health insurance coverage (20). However, the enrollment in pilot district was 41% in 2012, 48 % in 2013, 50% in 2014 and to 58% in 2015, while households do dropout (18% in 2013 and 19% in 2015) (21), and the dropout rate in West Shewa Ethiopia is 38% (11). Ethiopia has significant sustainability challenges from CBHI dropout rates.

Finally, this research project examined household heads (HHH) who worked in the informal sector, lived in Sodo Zuria Woreda, and dropped out of the CBHI membership. The study specifically focused on the CBHI scheme related factors, Individual-related factors, and health care services offered to members. Understanding why members drop out of CBHI has become an important research problem. The Ethiopian government is considering a nationwide rollout of the program, therefore this study is essential from a policy aspect. Sodo Zuria Woreda launched CBHI in 2015; however, its dropout is now a challenge. Furthermore, there is no research on the factors that affect CBHI dropout in the woreda.

1.2 Statement of the problem

Ideally, large adoption and renewal rates for the CBHI schemes were expected; but, in reality, uptake rates have become steadily lower. Even if it is successful in LMICs, low adherence rates and dropout rate pose a threat to its long-term viability (22, 23). Low-income countries struggle to keep the CBHI scheme sustainable because of the dropout rate, which hurts further enrollment (13, 14, 24). Plus, in many nations, poor engagement in CBHI continues to be a problem. In Asia, a few studies reported a high dropout rate in rural India 45.7−80% (10), in Pokhara Nepal 28.2% (25), in Northern Vietnam 21.2% (26), and in Southern Nepal 38% (27).

In Africa, Out of a total population of 900 million, only 2 million residents participated in the CBHI program, or 0.2% of the catchment's total population (28). Low income is the main obstacle to enrollment, which results in dropouts since CBHI's sustainability is determined mainly by its renewal rate (7, 29) . A study in Senegal, Ghana, Uganda, and another study in Ghana, revealed that the magnitudes of dropout were 72%, 53%, 25.1%, and from 6.8% in 2008 to 34.8% in 2012 respectively (8, 29-31). According to studies from Ghana indicate that the nation's medical care Insurance System is a crucial resource for African nations (32, 33).

In Ethiopian, CBHI was launched in June 2011 in different 13 districts, with just 30% of the communities participating when the pilot was launched. In 2015 48% enrolled but the 18% dropped out (15, 17), as well, in comparison to other African nations, Ethiopia has an extremely modest health insurance coverage rate of 28%. Health insurance coverage in SNNPR is 4.06 time more than compered to Afar (18), but another study reported the non-enrollment rate was reported on adjacent region of the study area as 87.2% (34). This is the obstacle and ventures the sustainability of the scheme. The drop out magnitude in varies from study to study, Gedo 17.32% (35), Jimma 31.9% (36), Dera Ethiopia 37.3% (37), and west Shewa Ethiopia 38% (11) 29.14% Northeast (38). Given Ethiopia's low level of CBHI development, the majority of the previous researches on CBHI dropout or renewal have mostly neglected the vitality of mixed approaches for data analysis as well as the impact of trust in a government-run medical center and insurance programs.

Different strategies implied to address CBHI schemes dropout. These includes flexible payment option(14), quasi-mandatory as an enrolment strategy indicated that temporarily increase in enrolment rates (39) and transferring to the National Health Insurance level. Imposing reforms to a complicated health system (40). According to the study in LMICs, strong and stringent inclusion requirements, such as limiting enrollment to families of five or demanding 60% of a community to participate earlier than offering services or guaranteeing the entire household (41). The people's financial state has a significant impact on Savannakhet Province Asia's ability to maintain participation in the program

Many factors affect the dropout, the study in Savannakhet Province Asia demonstrated that people's financial status has a significant impact on their decision to remain engaged in the program (41). Sociodemographic characteristics like age, gender, level of schooling, marital status, occupational status, wealth, and the number of families of HHH were among those impacting the dropout rate of CBHI. Health-related criteria included the standard of medical care, the distance from HF, the absence of medical equipment, and the difficulty of accessing HF. understanding of the CBHI program, perception of Health service quality, an adverse mindset towards CBHI, belief in scheme administration, expensive nature of the premiums, reduced satisfaction with the scheme's services, and a low expected return from the scheme were all factors that were individually associated. These are among the primary causes of CBHI dropout, according to different researches (24, 29, 30, 42, 43).

The study in Senegal found that socioeconomic factors primarily impacted dropout, however, it was conducted with a large number of dropout members and small sample size using an exploratory study design (8). Based on a study done in Ghana, the dropout rate of membership is determined by working in the unofficial sector. The weakness was that it did not identify the particular elements that contributed to informal worker dropout. Similarly, research in Cameroon found that a lack of information and awareness about CBHI caused participants to drop out. However, the study used an insufficient sample size, low adherence, and non-random sampling methodologies (44). While in Ethiopia, numerous studies have evaluated enrollment and its associated factors, but fewer studies have dealt with dropout. A study

carried out in Ethiopia revealed that an improved knowledge of the CBHI program is linked to a decreased dropout rate. However, this research was not conducted recently (15).

Finally, most studies on CBHI were done in western Africa and Asia, with the possible exclusion of Uganda and Rwanda in the eastern part of Africa. Thus, a previous study in Ethiopia found that SNNPR had a higher dropout rate than Oromia and Amhara (15). Furthermore, a lot of studies have been carried out, the majority of which discount the effects of trust issues on HF and CBHI programs and the importance of integrated (qualitative and quantitative) procedures in favor of using either quantitative or only qualitative methods of research. In the study by Woreda, no research has been done on the CBHI dropout rate and its determinants so far. The research presented here performed a mixed-methods study in rural Sodo Zuria Woreda to look into the factors that determine dropout among HHH (informal laborers), in order to get over the issues of earlier studies.

1.3 Significance of the study

The study's results will be beneficial in the identification of populations of interest, the clarification of goals, the definition of performance metrics, and the ability of health insurance companies to set increasing scale parameters. Assessing the factors that led HHHs in Sodo Zuria Woreda to drop out of CBHI would assist all parties involved in the study area in taking corrective steps to address significant issues.

This study additionally employed an effort to quantify the factors that contributes to CBHI dropouts, which will be used as a guide for designing quality-improvement programs for CBHI that are particular to the local contexts. These results might help in creating and planning the sets of healthcare services for community-based health programs that correspond with the medical care funding methods.

2. LITERATURE REVIEW

2.1 Magnitude and Conceptual aspects of CBHI

By sharing risks and resources at the local level, the CBHI system enhances the utsage of health service n and lowers OOPs. The scheme is unique by its establishment is based on voluntary membership, not having a profit-making intent, emphasis on risk pooling, and offering financial security to members against devastating OOPs expenses, which increases the recuperation of expenses for those in need. However, the CBHI's sustainability depends on increasing enrollment and minimizing dropout rates. Although CBHI schemes in LMICs have minimal renewal rates, little research has been done on the factors that lead to quitting membership in CBHI schemes (6, 14).

The magnitude of dropout among HHH varies from study to study. A survey study conducted among informal sector workers in Indonesia reported that the magnitude of discontinuation was 28% and revealed that the number of households was the reason for the dropout (45). Similarly a research conducted among households in Pokhara Lekhnath metropolitan Nepal showed 55.6% were dropouts (46). A survey study in rural India showed that 45.1%–80% of household heads dropped out of the CBHI scheme, indicating a substantial association between the affordability of the fee and dropping out of the scheme (10). Another survey study conducted in Vietnam showed that 21.2% and indicated young age and low education were reasons to drop out from health insurance (26), Another cross-sectional research was done with rural HHs in Nepal reported that the dropout rate of health insurance was 28.2% (25). A mixed study conducted in Nepal revealed that the renewal rate increased from 1% in 2016, 5% in 2017, 9% in 2018, and 11% in 2019, while the dropout rate decreased from 67% to 38% over a three-year period from 2016 to 2018. This was due to a lack of sufficient drugs, which resulted in participants quitting the scheme (27).

In Africa, a report on a study among Ghanaian slum residents showed dropout rates ranged from 6.8% to 34.8% (31). Another cross-sectional study in Ghana indicated that the rate of leaving health insurance ranged from 41% to 53% and that poor participants renewed and left the program (29). Another survey study conducted in south-western Uganda among

households with under-5 children indicated the dropout 25.1%(30). A comparative survey study in Senegal indicated the drop rate among households is about 72% (8). Similarly from study in Cameroon showed lack of knowledge and awareness regarding CBHI lead the people to drop out. However, the study employed a method of sampling that was non-random with a small sample number and only low adherence participants (44).

In Ethiopia, a cross-sectional study carried out in Dera district revealed a 37.3% dropout rate in CBHI (37), and a study carried out in west Shewa, Ethiopia, revealed a 38% dropout rate in CBHI (11). In Gedeo Ethiopia, a cross-sectional study revealed a 17.32% rate of drop-out in CBHI (35), A mixed study conducted among rural area households in North and South Gonder Ethiopia showed dropout from CBHI as 36%(47). A mixed study conducted among rural area households in Jimma Ethiopia reported 31.9% dropout from CBHI (36), Furthermore, studies have already been done to figure out what factors are associated with CBHI dropout. Those illustrated many variables that affect CBHI members quitting their membership.

2.2 Factors influencing CBHI dropout

2.2.1 Factors Related to Socio-demography

In rural Nepal, a community based cross-sectional study conducted among households found that families with more than 5 members were 2.19 times more likely to experience a dropout than smaller families (25). On contrary another cross-sectional study in Nepal indicated that HH who have more than 5 family member were enrolled by 79.8% and less likely to dropout (48).

Gender determines membership dropout. According to a study done in Nepal, HHs with female leaders were prone to get involved with the scheme and were less likely to leave (48). According to the study done in Tach Armachiho, Ethiopia, HHs with female heads were 2.79 times more probably choose to participate in CBHI than households with male heads (49). In contrary a studies on Burkina Faso and Nigeria, it was discovered that males were more wanting for premium payment than women (16).

Based on a cross-sectional study involving rural HHs in Vietnam, dropping-out rates were 4.2 times higher for younger age groups than for older ones (26). In contrast, a cross-sectional study of rural HHs in West Shewa Ethiopia found that older age groups are 1.8 times more likely than younger ones to leave CBHI (11).

In Pokhara Lekhnath metropolitan Nepal, a cross-sectional study of HHs revealed that 63.5% of HHs with informal education levels quit CBHI (46). In Vietnam, a cross-sectional study of households in sub-rural areas found that dropout rates were 7.8 times higher for individuals with less than secondary education (26). According to a cross-sectional investigation done in rural Uganda, the dropout rate for HH who have completed secondary education is 3.5 times greater than for those who have completed higher education (30). Another survey study carried out in East Sudan indicates that educated HHs are 38.78% more unlikely to drop out (22). A mixed-methods study carried out in Lao revealed that secondary or post-secondary education greatly increases the likelihood of enrollment and decreases dropout (50).

With HHs in a rural area, a study was undertaken in Vietnam reported that non-poor were13 times more probably to be dropout than the poor (26). In contrary, a study in south-western Uganda rural area showed dropping of the poorest households out are also 6.7 times more than the rich (30). Similarly, a mixed study conducted in Ethiopia revealed that second-quartile HHs were more probable to have dropped out (15).

2.2.2 Factors Related to health services

A mixed study carried ou in Nepal indicated that due to a lack of sufficient drugs, which led to participants leaving the program. This study demonstrated that the main cause of dropout was a lack of adequate drugs and diagnostic facilities (27). According to a cross-sectional investigation done in Nepal, there are 4.75 times more people who discontinue their health insurance since there are not enough drugs available (25).

A qualitative study conducted in Karnataka southwest India distances to hospitals induce dropout, requiring insurance providers to improve health services accessibly(51). In Nepal, a community-focused cross-sectional survey found that 58.6% of CBHI participants

who live far from a health facility and have health insurance left the program (46) In Nepal, a mixed-methods study found that low scheme adherence was caused by prolonged waits to see a medical professional and between appointments, a shortage of health personnel, and a lack of assessment equipment (27). According to survey research among HHs with children under 5 in southwestern Uganda, the probability of leaving increased by 21% for every extra kilometer from the hospital (30). The study in Southern Rwanda represented, the enrolment rate decreased 15% due to health service related factor (52). In Ethiopia, community-based cross-sectional research indicated that HHs not having enough access to healthcare displayed a 1.68 times higher chance of leaving the CBHI (37).

According to a cross-sectional investigation done in Ghana, the percentage of insured people who avoided the use of healthcare and dropped out was the most minimal at 54% in 2012 and the maximum of 82% in 2009 (53). A study that took place in Northwest Ethiopia found families with 4-6 yearly visits to HF had a 1.92-times higher dropout rate than for 1-3 of the yearly visitors (37). Another similar study in South Ethiopia found that program participant households used the hospital's resources more frequently, by roughly 39.1%. The results showed that the low services quality provided to program participants' non-members and members was a prominent complaint made by the majority of participants in both groups (54).

2.2.3 Factors Related to Individual

In Nepal, a cross-sectional investigation revealed all of the subgroups consistently cited the scheme's perceived low benefits as the cause for dropout (31) A mixed study conducted in Nepal showed unmeet expectation of members led to drop out from the scheme. This also suggests that members were not properly informed about the services (55).

