



**ADDIS ABABA UNIVERSITY**

**COLLEGE OF BUSINESS AND ECONOMICS**

**SCHOOL OF POST GRADUATE**

**DEPARTMENT OF PUBLIC ADMINISTRATION AND DEVELOPMENT  
MANAGEMENT (PADM)**

**“COMMUNITY BASED HEALTH INSURANCE  
PRACTICE/ENROLLMENT AND CHALLENGES IN ETHIOPIA CASE OF  
OROMIYA REGIONAL STATE RURAL COMMUNITY OF ALELTU  
DISTRICT”.**

By:

Gutema Namomsa

Advisor:

Bikila Hurisa (Ph. D)

**June 2017**

**Addis Ababa, Ethiopia.**

**Addis Ababa University  
School of Graduate Studies  
College of Business and Economics  
Department of Public Administration and Development Management**

**“COMMUNITY-BASED HEALTH INSURANCE PRACTICE/ENROLLMENT AND CHALLENGES IN ETHIOPIA CASE OF OROMIYA REGIONAL STATE RURAL COMMUNITY OF ALELTU DISTRICT”.**

A thesis submitted to the Department of Public Administration and Development Management of Addis Ababa University in the partial fulfillment of the requirement for the Masters of the Public Management and Policy (MPMP).

By:

Gutema Namomsa

Advisor:

Bikila Hurisa (Ph.D)

**June 2017**

**Addis Ababa, Ethiopia.**

**Addis Ababa University**  
**School of Graduate Studies**  
**College of Business and Economics**

**Department of Public Administration and Development Management**

*This is to certify that the thesis prepared by Gutema Namomsa entitled “Community-Based Health Insurance Practice/Enrollment & Challenges in Ethiopia: Case of Ormiya Regional State; Rural Community of Aleltu District”. Which is submitted in partial fulfillment of the requirements for the Degree of Public Management and Policy (MPMP), complies with the regulations of the University and meets the accepted standards with respect to standards to originality and quality?*

*Approved by Board of Examiners:*

_____ <i>Advisor</i>	_____ <i>Signature</i>	_____ <i>Date</i>
_____ <i>Internal Examiner</i>	_____ <i>Signature</i>	_____ <i>Date</i>
_____ <i>External Examiner</i>	_____ <i>Signature</i>	_____ <i>Date</i>

***Declaration***

*I declare that this Research Report on “Community-based health insurance practice/enrollment & challenges in Ethiopia: case of Oromiya regional state; rural community of Aleltu district”. Is my own original work with assistances and guidance from my Advisor and not submitted before for any institution and any purpose. I further declare that all the sources used in this research report have been properly recognized and acknowledged as in-text-citation and reference list.*

Gutema Namomsa Daraje \_\_\_\_\_

\_\_\_\_\_  
*Signature*

*Date*

## Acknowledgment

First & for most I owe my heartedly thanks to almighty God, the merciful and compassionate, for helping me to carry the entire burden via my study & research conduct.

My heartfelt gratitude goes to my families (Especially My dad Mr. **Namomsa D. Keba** & My Mam **Kebebush Bayisa** as well as my sisters Alganesh, Aster & Mimi) for their infinite support in my study journey).

My especial thanks go to my thesis advisor **Bikila Hurisa (Ph. D)** whose kind support, insight & guidance have turned the whole process of this study endeavor full of learning and enjoyable.

I would also like to thank to the employees and management of EHIA & district office who cooperate with me by filling honest interview that provide valuable information for conducting & completing this study.

Finally, yet important, special thanks go to Mr Demise (CBHI Finfine branch manager) Mr Kidane Irana (Team leader of Aleltu CBHI).

### ***Dedication***

*I would like to dedicate this thesis to my grandfather Mr. Bayisa Bekere. His role in my life (especially) in my academic life is very significant. I can't express his role within one page of paper, I know my grandfather "Akakeyu" without your constructive advice I will not reach this stage your special model. So my lovably grandfather when I decide to dedicate my thesis work to you it is without any doubt hence I love you & RIP.*

*Ermiyas Namomsa.*

## Table of content

	Page
Acknowledgment .....	i
<i>Dedication</i> .....	ii
Table of content .....	iii
List of table .....	vi
List of Figure.....	vi
Acronyms .....	x
<i>Abstract</i> .....	xi
CHAPTER ONE .....	1
1.INTRODUCTION & BACKGROUD OF THE STUDY .....	1
1.1.Introduction .....	1
1.1.1.Ethiopian Health Insurance Agency .....	2
1.2.Statement Of The problem .....	3
1.3.Objectives of The study.....	6
1.3.1.General research Objectives .....	6
1.3.2.Specific research Objectives.....	6
1.4.Research question.....	6
1.5.Significance of the study .....	7
1.6.Scope of the Study.....	7
1.7.Limitation of the study .....	8
2.Literature Review.....	9
2.1. Concept of Community Based Health Insurance .....	9
2.2 Weakens of Community Based Insurance. ....	12
2.3 Types of Community Based Health Insurance.....	12

2.3.1. Community prepayment health organizations .....	15
2.3.2 Provider based health insurance schemes.....	15
2.3.3. Government runs community-involved health insurance.....	15
2.4. Community Based Health Insurance in Developing country.....	16
2.5 Community Participation .....	19
2.6 Empirical findings concerning the performance/enrollment of CHIs.....	20
2.6.1 Performance criteria .....	20
2.6.2. Exploring factors that influence performance .....	21
2.6.2.1 Factors influencing membership.....	21
2.7. Health Sector in Ethiopia .....	23
2.7.1 Community Based Health Insurance in Ethiopia .....	25
2.7.1.1. Knowledge, Enrollment, and Affordability .....	29
2.7.1.2. Major Challenges in quality services provided.....	30
2.7.1.3 Mobilizing Additional Resources to Health Providers .....	30
2.7.1.4. Remove Overall Health Systems Constraints .....	32
2.7.2. Enrollment & significance of CBHI in Ethiopia .....	32
3. Research Methodology & Methods .....	39
3.1. Research Design.....	39
3.2 Study & sample population .....	40
3.3 Sample Design.....	40
3.3.1 Sample & Sample size determination.....	40
3.3.2 Sampling Techniques .....	41
3.4 Types of data and data collection Technique.....	42
3.4.1 Types of data .....	42
3.4. 2 Primary data collection Technique.....	42

3.5 Secondary data collection Method .....	43
3.5.1 Data Analysis Methods.....	43
3.6 Data Presentation Modality.....	44
3.7 Ethical Consideration .....	44
4. Data Presentation and Analysis .....	46
4.1 Introduction.....	46
4.2 Background of the respondents.....	46
4.3. Beneficiaries (insured household"s) response on CBHI .....	53
4.3.1 Awareness level of Community on the concept of Community based health insurance .....	53
4.3.2. Households health status & income impact on the CBHI .....	62
4.3.3. CBH, its challenges & benefits.....	66
4.3.4. Participation in CBHI programs .....	84
4.4 Discussion of the result .....	87
4.4.1 Practice/enrollment of Community based health insurance .....	87
4.4.2 Challenges faced on enrolling the Community based health insurance .....	88
4.4.3 Major benefit the society is getting from enrolling in CBHI .....	89
5. Conclusion & Recommendation.....	90
5.1. Introduction .....	90
5.2 Conclusion.....	90
5.3 Recommendation.....	92
Bibliography .....	94
Annexes.....	96

## List of table

	<b>Page</b>
Table 2.1: Features of different CBHI models.....	13
Table 2.2: List of pilot and control woreda"s.....	27
Table 2.3 Projected Annual Financial Implications of CBHI Scale-up to Federal, Regional, and Woreda Governments ('000 Birr).....	31
Table 2.4 Major Parameters of Ethiopian CBHI Pilot Schemes.....	34
Table 3.1 shows the population & sample selection of the study.....	42
Table 3.2 Profile of the officials (employees).....	42
Table 4.1: Beneficiaries Age related distribution.....	47
Table 4.2: Martial status of the respondents.....	49
Table 4.3: Occupational status of the respondents.....	51
Table 4.4: Number of children"s $\geq 18$ & $< 18$ years old.....	53
Table 4.5: Response on: Do you know Community based health insurance.....	54
Table 4.6: Response on: Do you attend any local meeting on detail of how scheme work CBHI?.....	55
Table 4.7: Response on: Enrolling in community based health insurance has advantage ....	58
Table 4.8: Response to: Level of knowledge & understanding on the CBHI.....	61
Table 4.9: Response on: Products you produced.....	64

Table 4.10: Response on: when you started enrolling in CBHI.....	67
Table 4.11: Response on: Our health status is improved after enrolling in CBHI.....	70
Table 4.12: Response on: Do you renew your membership ID timely.....	73
Table 4.13 Responses on: I haven't get any advantage in enrolling in CBHI.....	74
Table 4.14: Response on: I decided to resign my membership from CBHI.....	75
Table 4.15: Response on: Am happy with Current premium & timing of collecting.....	79
Table 4.16: Response on: The nearest conventional health institution to you.....	83
Table 4.17: Are you getting medicines prescribed to you timely (especially very essential....	84

## List of Figure

	<b>Page</b>
Fig: 2.1 socioeconomic inequalities in health service coverage.....	25
Fig: 2.2 Enrollment rate (%) and indigent HHs registered as members, June 2013.....	37
Figure 2.3 Regional Enrollment Rate and % of HHs Registered as Indigents, June 2013.....	37
Figure 2.4 Framework of analysis.....	38
Figure 2.5: Own conceptual frame work.....	38
Fig: 3.1 the study area of the research .....	45
Fig 4.1: Gender of the respondents & its distribution.....	47
Fig 4.2 realltion of the respondents to household.....	48
Fig 4.3 Martial status of the respondents.....	49
Fig: 4.4 Educational status of the respondents & its distribution.....	50
Fig: 4.5 Family sizes of the respondents.....	52
Fig 4.6 Do you attend any local meeting on detail of how the scheme work.....	55
Fig: 4.7 from whom/what you heard about CBHI.....	57
Fig: 4.8 Have you started getting health service via your insurance.....	60
Fig: 4.9 Level of knowledge on CBHI .....	61
Fig: 4.10 how do you rate the health status of your family?.....	63
Fig: 4.11 Number of wild-animals that households have.....	65

Fig: 4.12 before enrolling in CBHI how you covered you medical expense.....	68
Fig: 4.13 Type of membership.....	72
Fig: 4.14 Challenges in CBHI drugs).....	76
Fig: 4.15 how is health facility utilization in health institution you are getting service via CBHI? .....	81
Fig: 4.16 have you get opportunity to discuss with responsible body from the Woreda/ federal health insurance agency?.....	85
Fig: 4.17 Do you have enough participation on CBHI than paying the premium for your membership.....	86

## Acronyms

- CBHI:** Community Based Health Insurance.
- EHIA:** Ethiopian Health Insurance Agency.
- WHO:** World Health Organization.
- SSA:** Sub-Saharan Africa
- LMICs:** Low-income and middle-income countries.
- SHI:** Social Health Insurance.
- EMOH:** Ethiopian Minister of Health.
- SNNP:** Southern Nations, Nationalities, and Peoples.
- UHC:** Universal Health Coverage.
- HEP:** Health Extension Program
- PHC:** Primary health care
- PHCU:** Primary Health Care Units
- USAID:** The United States Agency for International Development
- MDG:** Millennium Development Goals
- HSDP:** Health Sector Development Program
- HSFR/HFG:** financed Health Sector Financing Reform/Health Finance and Governance
- OOP:** Out of pocket payment
- PFSA:** Pharmaceutical Fund and Supply Agency

## ***Abstract***

*This study examines the Community based health insurance Enrollment/practice & challenges in Ethiopia by taking Aleltu district as case of study. The study, with the prime objectives of to find out & mention the roots of problems & was geared towards answering key research questions germane in enrollment of the CBHI in the Aleltu woreda.*

*Primary data have been collected from beneficiary's (members) of CBHI by taking 150 respondents from five Gandas namely Maru, Mikawa, S/sageda, Ejersa & W/dera using structured self-administer questioner. Three employees of CBHI were contacted for in-depth interview & one manager of CBHI Finfine branch also has been contacted for triangulation purpose. The data were putted in SPSS version 21 in order to get descriptive statistics or result. The Qualitative data collected via in-depth interviews & open ended questions were analyzed through transcription in to micro-soft word processing then by categorizing & coding on their theme.*

*The result, of the analysis shows that supply side challenges such as Lack of skilled man power in handling the CBHI in the woreda, Lack of budget to perform the enrollment rate of CBHI in different villages of Aleltu, Absence of available nearest government hospitals at the distract level, lack of enough man power because, Absence of digital camera in order to take the photo of households during their membership, Absence of enough computers & printers (In order to encoding the file of each members), the office is not covenant (narrow in size), the government health service is not satisfactory like the private health sectors therefore peoples prefer to a place where good service is provided. Among demand side challenges; during registration time households will not bring required things (For instance Photo graphs, filling of necessary data's), during the claim of money paying during the refer time they will forget the receipt for the payment they made at the referral hospitals, During the filling of ID membership they will not tell necessary information, dalliance on Id renewal, during registration time they will not bring their family member.*

***Key Words: CBHI, Enrolment, Challenges, Aleltu District & Northern Shoa Zone***

## CHAPTER ONE

### 1. INTRODUCTION & BACKGROUD OF THE STUDY

#### 1.1.Introduction

Hundred million people every year are driven into poverty due to catastrophic health expenditure across the world. It is imaginable that most reside in resource poor settings such as SSA with very weak modern health care systems and in most cases without any functioning health insurance schemes,(Guy, 2003).

The result is high disease burden as well as a high risky propagating sickness and being absent from productive works. In Sub-Saharan Africa, formal and well-functioning health insurance scheme generally exist for few people who are employed in formal sectors. For the majority, health care is accessed and/or covered from own source of money which is mostly sourced from existing funds or assets, this mostly leads to least use of health care services,(ibid).

If CBHI schemes are to serve as a means to providing access to health services, at least in the short term, then attention should be paid to the issues that militate against their success.

Community Based Health Insurance Schemes (CBHISs) are promising alternatives for a cost sharing health care system which hopefully also leads to better utilization of health care services, reduce illness related income shocks and eventually lead to a sustainable and fully functioning universal health care system. The source of finance used to supplement the Health sector in Ethiopia are from government sources, out of pocket payments at the time of service, from external donors and charity activities, as well as from insurance sources,(WHO, 2005).

More than 80% of total private health expenditure in Ethiopia is in the form of out-of-pocket payments, revealing an inefficient, inequitable structure of private health expenditure. It is hoped that insurance will help stabilize the government's health budget, and make financing more efficient and equitable, thereby bolstering the country's Health Sector Development Program. (MLI, 2013)

Based on the 2007 national health account around 7.14 USD were spending per person. Compared to the world health organization standard which estimated around 34 USD per person per annum is much higher than the national health accounts. Thus spending for health expenditure were so low and the expenditure were accounted from different sections and sectors accordingly around 31% from government, 37 % from donor/development organizations and directly from user fees are 30%,(FMOH, 2009).

From this we can understand that a payment rate that is paid directly by users at the time of service is unaffordable, especially for the poorest of the poor (indigent) which also inhibits beneficiaries from visiting health facilities.

At different time the government of Ethiopia has been taking different reform"s among them health sector reform is a part of it. Currently, the government is introducing various tools to finance health sector programs among them CBHI is for the informal sectors & those lead their lives on agricultural sectors where as SHI involves formal/employed sector of the economy, once policies are issued premium collection would be directly deducted from salary of beneficiaries. Both are insurance types what differs is the premium collection methods, the type of participants that involve and largely in case of CBHI continuous and rigorous awareness creation and behavioral change activities are highly demanded,(EHIA, 2015).

### **1.1.1. Ethiopian Health Insurance Agency**

Ethiopian Health Insurance Agency (EHIA) is a federal government agency established as an Agency in 2010 with regulation No.191/2010. With the responsibilities of: establish and implement efficient and effective health insurance system, Collect and administer monthly contributions of the social health insurance system, Undertake public education and sensitization on health insurance, (EHIA, 2015)

#### **1.1.1.1 Mission of the Agency**

The primary mission of this EHIA is to provide quality and sustainable universal health care coverage, (ibid).