A qualitative study conducted in Bangladesh indicated the participants are not satisfied by the attitude of health provides toward CBHI members. They suggest that delivering poor quality services and misbehaving toward patients with insured families by clinicians will reduce community acceptance and increase the likelihood that patients will not stick with the program (50). A cross sectional study conducted in Nepal perceived unfriendly behavior of service providers by 3.09 (25). A mixed study conducted in Nepal indicated that unfriendly

behaviors of health professionals dropout. This could be health professionals acted in unprofessional behavior that may have been deliberate and did not give enough information (27). A mixed study conducted in Burkina Faso reported that healthcare providers misbehaved due to higher demand for services from CBHI participants, which is what caused dropouts (56).

A mixed study conducted in Lao in Asia indicated that The probability of enrollment in CBHI is associated with a higher perception of healthcare quality (50). In Ghana, 31% of those who participated in the same study design felt that there were no variations in the program's service quality (57). A study conducted in Rwanda revealed a poor opinion of the quality of medical care, such as satisfaction About 56.6% of the workers are friendly, which has an impact on the low scheme adherence rate (52). The HHHs were prone to leave the CBHI if they thought the care was of poor quality. According to a mixed-methods study carried out in Ethiopia, the perception of low care quality had a negative association with participation in the program (15). However, a study using mixed methods carried out in Northwest Ethiopia revealed that HHs with a positive perception of the quality of healthcare were about 1.7 times participated in CBHI (58).

A mixed study conducted among households in Kenya indicated that those who have good knowledge do not wants to drop out from CBHI than the poor knowledge (59). But the cross sectional conducted among rural households in Uganda concluded that client perceptions and understanding do not affect dropout behavior (30). Another mixed study in Ethiopia showed that those who participated were more likely to leave the CBHI because they had a poor understanding of the program (15). A quantitative cross-sectional assessment of HHs in Northwest Ethiopia revealed that households with inadequate knowledge leave the CBHI program 1.93 times more frequently than those with good knowledge (37).

The CBHI dropout is affected by lacking trust in contracted HF and the CBHI committee. A mixed study conducted in Dera North Ethiopia indicated that by 63.8% CBHI members dropout of the scheme (37). In Kenya a mixed study conducted among rural households indicated the awareness created that 40% of the respondents trusted the scheme but only 10% had a sense of ownership but 51% had neither a sense of ownership nor trust on the program (60). According to a mixed study carried out in Jimma, Ethiopia, a 1% improvement in the

trust score for HF reduces dropout rates by 57%. Similarly, the dropout rate decreases by 39% for each unit increase in management trustworthiness. Despite the fact that much research has been done on the factors influencing CBHI membership, most of them neglected the impact of institutional trusts or trust in HF(36). Rural households in Gedeo SNNPR Ethiopia participated in the study found that lacking trust in the CBHI program, are lacking trust in contracted HF HPs, and lacking trust in the CBHI committee were the three main causes of dropout from the program, accounting for 38.7%, 15.1%, and 12.9% of dropouts, respectively (35). A mixed study carried out in Segen SNNPR Ethiopia revealed that a lacking trust is a barrier to CBHI enrollment and increases dropout. Members currently lack confidence in CBHI managements because they were not trustworthy (61).

2.2.4 Factors Related to CBHI scheme

In Nigeria, a study revealed that around 82% of HHs could afford the premiums for their families, which enhanced uptake of insurance (62). However, a mixed study conducted in Kenya indicated that dropout rates of 45.5% were due to unaffordability of annual membership payment (59). A cross sectional study in Ghana indicated that 29% of all the HHs were catagorized as unable to afford the premium that resulted the dropout (63). A study among informal sector workers in East Sudan showed that affordability does not have effect on dropout (22). A mixed study conducted in Northeast Ethiopia among rural households indicated that premium affordable increase membership renewal by 12.6 times than HH that cannot afford (38). A study conducted among rural households in Gedeo Ethiopia indicated that 46.2% of households discontinuation from CBHI scheme membership was reasoned out premium unaffordability (35).

In summary, to evaluate the factors that contribute to CBHI dropout, numerous researches have been undertaken. Findings show that a variety of factors play a role in CBHI dropout and membership renewal. However, there aren't many studies conducted in East Africa, especially mixed studies. Consequently, Woreda policymakers must consider specific national analysis, which might add to the region's inadequate amount of empirical evidence. For stakeholders and policymakers, a specific analysis of the research area is crucial. It can back up the scant empirical data in the Woreda

Conceptual Framework

The conceptual framework is drawn up after reviewing many theoretical and empirical works of literature. As previously discussed, socio-demographic characteristics, health status factors, individual factors, and scheme process-associated variables all have an impact on CBHI (14, 29, 40, 41, 64).

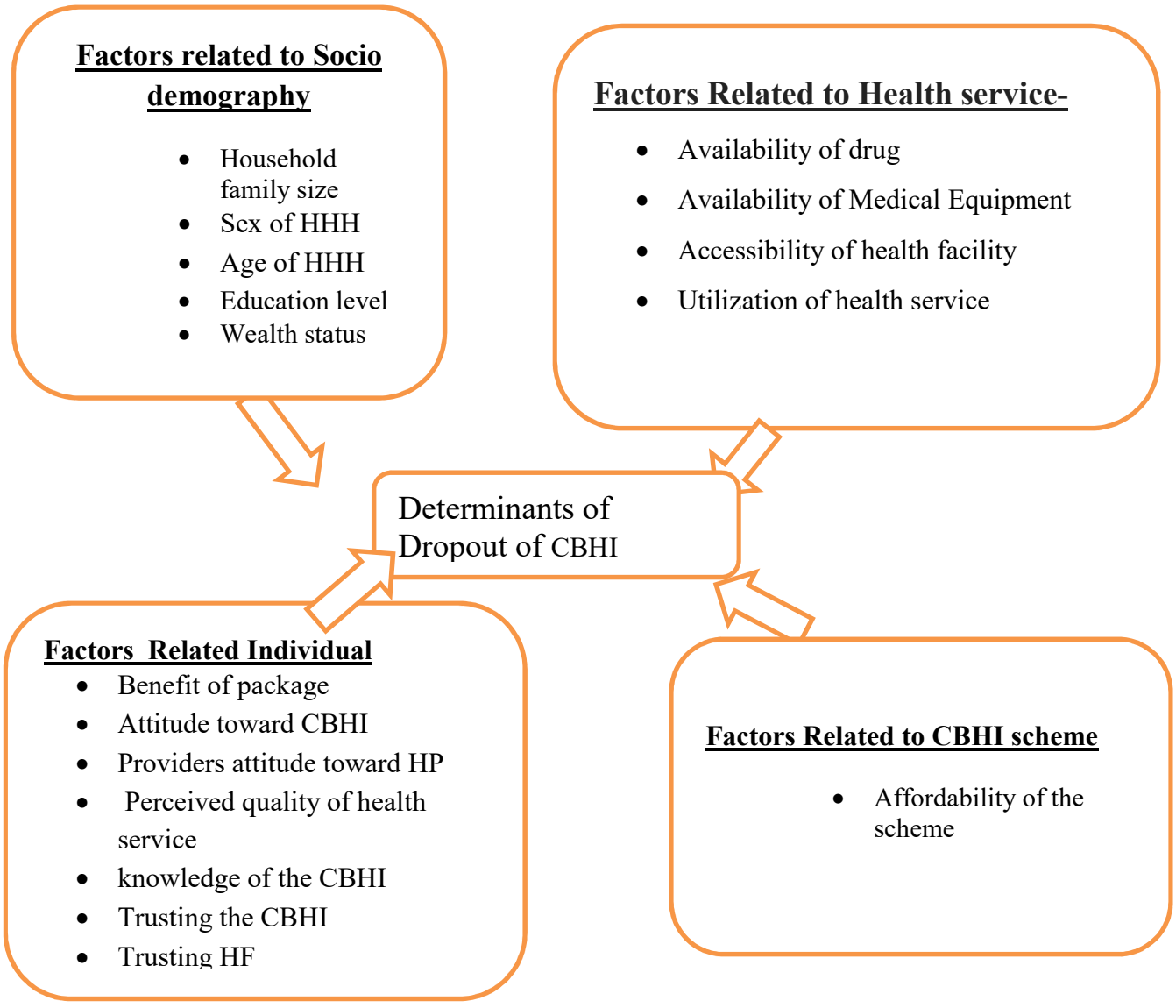

Figure 1: A conceptual stracture to review the determinants of CBHI dropout among household heads in Sodo Zuria Woreda, southern Ethiopia 2023.

CBHI Dropout and its determining factors in Sodo Zuria Woreda and adapted from research article (64)

3. OBJECTIVES OF THE STUDY

3.1 General objective of the study

To asses determinants of dropout from community based health insurance among household heads in Sodo Zuria Woreda, Southern Ethiopia, 2023.

3.2 Specific objectives

1. To assess the dropout rate from CBHI in Sodo Zuria Woreda, Southern Ethiopia, 2023.

2. To identify factors associated with dropout from CBHI in Sodo Zuria Woreda, Southern Ethiopia, 2023.

4. METHODS AND MATERIALS

4.1. Study area and period

Sodo Zuria Woreda was the location of the study, which was randomly selected at random from the Wolaita zone of the SNNPR, between December 26 and January 06, 2023. It is around 326 kilometers from Addis Abeba, Ethiopia's capital city, and 90 kilometers south of Hawassa, the SNNPR's capital. There are 27 Kebeles and 20,134 CBHI-eligible HHs in the woreda. The estimated population for 2022-2023 is 110,848, with the female population contributing 56,532 and the male population contributing 54,316. In terms of HF, the Woreda has seven government health centers. Has also established three different levels of private clinics and has a contractual agreement with one specialized government hospital. The Woreda started CBHI in 2015 and provides health services by making agreements with health centers and hospitals.

4.2. Study design

With respect to the thesis objectives, a quantitative community-based cross-sectional study design and qualitative in-depth interview research methods were used. The primary research design was a cross-sectional study with a concurrent qualitative component.

4.3. Source population

All HHs heads who were members of CBHI in Sodo Zuria Woreda.

4.4. Study population

Selected HHs those were members of CBHI were found in 06 kebeles of Sodo Zuria woreda.

4.4.1. Inclusion criteria

Households, whether or not they were CBHI members, Households that is resident in the Woreda, HHs that did not previously have health insurance, household heads who do not work in the formal sector, and CBHI-paying households.

4.4.2. Exclusion criteria

Households that have lived in the Woreda for less than six months, HHs working in formal-sector, HHs member of other health insurance, and HHs who do not pay HHHs and who have been enrolled in CBHI for less than a year.

4.5 Sample size determination

A single population proportion formula was employed to calculate the number of sample. According to a study undertaken in an Ethiopian setting, CBHI coverage is 45% (11).

$$n = \frac{[Z\ a/2]^2\ p\ (q)}{D^2} = \frac{(1.96)^2\ (0.45)\ (0.55)}{(0.05)^2} = \frac{3.84*0.2475}{0.0025} = \frac{0.95}{0.0025} = 380$$

Where n = intended sample size,

p = expected coverage of CBHI in Ethiopia, significance at 95% CL (1.96),

D = margin of error 5%

Using 10% of non-response rate and 1.5 design effect, the total sample size is (380+38)*1.5 = 627.

4.5. Sampling procedure

Quantitative study: a multistage sampling procedure was used to choose representative HH among randomly selected kebeles in the woreda. CBHI was implemented in 27 kebeles in the woreda, and 06 kebeles were included by the SRS method. The computed sample was then proportionally allotted to each selected kebele in accordance with their number of CBHI membership enrollments using the proportional allocation formula:

$$\mathbf{nj} = \frac{n.Nj}{N}$$

Where: nj = samples number in selected Kebele

n = Estimated sample (n = 627)

Nj =Total size of HH in selected Kebele (N = 3274)

Finally, as a sampling frame, the Woreda administrative Office provided a list of CBHI HHs. The participants were chosen by lottery method.

Qualitative study: purposively chosen samples for in-depth interviews there are two CBHI scheme officials and six kebele leaders. An in-depth interview with all stakeholders yields far more extensive information regarding CBHI. This is due to the belief that they have a more extensive and deep comprehension of the problem in question. Participants were considerably comfortable sharing information about the program with the researcher.