## **1.2.Statement Of The problem**

The catastrophic nature of health care financing mechanism for the poor and often rural population has been a source of concern in African Countries. According to WHO; one hundred fifty million people globally suffer financial catastrophic shock each year, and one hundred million are Pushed into poverty because of direct payments for health services. Community-based health insurance schemes are becoming increasingly recognized as an instrument to finance health care in developing countries, with certain weaknesses such as low capital start up base, small size of risk pool, lower level of revenue mobilization, limited management capacity, and isolation from more complete benefits. (Adane K. et al , 2013)

Both supply and demand side constraints contribute to the low health care utilization of Ethiopia. In 2009, the number of hospital beds per 10,000 people was 2 (while the average availability for SSA region was 9), the number of nurses and midwives per 10,000 populations was 2 (11 for SSA) and that of physicians (generalist and specialist medical practitioners) was only 0.4 (2 for SSA), (WHO, 2010).

Poor health care financing remains a major challenge for the health system of Ethiopia. It leaves households vulnerable to impoverishment from catastrophic health expenditures, and slows progress towards health improvements such as the Millennium Development Goals by limiting access to essential health services among the poor. Important barriers to improved health care financing include: low government spending on the health sector, Strong reliance on out of pocket expenditure, inefficient and inequitable utilization of resources, poorly harmonized and unpredictable donor funding , (ibid, 2010).

As different studies showed that in developing countries the majority of the people from poor families cover costs for health care out of pocket. As a result many fell into debt which aggravate sever poverty conditions.

Study that conducted by Adebayo et al. (2015) support the above truth in LMICs, while CBHI schemes may be helpful in the short term to address the issue of improving the rural population and informal workers” access to health services, they still face challenges: Lack of funds, poor quality of care, and lack of trust are major reasons for low CBHI coverage in LMICs.

Haile (2014) Conduct research on Willingness to join community based health insurance among rural households of Dehub Bench District, Bench Maji Zone, South west Ethiopia. Cross-sectional community based study was conducted in Dehub Bench District in March 2013 using a pretested structured questionnaire. About 78% of the respondents were willing to join the scheme. Most of demographic, socioeconomic variables and social capital were found to be significantly associated with willingness to join community based health insurance. Finally, the researcher concluded that if the scheme is initiated in the district, majority of the households will enroll in the community based health insurance. Therefore initiation of the scheme is beneficial in the district.

(Adane K. et al , 2013) Studied on Willingness to pay for community based health insurance among households in the rural community of Fogera District, North West Ethiopia. The study concludes and recommends that willingness to pay for the Community based health insurance scheme was encouraging. However, the amount of the premium should consider the family size, wealth status and the willingness of the households.

Yilma et al(2015)also conducted study on impact of Ethiopia's Community Based Health Insurance on Household Economic Welfare. The findings of the study showed that main benefit of the scheme is its effect on reducing the need to borrow. This may have longer-term benefits in reducing vulnerability to other forms of shocks. The combined results provide support to the government's recent move to extend the CBHI pilot to a total of 161 districts for further testing. However, a nationwide scale up requires an examination of the scheme's financial sustainability.

Further Hilina (2014) conducted research on Socio Economic Determinants of Community Based Health Insurance the Case of Kilde Awelaelo District, Tigray Regional State in the study a logit regression model was employed to analyze the determinants of household head to enroll in CBHI scheme.

The result of the analysis shows that human capital variables such as household head age, education, attend local meeting and participate in PSNP, awareness level regarding the program have a positive impact that household heads would become members/participants of the scheme while accessibility to credit negatively influence for their decision.

Further, empirically different scholars interested on related title from different countries like:

Nair D.(2015)Conducted research on Determinants of Enrollment in Comprehensive Health Insurance Scheme and Implementation Challenges: A Study in Kerala, South India.

The study uses a qualitative case study design. The result of the study shows that major demand side factors traced out through in depth group interviews are: lack of awareness regarding the benefits of the scheme, outpatient care is excluded, coverage is not enough, provider choice is limited, not happy with the public health facilities etc. The supply side factors are: delay in getting funds from government, less incentive, over work load etc. Moral hazards were less compare to other insurance schemes.Finally, the researcher concludes thatPoor people were benefited through the scheme, but delay in settling finds. Gender equity is addressed. Real beneficiaries were not identified and included in the list. So income based equity is questionable.

In the above reviewed study majority of the study conducted (case of Ethiopia) merely during pilot woreda of CBHI implementation but currently CBHI enrollment in Ethiopia is expanded & enrolled in its full woreda expansion beyond the first 13 identified pilot woreda"s since the challenges encountered on CBHI enrollment before the polit woreda schemes & after may not the same the other critics can be raised from the methodology they were employed majority of the researcher"s employed the quantitative approach specially logit regression model.

Hence, this study would fill the gap that exist in the previous studies conducted on pilot woreda"s but this study was conducted after the completion of the first stage of selected pilot woreda"s or during the full enrollment moment/scale up of CBHI in Ethiopia across the rest woreda"s in addition to the previous pilot woreda"s via employing mixed research method.

This identified the major challenging problems in enrolling CBHI; it assessed the current progress/enrollment of CBHI, taking Aleltu as study woreda.

### **1.3.Objectives of The study**

#### **1.3.1. General research Objectives**

The general objective of this study was: to examine the practice/enrollment & challenges of CBHI schemes in Aleltu woreda.

#### **1.3.2. Specific research Objectives**

Specifically, this study intends:

- ❖ To investigate challenges encounter on enrolling of CBHI program in both demand side & supply side problems.
- ❖ To examine the enrollment status of CBHI in the district.
- ❖ To identify the household"s level of knowledge & awareness they have on the concept of Community based health insurance.
- ❖ To assess the households participation level on CBHI enrolment
- ❖ To assess the impact of a households health status, family size & income on enrollment of CBHI?
- ❖ To find the way how to overcome the challenges facing the CBHI in Aleltu District.

#### **1.4.Research question**

This study is intended to answer the following research questions:

- ❖ What are demand & supply side challenges faced by the study woreda on enrolling the CBHI schemes?
- ❖ What is the enrollment status of CBHI in Aleltu district?
  - ❖ What is level of society"s knowledge & awareness on CBHI program?
  - ❖ What is the participation level of the households on CBHI enrolment?
- ❖ What is the impact of household"s family size (underage), family"s health status & income level on enrollment?
- ❖ What are ways used to overcome the challenges facing the CBHI in Aleltu district.



### **1.5. Significance of the study**

As part of its health care financing strategy in general and its health insurance strategy in particular, the Government of Ethiopia endorsed and launched community-based health insurance (CBHI) schemes in 13 pilot woreda in Amhara, Oromia, SNNP, and Tigray regions in 2010/11 to provide risk protection mechanisms for those employed in the rural and the informal sectors. Three years on, the government has decided to scale up CBHI, with schemes in 161 woreda (EHIA, 2015).

Different studies" were conducted on CBHI but the researcher viewed that there is gap on the practice & challenges of the schemes on the implemented Ethiopian pilot woreda"s hence this study will fill the gap on this area.

Moreover, the CBHI is new reform in health sectors mainly in achieving UHC expanding high-quality health care services that are equitable & accessible to all hence based on the findings the researcher will forward critical recommendation to sustain the scheme.

### **1.6. Scope of the Study**

This study focused on the health services than other public sector"s & among different health reforms it scoped on health insurance reforms which works on universal health coverage. Commonly there are two schemes of Health insurance schemes those are Community based health insurance (CBHI) which scoped itself on peoples engaged on informal sectors of the economy & the second schemes is Social health insurance (SHI) that focuses on citizens employed in formal sectors of the economy. For the sake of the study this research focused on CBHI due to it is the only schemes now implemented/come in to action than the SHI. For the sake of case study area Aleltu woreda was selected due to there is good performance & some challenges on enrolment.

The District Performance last year is 54% which is the highest as compared with other schemes woreda (EHIA, 2015).

### **1.7.Limitation of the study**

In this study I faced challenges like time constraints, budget constraints & respondents were not available within the time framed. Even if the researcher faced the above listed challenges I used different techniques to cope up the problems.

## **Chapter Two**

### **2. Literature Review**

#### **Introduction**

In this chapter various published & unpublished literatures related with this study title would be reviewed this helps in order to Place each work in the context of its contribution to understanding the research problem being studied, describe the relationship of each work to the others under consideration, & In order to triangulate various theories & ideas models with findings collected via the questioner & interview in this specific study.

#### **2.1. Concept of Community Based Health Insurance**

Health is increasingly being viewed not only as an “end” in itself but also as a crucial “input” into the development process. Indeed a positive link between health and economic growth is widely established, particularly for low-income countries. As these countries embrace market reforms as well as integrate themselves with the world economy, there is a concern about insulating the poor from any possible adverse consequences. While the role of state is on the retreat in most economic spheres, in social sectors such as health state’s role will continue to be important,(Jutting et al , 2003).

Increased expenditure caused by the need to cope with injury and illness has been identified as one of the main factors responsible for driving vulnerable households further into poverty,(WHO, 2000).

Consistent with Tabor, Steven R.(2005)CBHIs are called by many different names, including: micro-insurance, community health finance organizations, mutual health insurance schemes, pre-payment insurance organizations, voluntary informal sector health insurance, mutual health organizations/ associations, community health finance organizations, and community self-financing health organizations. There is little to distinguish one from another, except that some terms are more commonly used in one part of the world than another.

According to Meghan, (2010) more than half of health expenditure in poor countries is covered by out of pocket (OOP) payments incurred by households. An increase in such expenditure can have catastrophic effects and may deplete a household's ability to generate current and future income and have inter-generational consequences as households may be compelled to incur debt, sell productive assets, draw down buffer food stocks, or sacrifice children's education.

Health insurance can be defined as a way to distribute the financial risk associated with the variation of individuals' health care expenditures by pooling costs over time through pre-payment and over people by risk pooling, (OECD, 2004).

Since the late 1990s, in a move away from user fees for health care and with the aim of creating universal access, several low and middle income countries have set up community based health insurance (CBHI) schemes, (Angaw, 2015).

Health financing systems through general taxation or through the development of social health insurance are generally recognized to be powerful methods to achieve universal coverage with adequate financial protection for all against healthcare costs. These systems intend to respond to the goal of fairness in financing, in that beneficiaries are asked to pay according to their means while guaranteeing them the right to health services according to need. In tax-funded systems, the population contributes indirectly via taxes, whereas in social health insurance systems, households and enterprises generally pay in via contributions based on salaries or income, (Guy, 2003).

Due to the limited ability of publicly financed health systems in developing countries to provide adequate access to health care, community based health financing has been proposed as a viable option. This has led to the implementation of a number of Community based health insurance schemes, in several developing countries. The review shows that the ultra-poor are often excluded and at the same time there is evidence of adverse selection. The bulk of the studies find that access to CBHI is associated with increased health care utilization, especially with regard to the use of relatively cheaper outpatient care services as opposed to inpatient care. The schemes also appear to mitigate catastrophic healthcare expenditure. There are clear links between

scheme design and effectiveness suggesting the importance of involving the target population in designing and implementing CBHI schemes (Angaw, 2015)

CHI is a common denominator for voluntary health insurance schemes that are labeled alternatively as mutual health insurance schemes, and medical aid societies or medical aid schemes. The common characteristics, however, are that they are run on a non-profit basis and they apply the basic principles of social health insurance. The question addressed here is to what extent CHI can be used as a component in a strategy to enhance universal financial protection. (Angaw, 2015)

Scarce economic resources, low or modest economic growth, constraints on the public sector and low organizational capacity explain why the design of adequate health financing systems in developing countries, especially the low income ones, remains cumbersome and the subject of significant debate. Earlier on, cost-recovery for health care via user fees was established in many developing countries usually as a response to severe constraints on government finance. However, most studies alert decision-makers to the negative effects of user fees on the demand for care, especially that of the poorest households, (Angaw, 2015).

Community based health insurance schemes (CBHIs) apply the principles of insurance to the social context of communities, guided by their preferences and based on their structures and arrangements. CBHIs can help communities manage healthcare costs and provide access to basic healthcare for the poor and other vulnerable groups. The schemes are especially useful in reaching rural residents and the informal sector the part of the society that is not easily insured including self-employed people (e.g., farmers, petty traders, and laborers). These people tend to be unable to pay out-of-pocket (OOP) costs for basic healthcare at the point of service use, which if persistent, could possibly drive them into poverty (Calapar, 2011).

Typically, CBHIs are organized and managed by a local community organization. The CBHI plan establishes agreements with various health providers, thereby forming a network of facilities. Most schemes cover basic healthcare services (e.g., antenatal care, deliveries, and child healthcare) and family planning services, while some schemes may also cover costs of hospital treatment. The value of CBHIs is that they engage community members as enrollees and

volunteers ensure that health services meet community needs, and make primary healthcare accessible and affordable to members by pooling their resources and sometimes supplementing them with external funds,(Calapar, 2011).

## **2.2 Weakens of Community Based Insurance.**

Among weakness of CBHIs is that they are often highly dependent on external funding from the government and donor agencies. Such schemes tend to cover a relatively small, low-income group of enrollees and thus they do not have a sufficiently large risk pool to cover their operating costs. Premium payments and local subsidies are usually inadequate to cover the costs of healthcare, since most enrollees are poor and cannot afford high premiums. Also, while community involvement is beneficial to CBHIs, it is sometimes ineffective due to weak management and technical skills of serving members of the community within the CBHI structure, (Angaw, 2015)

Generally, to handle the weakness of CBHIs it should be part of a broader package of financing mechanisms such as fee exemption schemes, equity funds, vouchers for beneficiaries, and results based financing that extend health coverage to underserved groups. CBHIs may not fit all situations, but they can make an important contribution to healthcare programmes.

## **2.3 Types of Community Based Health Insurance**

As Krishnan, (2001)&Tenkorang, (2001)cited in Angaw, (2015)Community based health insurance is a generic term for a variety of resource mobilization models designed to finance access to health care through a greater involvement of the target population in the design and implementation of the scheme as compared to private or national level health insurance schemes.

The most common type of community health financing schemes is

- (i) Community prepayment health organizations
- (ii) Provider based health insurance and
- (iii) Government-run but community-involved health insurance.

These schemes differ in terms of design and the involvement of the community in setting up the scheme, mobilizing resources, management and supervision.

The remainder of the section characterizes these different schemes and highlights the role of the community in each scheme type while Table 2.1 provides a snapshot of various scheme characteristics.