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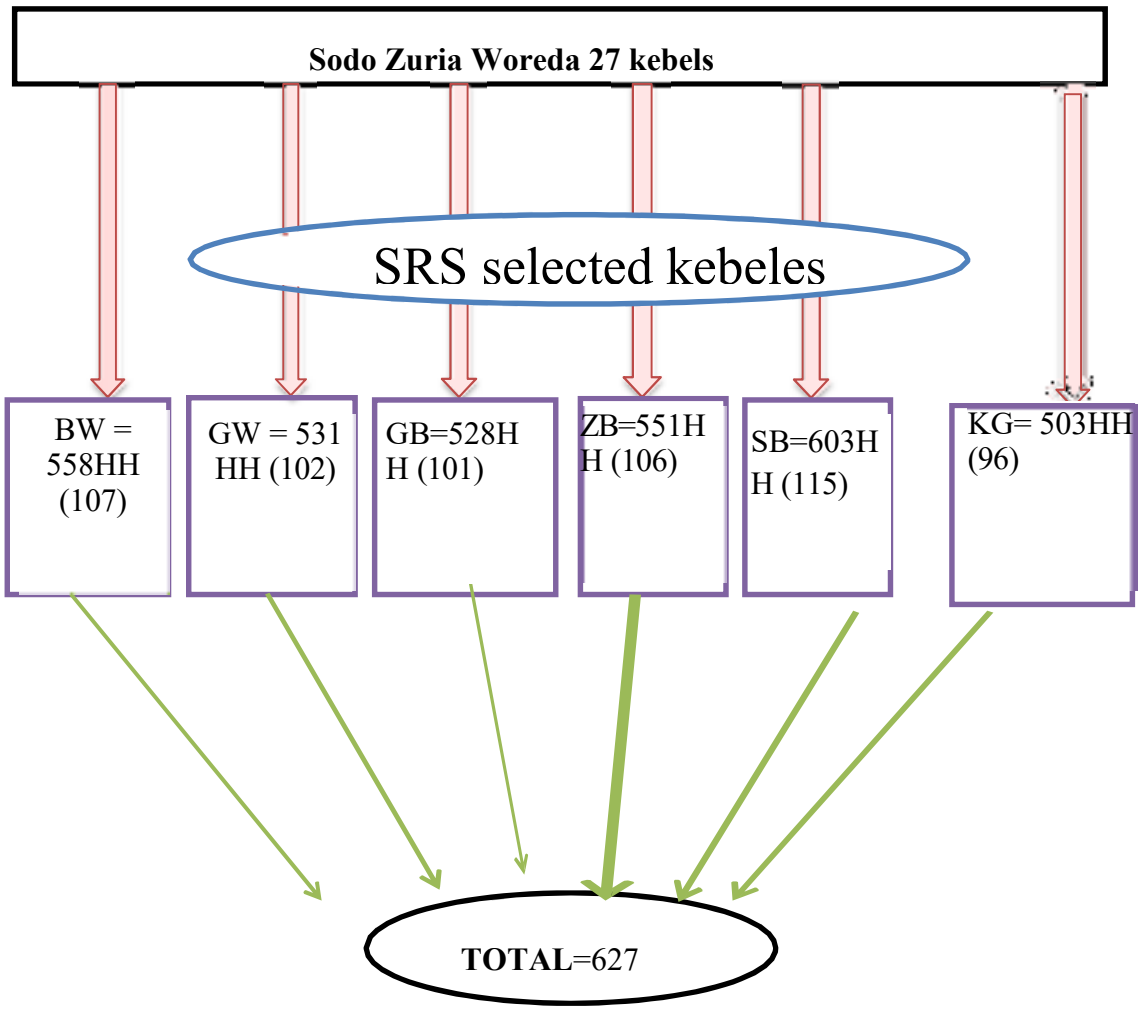

Key: B.W-Buge wanche, **G**.W –Gurumo woyide, **G.B** –Gillo Bisare, **ZB** Ziga Borkoshe, **SB** –shella Borkoshe**, KG** kodo Gawulia

Figure 2: The method of sampling used to analyze dropout from CBHI among HH in Sodo Zuria Woreda in 2023 is shown graphically.

4.6. Operational definition

- **CBHI dropout:** HH that was CBHI member but did not renew the membership was identified as dropout.

- **Renew:** HHs that renewed their CBHI membership and continued to be enrolled at data collection period, as well as HHs that were engaged during the initial year of operation but dropped out in the next years and then were re-enrolled in the ninth year. Categorized as "renewal".

- **Knowledge on CBHI**: A 10-item knowledge question was used to evaluate household head knowledge. According on the respondents' overall results, they were divided into two categories: below-average knowledge and above-average knowledge (25).
- **Attitude towards CBHI Scheme:** A 10-item question containing a Likert scale of five points was provided to the HHHs. The total score expressing the respondent's position was examined using the presumptions of summated scales. thereby, according to the favorableness scale, it was divided into three categories: the program is regarded more favorably when each participant's total score is 31-50, the program is considered least favorably when the score is 10-29, and 30 is neutral. To determine the internal consistency Cronbach's alpha was used, which was determined to be 72% (65).
- **Perceived Provider's Attitude toward CBHI members:** A Likert scale with five possible results was implemented to measure the ten-item question. To derive factor scores PCA was employed to evaluate if a member thinks the HPs exhibit an unfavorable, neutral, or favorable attitude. The obtained factor scores at one eigenvalue were subsequently arranged by percentile and grouped into three dummy variables with a total variance of 55%. Lastly, the KMO adequateness of the sample measure was 0.73, with a substantial Bartlett's test of sphericity. Cronbach's alpha assessed the items' internal consistency, which resulted to be 0.659 (36).
- **Perceived health service quality**: 06 questions with 5-point Likert scale was used to measure it. Following that, it was categorized again into three statistical importance categories: poor, medium, and good (36).
- **Trust in HF:** One continuous variable was used in the study after exteracting factor score using PCA. Participants were asked ten items on a Likert scale and. The KMO adequateness of the sample measureed 0.908, having statically a significant Bartlett's test of sphericity. Cronbach's alpha was measured 0.89 (47).
- **Trust in CBHI Scheme:** The derived factor score using PCA was employed as a continuous variable after the Participants were presented a Likert scale with 05. The KMO adequacy of

the sample score was 0.821, having a statistically significant Bartlett's test of sphericity. Cronbach's alpha was measured 0.795 (47) .

- **Household Wealth Index**: Data on HH proprties were gathered according to resources that individuals owned; after computing scores using PCA, and five quantiles have been formed from the scores. The lowest 20% quantile was considered the poorest, while the last 20% quantile was considered the richest (65).

4.7. Study variables

4.7.1. Dependent variable

CBHI membership Drop out

4.7.2. Independent variable

- **Factors Related to Socio-demography:** Age, household family size, education level, and wealth status.
- **Factors Related to CBHI and Individual:** knowledge on CBHI, affordability of premium and perceived quality, provider attitude and trustworthiness in scheme management and HF.
- **Factors Related Health:** Accessibility of HF, Utilization of health service, availability of drug, and availability of Medical Equipment.

4.8. Data collection procedures

For the qualitative investigation, open-ended in-depth questions were employed to elicit additional data that did not pertain to the questions by using a thematic approach. For the quantitative study, an interviewer-administered structured questionnaire, a community-based cross-sectional study design was used.

The Quantitative data: the questionnaire was prepared in English language translated into Amharic language and then back into English language to check its consistency. Prior to the start of the real data collection, 5% (30) of the sample's total households in identified kebeles that were excluded from the study took part in a pretest. The structured pretested questionnaire was adapted from reviewing prior literature (15, 36, 47, 65-67). The household questionnaire

contained four main sections. Section one, factors related to socio-demography; section two, factors related to CBHI; section three, factors to related health; and section four, wealth status.

The data collection involved three BSc health professionals and one supervisor, and it lasted for two weeks between December 26 and January 06 2023. Interviewers verbally briefed participants on the study area before to data collection and obtained their informed consent. Two days of orientation on the importance of the study and data-gathering methods were provided. At last, pieces of information were collected based on structured questionnaires, and CBHI scheme officials served as supervisors.

In cooperation with the investigator, the supervisor monitored every step of the data collection process and regularly checks each questionnaire for precision, transparency, and appropriate identification of the respondents. Throughout the duration of data collection, the supervisor and data collectors had daily discussions.

The Qualitative data: In-depth Interviews were held in six Kebeles where CBHI is implemented. Where the quantitative research had already been carried out purposve sampling procedures was employed.

4.9. Data quality management

Before beginning the actual data-collecting procedure, a pre-test was done on the study population to increase the validity. To assure data quality, data was examined for accuracy and completeness; those that were found lacking other crucial elements were eliminated and the data was kept confidentially.

4.10. Data analysis procedure

The main research methodology is the quantitative approach. For descriptive analysis, after the data had been gathered and checked for accuracy, exported to SPSS version 25 after feeding into EPI-data version 4.6, and. To reduce variables PCA was implemented, while to

examine determinants of the dropout logistic regression analysis was conducted. The values attitude providers towards CBHI members, scheme experience, trust in the HF and scheme were all evaluated using PCA. To determine whether the data were adequate for PCA, the Kaiser-Mayer-Olkin's (KMO) and Bartlett's test of sphericity were run. The right number of elements to be retrieved was chosen using the Eigenvalue larger than one decision rule. The Cronbach's alpha to measure the reliability of scales was used.

Tables, figures, and text were used to summarise the results, which included mean, median, frequency, and a variety of other characteristics. Frequencies and percentages were used to define the pertinent factors. Binary logistic regression analysis evaluated the magnitude and degree of significance of the bivariate association, together with the associated odds ratio and 95% confidence interval. Any independent variables having p-values of 0.25 and less in bivariate analysis were subjected to this operation in order to draw up a multivariable logistic model for the dropout and figure out the association of each independent variable on the outcome variable. Finally, variables discovered using multivariable logistic regressing analysis as associated (P 0.05) with a dropout of CBHI were reported as determinants of dropout. Diagnose variable relationships by using methods like the sample adequacy test, multicollinearity, and the goodness of fit test by Hosmer and Lemesho.

As a result, adding a qualitative element to the findings is important because it would be difficult to draw outcomes from the study design implemented quantitatively. The qualitative component is meant to support the quantitative results. Data collecting, transcribing, coding, and thematic analysis of the qualitative data was done. Data Following repeated readings of the text data, themes and groupings were apparent. To complement quantitative outcomes, the quotes which can support quantitative results were chosen and listed below the key quantitative determination.

4.11. Ethical consideration

After receiving an ethical clearance statement issued by AAU's ERC of the College of Health Sciences, School of Nursing and Midwifery, and additionally a letter of agreement from the

Zonal Health Bureau and Sodo Zuria Woreda CBHI office, the data collection was launched. Each Kebele from the Sodo Zuria Woreda CBHI office received an official letter of participation, and each participant gave verbal consent after being informed of the purpose of the study. Respondents became aware of the study's voluntariness, their choice to decline or withdraw at any time, and the necessity of maintaining their privacy.was guaranteed by using codes to analyze the data for both quantitative and qualitative studies, including participant interest.

4.12. Dissemination of the results

The final study document is going to be submitted to the School of Nursing and Midwifery at the AAU College of Health Sciences in both hardcopy and electronic format. The thesis result is reported to Sodo Zuria Woreda of the CBHI scheme, the Wolaita administrative Zone, and the SNNPR Health Bureau.

5. RESULT

This chapter analyses and summarizes the outcome of the study through the use of data acquired from HHH using a structured questionnaire administered to HHH and in-depth interviews with both CBHI scheme coordinators and Kebele administrators.

5.1 Study population socio-demographic status

Out of 627 study HHs reached, 591 were part of this study, having a response rate of 94.25%, with 203 (34.35%) dropping out. Among the HHs, 546 (92.4%) were payers, while 45 (7.6%) were poor and were not required to pay CBHI premiums. Almost every single one of them (586; 99.1%) received CBHI IDs. Only 88 (15%) of the individuals who renewed their membership had done so in the past over the previous four years. The statistics revealed that the mean HH's age was 42.7+ 11.5 SD, ranging from 21 to 75 years. Approximately 183 (31%) of HHs were 41–50 years old, while 135 (22.8%) were 50 and older. The vast majority of the residents, approximately 549 (92.89%), were Wolaita in ethnicity, with Protestants accounting for 279 (47.2%) and Orthodox believers accounting for 233 (39.4%).

In terms of HH's educational status, 179 (30.3%) of the individuals who participated were uneducated; 124 (21%) of the HHHs were able to write and read, 193 (32.7%) of HHHs had a primary school education, and 95 (16.1%) of HHHs had secondary education and higher. In terms of occupation, 365 (61.8%) of HHHs comprised farmers, 82 (13.9%) were merchants, and 41 (6.9%) were daily laborers.

Table 1: Socio-demographic variables associated with dropout from CBHI in Sodo Zuria Woreda, 2023.

Variable	Category	Dropout of CBHI		Frequency	Percentage
		Dropout	Renew		
Age in years	18-30	23(3.9%)	82(13.9%)	105	17.8
	31-40	68(11.5%)	100(16.9%)	168	28.4
	40-50	63(10.7%)	120(20.3%)	183	31
	≥ 50	49(8.3%)	86(14.5%)	135	22.8
Sex	Male	137(23.2%)	231(39.1%)	368	62.
	Female	66 (11.2%)	157(26.5%)	223	37.7
Ethinic group	Wolaita	188(31.8%)	361(61.1%)	549	92.9
	Others	15(2.5%)	27(4.6%)	30	5.1
Marital status	Single	17(2.9%)	9(1.5%)	26	4.4
	Married	176(29.8%)	370(62.6%)	546	92.3
	Divorced	9(1.5%)	7(1.2%)	16	3
	Widowed	1(0.12%)	2(0.3%)	3	0.5
Religion	Protestant	104(17.6%)	175(30%)	279	47.2
	Orthodox	78(13.2%)	155(26.2%)	233	39.4
	Catholic	19(3.2%)	52(8.8%)	71	12
	Muslim	2(0.3%)	8(1.8%)	8	1.7
Educational status	Illitereate	49(8.3%)	130(22%)	179	30.3
	Read and Write	49(8.3%)	75(12.7%)	124	21
	Primary	58(9.8%)	135(22.9%)	193	32.7
	Above Secondary	47(7.95%)	48(8.1%)	95	16
Occupational status	Farmer	123(20.8%)	242(40.9%)	365	61.7
	Merchant	29(4.9%)	53(9%)	82	13.9
	Employed	26(4.4%)	37(6.3%)	63	10.64
	Petty trader	10(1.7%)	30(5.1%)	40	6.8
	Daily laborer	15(2.5%)	26(44%)	41	6.9
Family size of the	≤ 5	89(15.1%)	215(36.4%)	304	51.4

Respondent	≥5	114 (19.3%)	173(29.3%)	287	48.6
Time it takes to	<30min	61(10.3%)	124(21%)	185	31.3
reach HF	30-60min	65(11%)	131(22.2%)	196	33.2
	>60min	77(13%)	133(22.5%)	210	35.5
Distance	<500meter	68(11.5%)	119(20.1%)	187	31.6
	500-1000meter	98(16.6%)	212(35.9%)	310	52.4
	>1000 meter	37(6.3%)	57(9.6%)	94	16

5.2. Magnitude of CBHI dropout

In general, 65.6% of the 591 HHHs extended their membership in 2022, while the total number of dropouts of membership among HHHs after 9 years of functioning was determined as 203(34.35%), 95% CI =30.5–38.3%.

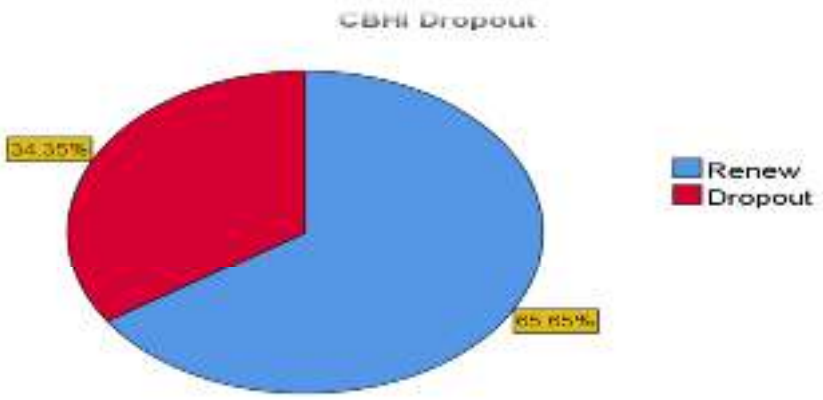

Figure 3: Magnitude of the dropout of CBHI among HHHs in Sodo Zuria Woreda, 2023.

There were 137 (22%) male HHs and 66 (11.1%) female HHs among the total study participants who dropped out of the CBHI scheme. Also, 23 (38.9%) of HHs were 18 -30 years, 68 (11.5%) were 31 and 40 years, 63 (10.7%) were 41-50 years, and 49 (8.3%) were beyond 50 years (Table 1). About 293 (49.6%) HHHs cannot afford the premium price, while

118 (20%) are on the lowest quantile wealth index. About 36.4% of HHH disagreed for the return of expected return from CBHI.

A 42-year-old male kebele manager said, "…*In my opinion the problem relate with CBHI dropout is the expectation of the members and practically happening in the health care system wasn't fit or similar. Negative perception to the program is may be due to unmet expectation of members."*

5.2.1. A single Reasons to renew CBHI among households

The households renewed their membership of CBHI because of different reason were 388 (65.7%). The most compelling single reasons for extending the membership were 121(31 %) to prevent my family from unanticipated catastrophic health-related expenses, which was followed by 74(19.02%) to access current health care services (Figure 4).

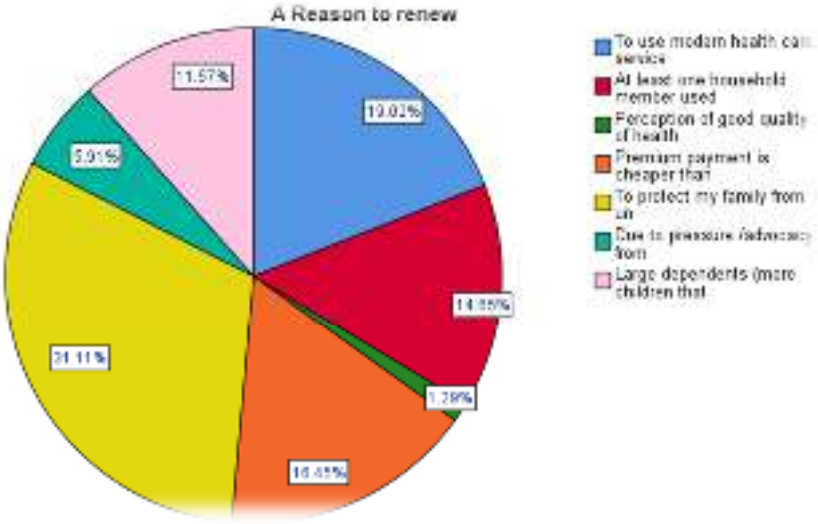

Figure 4 CBHI related single reason for extending CBHI.

5.2.2. A Single Reasons not to renew (Dropout) CBHI membership

Out of 203 dropped out study HHs 67 (33%) of households said that we dropout because Illness does not experience frequently in HH members. Similarly low quality of health care

service and we continue to pay other extra costs for the service despite the fact that the scheme's area of illness is limited was rated as 44 (21.7%), 19 (14.3%) respectively.

The Kebele manager, a man age 35 said "*...The goal of health insurance is attempting to support its customers in reducing treatment expenses to keep away from external medical expenditure when a family member falls sick. However, member households were now leaving the program because the program excludes some illnesses or limits the scope of illnesses covered by the program, so the government needs to address the problem by scaling up the program."*

Additionally, it has been discovered that the availability of medical equipment may affect people how to use health services and how happy they are with them. The contracted health center offers few medical services and frequently lacks pharmaceuticals in stock and unavailability of medical equipment; 22 (10.84%) of study HHH said that we dropout because the benefit package is not meet our needs. 20 (9.85%) of study participants were dropped from CBHI because of Unavailability of medical equipment. Additionally, 15 (7.4 %) of HHHs drops due to the contracted HF is far from their home. While the rest 3 (1.48%) were not renew their membership because of CBHI premium is expensive for me.

Another 42-year-old male kebele administrator reported: "…*The most common problem that is seen frequently in the scheme is related to the lack of drugs and medical equipment. There are good, industrious, and hardworking nurses and health professionals in the health center and hospital. But, there are no efficient drugs in the institutions or necessary equipment for the patients. This is an obvious problem affecting the CBHI member's morale to stay as a member for the future and decreasing the number of participants."*

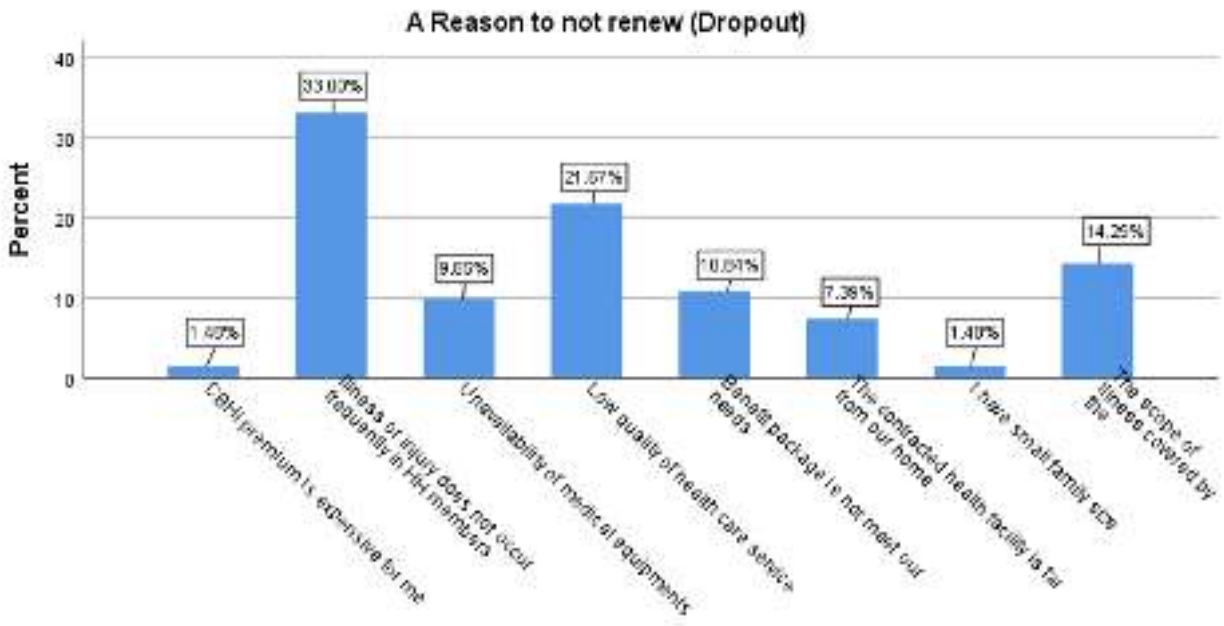

Figure 5: Single reason not to renew (dropout) membership.

5.3. Bivariate and Multivariate Analysis

The Age, education, and family size appeared to be significantly linked with dropout of CBHI as an outcome of binary logistic regression bivariate analysis of sociodemographic variable. The bivariable logistic regression indicated younger HHHs were more likely to drop out than older HHHs, COR= 0.412; 95% CI (0.237, 0.719). Those HHHs can read and write [COR: 0.57795% CI: (0.354-939)] and HHHs with satisfying scheme experience [COR: 0.821; 95% CI: (0.681-989)], have been associated with dropping out of membership accordingly (Table 2).

Table 2: The logistic regression analysis for determinants of HHHs dropout from CBHI in Sodo Zuria Woreda, 2023.

Variable	Category	Dropout from CBHI		COR(95%CI)	AOR(95%CI)	P-Value
		Dropout	Renew			
Age in years	18-30	23(3.7%)	82(13.5%)	R	R	R
	31-40	68(11.7%)	100(17%)	0.412(.237-0.719)**	0.427(0.233-0.783)**	0.006
	40-50	63(10.7%)	120(20.3%)	0.534(0.307-930)**	0.554(0.302-1.017)	0.057
	≥ 50	49(8.2%)	86(14.9%)	0.492(0.276-0.880)**	0.451(0.238-0.853)**	0.014
Educational Status	Illitereate	49(8.2%)	130(22%)	R	R	R
	Read and Write	49(8.2%)	75(12.7%)	0.577(0.354-939)**	0.598(0.351-1.019)	0.059
	Primary	58(9.8%)	135(22.8%)	0.877(0.559-1.376)	0.872(0.530-1.436)	0.591
	Secondary and above	47(8%)	48(8.1%)	0.385(0.229-0.647)*	0.353(0.197-0.632)*	0.000
Family size of the households	≤ 5	89(41%)	215(53.3%)	R	R	R
	≥5	114 (59%)	173(46.7%)	0.628(0.446-0.884)**	0.605(0.412-0.889)*	0.01
Knowledge	Poor	86(60.7%)	199	R	R	R
	Good	117(59.6%)	189(41.2%)	0.655(0.466-0.923)	0.622(0.423-0.917)**	0.016
Utilization of Health service	Yes	120(20.3%)	162(27.4%)	R	R	R
	No	83(14.04)	226(38.24%)	2.017(1.428-2.848)*	2.230(1.507-3.300)*	0.000
Perceived quality Of health service	Good	23(3.9%)	75(12.7%)	R	R	R
	Medium	15(2.5%)	11(1.9%)	0.401(0.180-0.892)**	0.772(0.309-1.931)	0.58
	Poor	165(27.9%)	302(51.1%)	1.782(1.076-2.950)**	2.488(1.416-4.372)*	0.002

P<0.05 **, p,0.01*

The unaffordability to pay the registration and premiums regularly led to dropouts from CBHI, with the odds of dropping out 1.58 times higher than those who could pay [AOR (95% CI)=1.576 (1.075-2.311)] at p=0.02. Again, those in the lowest quantile wealth index were twice as likely as those in the richest quantile to drop out of CBHI at p = 0.023 [AOR (95% CI) = 2.027 (1.101- 3.731)]. Lowest middle quantile wealth index odds of drop out of CBHI were 2.27 times more at p-0.09 [AOR (95% CI) = 2.269 (1.223-4.210)] than the richest.

A 35-year-old male kebele manager said, *"...impossible to say all of the households in our keble can afford the scheme. At least all of the kebele residents know the benefits of CBHI by looking at their neighbors, but due to low income and inability to afford, they drop out."*

This study found HHHs who do not use the CBHI program and health services are 2.23 times more probably to drop out than the opposite part [AOR (95% CI) = 2.230(1.507-3.300)]. The households with satisfying CBHI scheme experience was [AOR (95% CI)=0.57 (0.660-1.006)].

42 years old kebele manager said: *"...we have no complaint about the management system of my woreda and kebele. The people around this kebele were utilizing CBHI since 2007E.C. But some people carelessly wait to go to health facilities to see health professionals until they are severely ill, unfortunately when they come to see health professionals after severe illness the CBHI premium will expire because they did not use the scheme for their illness."*

Accordingly, dropout of the program was 2.5 times more common among HHs who had poor perceived service quality compared to HHs with the good perceived service quality of health (AOR (95% CI) = 2.488 (1.416-4.372)) at p- 0.002

Dropout membership was also influenced by the HP's attitude toward CBHI members. The HHHS with perceived a favourable provider attitude, the likelihood of dropout were 1.3 times higher for those who perceived an unfavorable provider attitude (AOR (95% CI) =1.343(1.008-1.789)).

Another 31 years old male kebele manager said *"...it is obvious the health professionals are competent that they provide good health care service to the people , but sometimes we hear*

some complaint regarding unfavorable behaviors of health professionals which in turn affect the interest to continue the program."

Trust in contracted HF and the CBHI program was also associated with CBHI dropout. As a result of the study, the CBHI dropout rate decreased by 25.6% for every one score increase in trust score in public HF [AOR (95% CI) =0.774(0.634-0.943)]. Similarly, a one-score increase in the CBHI scheme's trust decreased the dropout by 25.3% AOR (95% CI) =0.747(0.602-0.926)].