**Table 2.1: Features of different CBHI models**

Features of Different models	Types of CBHI		
	Community prepayment health organizations	Provider based health insurance schemes	Government-run community-involved health insurance
Designfeatures	<p>Financed by contribution from members</p> <p>Small financial contribution mainly to cover primary health care services</p> <p>Membership is on a voluntary basis</p>	<p>Designed by local health care providers (hospitals) to encourage service utilization</p> <p>Often cover expensive inpatient care</p> <p>Membership is on a voluntary basis</p>	<p>Designed by governments as part of the health financing system</p> <p>Often includes both primary care and hospitalization</p> <p>Membership may be voluntary or mandatory</p>
Management features	<p>Strong community involvement in decision making and supervision</p>	<p>Providers involved in scheme management</p>	<p>Schemes are organized and managed through a top down approach by central and local governments but the community may also be involved in decision making processes</p>

OrganizationalAnd institutionalfeatures	<p>The provider is not involved in the administration of the scheme</p> <p>The schemes may sign contractual agreement with local providers to obtain preferential prices and insure quality of services</p>	<p>Providers administer the schemes and collect premiums from scheme members</p> <p>Providers may obtain technical assistance from the government and NGOs</p>	<p>Governments are strongly involved in the design, implementation, and evaluation of the scheme.</p>
Role of government and NGOs	<p>NGOs often provide technical assistance and provide start-up funds</p> <p>Governments provide legal recognition and encourage their establishment</p>	<p>NGOs and governments may improve the facility of the providers</p>	<p>Government and NGOs may subsidize the scheme and provide exemption from premium payment for lower income groups</p>
Role of the community	<p>Pay premiums All round community involvement in design, implementation and supervision</p>	<p>Pay premiums Provide feedback on Quality</p>	<p>Pay premiums Communities may be involved in design and administration of the schemes</p>
Strongside of the scheme	<p>Trust and feeling of ownership</p>	<p>Does not require management and technical skills from the community</p> <p>Scheme management and service provision are integrated</p>	<p>The possibility of subsidized premiums</p> <p>Large size of scheme and enhanced sustainability</p>
Weakness Of the scheme	<p>Small size in nature and low ability to pool enough resources</p> <p>Lack of technical and managerial skills about health</p>	<p>Limited scale</p> <p>Relatively low power of the community to influence benefit package and quality of care</p>	<p>Limited feeling of community- ownership</p> <p>Potentially high administrative costs</p>

	insurance administration		
--	-----------------------------	--	--

Source: Adapted from As Krishnan, (2001), Tenkorang, (2001)and Ekman (2004), Cited by Angaw, (2015)

### **2.3.1. Community prepayment health organizations**

According to Tenkorang, (2001)cited by Anagaw (2015) these types of health organizations are characterized by voluntary membership and payments are made in advance in order to cover potential medical costs. Members of the schemes pay premiums on a regular basis, usually when their incomes are high. Such schemes are often initiated with the technical and financial support of NGOs and thereafter the community takes full responsibility for administering and managing the scheme. Local governments may also play a role in encouraging and supporting the efforts of such schemes. The community participates in designing the scheme and decides on the level of benefit and the corresponding premium. In addition, members participate actively in administration and supervision.

### **2.3.2 Provider based health insurance schemes**

According to Tenkorang, (2001) these types of health insurance schemes are initiated by healthcare providers (such as a town or regional hospitals) to encourage utilization of healthcare services. The schemes mainly cover expensive inpatient care and hospitals and may have recourse to external funds to subsidize service costs. In this framework, the health care providers are responsible for mobilizing resources and providing health care services. The role of the community in designing and administering the scheme is limited. However, members of the schemes are given a chance to participate in scheme supervision and provide feedback on service quality through meetings organized by the health care providers. Such schemes are often restricted to those households living in the catchment area of a health facility.

### **2.3.3. Government runs community-involved health insurance**

According to As Krishnan, (2001) Government run and community-involved health insurance schemes are often linked to formal social insurance programmes with the objective of creating access to a universal health care system.

According to Tenkorang, (2001) unlike other models, government initiated schemes often cover both basic curative and inpatient care. The government (national or regional) plays a substantial role in initiating, designing and implementation of such schemes.

The participation of the community in such schemes varies substantially across countries. Some governments create conditions which enable community involvement in defining the benefit package, setting of premiums and scheme management while others introduce the schemes in a top-down manner and limit the role of the community. Membership in such government-initiated health insurance may not always be voluntary, (Angaw, 2015).

Unlike other forms of CBHI, government supported health insurance schemes have the potential to reach a relatively large number of households. Governments in co-operation with donor agencies may provide reductions in premium and fee waivers for the poorest segments of society while retaining a universal benefit package. The disadvantage of these schemes may lie in their design and implementation features. Since such programmes are the result of a top-down approach, they may not be sensitive to local needs. Limiting the role of community participation in awareness-raising, decision-making and supervision probably robs such schemes of a sense of ownership which in turn may hamper sustainability, (ibid).

#### **2.4. Community Based Health Insurance in Developing country**

In the absence of third party and prepayment systems such as health insurance and tax based healthcare financing; households in many low-income countries are exposed to the financial risks of paying large medical bills from out-of-pocket. In recent years, community based health insurance schemes have become popular alternatives to fill such void in the healthcare financing systems, (Abebe, 2010).

Further, the study finds that community based health insurance program has non-linear and mixed impacts on out-of-pocket expenditure. While the program significantly increases the probability of overall spending, it decreases the amount of per capita spending on healthcare. The program also significantly reduces spending on drug but increases outpatient spending with no detectable impact on inpatient services. Furthermore, we find notable heterogeneity in treatment

effects in which households in the top income distribution realize the highest reduction in out-of-pocket spending,(Abebe, 2010).

Community based health insurance is a valuable way to finance the delivery of health services in developing countries. By combining the risk of falling sick with resources, such insurance facilitates access to care and offers financial protection against the cost of illness. In doing so, community based health insurance aims to overcome inequities in access and socioeconomic status by reducing existing gaps between the poor and the less poor, (ibid).

Importantly, one of the outcomes measured in the trial was the actual birth method, which usefully separates how choices are experienced from the option chosen. The trial found that both aids significantly improved the subjective experience of women about their choices compared with usual care. However, rates of caesarean delivery were similar in the information group, and lower in the decision analysis group compared with usual care, (ibid: 15).

Research from Asia and sub-Saharan Africa shows that community based health insurance has been less effective in securing equity than expected. Poor people are less likely to enroll in such schemes and limited evidence shows that once enrolled their use of the services is not great enough to compensate for pre-existing inequities in access. Therefore, the major challenge for community based health insurance is how to secure greater equity across socioeconomic groups, in terms of both enrolment and access to services, (ibid: 25).

Majority of Sub-Saharan African citizen"s informal sector workers and the rural population have never had access to wage-based social health insurance or privately run health insurance. As a response to the lack of social security, to the negative side-effects of user fees introduced in the eighties and to persistent problems with health care financing, nonprofit, voluntary community-based health insurance (CBHI) schemes for urban and rural self-employed and informal sector workers have recently emerged. CBHI seems to be a promising attempt to improve access to health care, health outcomes and social protection in the case of illness. Given the unique ethnic, lingual and cultural diversity within African nations, the CBHI approach may be particularly valuable because it allows adaptation to local conditions. The actual implementation of CBHI schemes in Sub-Saharan Africa has had mixed results so far, with viability and acceptance

largely depending on design and management of the scheme, community participation, regulations at the level of the health care provider, quality of services and on the socio-economic and cultural context. As it has turned out that small-scale health insurance can supplement other sources of finance rather than being a substitute for them, public-private partnerships may provide scope for improvement of CBHI performance, (Jutting, 2000).

Community Based Health Insurance Schemes (CBHIs) have flourished all over the developing world. CBHI is a not for profit type of health insurance that has been used by poor people to protect themselves against the high costs of seeking medical care and treatment for illness. In principle, CBHI schemes are designed for people who live and work in rural areas, or in the informal sector. Most often, these people are unable to access adequate public, private, or employer-sponsored health insurance. Significantly, by reaching those who would otherwise have no financial protection against the cost of illness, CBHIs also contribute to equity in the health sector. However, many schemes do not perform well due to a number of problems related to their implementation,(Habiyonizeye, 2013).

The literature suggests that there are four factors that are most likely to influence renewal rates: the quality of care on offer, health status, and affordability of insurance and information failures. The last issue includes a lack of understanding of insurance and insufficient information on how to use the insurance policy. High dropout rates clearly threaten the sustainability of such schemes, even if initial uptake is high, (Angaw, 2015).

As watkins, (2003) cited by Angaw, (2015)concluded that while affordability is an issue, the main reason for the declining enrolment rate was the poor quality of care at the health centers accessible to scheme members.

As Ontiveros, (2013) show for Maharashtra that households with greater scheme information and better understanding of insurance were more likely to renew contracts, they also demonstrate that a better understanding of insurance reduces the negative effect of not having received any pay outs through insurance on contract renewal.

However, limited knowledge about the details of the programme (like benefit packages, referral system, and requesting for reimbursements) emerged as one of the major reasons for dropping out of the scheme, (Angaw, 2015).

A good understanding of health insurance may lead to a greater appreciation of the potential usefulness of such a scheme and knowledge of the manner in which the scheme operates may make it easier for households to obtain benefits. Knowledge of insurance may also mitigate the tendency to drop out even if a household did not make use of the scheme, (ibid: 157).

Different awareness creation tools are used in order to raise the understanding level of the society such as Village officials, community leaders and health workers provide information about health insurance by moving door to door, at churches and mosques, and during other social gatherings. In addition to these, the scheme used documentary films, local mass media, amplifiers, amateur artists, pamphlets, posters, and T-shirt advertisings for awareness creation and community mobilization, (ibid, 2015).

## **2.5 Community Participation**

The degree of community participation in the design and running of the CBHI can vary widely and is usually greater if funds are owned and managed by the members themselves than if schemes are run by health facilities. If members can identify themselves with “their” schemes because they control the funds and have decision-making power, they will tend less to unnecessary use of health care services (“moral hazard”), (Jutting, 2000).

Furthermore, different studies manifested that strong community participation can facilitate health education and sensitization of members in order to promote healthy behavior and the use of preventive services, as the members share a common interest in keeping the costs of health care low. For example, the members of a self-governed CBHI comprising several villages in Benin realized that many cases of sickness and a considerable amount of health care costs reimbursed by the scheme originated from one distinct village. In consequence, CBHI members of that village and the local nurse organized sensitization sessions on water hygiene and vaccination

Members of the Kisiizi Hospital Health Society in Uganda cited health education on preventive medicine as one of the main benefits of the scheme (Musau 1999),(Jutting, 2000).

In principle it would seem redundant to examine the link between community participation in community-based health financing as the target population is expected to be engaged in various aspects of such schemes. However, the extent to which potential beneficiaries participate in the design, implementation, management, and supervision activities varies across schemes. Providing space for community participation may have an impact on the willingness of individuals to buy insurance and the overall performance of the scheme. The review reveals that participation of the community in design and implementation has a positive impact on healthcare utilization and financial protection. For instance, all 9 schemes in which communities have a role in programme design are associated with an increase in access to healthcare and 4 out of 5 display a reduction in OOP expenditure. The corresponding figures for schemes without such participation are 6 out of 11 and 1 out of 4 for utilization and OOP expenditure, respectively. Participation of members in management and supervision activities is also linked with increases in access to healthcare service (7 out of 7) as opposed to 9 out of 14 for schemes where members are not involved, (Angaw, 2015).

## **2.6 Empirical findings concerning the performance/enrollment of CHIs**

In This sub-section different empirical literatures regarding the CBHI would be presented based on different facts written & conducted at different time.

### **2.6.1 Performance criteria**

#### **Enrollment**

An extensive WHO review was made in 1998 (henceforth called WHO Study) concerning 82 non-profit health insurance schemes for people outside formal sector employment in developing countries. It was observed that very few of these schemes covered large populations or did not even cover high proportions of the eligible population, (Guy, 2003).

Further, information became available since 1998. Low percentages of enrolment were observed in a study on 5 CHIs in East and Southern Africa. In four schemes, enrolment percentages vary

between 0.3% to 6.5% of the target population; one scheme is very small with 23 members out of a target population of 27 cooperative society members, (Guy, 2003).

In Rwanda, a project was launched, establishing 54 CHIs in three districts in July 1999 (henceforth called Rwanda Project). By the end of the first year of operation, the enrolment rate reached in the three districts was 7.9% (88,303 members out of a total target population of 1,115,509). Another study was made in nine West and Central African countries (henceforth called WCA Study) on 22 CHIs. From the available information on beneficiaries and target membership, one CHI's in Benin reached an enrolment rate of 24% in 1998, whereas another achieved an enrolment rate of 8%; the target population in these CHIs was 13,000 and 7,300, respectively. In one CHI's in Ghana and Mali, 53% and 25% of the target population of 25,000 and 200,000 was covered, respectively, (ibid: 11).

Generally, it is also important to see whether community health insurance is accessible across different population groups. One conclusion from the WHO Study was that very few schemes reached the vulnerable population groups, unless Government or others facilitated their membership through subsidies.

## **2.6.2. Exploring factors that influence performance**

### **2.6.2.1 Factors influencing membership**

#### **Affordability of contributions**

Not unexpectedly given the voluntary character of CHIs, affordability of premiums or a contribution is often mentioned as one of the main determinants of membership. A number of schemes in the WHO Study had addressed the issue of affordability. For instance in the Nkoranza scheme in Ghana, the estimated cost of contributions varied from 5 to 10% of annual household budgets. It was recognized that such contributions could be a financial obstacle to membership. Contributions are also generally levied as flat sums, which is a disadvantage for the poorest: flat contributions are regressive, a flat-rate contribution as a percentage of income being higher for poor than for the non-poor a flat-rate contribution as a percentage of income being higher for poor than for the non-poor,(Guy, 2003).

## **Unit of enrolment**

Achieving adequate membership rates is likely to be easier when households or even villages, cooperatives or mutual benefit societies are taken as the basis of membership. In the WHO Study, almost half of the schemes surveyed had the family as the unit of membership, (ibid: 15).

## **Distance**

According to Demste, (1999) cited in by Guy, (2003) Membership rates are often determined by the distance of the household's home from the nearest health facility where (insured) services are provided. For instance, in the GK scheme, membership among the two lowest socio-economic groups appeared to be related to distance: up to 90% of that target population from nearby villages subscribed, whereas only 35% did so for the target population in the distant villages.

Further, Schneider and Diop (2001, :25) in the Rwandan Project Study, it was also found that households who lived less than 30 minutes from the participating health facility had a much larger probability to enroll in the CHIs than those who lived farther away (ibid:15-16).

## **Timing of collecting**

From the WHO Study, it was observed that schemes in urban areas were more inclined to establish monthly or quarterly contributions so as to match the income patterns of urban informal sector workers. Annual contributions seem to be prevalent among schemes in rural areas. However, in some schemes, such as the ORT scheme, payment schedules were held flexible, with monthly, quarterly or semi-annual payments. Flexibility was introduced as it was judged that few households were able to pre-pay for a one year or even six-month membership, (ibid, :16).

## **Quality of care**

One of the reasons for non-membership invoked was the fact that members did not have access to better quality care at mission health facilities. As yet, only health care in public health facilities was part of the health insurance benefit package,(Guy, 2003).

## **Trust**

According to Van Ginneken (1999) as cited by Guy, (2003), The existence of entry-points in the community, such as a micro-credit scheme, a development cooperative or other social groups, may facilitate the establishment of CHI. If such existing initiatives have won the population's trust, it may become easier to start up a CHIs. Information from some selected schemes is worth mentioning (ibid: 17)

### **2.7. Health Sector in Ethiopia**

Ethiopia is developing with a promising rate to join middle income countries in a decade. The health sector should be the contributor to the economic growth by turning the vision of seeing healthy and prosperous Ethiopians to reality as well as benefit from the economic growth to avail adequate resources to provide quality services. Envisioning the future of Ethiopia's health sector has taken into account the assumption of Ethiopia becoming a lower-middle income country by 2025 and a middle-middle income country by 2035 to come up with indicative targets with benchmarking of other countries and strategic recommendations to meet those targets. The coming health sector strategies are expected to cope with a changing landscape in socioeconomic situations as well as addressing existing and anticipated challenges such as quality of care and inequalities. A feasible approach to address such challenges is to rehearse universal health coverage through ever improving primary health care with seamless continuation to higher level of care,(FMOH, 2014).

It is high time to envision the future of the health sector as we are at the final year of the current HSDP, which is the fourth phase (HSDP IV) of the twenty year plan launched in 1997 (FMOH, 2010). HSDP IV is aligned with the MDG ;while Ethiopia has already met MDG 4 and most of the targets of MDG 6, further efforts are needed to meet MDG 5 by 2015 (FMOH, 2013). The next health sector strategies are expected to set goals based on lessons learned from current and past experiences, as well as anticipating the future in the socio-economic dynamics of the country in general and the health sector in particular, (ibid:3).