A 42 years old male kebele manager who said "*…We had been working for long periods in this kebele. But it is not completely clear for the community about the purpose of the program. The scheme has great importance to the poor but due lack of trust in health facility and unsatisfied experience people leaves the scheme overtime, related to this bad behaviors of health professionals and low quality of health service members loss trust in health facility and we do not have power except reporting to the concerned bodies specially to wereda health bureau. This has a great pressure on us."*

6. DISCUSSION

By sharing risks and resources at the population level, CBHI promotes access to HF and minimizes OOPs associated with health costs (14, 68). However, the CBHI member rate of dropout continues to render it difficult for the program to remain successful.

This study focused on estimating the level of HHHs dropout rate of the CBHI scheme in the Wolaita Zone's Sodo Zuria Woreda. It tried to identify factors that were significantly determining the dropout of the scheme. Prior study conducted in Ethiopia showed higher dropout rates in the SNNPR than in Oromia and Amhara regions (15). This study found that the proportion of HHHs who dropped out of CBHI was 34.35% (95%, CI: 30.5–38.3). This outcome was comparable with the research carried out among HH in Jimma Ethiopia 31% (36), in Northwest Ethiopia 34% (69) , and in Ghana 34.8% (31) , Ethiopia 36% (47). The potential explanation could be that the study designs were comparable or that the source populations were similar, given both investigations involved rural household heads and discovered similar reasons for leaving out.

However, this result was greater in magnitude than those of the researches conducted in Vietnam 21.2% (26), in Nepal 28.2% (25), in Uganda 25.1% (30), and in Gedeo Ethiopia 17.32% (35). This gap may be the result of variations in the level of HF among the research areas. Again, differences in socio-demographic and economic variables may be the cause of this disparity. Possibly, due to difference in financial position, study period and premium collection period among the study populations. Additionally, each of these nations has a different healthcare system depending on the population's health. The variance in the results may also be explained by variations in sociocultural practice among the countries. Furthermore, the discrepancy might also be due to differences in policy.

However, this result was smaller in magnitude when compered to studies done in rural areas of India 45.1-80% (10), Nepal 38% (27), in Senegal 58%-83% (8), in Ghana 53%(29), East Shewa Zone Ethiopia 38% (11), Northwest Ethiopia 37.3 % (37). This might be because different communities are more or less receptive to the CBHI program, and diverse study

participants may have different socioeconomic or sociodemographic variables as a result of different study populations and study designs.

The age of HHHs was the first important sociodemographic variable to be associated with dropout of CBHI. According to this study, younger age groups had higher rates of CBHI dropouts than household heads over the age of 50. About 55% of younger HHHs dropped out of the scheme when they were compared to older than 50 HHHs (AOR (95% CI) = 0.451(0.238-0.853)). This otcome is analogues with the study in Vietnam (26). The elderly may continue to participate in the scheme because as people get older, their defense against infection declines, and they become more vulnerable to illness than younger people. Additionally, the experience of illness of the older age groups might increase the health care-seeking behaviors than the young and greater perceived risk of care seeking, which in turn increased their intention to renew the scheme than the young age groups (70). Also the dropout related to young age might be due to the fact that those groups tend to look for other health institution such as private health facility to improve their life and withstand the contracted health facility.

Another important socio-demographic factor that significantly influenced dropout from CBHI was the educational level of the HHHs. In comparison to uneducated HHHs, household heads with secondary education or higher were 64.7% [AOR (95% CI) = 0.353 (0.197-0.632)] less probably to leave the scheme. This discovery is consistent with research done in Sudan and Bangladesh (22, 71). This is possible that people with more education are less willing to leave CBHI because they have a better understanding of how things work in HFs, the financial safeguards that CBHI provides, how the system in generally operates, and the difficulties associated with the hierarchy of duties in CBHI (31).

The other statistically significant factor with CBHI dropout was the HH wealth status. The lowest quantile and lowest middle quantile households were 2 and 2.27 times more likely to quit CBHI than the richest, respectively. The reason for the poorest to dropout from CBHI may be due the fact that they cannot afford the premium when compared to the richest one. similarly, the study conducted in Ethiopia indicated people dropout because of unaffording the scheme (15). A study in Uganda had showed the exact same way, the richest exhibit a lower dropout rate than the poor (30). A study conducted in Burkina Faso confirms the finding by

indicating that less economic status as a factors enhances drop out from the scheme (14). Additionally, study in Ghana and Uganda showed adherence of richest households to CHBI. The similarity for this finding of countries could be the similarity in level of socio-economic background among rural households participated in the program (63, 72).In contrary, a study carried out in Gurage zone Ethiopia indicated that HHHs with a better economy will drop out to get treatment from private health facilities because consider they get better health service (43).

This finding was supported by qualitative component; *"...there is nobody who does want to drop out from CBHI but poverty makes most people can not afford the premium. Over here, poverty as well as inflation is obvious in Ethiopia currently. Money is the problem for renewing the scheme additionally it has a limited time duration for the collection of the premium fee, and those who don't have cash want to register but miss it. With the exception, those who have better income leave the scheme because they assume they can get better treatment from private health institutions and contracted health facilities in our kebele. (Male, age- 32, and kebele administrator)*

The other determining sociodemographic factor of drop out in this study was HH family size. Compared to those with 5 or fewer family members, those with more than 5 were less likely to leave CBHI by 74%. It might be due to increase in family size increase health expenditure during illness compered to small family size. This outcome seems to correspond with the research that was conducted in west Shewa, Ethiopia (11). Similarly study conducted in Bangladesh confirmed the small family size (6) and Nepal (48, 73) showed that families with more than five individuals were far less probably to drop out of the program than families with less than five individuals. This may also be because larger families may experience an increase in the rate of frequency and the likelihood of illness, which could lead to OOPs seeking medical care and a resulting financial crisis. In the case of this study the large family size households less drop out due to the intension of lowering health care costs.

Additionally, the study attempted to demonstrate that the odds of dropout were reduced by 37.8% for HHHs with good knowledge [AOR (95% CI) = 0.622(0.423-0.917)] as compared to poor knowledge HHHs. The outcome is comparable to studies carried out in India and Sudan (10, 22) and Ethiopia (34, 74). The explanation could be the CBHI membership and

understandings of the services offered under the scheme are influenced by their knowledge of the scheme. Likewise a study in Cameroon and had indicated that poor knowledge make people not to join CBHI (44), and Northwest Ethiopia study showed as the knowledge of the CBHI raised by a single score, the likelihood of being enrolled into the scheme increased by 1.8 scores. (58).

The qualitative component supports this finding as; A 46 years CBHI officer said, "…*the gap in knowledge related to CBHI in the community is obvious this is due to bad experienced neighbors miss inform the rest at iddr or market places and is still becoming a reason for many members to dropout from the scheme"*

The other significant determiant factor indicated was poor perception to service quality. Which highers the likelyhood of dropout by tow and half times [AOR (95% CI) = 2.488(1.416-4.372] as compared to the opposite. This outcome was coparable to study undertaken in Ethiopia which confirmed that poor perceptionof service quality given to members was the determining factor for the dropout from the membership, respectively (69). Additionally a study in Lao southeast Asia demonstrated poor perceived quality of care resulted in less likely to enroll further leads to dropout (50). This might be due to unmeet expectation of the scheme utilizers. From this finding it could be easy to conclude that improving the health service quality is basic for the sustainability of the scheme.

Additionally, this study revealed an inverse association between HP's attitude towards CBHI members and CBHI membership dropout. Accordingly, an unfavourable HP's attitude raised the likelihood of dropout by 1.3 times when compared to a favourable provider attitude. However, a cross sectional study conducted in Nepal perceived unfavorable behavior of service providers by 3.09 times increases the dropout (25). This might be due to unequal treatment between the uninsured and insured members. In Northeast Ethiopia, a study with mixed-methods showed that 93% increased the enrollment due to good HP's attitude (75).

The qualitative aspect was possibly supportive of this outcome; A 46 years CBHI officer said, "…*some of the health professionals attitude toward the CBHI member is not good and are not collaborative, not all but the health professionals are rude to clients during consultation. The*

complaint from our members is they feel mistreated by the health professionals specially related to dispensary they could not get injectable drugs as they want. "

Furthermore, every additional level of trusting the HF reduces the likelihood of leaving the CBHI by 25.3% AOR (95% CI) =0.747(0.602-0.926)]. The study conducted in Gedeo Ethiopia confirmed similarly that lack of trust in the contracted HF was significant factor for drop out from CBHI scheme by 38.7%. This could be due to drug shortages and HP's attitude toward CBHI scheme members (35). This is because of the correlation between trusting the CBHI system and delays in waiting for Health service in the HF, poor perceived service quality, and a reported unfavorable attitude of HPs towards CBHI participants, and is related to many other factors which lead to fear and uncertainty then to dropout. This result is similarly sided with a study performed in Ethiopia (65).

Additionally, for every additional unit of trust of the CBHI scheme, the likelihood of leaving the program decreases by 25.6% [AOR (95% CI) =0.774(0.634-0.943)]. This may be members have questions about the CBHI officials' integrity or they have a history of misappropriation. In contrary, a mixed study conducted in Senegal showed lack of trusting CBHI managers were not statistically significant for not to enroll or to dropout (8).

The findings of this study may have a number of diverse conceptual and practical effects and have now more information about the extent and causes of dropout from the CBHI scheme. It also reminds the CBHI committee and other interested parties to study more about the likelihood of CBHI dropout and the factors that contribute to it. They should improve members' trust in the HF and CBHI scheme managers to raise the rate of membership continuation.

7. STRENGTHS AND LIMITATIONS

7.1 Strengths

- Data was collected using both types of methods (qualitative and quantitative), which gives a better understanding of the study.

7.2 Limitations

- single area study
- It is challenging to determine causality in this study design

8. CONCLUSIONS

To identify the variables that determined HHs in Sodo Zuria Woreda to drop out of CBHI was the objective. The majority of factors associated with dropouts, in general, include the household head's young age, low educational level, small family size, poor knowledge of CBHI, HP's negative attitude to CBHI members, a poor perception of the healthcare quality, and untrusting the HF and administrator of CBHI. The low frequency of illness or injury in HH, the limited range of illnesses covered by the insurance, and the demand that they continue to cover extra expenses for their care were the factors that caused CBHI members to discontinue their membership. They had been forced by their circumstances to discontinue their membership, and these factors were linked to CBHI discontinuation. But in order to avoid unmanageable medical costs, Members of the CBHI were reminded to continue their membership, additionally the trust of issue of CBHI members toward HF and CBHI should be critical emphasized by HP and CBHI committee.

9. RECOMMENDATIONS

The Woreda CBHI scheme is generally being implemented well. However, this study clearly showed that CBHI dropout rates are high and that participation in the scheme is fluctuating, regardless of community development. The Woreda should endeavor to find solutions to the issues the CBHI is experiencing. The researcher has made the following recommendations in light of the data that have been analyzed and the conclusions reached:

To the woreda CBHI office: - The CBHI administration's contribution to creating awareness of and providing education regarding the CBHI operations provided positive benefits. However, the study revealed an incomplete comprehension of the CBHI scheme. This advice raises insurance knowledge among all relevant parties, focusing notably on the younger and less educated populations.

To the Woreda health bureau:- by implementing various measures to make health service providers responsible to patients, dropouts across populations as a result of drug shortage and poor service quality can be decreased. For instance, by employing administrative sanctions to change the way medical practitioners communicate with CBHI users and address the pharmaceutical shortage.

To policy makers:- prior to the nationwide launching of SHI in Ethiopia, multiple policy initiatives need to be taken into account. The adverse selection must be combated with methods including group enrollment, unequal premiums, and obligatory enrollment. The government should provide a different option for low-income people to pay their premiums in two or more periods throughout the year. The federal government should also amend the WHO's for establishing SHI to attain UHC

Finally to researchers: - it's possible that not all CBHI schemes in the nation and the region are represented by these findings. The researcher thus advises further research into these and other variables linked to CBHI members dropping out.

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ANNEXES

Annex 1. Participant Information Sheet

Introduction: I'm BSc. Nurse Data collector and I respectfully request your keen interest in order in order to clarify the research study to you and how your participation in it was chosen.

Title of Thesis: To assess determinants of dropout of CBHI among HHHs in Sodo Zuria Woreda, southern Ethiopia, 2022: mixed approach.

Purpose: In order to partially meet the criteria for the MSc in Adult Health Nursing, this study will examine the factors that lead household heads in Sodo Zuria Woreda, southern Ethiopia, to discontinue their membership.

Procedure and Duration: the study participants will be selected randomly by lottery method. We will read the questionnaire to study participants. It takes roughly 25 minutes to complete the four questionnaires. I respectfully demand that you give me your time to answer these questions.

Risks: Participating in this study carries no risks other than the fact that it will take just a little of your time. besides this, the study will not negatively affect participants' psychological or physiological well-being.

Benefits: Policymakers and academics will benefit from the study's findings, which will help them to further develop CBHI-related healthcare for HH members by identifying the factors that lead CBHI members to drop out of insurance.

Confidentiality: Any data you share is going to be kept completely private. You will never be asked for or given any information that can be used to identify you by anyone else. The results of this study will not be specific to any one person and will be generic throughout the study population. No mentions will be included in either written or verbal statements that could connect participants to the research, and the survey responses will be coded to omit names.