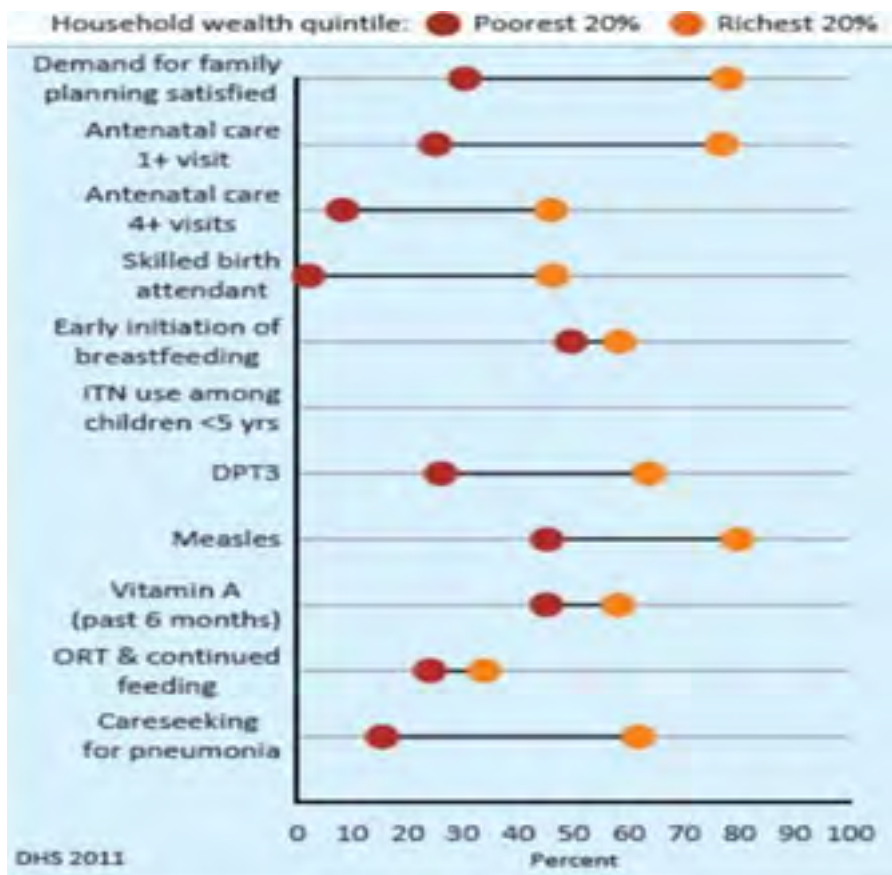
It is for these reasons that the MOH is developing the 20-year health sector vision to achieve the health outcomes that commensurate with lower middle income country (LMIC) by 2025 and middle-middle income country (MMIC) by 2035 (FMOH 2014), (ibid, 2014: 3).

As Ethiopia advances to middle income country status, its goal is to progressively realize progress towards UHC and ultimately to achieve UHC for all Ethiopians. Achieving UHC requires progress along two related dimensions of health system development.

UHC has been defined as guaranteeing access to all necessary services for everyone while providing protection against financial risk. Therefore, services must be physically accessible, financially affordable and acceptable to patients if UHC is to be attained (ibid 2014: 4)

Achieving UHC requires progress along two related dimensions of health system development. First, quality health services must be provided to all those in need; second, mechanisms to pay for these services must be developed that protect those who need and use the services from facing significant financial risks from direct payment of services. (ibid 2014)

Ethiopia is developing PHC through HEP and PHCU as the principal means to achieve service coverage, the first dimension. It is investing to reduce disparities and improve equity in access. This will be complemented by strengthening of hospitals at various levels and other complementary services. Ethiopia has also made efforts to assure financial risk protection through the expansion of community-based health insurance and social health insurance, the second dimension. Expanding both service coverage and financial protection will emphasize equity in reaching the more disadvantaged and reducing disparities within Ethiopia's population. (ibid 2014:4-5)



**Fig: 2.1 socioeconomic inequalities in health service coverage**

Source: UN, 2013 cited by FMOH, (2014)

### 2.7.1 Community Based Health Insurance in Ethiopia

Prior to 1998, the per capita expenditure for health in Ethiopia was very low: in the years from 1980 into the mid-1990s, it fluctuated between US\$1.00 and US\$1.20, which was far below the sub-Saharan African per capita average of US\$6.70 (FMOH, 1998). The resource allocation was also skewed in favor of hospitals and urban areas. The user fees charged in health facilities did not reflect the cost of health care and all revenue collected was remitted to the government treasury. There was no or little insurance coverage in the country. The involvement of the private sector in health was limited. All these circumstances made accessing health care a challenge for many households. To resolve these issues, a Health Care Financing strategy was endorsed by the Council of Ministers in 1998. Its objectives were to mobilize additional resources from both domestic and external sources, improve efficiency especially by shifting resources to primary

care, and ensure sustainability of quality health care services. It also aimed at enhancing community participation and ownership of health services, (EHIA, 2015).

As part of its health care financing strategy in general and its health insurance strategy in particular, the Government of Ethiopia endorsed and launched community-based health insurance (CBHI) schemes in 13 pilot woredas in Amhara, Oromia, Southern Nations, Nationalities, and Peoples (SNNP), and Tigray regions in 2010/11 to provide risk protection mechanisms for those employed in the rural and the informal sectors. Three years on, the government has decided to scale up CBHI, with schemes in 161 woredas, (ibid).

The scheme was introduced by Ethiopia's, Federal Ministry of Health (FMoH) in collaboration with USAID, Abt Associates Inc. an international consultancy company and CARE Ethiopia an international nongovernmental organization. The scheme is part of the government's broader health care financing reform strategy which aims to improve quality and coverage of health services by identifying alternative healthcare resources,(USAID, 2011).

While the scheme has been introduced by the government, it is „community based“ in the sense that the community determines whether or not to join the scheme and is subsequently involved in scheme management and supervision. In particular, after being exposed to a range of awareness creation activities a general assembly at the village (kebele) level decided whether or not to join the scheme (a simple majority had to support the decision) and then households decide individually whether to enroll in the scheme. In order to reduce the possibility of adverse selection the unit of membership is the household rather than the individual and new members can use their CBHI card to get healthcare services after waiting for at least for one month,(FOMH, 2008).

The Health Care Financing strategy, implemented over the past 15 years, is meeting its objectives. It has provided greater autonomy to health care facilities and mobilized revenue for facilities, including primary care facilities, by reforms such as establishing facility boards, retaining user fees, outsourcing non-clinical services, opening private wings in public hospitals as an income-generating and retaining mechanism for medical professionals and health facilities, and introducing a third-party payer for fee waived patients(EHIA, 2015).

**Table 2.2: List of pilot and control woreda's**

**Table 1.1: List of Pilot and Control Woredas**

Amhara	Oromia	SNNP	Tigray
<b>A. Pilot Woreda</b>			
South Achefer	Gimbichu	Yirgalem town	Kilte Awlaelo
Fogera	Kuyu	Damboya	Ahferom
Tehuledere	Deder	Damot Woyde	Tahitay Adiabo
	Limmu Kossa		
<b>B. Control Woreda</b>			
Dembia	Merti	Wonago	Raya Azebo

Source: (EHIA, 2015).

After three years of piloting, the government decided to expand CBHI schemes to 161 woreda's of the country. So that the scale-up process would benefit from the experiences of the pilot schemes, it was decided to evaluate the impact of CBHI in the pilot woreda with respect to the intended objectives. USAID, HSNR/HFG, Project engaged Breakthrough International Consultancy (BIC) to carry out the evaluation.(ibid: 22).

Overall there is no "one size fits all" strategy for implementing risk-pooling mechanism. Some countries have used top-down public financing (tax based) and social health insurance (SHI) without CBHI, while others have used CBHI as the main model of reaching the informal sector. As a result of these differences in design, country experiences show huge variation in the breadth, depth, and height of coverage achieved. Successful CBHI models show that there are important conditions for CBHI to grow and develop, including: (i) existence of a minimal level of (perceived) quality of care and gradual improvement of quality at the supply side; (ii) instituting adequate organizational practice and design including responsiveness to people's felt needs by the scheme management; (iii) government commitment and political will with clear action plans, national scope of implementation, existence of regulatory frameworks, and - last but not least - the unequivocal commitment to subsidize and finance the premium for the poorest in society; and (iv) the need for CBHI schemes to join forces to expand risk pooling and ensure financial sustainability, (ibid 2015).

Evidence from the experience of countries worldwide informed Ethiopia's CBHI design, which eschewed small-scale, voluntary membership and included mechanisms to finance the membership of the poor. The willingness and ability to pay of the pilot woreda population conducted by HSFR during the design phase as well as the assessment of readiness of facilities in the pilot woreda's to provide health services informed the design parameters. Certain major features are unique to Ethiopia. Enrollment in a CBHI scheme is decided collectively at the kebele/tabia level as opposed to the household level. Associated kebeles/tabias form a larger woreda-wide scheme, (ibid).

Scheme management is integrated and works within the woreda administration office. A general subsidy from the federal government is provided for all scheme members and a targeted subsidy from the regional and woreda governments is provided for the very poor who cannot afford to pay the contribution. Scheme staff is employed through the government payroll. The federal government also provides resources to health facilities contracted to provide services to CBHI members, so that the providers maintain an acceptable quality of care. Although there is overall guidance from the federal level, scheme parameters are decided at the regional level based on the regional CBHI directives; as a result, there are minor variations in schemes in different regions in terms of registration and enrollment rates, membership caps, and service provider contracting, (ibid).

The CBHI routine monitoring data from HSFR/HFG show that as of June 2013 the overall enrollment rate in pilot CBHI schemes is 48 percent of households (range: 25 percent in Deder to 100 percent universal enrollment in Yirgalem). Of the total eligible households, 7 percent registered as indigents (range: 1 percent in Deder to 15 percent in Tehuledere and Yirgalem). The average enrollment of the very poor is greater in Tigray and Amhara than in SNNP and Oromia. The per capita health service utilization rate of CBHI members was 0.7 outpatient visits in 2005 EFY (2012/13), more than twice the nationwide average of 0.3 visits. Ten of the 13 schemes are financially sound, while the other three (one in Amhara and two in SNNP) are having financial difficulties, (ibid).

### **2.7.1.1. Knowledge, Enrollment, and Affordability**

Knowledge about CBHI: 95 percent of both members and non-members in pilot woreda are aware of the CBHI schemes. The main sources of information are a neighbor, a CBHI official, or a house-to-house sensitization program; these three represent 100 percent of information sources in Amhara, 96 percent in Oromia, 86 percent in SNNP, and 81 percent in Tigray. More than 96 percent of member households and 87 percent of non-member households know that it is not only those who are sick who should enroll in CBHI. This clearly shows the value of the intensive sensitization work done by government and especially by the HSFR/HFG project, (ibid).

Reasons for enrollment: 37 percent of CBHI members joined primarily to reduce out-of-pocket (OOP) expenditure when seeking health care, 35 percent joined to more frequently seek care in order to improve their health status, and 18 percent joined because their premium is less than their OOP payments; only 4 percent said they joined because government paid their registration fees and premiums. Although the design of CBHI in Ethiopia states that the decision on whether to join the scheme is taken at the kebele/tabia level, there was no pressure by either the community or the kebele/tabia administration during the enrollment process, (ibid).

The affordability of premiums and registration fee is therefore an issue for only 16 percent of registered members.

The evaluation looked at the determinants of enrollment in CBHI and found the major factors to be household size; age, education, and sex of the head of household; and size of cultivated land (not only owned land). Larger families and those with older household heads are more likely to enroll than those with the opposite characteristics. Household heads that are literate are also more likely to enroll in to the scheme than those with no education. Household heads that completed primary education are more likely to join a scheme than those with no education. There is no significant difference in the enrollment rate in Amhara, Oromia, and Tigray regions, while the rate in SNNP is lower than in Amhara (the reference region for this comparison), (ibid,).

### **2.7.1.2. Major Challenges in quality services provided**

There are major challenges in the quality of services provided. First, contracted providers differ in their readiness in terms such as pharmacy services, laboratory facilities, reception, and outpatient services. Second, health facilities, especially hospitals, are frequently short of drugs and patients must buy items from outside (private) retailers. Health facilities attribute the shortages mainly to shortages at Pharmaceutical Fund and Supply Agency (PFSA) hubs. The practice of moral hazard by pharmacists at contracted health facilities was reported to exacerbate the shortages. Third, there are frequent breakdowns of medical equipment, due mainly to lack of preventive maintenance but also to health worker negligence and mishandling. Fourth, there are complaints about availability and capacity of staff. Finally, no pilot woreda has systematic, regular, and standard mechanisms for collecting and properly addressing complaints, (ibid).

### **2.7.1.3 Mobilizing Additional Resources to Health Providers**

The CBHI schemes have been able to collect a total of Birr 22.7 million in premium payments. Amhara and Oromia regions have mobilized more than the other two regions. Revenue collected was greater in the first year of CBHI than in subsequent years, evidence of a decline in new and renewing membership. Inadequate contribution/premium collection from the community affects the total available resources. However, resources available to the schemes in the form of targeted subsidy are not affected because the woreda and regional governments are paying these premiums (ibid 2015).

CBHI schemes reimbursed about Birr 16.9 million to contracted health centers and hospitals for services rendered.

More than 90 percent of service utilization by members takes place in, and more than 90 percent of reimbursement is made to, health centers in Amhara, SNNP, and Tigray. In Oromia, hospitals account for only about 5 percent of CBHI member utilization but they took in about 31 percent of the total reimbursement paid out. Overall CBHI schemes seem to provide the correct utilization pattern (using lower-level facilities more) and payment trends also follow this pattern. The reasons for a large proportion of payment going to hospitals in Oromia needs to be further explored to reduce the undesirable impact on scheme financial status (ibid 2015)

According to the CBHI design, there are three types of government subsidies to the schemes: targeted and general subsidies, and financing the scheme management costs (salaries, office space, and operational costs). The regional and woreda governments finance premiums of indigents using different arrangements. In Tigray, the regional government finances 70 percent of indigents' premium contribution and the woreda finance 30 percent. In Amhara, the split is 90/10. In SNNP and Oromia, woredas finance all the costs of indigents. Woreda governments also finance the salaries and operational costs of all schemes. The federal government subsidizes 25 percent of the CBHI premiums, for both paying and non-paying members. Through the end of June 2013, the total amount of subsidy paid to the 13 pilot woredas was Birr 16.5 million: Birr 9.7 million from the general subsidy and Birr 6.8 million from the targeted subsidy. The total subsidy constituted about 42 percent of the total revenue generated by schemes. Of this, the general subsidy accounts for 25 percent and the targeted subsidy for 17 percent. Members' contribution/premium accounts for 58 percent of total revenue collected by the schemes. Of the total revenue generated from all pilot schemes, 35.3 percent was from Amhara, 27.3 percent in Oromia, 24.2 percent in Tigray, and 13.1 percent in SNNP. However, there is still a very strong government commitment to CBHI, (ibid).

**Table 2.3 Projected Annual Financial Implications of CBHI Scale-up to Federal, Regional, and Woreda Governments ('000 Birr)**

	161 expansion woredas			All non-pastoralist woredas		
	10%	Pilot	29%	10%	Pilot	29%
Total Budget	148,346	146,466	203,087	817,962	836,801	1,196,815
Federal Budget	93,875	93,875	93,875	616,680	616,680	616,680
Regional Budget	32,090	31,212	68,241	118,883	140,501	342,423
Average woreda budget (161 woredas)				Total woredas' subsidy budget, all non-pastoralist woredas		
Total	121.96	117.74	221.93	82,398	79,260	237,712

Source: FMOH (2008)

#### **2.7.1.4. Remove Overall Health Systems Constraints**

The ultimate goal of health insurance is to improve health status through increased access to quality health services. CBHI schemes can only be successful if members have access to good quality care, which depends on the performance of the overall health system. The findings of this evaluation imply that government should continue investment in removing health system constraints. There is also a need to improve the availability of drugs and medical supplies by closely working with PFSA. Finally, it is clear that CBHI increases health services utilization by beneficiaries; thus, there is a need to design mechanisms to address complaints by and create incentives for health workers in reference to the additional work burden that increased utilization will mean for them, (ibid, 2015).

#### **2.7.2. Enrollment & significance of CBHI in Ethiopia**

In Ethiopia, there is an old tradition called idir or kire of community organizations providing financial help to families for emergencies, like funerals. But a new form of “idir/kire” nicknamed “edir/kire while alive” is gaining traction as the Ethiopian government pursues its goal of providing universal health coverage. That scheme is community-based health insurance or CBHI. CBHI is health insurance that pools members’ premium payments into a collective fund, which is managed by the members, and covers basic health care costs at local health centers when a member is sick. The insurance is even accepted at hospitals when a member is referred by the lower level health facilities “Now the CBHI scheme helps us to get treated when we get sick rather than waiting until we die to support our funerals,” said a farmer in Tehuldere district, Amhara, (Ethiopian Herald , 2015)

Piloted in 13 districts or woredas in Amhara, Oromia, Southern Nations Nationalities and Peoples, and Tigray, CBHI has been well received by the communities since being introduced in April 2012. More than 144,000 eligible households have enrolled and more than 650,000 beneficiaries have accessed health services. Most of the services have been accessed at local health centers, but some beneficiaries have also been seen at hospitals, following referral, (ibid).

Piloted in 13 districts or woredas in Amhara, Oromia, Southern Nations Nationalities and Peoples, and Tigray, CBHI has been well received by the communities since being introduced in

April 2012. More than 144,000 eligible households have enrolled and more than 650,000 beneficiaries have accessed health services. Most of the services have been accessed at local health centers, but some beneficiaries have also been seen at hospitals, following referral. CBHI primarily covers essential health service packages at the health center level. The benefits includes both inpatient and outpatient services. All types of essential health services that would be covered through out-of-pocket spending at time of sickness are covered by CBHI schemes. Due to CBHI's initial success, the EHIA decided to scale up CBHI to an additional 161 districts, with technical support from the HFG Project while the CBHI schemes in 13 districts are under evaluation to inform more people about CBHI and its financial protection benefits, the EHIA recently launched a national communications campaign, (EHIA, 2015).

Based on lessons learned from the current scale-up, the EHIA plans to extend CBHI to over 800 woreda's in Ethiopia's quest to achieve universal health coverage for its people. From this we can conclude that their acceptance of CBHI by the community as whole so they have willingness to join the membership of this is one of good pave for EHIA in order to expand the schemes to unreached woreda so this is a track to meet universal health coverage.

According to EHIA study on pilot woredas, the major features of the Ethiopian CBHI pilot scheme include:

The decision to join the CBHI scheme is made collectively at the kebele/tabia level with the direct participation of the kebele/tabia population. However, actual enrollment to scheme happens when the household decide to pay contribution.

CBHI will have sections in each kebele/tabia. The association of these kebele/tabia sections will form the woreda-level CBHI scheme.

Woreda CBHIs are integrated and work within the woreda administration office, and will be responsible for pooling and administrating CBHI funds, contracting with and processing reimbursements for health service providers. To ensure schemes are accountable to their members, woreda-level boards will be established that will comprise members of the CBHI.

The bylaws, endorsed by each CBHI scheme, provide the legal status supported by the federal health insurance strategy and regional CBHI directives.

General and targeted subsidies are an integral part of the design of the pilot scheme. A general subsidy is provided to all members of the CBHI by the federal government, while a targeted subsidy from the regional and woreda governments is provided to the very poor who cannot afford to pay the contribution.

The federal government has also provided resources for investing in CBHI contracted facilities to make sure that the service providers have some acceptable quality of care when services to members of the CBHI starts.

**Table 2.4 Major Parameters of Ethiopian CBHI Pilot Schemes**

No	Major Parameters	Federal Guidelines	Regional Adaptations			
			Amhara	SNNP	Oromiya	Tigray
1	Membership	Decision to enroll in scheme to be taken by kebele/tabia collectively	Membership determined collectively at kebele/tabia level based on majority vote	Membership determined collectively at kebele/tabia level	Membership determined collectively at kebele/tabia level based on majority vote	Membership determined collectively at kebele/tabia level based on majority vote
			Membership also based on household level	Membership limited to 5 HH members	All core family members (father, mother, and children under 18); households who wish to enroll children over 18 years of age pay Birr 30 per child.	Membership also based on household level
2	Registration fee and premiums	Registration fee set by regions	Fee of Birr 3 per HH	Fee of Birr 5 per HH	Fee of Birr 5 per HH	Fee of Birr 5 per HH
		Premium set by regions	Premium payment of 144 per family per year	Premium payment of 10.50 per month	Premium payment of Birr 180/ core family members and Birr 36	Birr 132 per household per year plus In addition

				per HH= Birr 126 per year	/additional noncore family member	Birr 30 per person/ year for dependents more than18 years of age.
3	Financing the very poor (indigents)	Regions and woreda pay registration fee and premiums of the very poor. Payment of this contribution covered 30% by the woreda and 70% by region.	90% of targeted subsidy from the region and 10% from the woreda. Beneficiaries selected with participation of the community.	No clear guideline by the region. Payment of contribution covered 100% by woreda. Beneficiaries selected with participation of the community.	No clear guideline by the region. Payment of contribution will be covered 100% by the woreda. Beneficiaries will be selected with participation of the community to ensure fairness and transparency.	70% of targeted subsidy from region and 30% from the woreda. A maximum of 10% of the eligible household will be selected.
4	General subsidy	Federal government finances 25% of enrollment contributions per year	Federal government finances 25% of overall enrollment contributions per year	Federal government finances 25% of overall enrollment contributions per year	Federal government finances 25% of overall enrollment contributions per year	Federal government finances 25% of overall enrollment contributions per year
5	Provider payment mechanism	Fee-for- service	Fee-for- service	Fee-for- service	Fee-for-service	Fee-for- service.
6	Housing of CBHI scheme		Woreda administration	Woreda administration	Woreda administration	Woreda administration
7	Benefit package	All services available in health centers and hospitals, excluding tooth implantation and	All services available in health centers and hospitals, excluding tooth implantation and eyeglasses	All services available in health centers and hospitals, excluding	All services available in health centers and hospitals, excluding tooth implantation and eyeglasses	All services available in health centers and hospitals, excluding tooth implantation

		eyeglasses		tooth implantation and eyeglasses		and eyeglasses.
8	Governance and management		Woreda CBHI board oversees the initiative. The scheme staff is employed by woreda administration.	Woreda CBHI board oversees the initiative. The scheme staff is employed by woreda administration.	Woreda CBHI board oversees the initiative. The WorHO assigns the curative core process owner as a coordinator in addition to his duties in the health office. Other CBHI executive staffs are employed by the woreda administration.	Governance and management

Source: EHIA (2015)

According to the data from the Health Sector Finance Reform/Health Finance and Governance (HSFR/HFG) project information system, the overall enrollment in the pilot schemes is 48 percent, with wide variation by woreda. Enrollment ranges from a low of 25 percent in Deder to 100 percent (universal enrollment) in Yirgalem5. The overall percentage of households registered as indigents is 7 percent, and ranges from 1 percent in Deder to 15 percent in Tehuledere and Yirgalem.

Figure 3.1: Enrollment Rate (%) and % of Indigent HHs Registered as Members, June 2013

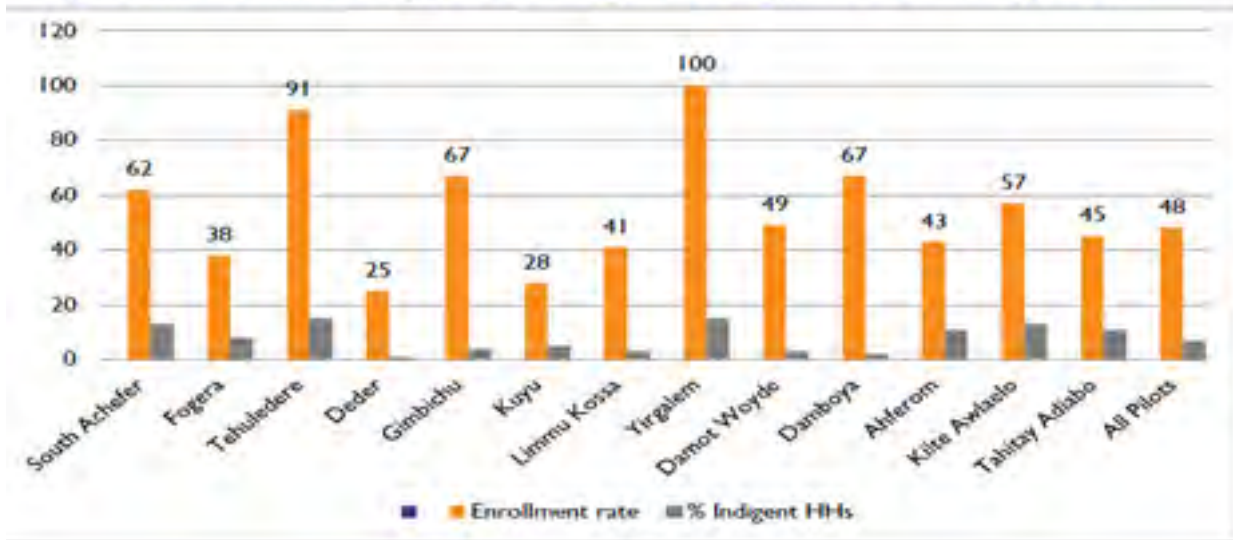


Fig: 2.2 Enrollment rate (%) and indigent HHs registered as members, June 2013

Source: HSFR/HFG

Looked at from the regional perspective, households enrollment rate ranges from 61 percent in SNNP to 36 percent in Oromia.

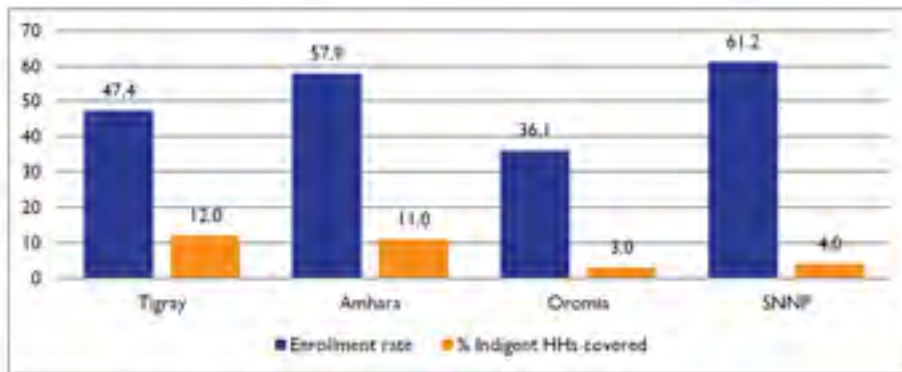


Figure 2.3 Regional Enrollment Rate and % of HHs Registered as Indigents, June 2013

Source: HSFR/HFG Project cited by EHIA (2015)



**Figure 2.4** Framework of analysis

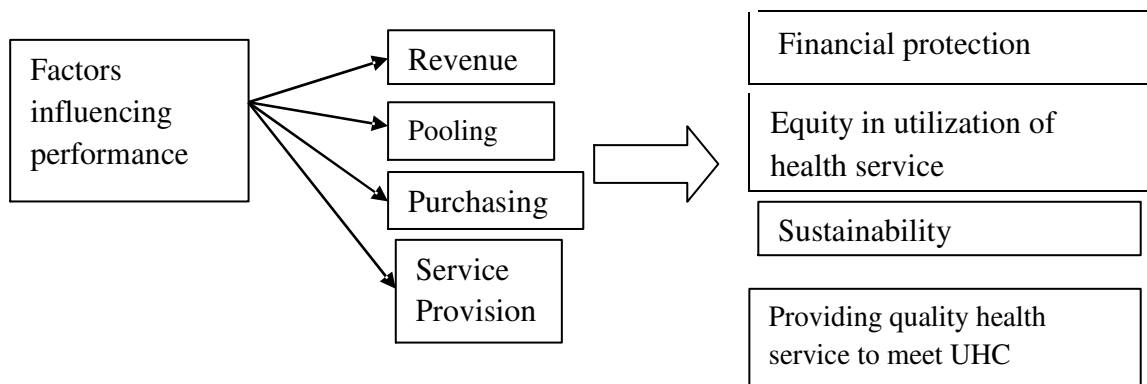
Source: Guy, (2003).

Conceptual frame work sketched in the above frame work showed that main factors influencing the performance of Community health insurance are revenue, pooling & purchasing that have direct impact on health system goal such as financial protection, equity in utilization & sustainability. But based on the given frame work for this purpose of this study the framework is adopted or modified as follows.

*Performance in health*

*Health system goals*

*Financing sub-function*



**Fig2.5:** Own conceptual frame work

## **Chapter Three**

### **3. Research Methodology & Methods**

The earlier section presented reviews of literature on Community based health insurance practice & challenges. The literature review shows that there was no sufficient study conducted on the CBHI practice & challenges in Ethiopia, particularly no research conducted in case of Aleltu district & its Ganda's /local villages. For this study the researcher selected five Gandas/local villages in which the CBHI is practiced.

The primary data were collected from field survey: a structured questioner was developed and administered in order to gather detailed information, followed by observation, structured interviews with the woreda CBHI employees & Finfine branch manager of CBHI were interviewed.

The purpose of this part is to present the detail way this research designed, the main principles of research methodology & the research method of the research used in this study.

#### **3.1. Research Design**

The design selected for research should be the one most suited so as to achieve an answer to the proposed research question Parahoo, (2006)cited by Diriba, (2013). For this particular study the researcher collected both qualitative & quantitative data on the CBHI practice & challenges. This research study used the descriptive method of study. It presents facts & reality about the CBHI practice & challenges at existing condition in the area of the study.

Statistical analysis of the research was descriptive statistics to reveal the current situation on the CBHI practice & challenges.

The main survey instrument used for this study was questionnaire. The use of the survey allowed the collections of large amount of data from large population in highly economic way as Saunders et al (2009: 144) cited by Diriba, (2013). The data analyzed quantitatively & qualitatively using descriptive.

### **3.2 Study & sample population**

The targeting/participants for sources of primary data via questioner & interview were beneficiaries/ households of Aleletu Woreda & Employees of community based health insurance found in Aleletu woreda & head office of Ethiopian health insurance. The participants for the interview case were selected by using purposive sampling but beneficiaries were selected out of five selected local village by using simple random sampling technique by lottery method the five Gandas /local village were selected out of twenty three Gandas by using stratified sampling technique the villages were stratified in to two; those enrolled as good & those enrolled as less. According to woreda CBHI office among those Kebeles enrolled as good include Gora, maru, Mikawa, & Sagani-sagda, from this kebeles top three kebeles on their performance on enrollment of community based health insurance were selected those are Maru, Mikawa, S/Sagada were down. But Ejersa & W/Darra were among the less enrolled kebeles on community based health insurance among the twenty three kebeles.

The total study population is 600 the sample population has been drawing using appropriate sample frame & sample size determination as mentioned below. The researcher selected Aleltu woreda due to it is among the good enrolled woredas in Ethiopia & it's nearest to Addis so appropriate for data gathering & observation personally. The case kebeles as indicated in the above is selected from the two strata's good enrolled & less enrolled kebeles.

### **3.3 Sample Design**

#### **3.3.1 Sample & Sample size determination**

The rule of thumb cited in Kevin Durrheim, (2006) was used 30% of sample size for small population up to 1000.

Therefore, the primary data for this study have been collected from 150 households/beneficiaries of community based health insurance. According to the data of woreda CBHI the total number of population in the selected villages were 600 among them those households enrolled above one year were 500 hence, purposively I exclude those households enrolled less than one year in order to get very depth information from those have good enrollment & stay with time on scheme

packages from selected stratified Ganda"s/kebel"s thus the researcher has randomly selected 150 respondents (30%) for the data collection through the questioner from the households.

### **3.3.2 Sampling Techniques**

The technique of sample selection used was stratified sampling technique; it was used to minimize the bias of data collections from each Gandas/ local villages and the population in each sample was sub-divided into subpopulations or strata.

Since the population is homogenous in nature a simple random sampling technique was conducted within each of the strata and the samples selected from each stratum by using lottery technique & were combined together and gave sample that represented the population of the study.

Such sampling method is more efficient than either simple random sampling or systematic sampling because they ensure representations of individuals or items across the entire population which ensures greater accuracy in the estimates of underlying population parameters, David M. Levine et al, (1999) as cited by DiribaA., (2013).