Rights: The decision to take part in this study is entirely up to you. You have the option to express your willingness to do so from the start and at any point, as well as to decline to a response to either one or every one of the inquiries posed by the study. However, hope you'll

take part in this research since the results will help the government improve health and health-related services for medical students.

Contact Address: if there is any ambiguity or questions that you need to be answered pkindly in touch the primary investigator

Name:	**Telephone**	**Email address**
Israel Asale	**0900515658**	**israelasale@yahoo.com**

ANNEX 2. Questionnaire for Quantitative studies English version

I. Form for a Statement of Agreement

I, the chosen respondent, received what was written on the study information sheet and comprehended the goal, advantages, requirements, and implications of participating in the study. I was aware that any information pertaining to me, including my name and any responses I provided, must not be disclosed to another person. I am aware that I can choose whether or not to take part in a research project and that I can leave at any time.

One who took part in the study Sign_____

Name of interviewer: _____ Sign:_____

The following page

TABLE 3 QUESTIONNIARE FOR THE CROSS-SECTIONAL ASSESSMENT

Section I: Socio-demographic characteristics

ID of Health Center: _____ ID of Study: _____	Name of Interviewer : _____Sign_____ Supervisor Name: _____Sign_____
Date of the Interview: _____	Time Interview Started_____ Completed_____

No	Questions	Coding Catagories
101	Sex of respondent	Female Male
102	Age in years	.....
103	Ethinic group	Wolaita Gamo Gurage Amhara Others, specify.....
104	Marital ststus	Never married/Single Married Divorced Separated Widowed
105	Religion	Protestant Orthodox Muslim Catholic Others, specify.....
106	Education	Illitereate Read and Write Primary Secondary

		Tertiary
107	Annual income(in Birr)	_____birr
108	Occupational status	Farmer Merchant Employed Petty trader Unemployed (jobless) House wife Other, specify.....
109	Family size of the Respondent	_____in no

Section II : Questions related community- based health insurance.

201	When you started enrolling CBHI?	_____years
202	Have you renewed your CBHI membership for this year?	1. Yes _____ 2. No _____ If your answer is no skip to Q no 204
203	If you renew membership what was the reason?	1. To use modern health care service 2. At least one household member used health care service 3. Perception of good quality of healthcare service 4. Premium payment is cheaper than out of pocket payments to get health care service 5. To protect my family from un expected catastrophic health care expenditure 6. Due to pressure /advocacy from CBHI/government office 7. Confidence in the management of CBHI

		8. The benefit package of CBHI is good and I benefit from the scheme 9. Large dependents (more children that need health care 10. Time and frequency of contribution is good for me_ 99. Other specify_
204	If you do not renew your membership for this year, what was the reason?	1.CBHI premium is expensive for me_ 2. Illness or injury does not occur frequently in HH members 3. Unavailability of medical equipment 4. Low quality of health care service_ 5. Benefit package is not meet our needs__ 6. The contracted health facility is far from our home_ 7. I have small family size__ 8. The scope of illness covered by the scheme is limited we still pay other additional costs for the treatment 9. Lack of detail awareness about CBHI 99. Other specify
Questions related to knowledge of CBHI (Q 205-Q 2014)		
205	Do you know health services covered under CBHI scheme?	Yes 2. No
206	Which services do you know CBHI benefit covers?	Inpatient Outpatient Both in and out Patient Abroad treatment Cosmetic surgery
207	In the case of CBHI programs you have to pay money (premiums) but do not know whether you will get the money back?	Correct Not correct Do not know
208	CBHI programmed are like savings scheme; you will receive interest and get your money back?	Correct Not correct Do not know

209	All health care costs will be covered by CBHI programs?	Correct Not correct Do not know
210	If you do not make claim any costs through CBHI your premium will be returned?	Correct Not correct Do not know
211	The timing/time interval of premium payment is convenient for my household	Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree
212	The CBHI registration fee is affordable for my household.	Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree
213	The CBHI regular contribution (premium) is affordable for my household.	Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree
214	The CBHI management officials are trustworthy.	Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree
	Questions related to Attitude toward CBHI (Q 215-Q 224) Please ask the following statements and circle level of agreement of participants Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree	
215	CBHI has potential in promoting HC seeking Behavior?	1 2 3 4 5
216	CBHI protects households from unaffordable health care	1 2 3 4 5

	expense?	
217	The Premium payment for CBHI is expensive?	1 2 3 4 5
218	CBHI is a means of collecting revenue(profit) for government?	1 2 3 4 5
219	CBHI members receive low quality services than non-members?	1 2 3 4 5
220	Mistreatment of patient by the HP is common in members than non-members?	1 2 3 4 5
221	I did not have trust in management and administration of CBHI?	1 2 3 4 5
222	CBHI is relevant only to promote health condition of the poor?	1 2 3 4 5
223	CBHI is good to pool the risk of health expenditure within sick and healthy individual	1 2 3 4 5
224	CBHI should be advocated and scaled up to improve the health of a rural community	1 2 3 4 5
	Questions related to scheme experience of CBHI (Q 225-Q 231)	
225	The local CBHI agent tries hard to solve CBHI implementation problems?	1 2 3 4 5
226	The CBHI members have the right to guide and supervise the activities of the CBHI management	1 2 3 4 5
227	The CBHI benefit package meets the requirements of my household	1 2 3 4 5
228	I am satisfied with the experience at the local CBHI office when I go to register	1 2 3 4 5
229	I am satisfied with the local CBHI office when I go to pay the regular contribution (premium)	1 2 3 4 5
230	Members of CBHI is treated the same as non-members	1 2 3 4 5
231	Household members are satisfied with the information provided about CBHI	1 2 3 4 5
	Questions related to Affordability and expected returns from the insurance(Q 232-Q 235)	

232	The timing/time interval of premium payment is convenient for my household	1 2 3 4 5
233	The CBHI registration fee is easily affordable	1 2 3 4 5
234	The CBHI regular contribution (premium) is easily affordable	1 2 3 4 5
235	Received the promised benefit packages during membership	1 2 3 4 5
	Questions related to the provider's attitude toward CBHI members (Q 236-Q 245)	
236	Health Professionals (HPs) well-come the clients in a good manner	1 2 3 4 5
237	HPs provide enough time to insured patients	1 2 3 4 5
238	HPs respond the right answer to all questions of clients ?	1 2 3 4 5
239	HPs give equal treatment for members and nonmembers?	1 2 3 4 5
240	HPs never rude to a client during the consultation?	1 2 3 4 5
241	HPs treat a client with respect/courtesy	1 2 3 4 5
242	HPs are always helpful for all patients	1 2 3 4 5
243	HPs provide error-free services for CBHI members	1 2 3 4 5
244	HPs have good discipline	1 2 3 4 5
245	HPs respond immediately when called	1 2 3 4 5
	Questions related to the Perceived Quality of Health Service (Q 246-Q 251)	
246	The clinical staff is polite and friendly?	1 2 3 4 5
247	The clinical staff easily understands my health situation?	1 2 3 4 5
248	The Health facility provides a comfortable and safe environment for users?	1 2 3 4 5
249	I felt confident about the professional performance of the entire clinical staff?	1 2 3 4 5
250	I feel that the health care was appropriate for my medical situation?	1 2 3 4 5
251	Time spending in a facility from arrival at the registration desk until last service is proper?	1 2 3 4 5
	Questions related to Trust on contracted health facilities (Q 252-Q 261)	
252	health facility (HF) provides all services expected to be given	1 2 3 4 5

	at its level	
253	HF always has sufficient health professional	1 2 3 4 5
254	HF always has sufficient drugs	1 2 3 4 5
255	HF has improved referral system	1 2 3 4 5
256	The physical facility is visually clean, attractive and comfortable	1 2 3 4 5
257	HF staff has sufficient competency to treat a patient	1 2 3 4 5
258	HF staff is committed in providing service	1 2 3 4 5
259	HF provide services timely	1 2 3 4 5
260	HF is concerned about the need for CBH member	1 2 3 4 5
261	HF is reliable in handling the patient's problems	1 2 3 4 5
	Questions related to Trust of CBHI Members on schemes (Q 262-Q 266)	
262	The community is involved in the management of the local CBHI scheme	1 2 3 4 5
263	Premium contributed by member used for CBHI purpose only	1 2 3 4 5
264	CBHI scheme is providing the reimbursement service	1 2 3 4 5
265	The local CBHI management is trustworthy	1 2 3 4 5
266	CBHI scheme distributes ID card as early as member enrolled/return as early as they send for renewal	1 2 3 4 5

Section III : Questions related Health status

No	Questions	Coding Catagories
301	In general, how do you describe the health status of this household member now?	Excellent Very good Good Poor Very Poor Family
302	Did any household member encounter any acute illness, accident or injury during the past 12 months and seek medical treatment ?	Yes No

303	Where do you get treatment when any family member becomes sick?	Private Heath Facility Public health Centre Public hospital Self-treatment Traditional healer Local drug vendor
303	Reasons for going there?	The HF was physically accessible The HF was not expensive The health facility not too crowded (Short-waiting time) The health service was…..
304	Perceived quality of the health care service given?	Very low Low Neutral High Very high
305	How much minutes do you take to walk to get nearest health facility from your home?	<30 min 30-60min >60mi
306	Distance in Meters?	<500 m 500-1000m >1000

ANNEX 3: Questionnaire for In -depth Interviewee in English form

Time: ---------- Interviewer: ----------The position involves -------- The participant: ---------- School level: ---------- Timing of the interview: ----------Phone: ---------- Location: ---------- Kebele and village Name: ----------Interview time: ----------

In-depth interview questions

1. Could you inform me regarding the CBHI members' current situation? How many existed the year prior to last yr?

_____

_____

_____

2. What is the trend in new memberships? Has the number of new members joined grown or shrunk?_____

_____

_____

_____

3. What amount of participants in CBHI have left or stopped participating over the past nine years? What exactly were the primary and prevalent causes? What measures did your organisation take?

_____

_____

4. Do you believe that HH wealth has an impact on CBHI renewal? Then why?

_____

__

_____

5. When does premium collection occur?

_____

6. Do you believe that age and number of families have an impact on whether or not a Kebele member's membership is renewed? Then why?

_____

_____

7. Do you believe that the medical care provided to CBHI members and non-members is comparable? Unless, why?

_____

__

_____

8. Do you believe that the CBHI expected return fulfils the needs of the community in your catchment area?

_____

_____

9. What were the key socioeconomic, demographic, and benefit package factors that influence renewal in this kebele?

_____

_____

_____

10. Which approaches or methods are you employing to address the issues mentioned above?

_____

_____

_____

11. What encourages HHs to keep their CBHI memberships in general?

_____

_____

_____

12. What percentage of the HHs in the kebele have dropped out of the program? In addition, what is the underlying cause of the dropout?

_____

_____

_____

13. What measures is your office implementing to mitigate or possibly decrease the rate at which members are dropping?

_____

_____

አባሪ

አባሪ 1. የአሳታፊ መረጃ ወረቀት

መግቢያ፡ BSc ነኝ። የነርስ መረጃ ሰብሳቢ እና ስለ ጥናቱ እና ለጥናት ተሳታፊ መመረጥዎ ለእርስዎ ለማስረዳት ትኩረትዎን እንዲሰጡኝ በአክብሮት እጠይቃለሁ።

የጥናት ርዕስ፡ በደቡብ ኢትዮጵያ በሶዶ ዙሪያ ወረዳ ከማህበረሰብ አቀፍ የጤና መድህን ማቋረጥን የሚወስኑትን የቤተሰብ አስተዳዳሪዎች ለመገምገም 2022፡ ቅይጥ አቀራረብ

ዓላማ፡- ይህ ጥናት በደቡብ ኢትዮጵያ በሶዶ ዙሪያ ወረዳ የሚገኙ የቤተሰብ አስተዳዳሪዎችን ከማህበረሰብ አቀፍ የጤና መድህን ማቋረጣቸውን የሚወስኑትን ለመገምገም እና በአዋቂዎች ጤና ነርስ ሳይንስ ማስተርስ የሚያስፈልጉትን መስፈርቶች በከፊል ለማሟላት ጥናታዊ ፅሁፍ ለመፃፍ ያለመ ነው።

ሂደት እና የሚቆይበት ጊዜ፡- የጥናቱ ተሳታፊዎች በዘፈቀደ በሎተሪ ዘዴ ይመረጣሉ። ተሳታፊዎችን ለማጥናት መጠይቁን እናነባለን። ለመመለስ ወደ 3 የሚጠጉ መጠይቆች አሉ እና 25 ደቂቃ ያህል ይወስዳል። ስለዚህ ለእነዚህ መጠይቆች መልስ ለመስጠት በዚህ ጊዜ እንድትቆጥቡልኝ በአክብሮት እጠይቃለሁ።

ስጋቶች፡ በዚህ ጥናት ውስጥ ከመሳተፍ ጋር የተያያዙ ምንም አይነት አደጋዎች የሉትም ጊዜያችሁ ጥቂት ደቂቃዎችን ከመውሰድ በስተቀር። ከዚህ ውጪ ጥናቱ ምንም አይነት አካላዊ እና ስነልቦናዊ ጉዳት አያስከትልም።

ጥቅማ ጥቅሞች፡ በዚህ ጥናት ላይ ለመሳተፍ ምንም አይነት ቀጥተኛ ክፍያ አይኖርም፣ ነገር ግን የዚህ ጥናት ግኝቶች መንግስት እና አስተማሪዎች የማህበረሰብ አቀፍ የጤና መድህን አገልግሎት ለቤተሰብ አባላት እንዲሻሻሉ ይረዳቸዋል በ CBHI ቤት ኃላፊዎች መካከል የማቋረጥ ምክንያቶችን በመገምገም።