The method of data collection employed gave equal chance of being selected for each strata members which has enabled the researcher to acquire the required information from all levels to reduce coverage error which comes from exclusions of certain groups of the populations.

The researcher used two methods of selecting the sample for this study, both probabilities sampling and non- probability sampling technique.

The probability sampling used to select samples of the households from the selected 5 Gandas/ local village under the investigation. The researcher has also used the non-probability sampling to select the employees of CBHI, Accordingly 3 employees of CBHI from woreda were selected & one from the EHIA (Finfine Branch manager).

**Table 3.1 shows the population & sample selection of the study**

Name of Gandas/ local villages	Total Population	No of respondents
Gora	100	35
Mikawa	150	40
S/segeda	100	35
Ejersa	60	15
W/dera	90	25
Total Population	500	150

The researcher has hand-picked respondents interviewed question from the Aleltu woreda of community based health insurance employees. Normally, community based health insurance scheme have three employees (coordinator, accountant, data encoder), here for the interview purpose these employees were taken together with CBHI Finfine branch manager from the Ethiopian health insurance Agency.

**Table 3.2 Profile of the officials (employees)**

No. of interview	Sex	Education	Status
1	F	BA	Accountant
2	M	BSC	Data Encoder
3	M	BSC	Coordinator
4	M	BSC	CBHI Finfine branch manager

### **3.4 Types of data and data collection Technique**

#### **3.4.1 Types of data**

This research is based on primary and secondary data collected from primary and secondary sources.

#### **3.4. 2 Primary data collection Technique**

**Questionnaire:** Self-administer questionnaire was designed and administered to 150 individuals selected based on sample selection technique outlined above. The questionnaire has structured

nature & was self-administered. It includes both open ended and close ended questions. The actual data was collected from Feb. 1-Mar. 4, 2017. At Mikiwa town & other neighboring gandas/kebeles found in Aleltu woreda.

**In-depth interview:** the researcher has collected data through in-depth interview from 4 individuals in the woreda and head office (Ethiopian health insurance, Finfine branch office) for triangulation purpose. Respondents contacted for the in-depth interview were selected purposively by the researcher as key informants on the basis of their closeness to the implementation (enrolment) of community based health insurance. The interviews were held on Feb, 28-March 3, 2017 at Aleltu Woreda (Mikiwa town) & Addis Ababa head office of Ethiopia health insurance agency respectively.

### **3.5 Secondary data collection Method**

In this study, information from the secondary sources of data have been collected from different published and unpublished materials which include government official documents such as health plans, reports, and evaluation checklists, manuals, and performance evaluation reports of woreda on community based health insurance enrollment have also been used as inputs of main sources of secondary data.

#### **3.5.1 Data Analysis Methods**

The researcher has applied both qualitative & quantitative data analysis methods depending on the nature of the data collected. The data gathered through structured questionnaire were processed via SPSS (Statistical package for social science) of version 21 in order to generate descriptive statistics result & expressed through descriptive way such as frequency, percent, mean & standard deviation. The qualitative data gathered through interviews, using open ended questions of the questioner and document review were analyzed via categorization or type of the question item (gadgets) as putted in the questioner & interview.

### **3.6 Data Presentation Modality**

The result of the study from the questioner has been presented via frequency, percentage, mean & standardization. Data collected via interview in the form of case stories with direct word of the respondents were presented in the analysis part.

### **3.7 Ethical Consideration**

According to Brynard et al (1997) as cited Shafudah, (2011) it is unethical to a researcher to present a biased report or not to report the truth as it is. Required information about the research has been written on the cover page of the questioner & interview so the information provider can read it & understand before they provide the required information. The questionnaire is translated to the language of the respondent's i.e. Afan Oromo in order to make the questioner easily understandable & clear.

In order to ensure the application of this principle, a form was provided to the participants who outlined, for the participants' clarification, the study's purpose, potential risks and benefits of participating in the study, as well as statements about confidentiality. Respondents of the research were informed about the purpose of the study and personal information is kept anonymous. Undertaking research study conducted elsewhere by somebody is plagiarism so here any cited paper for the purpose of this study is given credit for that specific author.

**Political Map of Northern Shoa Zone**



**Fig: 3.1 the study area of the research**

## **Chapter Four**

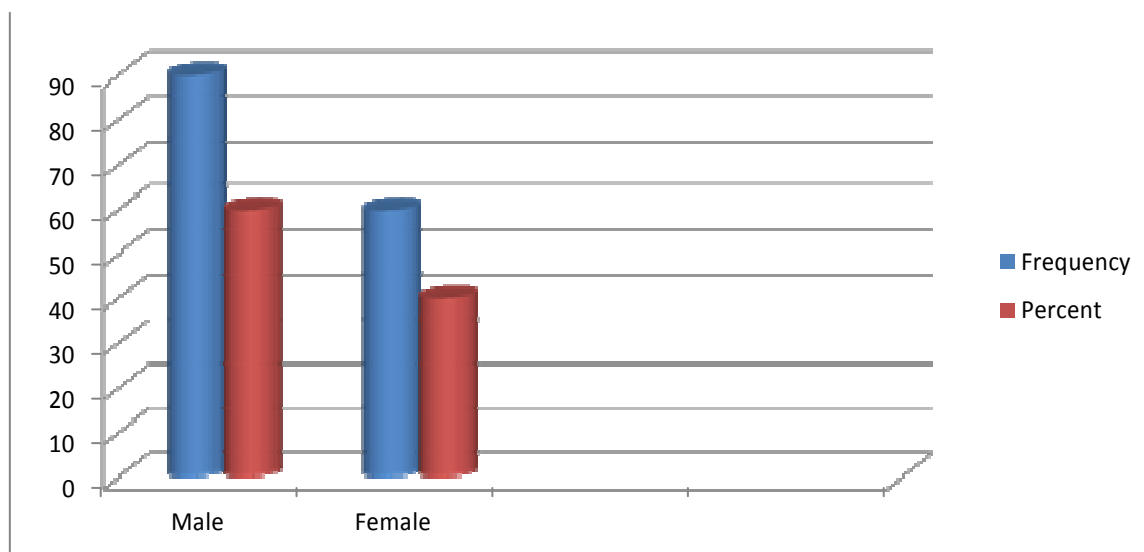
### **4. Data Presentation and Analysis**

#### **4.1 Introduction**

This part of the paper presented and analyzed the data collected to seek appropriate answer for the basic questions raised under chapter one of this study. In order to collect the primary data interview was conducted with concerned employees of the CBHI & questioners were distributed to collect data from the beneficiaries (members of CBHI). The output was processed using the SPSS version 21 to get frequencies & other descriptive statistics. Data have been collected from the beneficiaries of CBHI that have stayed at least for the past one year as membership within the CBHI & the interview data was collected in-depth interview with the district CBHI workers & branch manager of CBHI Finfine branch office. Thus, this section presents the results of the primary data collection tool"chiefly questioner & interview. The results are arranged in line with the research question, literatures review & logically constructed questioners. The results are presented in tables, pi-chart, histogram & graph to show frequency counts, percentage& Statistical descriptive such as mean & standard deviation for each question and followed by narrative explanations by supporting the explanation with interview results as well as necessary secondary data triangulation has been made to support the explanation.

#### **4.2 Background of the respondents**

As indicated in the fig 4.1 of below, 40 % (60) of them was female beneficiaries of community based health insurance in the Aleltu district. The percentage of male respondents constitutes the largest part that is 90 (60%) of the total respondents. This shows that majority of enrolled peoples in CBHI in the selected Ganda"s/ villages is male than female households



**Fig 4.1: Gender of the respondents & its distribution**

Source: Own survey data (2017)

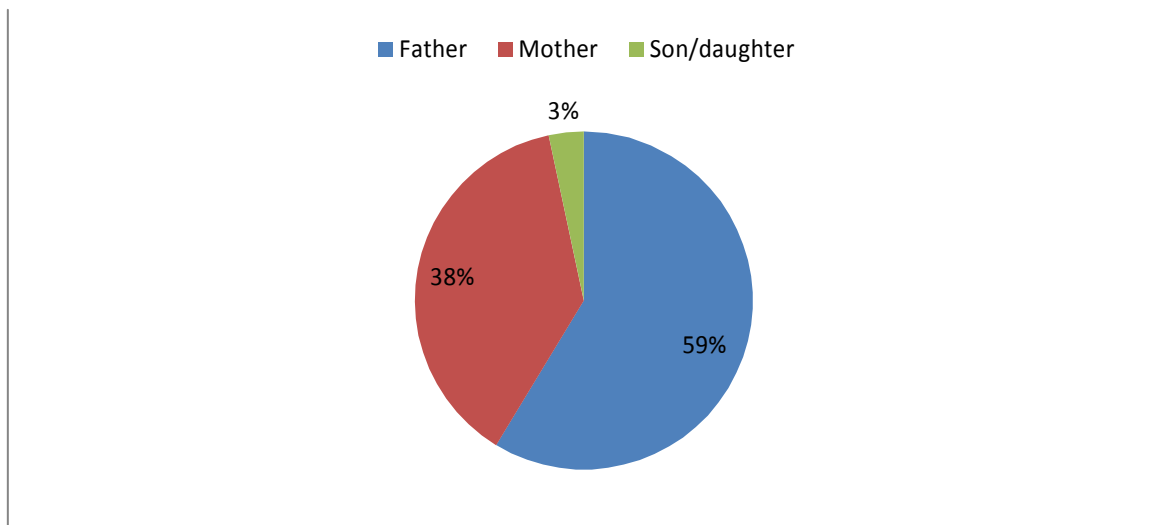
In regarding the age distribution of the respondents 20% of respondents are within the age range of 18-48; 26.7% are within the age range of 49-69 years old whereas the rest 53.3% of them are within the age range of 70-90. As Hilina, (2014) & different conducted studies shows that Age is determinant factor for the households enrolling in the CBHI. As people getting older in age they need security/guaranty for their health so they will become the member of this insurance in order to get health service from the health institution through their premium payment.

**Table 4.1: Beneficiaries Age related distribution**

	Frequency	Percent	Valid Percent	Cumulative Percent
18-48	30	20.0	20.0	20
Valid 49-69	40	26.7	26.7	46.7
70-90	80	53.3	53.3	<b>100</b>
Total	<b>150</b>	<b>100.0</b>	<b>100.0</b>	

Source: Own computation (2017)

Regarding the relation of the respondents to the households as indicated in fig 4.2 below among total respondents 58.7% of them are the head of the family (father) to that particular family whereas 38% of them are mother for that particular family respondent's but the rest 3.3% of them belong to daughter/son of the family. This suggested that those family headed by the male is more enrolled than those of female headed that support the above data indicated in the gender of the respondents male respondents are more enrolled than female respondents this is true in terms of head of family. Those family headed by father become more enrolled than women headed family.



**Fig 4.2 reation of the respondents to household**

Source: Own comupation (2017)

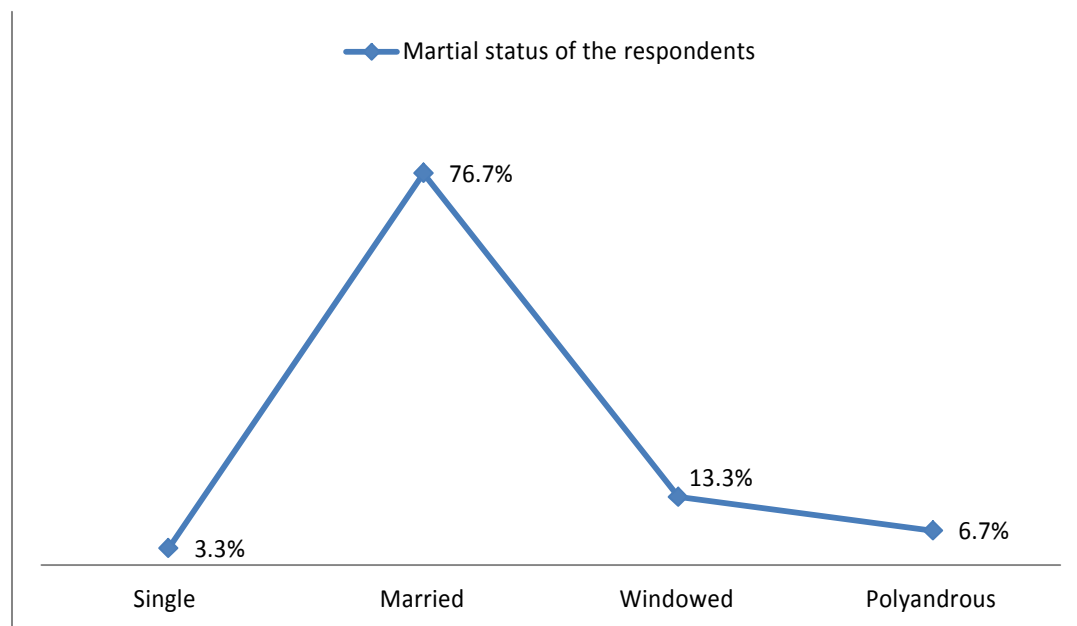
Concerning marital status of the respondents, as it can be seen in table 4.2& figure 4.3; only 3.3% of them are not married yet they are bachelor, however 76.7% of them are already married respondents but 13.3% & 6.7% of them are windowed & polyandrous respectively. This shows that among the majority of the respondents (96.7%) of them are not bachelor from this 20% of them lost their wife/husband so, currently they are living with their children. As different studies shows that marital status is an important factor for being enrolling &to renew CBHI membership (To stay within the CBHI). As the data at hand shows that majority of the respondents are married households currently, enrolling in the CBHI. This suggested that household's having

children (own family) is need to be secured than those of have not their own family (Children or not married). The marital status is one of the factors to enroll & stay in the insurance scheme.

**Table 4.2: Martial status of the respondents**

	Frequency	Percent	Valid Percent	Cumulative Percent
Single	5	3.3	3.3	3.3
Married	115	76.7	76.7	80
Valid Windowed	20	13.3	13.3	93.3
Polyandrous	10	6.7	6.7	100
<b>Total</b>	<b>150</b>	<b>100</b>	<b>100</b>	

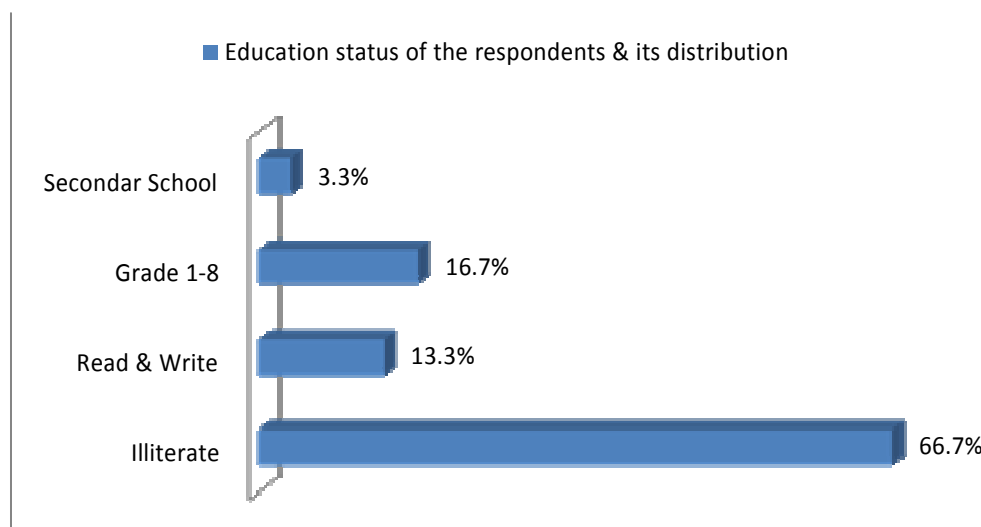
**Source: Own computation (2017)**



**Fig 4.3 Martial status of the respondents**

**Source: Own computation (2017)**

Regarding, the education status of the respondents, as it can be seen in the fig 4.4; only 3.3% of them are completed secondary education level where as 16.7% of them completed elementary school (1-8); whereas majority of the respondents 66.7% of them are illiterate they couldn't write & read the rest of them 13.3% of them can read & write or they can understand specific written material. On increasing the level of understanding & knowledge about CBHI level of education is important as data in table below shows that only 33.3% of them are not illiterate this can make the households level of knowledge differ from each other. The impact can be positive on the CBHI since educated households can easily understand & will have good knowledge on CBHI than those of illiterate.