ሚስጥራዊነት፡ ማንኛውም የሚያቀርቡት መረጃ በጥብቅ ሚስጥራዊ ይሆናል። እርስዎን የሚለይ መረጃ ከዚህ የመረጃ-ስብስብ እንቅስቃሴ ውጭ ለማንም አይሰበሰብም ወይም አይለቀቅም። የዚህ ጥናት ግኝቶች ለጥናቱ ህዝብ አጠቃላይ ይሆናል እናም የግለሰቦችን የተለየ ነገር አያንፀባርቅም። መጠይቂያው ስሞችን ለማግለል ኮድ ይደረጋል; ተሳታፊዎችን ከጥናት ጋር ሊያገናኙ የሚችሉ የቃል ወይም የጽሁፍ ዘገባዎች ምንም አይነት ማጣቀሻ አይደረግም።

መብቶች: በዚህ ጥናት ውስጥ ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት ነው; በዚህ ጥናት ውስጥ ለመሳተፍ ወይም ላለመሳተፍ ከመጀመሪያው እና በማንኛውም ጊዜ የማውጅ መብት አልዎት ፣ ወይም

ማንኛውንም የግለሰብ ጥያቄ ወይም ሁሉንም ጥያቄዎች ላለመመለስ መምረጥ ይችላሉ። ሆኖም ውጤቱ መንግስት የጤና እና የጤና ነክ አገልግሎቶችን ለህክምና ተማሪዎች ለማሻሻል የሚረዳ በመሆኑ በዚህ ጥናት ላይ እንደሚሳተፉ ተስፋ እናደርጋለን

የአድራሻ አድራሻ፡ መልስ ሊሰጡዎት የሚገቡ ማናቸውም አሻሚዎች ወይም ጥያቄዎች ካሉ እባክዎን ዋናውን መርማሪ ያነጋግሩ።

ስም:	ስልክ ቁጥር	ኢሜል አድራሻ
እስራኤል አሳሌ	0900515658	israelasale@yahoo.com

አባሪ 2. መጠየቂያ ጥናት የእንግሊዝኛ ቅጂ

I. የስምምነት መግለጫ ቅጽ

እኔ የመረጥኩት ምላሽ ሰጪ በጥናቱ መረጃ ወረቀት ላይ የተጻፈውን ተቀብዬ በጥናቱ ውስጥ የመሳተፍን ግብ፣ ጥቅሞች፣ መስፈርቶች እና አንድምታዎች ተረድቻለሁ። የእኔን የሚመለከት ማንኛውም መረጃ፣ ስሜን እና የሰጠኋቸውን ምላሾችን ጨምሮ ለሌላ ሰው መገለጽ እንደሌለበት አውቄ ነበር። በምርምር ፕሮጀክት ውስጥ ለመሳተፍ ወይም ላለመሳተፍ መምረጥ እንደምችል እና በማንኛውም ጊዜ መሄድ እንደምችል አውቃለሁ.

በጥናቱ ውስጥ የተሳተፈ አንድ ምልክት _____

የቃለ-መጠይቅ አድራጊው ስም፡- _____

ይፈርሙ፡_____

የሚከተለው ገጽ

TABLE 5 Questionnaire for client exit interview (Amharic version)

ክፍል 1 ማህበራዊ ነባራዊ ሁኔታ

ተ.ቁ	ጥያቄ	መልስ	ወደ - ይዘለሉ
101	ጸታ.	1. ወንድ_____ 2. ሴት_____	
102	እድሜዎ (በአመት ስንት ነው?	----------አመት	
103	ብሔር	1. ወላይታ 2. ጋሞ 3. ጉራጌ 4. አማራ	
104	የጋብቻ ሁኔታ	1. ያላገባች 2. ያገባች 3. የፈታች 4. የተለያየች 5. ባል የሞተባት	
105	በአሁኑ ወቅት ያላቸው ሐይማኖት	ፕሮቴስታንት ኦርቶዶክስ ሙስሊም ካቶሊክ ሌላ(ይጠቀስ)	
106	የትምህርት ደረጃ	ያልተማረች ማንበብና መፃፍ የምትችል 1-6 ክፍል የተማረች 7-12 ክፍል የተማረች ከ12ኛ ክፍል በላይ የተማረች	

107	አመታዊ የቤተሰብ ገቢያቹ ስንት ነው?	_____ ብር	
108	የስራ ሁኔታ	ገበሬ ነጋዴ ተቀጣሪ ችርቻሮ ንግድ ሰራ አጥ የቤት እመቤት ሌላ	
108	የቤተሰብ አባላት ስንት ናቸው?	_____ በቁጥር	

ክፍል ሁለት፡ የማህበረሰብ አቀፍ የጤና መዴህን ጋር የተዛመዱ ጥያቄዎች

201	ከመቼ ጀምሮ ነው የማህበረሰብ አቀፍ የጤና መድን አባል የሆኑት?	_____ዓመት
202	የአባልነት ካርዶትን አሳድሰዋል?	1. አዎ_____ 2. አይደለም_____ መልሶዎት አይደለም ከሆነ ወደ ጥያቄ ቁ. 204
203	የአባልነት መታወቂያዎትን ለማሳደስ ምክኒያቶ ምንድነው?	1. ዘመናዊ የሕክምና አገልግሎቶችን ለመጠቀም 2 ቢያንስ አንድ የቤተሰቡ አባል የህክምና እርዳታ ይጠይቃለል 3. በከፍተኛ ደረጃ የሕክምና እንክብካቤ ላይ እምነ አለኝ ብዬ ስለማስብ_____ 4. ፕሪሚየም መክፈል ለጤና አጠባበቅ አገልግሎት ከኪስ ውጭ ከመክፈል ያነሰ ውድ ነው። 5. ያልተጠበቀ ከፍተኛ የጤና እንክብካቤ ወጪዎችን ለማስወገድ ቤቴን ለመጠበቅ 6. ከ CBHI / የመንግስት ቢሮዎች ግፊት / ቅስቀሳ የተነሳ 7. የCBHI አስተዳደርን ማመን 8. የCBHI የጥቅም ጥቅል ጥሩ ነው፣ እና ፕሮግራሙ ይጠቅመኛል። 9. ብዙ ጥገኞች (የህክምና ክትትል የሚያስፈልጋቸው ብዙ ልጆች)

		10. የእኔ ተመራጭ የአስተዋጽኦ ጊዜያት እና ድግግሞሾች ናቸው። 99. ሌላም ይገልፃል።
204	አባልነትዎን ያላደሱበት ምክንያት ምን ነበር?	1. የእኔ CBHI ፕሪሚየም ዋጋ 2. የHH አባላት በተደጋጋሚ አይታመሙም ወይም አይጎዱም። 3. የሕክምና መሳሪያዎች በቀላሉ አይገኙም. 4. ደካማ የጤና እንክብካቤ አገልግሎት ጥራት 6. የጤና ጣቢያ ከቤታችን ያለው ርቀት. 5. የጥቅም ጥቅል ከፍላጎታችን ጋር አይጣጣምም። 7. ቤተሰቤ ትንሽ ነው__ 8. በዕቅዱ የተካተቱት የሕመሞች ብዛት የተገደበ ነው፣ እና አሁንም ለህክምናው ተጨማሪ ከኪስ ውጪ ወጪዎችን መክፈል አለብን። 9. ስለ CBHI ዝርዝር እውቀት ማነስ 99. ሌሎች ዝርዝሮች
ከማህበረሰብ አቀፍ ጤና መድህን ጋር ካለ እውቀት ጋር ተያይዞ ያሉ ጥያቄቆች (Q 205-Q 2014)		
205	የጤና አገሌግልት በማህበረሰብ የጤና መዴህን እንደሚሸፈን ያውቃሉ?	1.አዎ 2. አይ
206	የትኞች የጤና አገሌግልቶች በማህበረሰብ የጤና መዴህን እንደሚሸፈን ያውቃለ?	1.ተኝቶ ታካሚ 2.ተመላላሽ ታካሚ 3.ሁለቱም ተኝቶ ታካሚ እና ተመላላሽ ታካሚ 4. የውጭ ሀገር ሕክምና 5. ውበት የሚዯረግ የቀድ ሕክምና
	የክበብ ደረጃ ተሳታፊዎች ስምምነት 1. ትክክል 2. ትክክል አይደለም 3. አያውቅም	
207	በማህበረሰብ አቀፍ የጤና መዴህን በቅዴሚ ገንዘብ መክፈሌ ያሇብዎ ቢሆንም ገንዘቡን መሌሰው መቀበሌ እንዲሇብዎ አያውቁም?	1 2. 3.
208	በማህበረሰብ አቀፍ የጤና መዴህን ፕሮገራም ሇምሳላ፡ ቁጠባ፤ የቁጠባው ሇዴና የቁጠባ ገንዘብህ መሌሰው ያገኛlu?	1 2. 3.
209	በማህበረሰብ አቀፍ የጤና መዴህን ሇወዯፊት የጤና አገሌግልት ሇማግኘት ሇማህበረሰብ የጤና መዴህን ገንዘብ ይከፍሊለ።	1 2. 3.

210	ሁለም የጤና አገሌግልት ወጪዎች በማህበረሰብ አቀፍ የጤና መዴህን ይሸፈናሌ?	1 2. 3.
	2. የክበብ ደረጃ የተሳታፊዎች ስምምነት በጣም አልስማማም 2. አልስማማም 3. ገለልተኛ 4. እስማማለሁ 5. በጣም እስማማለሁ	
211	የእኔ ቤተሰብ የፕሪሚየም ክፍያዎች ጊዜ እና የጊዜ ክፍተት ጠቃሚ ሆኖ አግኝተውታል?	1 2 3 4 5
212	ለቤተሰቤ፣ የማህበረሰብ አቀፍየጤናመዴህን ምዝገባ ክፍያ ተመጣጣኝ ነው?	1 2 3 4 5
213	ቤተሰቤ የማህበረሰብአቀፍ የጤናመዴህን መደበኛ መዋጮ መግዛት ይችላሉ።	1 2 3 4 5
214	የማህበረሰብአቀፍ የጤናመዴህን አመራር ቡድን ሊታመን ይችላል?	1 2 3 4 5
	ስለማህበረሰብ አቀፍ ጤና መድህን ያለ ግንዛቤ ጋር ተያይዞ ያሉ ጥያቄቆች (Q 215-Q 224) እባኮትን የመረጡትን ምርጫ ያክብቡ 1. እጅግ በጣም አልስማማም 2. አልስማማም 3.ከሁለቱም አይደለሁም 4. እስማማለሁ 5. እጅግበጣምእስማማለሁ	
215	የማህበረሰብ አቀፍ ጤና መድህን የጤና ተቀማትን የመፈለግ ባህሪን የማስተዋወቅ አቅም አለው።	1 2 3 4 5
216	የማህበረሰብ አቀፍ ጤና መድህን ቤተሰቦችን ከማይቻል የጤና እንክብካቤ ወጪ ይጠብቃል።?	1 2 3 4 5
217	የማህበረሰብ አቀፍ ጤና መድህን መዋጮ/ክፍያ ውድ ነው?	1 2 3 4 5
218	የማህበረሰብ አቀፍ ጤና መድህ ለመንግስት ገቢ መሰብሰቢያ (ትርፍ) ዘዴ ነው።?	1 2 3 4 5
219	የማህበረሰብ አቀፍ ጤና መድህን አባላት የሆኑት አባላት ካልሆኑት ይልቅ ዝቅተኛ ጥራት ያለው አገልግሎት ያገኛሉ?	1 2 3 4 5
220	በጤና ባለሞያዎች የታካሚ መድልዎ አባል ካልሆኑት በአባላት የተለመደ ነው?	1 2 3 4 5
221	በማህበረሰብ አቀፍ ጤና መድህን አስተዳደር ላይ እምነት አልነበረኝም?	1 2 3 4 5
222	የማህበረሰብ አቀፍ ጤና መድህን የሚመለከተው የድሆችን የጤና ሁኔታ ለማስተዋወቅ ብቻ ነው።?	1 2 3 4 5
223	የማህበረሰብ አቀፍ ጤና መድህን በታመመ እና በጤናማ ሰው ውስጥ የጤና ወጪን አደጋ lemagarat ጥሩ ነው።	1 2 3 4 5
224	የማህበረሰብ አቀፍ ጤና መድህን የገጠር ማህበረሰብን ጤና ለማሻሻል	1 2 3 4 5

	ሊበረታታና ሊሰፋ ይገባል።	
	ስለማህበረሰብ አቀፍ ጤና መድህን ያለ ልምድጋር ተያይዞ ያሉ ጥያቄቆች (Q 225-Q 231)	
225	የአካባቢው የማህበረሰብ አቀፍ ጤና መድህን ወኪል የማህበረሰብ አቀፍ ጤና መድህን ትግበራ ችግሮችን ለመፍታት ጠንክሮ ይሞክራል?	1 2 3 4 5
226	የማህበረሰብ አቀፍ ጤና መድህን አባላት የማህበረሰብ አቀፍ ጤና መድህን አስተዳደር እንቅስቃሴዎችን የመምራት እና የመቆጣጠር መብት አላቸው።	1 2 3 4 5
227	የማህበረሰብ አቀፍ ጤና መድህን የጥቅም ጥቅል የቤተሰቤን መስፈርቶች ያሟላል።	1 2 3 4 5
228	ለመመዝገብ ስሄድ በአካባቢው ባለው የማህበረሰብ አቀፍ ጤና መድህን ቢሮ ባገኘሁት ልምድ ረክቻለሁ	1 2 3 4 5
229	መደበኛ መዋጮ (ፕሪሚየም) ለመክፈል ስሄድ በአካባቢው ባለው የማህበረሰብ አቀፍ ጤና መድህን ቢሮ ረክቻለሁ።	1 2 3 4 5
230	የማህበረሰብ አቀፍ ጤና መድህን አባላት እንደ አባል ካልሆኑት ጋር ተመሳሳይ አገልግሎት ያገኛሉ	1 2 3 4 5
231	የቤተሰብ አባላት ስለ ማህበረሰብ አቀፍ ጤና መድህን በቀረበው መረጃ ረክተዋል።	1 2 3 4 5
	ከተመጣጣኝ ዋጋ እና ከማህበረሰብ አቀፍ ጤና መድህን የሚጠበቁ አገልግሎቶች ጋር የተያያዙ ጥያቄዎች(Q 232-Q 235)	
232	የመዋጮ ክፍያ የጊዜ ልዩነት ለቤተሰቤ ምቹ ነው።	1 2 3 4 5
233	የማህበረሰብ አቀፍ ጤና መድህን ምዝገባ ክፍያ በቀላሉ ተመጣጣኝ ነው።	1 2 3 4 5
234	የማህበረሰብ አቀፍ ጤና መድህን መደበኛ መዋጮ በቀላሉ ተመጣጣኝ ነው።	1 2 3 4 5
235	በአባልነት ጊዜ ቃል የተገባውን የጥቅም ፓኬጆችን ተቀብሏል።	1 2 3 4 5
	ከጤና አቅራቢው ለየማህበረሰብ አቀፍ ጤና መድህን አባላት ካለው አመለካከት ጋር የተያያዙ ጥያቄዎች (Q 236-Q 245)	
236	የጤና ባለሙያዎች ደንበኞቻቸውን በጥሩ ሁኔታ ይቀበ<u>ላ</u>ቸዋል	1 2 3 4 5
237	የጤና ባለሙያዎች ኢንሹራንስ ላላቸው ታካሚዎች በቂ ጊዜ ይሰጣሉ	1 2 3 4 5
238	የጤና ባለሙያዎች ለሁሉም የደንበኞች ጥያቄዎች ትክክለኛውን መልስ ይመልሳል?	1 2 3 4 5
239	የጤና ባለሙያዎች ለአባላት እና አባል ላልሆኑ ሰዎች እኩል አያያዝ ያደርጉላቸዋል?	1 2 3 4 5
240	የጤና ባለሙያዎች በምክክሩ ወቅት ደንበኛን በጭራሽ አያሳዝንም።	1 2 3 4 5

241	የጤና ባለሙያዎች የጤና ባለሙያዎች ደንበኛን በአክብሮት/በአክብሮት ያስተናግዳሉ።	1 2 3 4 5
242	የጤና ባለሙያዎች ሁል ጊዜ ለሁሉም ታካሚዎች ጠቃሚ ናቸው።	1 2 3 4 5
243	የጤና ባለሙያዎች ለማህበረሰብ አቀፍ ጤና መድህን አባላት ከስህተት የጸዳ አገልግሎት ይሰጣሉ	1 2 3 4 5
244	የጤና ባለሙያዎች ጥሩ ዲሲፕሊን አላቸው።	1 2 3 4 5
245	የጤና ባለሙያዎች ሲጠሩ ወዲያውኑ ምላሽ ይሰጣሉ	1 2 3 4 5
	ከተገመተው የጤና አገልግሎት ጥራት ጋር የተያያዙ ጥያቄዎች (Q 246-Q 251)	
246	የጤና ባለሙያዎች ጨዋ እና ተግባቢ ናቸው?	1 2 3 4 5
247	የጤና ባለሙያዎች የእኔን የጤና ሁኔታ በቀላሉ ይረዳሉ?	1 2 3 4 5
248	የጤና ተቋሙ ለተጠቃሚዎች ምቹ እና ደህንነቱ የተጠበቀ አካባቢን ይሰጣል?	1 2 3 4 5
249	ስለ አጠቃላይ የክሊኒካዊ ሰራተኞች ሙያዊ አፈፃፀም በራስ መተማመን ተሰማኝ?	1 2 3 4 5
250	የጤና እንክብካቤው ለህክምና ሁኔታዬ ተስማሚ እንደሆነ ይሰማኛል?	1 2 3 4 5
251	የመመዝገቢያ ጠረጴዛው ላይ ከመድረሱ ጀምሮ የመጨረሻው አገልግሎት ትክክለኛ እስከሚሆን ድረስ በተቋሙ ውስጥ የሚያጠፋው ጊዜ?	1 2 3 4 5
	በኮንትራት በተያዙ የጤና ተቋማት ላይ እምነትን የሚመለከቱ ጥያቄዎች (Q 252-Q 261)	
252	የጤና ተቋም በየደረጃው ሊሰጡ የሚጠበቁ አገልግሎቶችን ሁሉ ይሰጣል	1 2 3 4 5
253	የጤና ተቋም ሁል ጊዜ በቂ የጤና ባለሙያ አለው	1 2 3 4 5
254	የጤና ተቋም ሁል ጊዜ በቂ መድሃኒቶች አሉት	1 2 3 4 5
255	የጤና ተቋም የሪፈራል ስርዓቱን አሻሽሏል	1 2 3 4 5
256	የጤና ተቋም አካላዊ ተቋሙ በእይታ ንጹህ፣ ማራኪ እና ምቹ ነው።	1 2 3 4 5
257	የጤና ተቋም ሰራተኞች ታካሚን ለማከም በቂ ብቃት አላቸው።	1 2 3 4 5
258	የጤና ተቋም ሰራተኞች አገልግሎት ለመስጠት ቁርጠኛ ናቸው።	1 2 3 4 5
259	የጤና ተቋም አገልግሎቶችን በወቅቱ ይሰጣል	1 2 3 4 5
260	የጤና ተቋም የማህበረሰብ አቀፍ ጤና መድህን አባል ፍላጎት ያሳስበዋል።	1 2 3 4 5
261	የጤና ተቋም የታካሚውን ችግር ለመፍታት አስተማማኝ ነው	1 2 3 4 5
	በማህበረሰብ አቀፍ ጤና መድህን ላይ ከማህበረሰብ አቀፍ ጤና መድህን አባላት እምነት ጋር የተያያዙ ጥያቄዎች (Q 262-Q 266)	
262	ማህበረሰቡ በአካባቢው የማህበረሰብ አቀፍ ጤና መድህን እቅድ አስተዳደር	1 2 3

	ውስጥ ይሳተፋል	4 5
263	መደብኛ መዋጮ በአባል የተበረከተ ለማህበረሰብ አቀፍ ጤና መድህን ዓላማ ብቻ ጥቅም ላይ ይውላል	1 2 3 4 5
264	የማህበረሰብ አቀፍ ጤና መድህን እቅድ የማካካሻ አገልግሎት እየሰጠ ነው	1 2 3 4 5
265	የአካባቢው የማህበረሰብ አቀፍ ጤና መድህን አስተዳደር ታማኝ ነው።	1 2 3 4 5
266	የማህበረሰብ አቀፍ ጤና መድህን እቅድ አባል እንደተመዘገበ/እንደተመለሰ ለመታደስ ሲልክ መታወቂያ ካርድን ወዲያው ያሰራጫል	1 2 3 4 5

ክፍል አራት፡የቤተሰቡን የቅርብ የሀብት ጠንንሆማወቅየሚነሱጥያቄዎችከዚህ በታች የተዘረዘሩትን ካሆዎት ይነግሩኛሌ ?

የቁምክብቶች	ቤተሰብምሊሆፉት 12 ወራትየሚከተለትን ነበረው		ሚሰጥርቁጥር
	አይ(0)	አዎ(1)	
1.በሬ			
2.ላሞች			
3.የርቢኮርማዎች			
4.ጥጃ			
5.በጎች			
6.የበግጠቦት			
7.የንብቀፎ			
8.ፍየልች			
9.ፈረስ			
10.አህያ			
11.ድሮዎች			
12.በቅልዎች			
13.አሳማዎች			
14.ጊኖሮች			
15.ላለ. (ይገሀጽ_____)			
የእርሻመሣሪያ፣, የቤትዕቃእናማሽኖች			
1. መኮትኮቻ			
2. ማረሻ			
3. መድሻ			
4. ኮሪቻ			
5. ጋሪ (በእንስሳትየሚጎተት)			
6. የሽመናዕቃ			
7. ወፍጮ			
8. ማጭዴ			
9. መክተፊያ/ቢለ.			
10. አካፋ			
11. ዘመናዊአሌጋ			

12. ወንበሮች/አግዳሚ			
13. ፋኖስ			
14. ራዲዮ/ቴሌቪዢን (የሚሰራ)			
15. ኮምፒውተር/ሊፕቶፕ			
16. ተንቀሳቃሽስሌክ /ገመዴአሌባ			
17. መሶብ /ሰፊዴ			
18. ካዊያ			
19. ቁምሳጥን			
20. የቆዲቦርሳ			
21. የቆዲሶፋ			
22. ቁርበት			
23. ጌጣጌጥ/ወርቅ/የእጅሰዓት			
24. ጠመንጃ			
25. ጎተራ			
26. የኩሺናዕቃዎች			
27. በርሜሌ			
28. ጠረጴዛ			
29. መኪና (ዎች)			
30. ትራክተር			
31. ብስክላት			
32. የውሃፓምፕ			
33. ሞተርሳይክሌ			
34. ዘመናዊምዴጃ			
35. ላለ. (ይገሇጽ_____)			
36. ላለ. (ይገሇጽ_____)			

Annex 5. in-depth interview questioner Amharic form

ጊዜ፡---------- ቃለ-መጠይቅ፡---------- --------ቦታው ----------

ተሳታፊው፡---------- የትምህርት ቤት ደረጃ፡---------- - የቃለ መጠይቁ ጊዜ፡----------

------ስልክ፡---------- -- ቦታ፡---------- የቀበሌና

የመንደር ስም፡------ ----------የቃለ መጠይቅ ጊዜ፡----------

ዝርዝር መጠይቆች

ጥልቅ የቃለ መጠይቅ ጥያቄዎች

1. የCBHI አባላትን ወቅታዊ ሁኔታ በተመለከተ ልታሳውቀኝ ትችላለህ? ካለፈው ዓመት በፊት ስንት ነበሩ?

_____

_____

_____

2. በአዲስ አባልነቶች ውስጥ ያለው አዝማሚያ ምን ይመስላል? የተቀላቀሉት አዲስ አባላት ቁጥር አድጓል ወይስ ቀንሷል?

_____

_____

3. ባለፉት ዘጠኝ ዓመታት ውስጥ በCBHI ውስጥ ምን ያህል ተሳታፊዎች ትተው ወይም መሳተፍ አቆሙ? ዋናዎቹ እና ዋናዎቹ መንስኤዎች ምን ምን ነበሩ? ድርጅትዎ ምን እርምጃዎችን ወሰደ?

_____

_____

4. HH ሀብት በCBHI እድሳት ላይ ተጽእኖ አለው ብለው ያምናሉ? ታዲያ ለምን?

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5. ፕሪሚየም መሰብሰብ መቼ ነው የሚከሰተው?

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6. የቀበሌ አባልነት መታደስ እና አለመታደስ ላይ የእድሜ እና የቤተሰብ ቁጥር ተፅእኖ አላቸው ብለው ያምናሉ? ታዲያ ለምን?

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7 የማህበረሰብ አቀፍ መድህን አባል ድርጅት እና አባል ተቋማት ተቋም ውስጥ
ተመሳሳይ አገልግሎት ያገኛሉ ብለህ ታስባለህ? ካልሆነስ ለምን ይመስላቹሃል?

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8 የማህበረሰብ አቀፍ ደረጃ መድህን ተቋም የሚሰጠው አገልግሎት የአባላቱን ፍላጎት አመልክቷል።
ብለው ያስባሉ ታስባለህ? ካልሆነስ ለምን?

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9 በቀበሌያቹ የማህበረሰብ አቀፍ መድህን ተቋም የታቀፉ ነዋሪዎች የመገልገያ
የመታወሻቸውን ለማሳደስ ተብሏል ሌላ ዋና ዋና ማህበራዊ፣ ኢኮኖሚያዊ እና
ዲሞግራፊያዊ ችግሮች ምንድናቸው? ዝርዝሩን ይፃፉ

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10 ካልኣይ ምክትታል ክፍተቶኽን ለማስተካከል ምን አይነት ዘዴዎችን
ተጠቅመውበታል?_____

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11 በቀበሊያው ውስጥ ያሉ የማህበረሰብ አቀፍ መድህን ተቋም አባል መስለው እማወራዎች እና
አባወራዎች የመገለጫ መታወቂያ ምንድን ናቸው ለማሳደስ የሚያነሷቸው?

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12 በቀበሊያው ውስጥ ያሉ የማህበረሰብ አቀፍ ደረጃ መድህን ተቋም አባል የመገለጫ መታወቂያ የማሳደስ ፍጥነት ምን ያህል ነው ዋናው ምክንያቱ ምንድን ነው?

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13 ይህንን የመገልገያ መታወቂያው ያለማሳደስ ፍጥነት ለመቀነስ እና ለማቆም በናንተ ይድናል። ስራዎች ተሰርተዋል?

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