**Fig: 4.4 Educational status of the respondents & its distribution**

**Source: Own Computation (2017)**

Regarding, the occupation of the respondents; as table 4.3 below displays that 63.3% of them are engaged on agricultural activity, 13.3% of the respondents are housewife where as 6.7% are engaged on trade (self-employed), however 6.7% of them are laborer however 10% of them are engaged on other (private). This shows that out of total respondents 60% of them are leading their life by agricultural activity the prime focus of community based health insurance is rural peoples engaging on informal activities of the economy for this matter the scheme is focused on farmers & some non-formal active.

**Table 4.3: Occupational status of the respondents**

	<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
Valid Farmer	95	63.3	63.3	63.3
Housewife	20	13.3	13.3	76.7
Trade	10	6.7	6.7	83.3
Laborer	10	6.7	6.7	90
Other (Private)	15	10	10	100
<b>Total</b>	<b>150</b>	<b>100</b>	<b>100</b>	

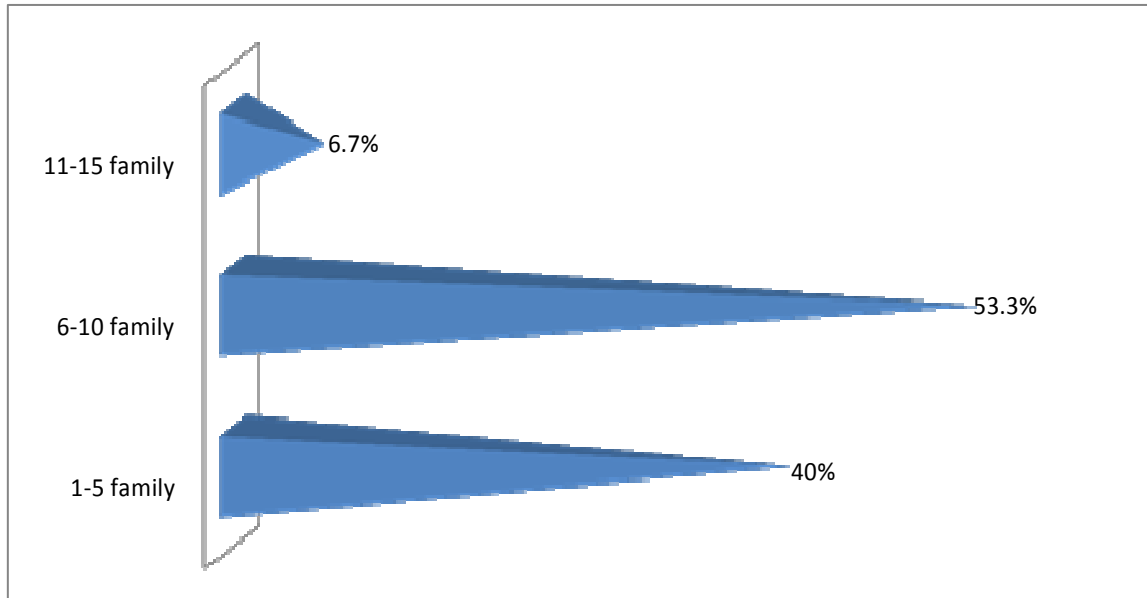
**Source: Own computation (2017)**

On the other hand, regarding the family size of the respondents as fig 4.5 shows that 40% of the respondents have children's 1-5 in number; whereas 6.7% & 53.7% of them have number of children ranges between 11-15 & 6-10 respectively. This shows that majority of the respondents or 60% of them have beyond half dozen of children's. As different literature Such as Guy, (2003) shows that family size can be considered as factors responsible for the poor access to health service & patients satisfaction in less developing countries. As survey of 2009 that conducted by WHO shows that in Ethiopia the number of hospital beds per 10,000 people were 2 which are very small as compared to other sub-Saharan African countries.

On this aspect the interview question was conducted (Presented to employees) on the impact of large family size on those have less family size on getting the service by their membership of CBHI they responded that „For now the impact is insignificant since the scheme is subsidized by the federal government in addition to premium payment contributed by the non-indigent member of the CBHI“.

According to the CBHI design, there are three types of government subsidies to the schemes: targeted and general subsidies, and financing the scheme management costs (salaries, office space, and operational costs). The regional and woreda governments finance premiums of indigents using different arrangements. In SNNP and Oromia, woredas finance all the costs of indigents.

Woreda governments also finance the salaries and operational costs of all schemes. The federal government subsidizes 25 percent of the CBHI premiums, for both paying and non-paying members, (EHI 2013: 21).



**Fig: 4.5 Family sizes of the respondents**

**Source: Own computation (2017)**

Vis-à-vis Number of children's both less than 18 & above, as table 4.4 below demonstrate that only 20% of the households have children's greater than eighteen years old whereas 80% of the respondents have minor children. One house hold can get free of health service via premium payment with their family without the limitation of number of minor children's where as if they have children's garter than 18 years old they will be asked to pay additional payment for their children's. In this data only 20% of the households have been paying additional premium payment for their children's.

Currently, SNNP region fixed that one house hold can get free of health service with their minor children the free health service is possible only for six minor childrenbut if they exceed the number they will pay additional amount of birr. Such kind of payment system is not applicable in Oromiya regional state. This also true for the Aleltu region there is no quota for minor children's



on getting health service. In long run this will have negative impact on the scheme in terms of health cost coverage & service provision, (EHIA, 2015).

**Table 4.4: Number of children's  $\geq 18$  &  $< 18$  years old.**

	<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
Valid <18	120	80.0	80.0	80.0
$\geq 18$	30	20.0	20.0	100.0
<b>Total</b>	<b>150</b>	<b>100.0</b>	<b>100.0</b>	

**Source: Own computation (2017)**

### **4.3. Beneficiaries (insured household's) response on CBHI**

In this particular section of the paper, the data related with the study is presented & analyzed in a very detail way. For this matter, data is collected from interview & questioner in relation to the title under the study.

For the connivance purpose, the presentation & analysis is categorized in to four major dimension"s awareness level of the community, households health status & income, CBHI its challenges & enrollment, & finally Community Participation in CBHI programs

#### **4.3.1 Awareness level of Community on the concept of Community based health insurance**

In this sub-section of the paper data were collected from the questioners, & relevant documents that are related with awareness level of community on the CBHI practice & enrolment. The data are presented & discussed as follows:

The major demand side factors traced out are lack of awareness regarding the benefits of the scheme, outpatient care is excluded, coverage is not enough, provider choice is limited, not happy with the public health facilities etc. The supply side factors are delay in getting funds from government, less incentive, over work load etc. Moral hazards were less compare to other insurance schemes, (Nair D. 2015).

A good understanding of health insurance may lead to a greater appreciation of the potential usefulness of such a scheme and knowledge of the manner in which the scheme operates may make it easier for households to obtain benefits, (Angaw, 2015).

There is some evidence that households with greater knowledge of health insurance and a greater understanding of the scheme is more likely to continue as CBHI membership. The analysis shows that greater knowledge of health insurance and a greater understanding of the scheme boost scheme retention, (ibid: 180).

Regarding, this beneficiaries were asked their understanding on the CBHI & their response is analyzed & interpreted below.

**Table 4.5: Response on: Do you know Community based health insurance**

		<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative</b>
Valid	Yes	150	100.0	<b>100.0</b>	<b>100.0</b>
	Total	<b>150</b>	<b>100.0</b>		

**Sources: Own computation (2017)**

The finding indicates that all of them (100%) of the respondent"s know the community based health insurance. This indicates that the respondents are aware of or have knowledge of Community based health insurance scheme so it is not new idea or concept for respondents. Generally, good awareness creation activities are performed in the Aleltu district & there is no problem (lack) of knowhow of the society on the community based health insurance. As bulk of literatures conducted on CBHI enrollment showed that among factors contributing for good enrollment of CBHI is creating awareness of the households regarding the scheme this contribute for the sustainability of the insurance by avoiding the drop out of the member. A greater understanding of health insurance, and in particular knowledge of the CBHI scheme, is expected to support retention. Regarding the awareness creation of the household on CBHI Aleltu woreda is good for this matter data gathered in the table 4.5 can justify this statement.

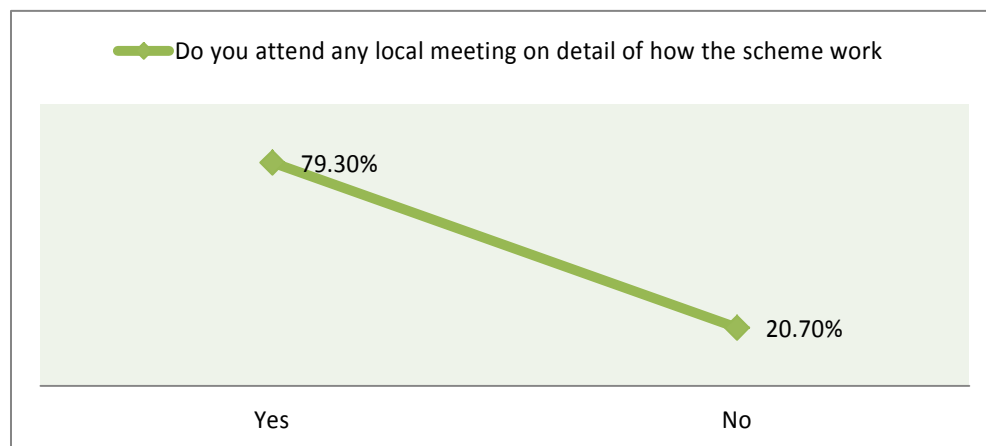
**Table 4.6: Response on: Do you attend any local meeting on detail of how scheme work CBHI?**

Despite the number of meetings attended and the high percentage of correct responses, the single most important reason for dropping out was lack of awareness about the details of how the CBHI scheme works, (Angaw : 157).

Visa-a-visa this fact the beneficiaries were asked whether they have attend meeting on awareness creation on how the CBHI scheme works. The responses of the enrolled member collected via questioner are presented in the table below& their response is interpreted under this table.

		<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
Valid	Yes	119	79.3	79.3	79.3
	No	31	20.7	20.7	100.0
<b>Total</b>		<b>150</b>	<b>100</b>	<b>100.0</b>	

**Source: Own computation (2017)**



**Fig 4.6 Do you attend any local meeting on detail of how the scheme work**

**Source own computation (2017)**

Pertaining to local meeting participation on CBHI as table & fig. 4.10 above indicates that among total respondents only 20.7% of them report that they are not participated (attend) in any

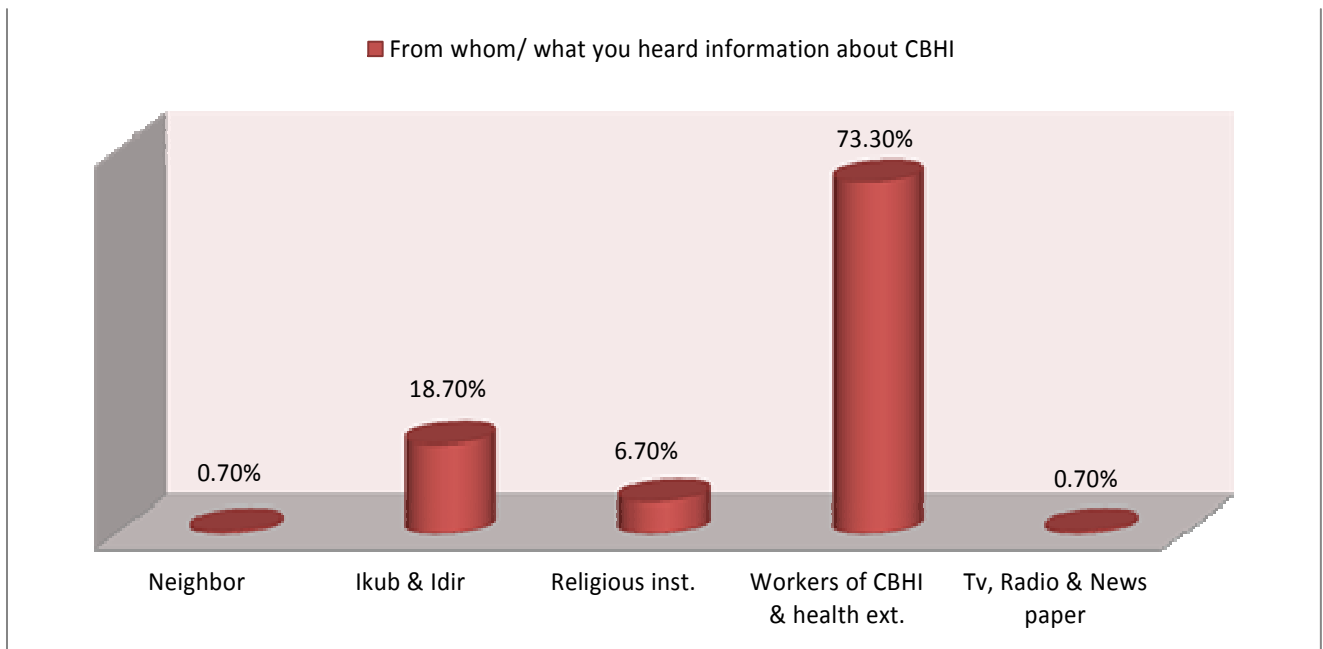
local meeting on CBHI where as 79.3% of the respondents are participated in local meeting about CBHI. This shows that good activity has been performed by the woreda CBHI on arranging meeting to the society on CBHI. As the above survey data shows that majority of the respondents are participated on the meeting at their local villages about how the CBHI works.

Arranging different local meeting play crucial role on awareness creation & raising the level of knowledge to the households. This can foster the sustainability of the CBHI by increasing the enrollment rate of the scheme in less enrolled area, (Angaw, 2015).

**Response on: From whom/what you heard or received information on CBHI**

Different awareness creation tools are used in order to raise the understanding level of the society such as Village officials, community leaders and health workers provide information about health insurance by moving door to door, at churches and mosques, and during other social gatherings. In addition to these, the scheme used documentary films, local mass media, amplifiers, amateur artists, pamphlets, posters, and T-shirt advertisings for awareness creation and community mobilization, (Angaw, 2015).

Below beneficiaries/ insured household were asked how they heard about the CBHI. Hence the feedback of the respondents putted in the following fig as follows.



**Fig: 4.7 from whom/what you heard about CBHI**

**Source: Own computation (2017)**

In the above fig. 4.7 beneficiaries were asked how they become aware about the community based health insurance here only 1.4% of them got the information regarding the CBHI via their Neighbors & TV, radio & Newspaper sources. However, majority of the respondents got information about the CBHI from the employees of woreda CBHI & workers of health extension which accounted 73.3% from the rest of respondents, whereas the rest 18.7% & 6.7% of respondents become aware via their „Ikub & idir“, & religious institution. Therefore this shows us the woreda CBHI workers in collaboration with health extension workers they are highly working on awareness raising activities. All of the respondents participated in this study have know-how about the concept of CBHI (fig 4.10). So this is the result of awareness creation activity made by the office. Different awareness rising tools are used in different countries in order to boost the understanding level of the society for instance in India Kudumsaree group & In Rawanda Performance based financing (PBF) in facilities to provide an incentive to health workers to improve service quality. The government is using various mechanisms (tools) in order to create the awareness of the household this is good mechanism since the health insurance

strategy is new to our country it requires awareness creation activities especially in uncovered areas.

**Table 4.7: Response on: Enrolling in community based health insurance has advantage**

CBHI primarily covers essential health service packages at the health center level. The benefits include all services available in health centers and hospitals, excluding tooth implantation and eyeglasses, (EHIA, 2015).

Below, beneficiaries were asked to answer whether enrolling in the community based health insurance has advantage. Accordingly the following data is the feedback of beneficiaries/ towards benefit of CBHI.

To calculate the point for each critical factor two considerations were taken in to account: the score for each significant element of the factor, and the weight for each significant element. A score of `5" (strongly agree) would yield a full mark of 5 towards that element; a score of "4 "" (agree) would yield a mark of 4 towards that element; a score of „3" (neutral) would yield a 3 mark whereas score of 2 (Disagree) would be 2 mark the last be „1"" (Strongly disagree) & would yield 1 mark.

	<b>Frequency</b>	<b>Percent</b>	<b>Cumulative Percent</b>	<b>Mean</b>	<b>Standard Deviation</b>
Valid Strongly Agree	40	26.7	6.7	4.2	0.543
Agree	100	66.7	73.3		
Neural	10	6.6	<b>100.0</b>		
<b>Total</b>	<b>150</b>	<b>100.0</b>			

**Source: Own computation (2017)**

According to the survey finding of table (4.7) of above majority of the respondents or (96.6%) of them believed that enrolling in the CBHI scheme has advantage. This suggested that majority of the respondents are enrolled with understanding of the scheme benefit. CBHI schemes are designed for people who live and work in rural areas, or in the informal sector. Most often, these

people are unable to access adequate public, private, or employer-sponsored health insurance. Significantly, by reaching those who would otherwise have no financial protection against the cost of illness, CBHIs also contribute to equity in the health sector.

In the above table (4.7) the value of the mean 4.2 & standard deviation 0.543 obtained implying that the households are getting advantage & positive thing from the CBHI scheme.

As respondents were asked in open ended question (questioner part) to list main advantage they are getting from the CBHI:

Accordingly respondents stated that „we are saved from unplanned health cost, our health is improved, we are insured by health insurance we are paying yearly““. Hence, the households are getting benefit from enrolling in the CBHI Questioner/open ended question).

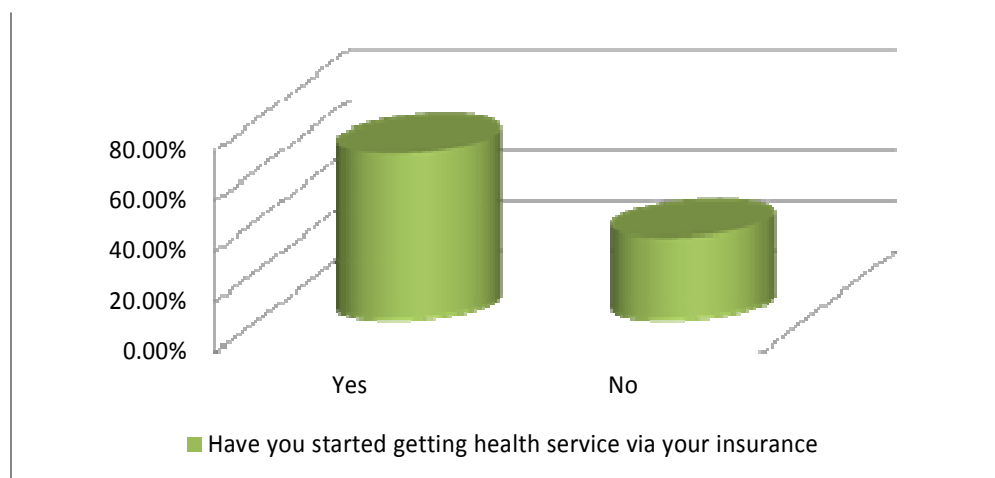
From the analyzed frequency, mean & standard deviation once can determine that respondents under consideration they are getting advantage as being enrolling in CBHI.

**Response to: Have you started getting health service via your insurance.**

In this sub-section of the paper beneficiaries were asked whether they have been started to get the health service through their membership to insurance scheme.

It is difficult to get the published conducted studies/ data concerning the insured members & the reasons why not yet now start to use the scheme.

To investigate this issue the beneficiary’s report is presented in this table & it is analyzed & interpreted as follows.



**Fig: 4.8 Have you started getting health service via your insurance**

**Source: Own computation (2017)**

Among total respondents or (66.7%) of them are actively using the community based health insurance when they become ill, so they are benefited from the scheme. Whereas 33.3% of the respondents so far not using the community based health insurance even if they are enrolling (insured) in the community based health insurance. In order to justify why they didn't still use scheme open ended question (under Q.No.5 Part II) were asked to list the reasons behind, according to them the main reason not using the scheme yet now is:

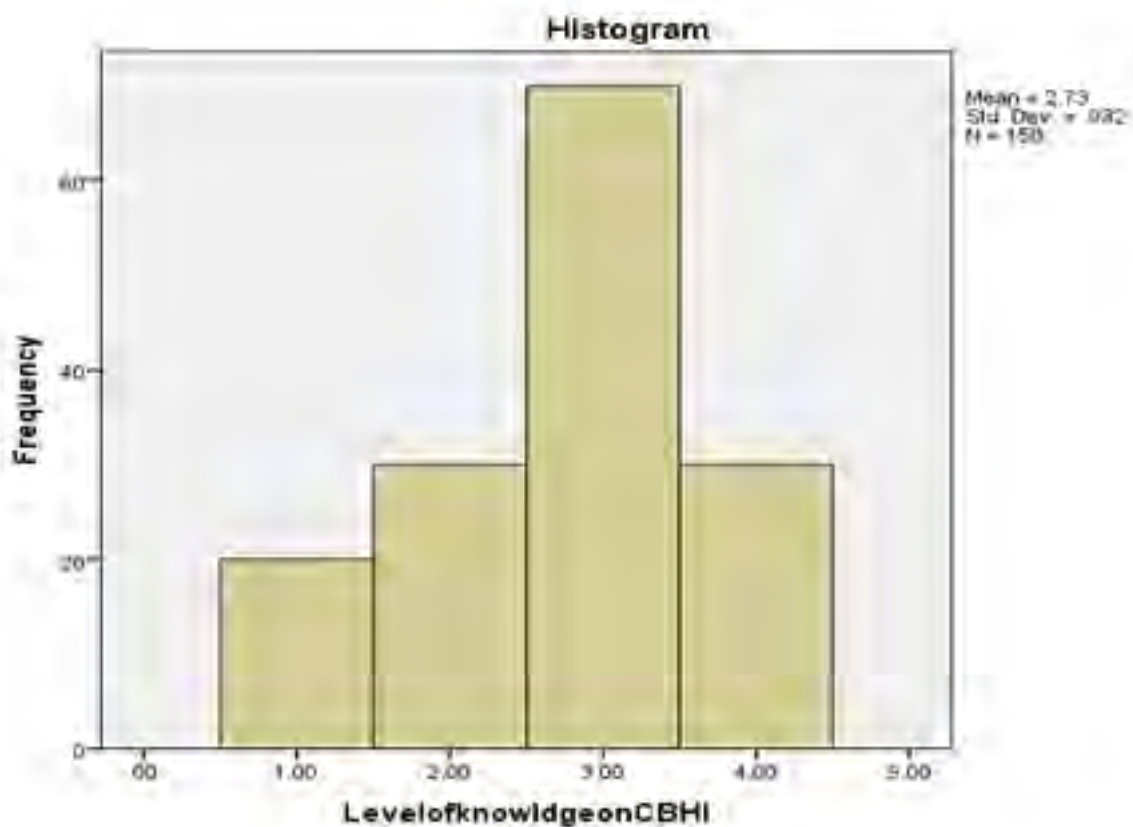
- „We prefer to go the private clinic (Due to having of enough income in order to cover the health expenses, Lack of trust (doubt) on the community based health insurance scheme & Lack of good health provision“ (Beneficiaries response).

This listed problem shows that still some permanent member of the beneficiaries have lack of trust on the scheme & the scheme packages so they didn't start using the CBHI yet or they prefer to use the out of pocket payment (OOP) for health expense through long run this have negative impact on the sustainability of the community based health insurance in the woreda since it will causes droop out that can result membership enrollment rate less.

**Table 4.8: Response to: Level of knowledge & understanding on the CBHI**

	Frequency	Percent	Cumulative Percent	Mean	Standard Deviation
Less	20	13.3	13.3	2.733	0.932
Medium	30	20.0	33.3		
Valid Good	70	46.7	80.0		
Very Good	30	20.0	100.0		
Total	<b>150</b>	100.0			

**Source: Own computation (2017)**



**Fig: 4.9 Level of knowledge on CBHI**

**Source: Own computation (2017)**

To calculate the point for each critical factor two considerations were taken in to account: the score for each significant element of the factor, and the weight for each significant element. A score of "4" (Very good) would yield a full mark of 4 towards that element; a score of "3" (Good) would yield a mark of 3 towards that element; a score of "2" (Medium) would yield a mark of 2 towards that element; "1" (Less) would yield a mark of 1 towards that element.

The findings of the survey from above table (4.8) shows that; among the total respondents 20% of them have very good understanding & knowledge of CBHI, however, 46.7% of the respondents have good knowledge & understanding of the CBHI whereas the rest 20% & 13.3% of them reported that they have medium & less knowledge of CBHI. This result shows that there is no equal understanding & knowledge about CBHI this can be resulted from different reason like Level of education, year of enrollment & training participation on CBHI at local community. The sum of those has less & moderate understanding on CBHI is 43.3% which is moderate level of understanding is there.

The result of the mean (2.733) is above average or medium (2) that support the frequency showed in the above table or it shows the moderate value on the level of understanding about the CBHI.

The level of knowledge the society possess can have impact on the active participation of the household on the CBHI when the society have sufficient participation they will develop loyalty & trust to the scheme. Possessing level of knowledge on CBHI vary from one member to the another this is due to level of education, exposure on participating on CBHI & year of enrollment (if they are new entries). Due to this the level of knowledge the households had on CBHI is differ from each other as shows in the above table (4.8).

#### **4.3.2. Households health status & income impact on the CBHI**

In this sub-section of study different question regarding the health status & income of the households & its relation with CBHI will be determined.

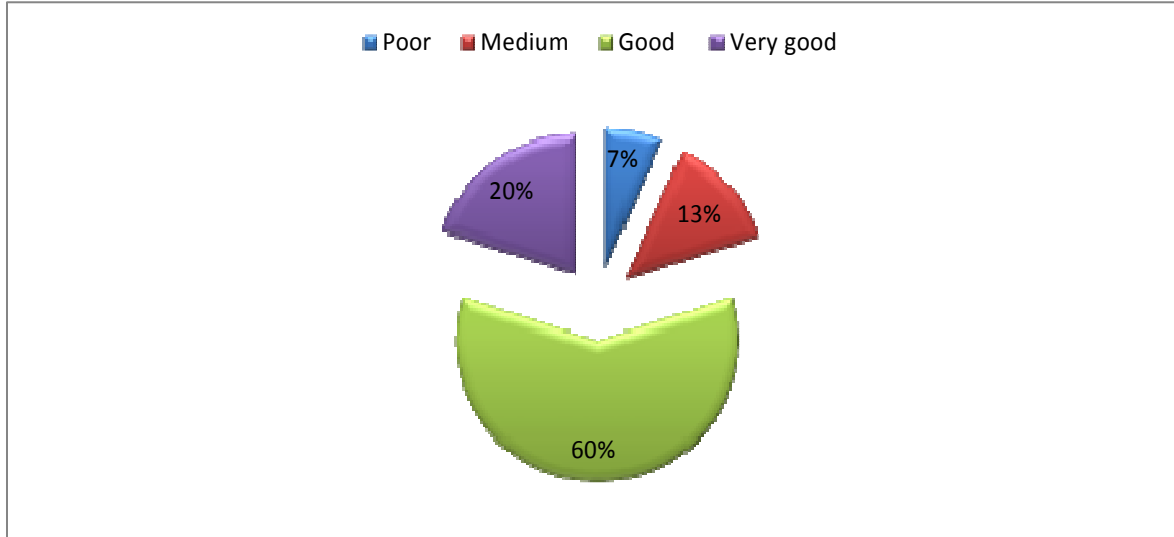
In third world countries the people attitude on their health is very poor. The people visit the health institution only when they are sick. Especially, in the rural areas such kind of trend is

much practiced. One of the determinant factors for enrollment of CBHI is poor health status of family (Existence of chronic ill).

Not unexpectedly given the voluntary character of CHIs, affordability (Income) of premiums or a contribution is often mentioned as one of the main determinants of membership. A number of schemes in the WHO Study had addressed the issue of affordability, (Guy, 2003).

Below Respondents were asked to state their health status & income (production per quintal) in order to assess its impacts on the CBHI practice. Hence based on the feedback of beneficiaries analysis & interpretation is given in this regard.

To calculate the point for each critical factor two considerations were taken in to account: the score for each significant element of the factor, and the weight for each significant element. A score of `4" (Very good) would yield a full mark of 4 towards that element; a score of "3 "" (Good) would yield a mark of 3 towards that element; a score of „2" (Medium) would yield a mark of 2 towards that element; „1" (Less) would yield a mark of 1 towards that element.



**Fig: 4.10 how do you rate the health status of your family?**

**Source: Own Computation (2017)**

As it can be seen in the above fig (4.10): among total respondents majority or (80%) of the respondents are healthier. This shows that the health status of the family is improving & become better hence it is good in terms of having healthier peoples mainly in rural areas. In the less developed country the attitude of the people on health is very poor they will not go to health centers or hospital till they become very sick even they will consider the checkup treatment as luxury or expenses made untimely so they prefer to go health institution when they become very ill. Therefore, the current health status have negative impact on the enrollment of the CBHI they may think how am going to simply pay the premium without I become (family member) sick they may consider as expense or extravagant than insurance of health for their life.

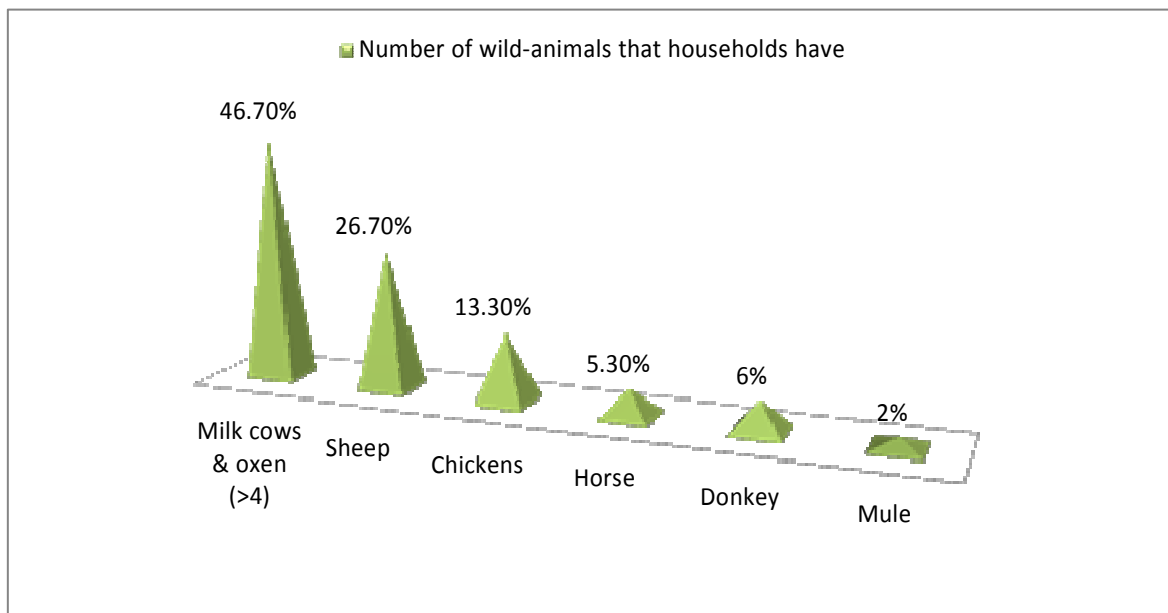
As the mean value (2.93) shows that the respondent's response on their health status is moderate; this data supports the frequency result found in the above table.

**Table 4.9: Response on: Products you produced**

	<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
ValidTeff (>=15 quintals)	80	53.3	53.3	53.3
Wheat (>=7 quintals)	40	26.7	26.7	80
Beans (>=10 quintals)	20	13.3	13.3	93.3
Barley (>=8 quintals)	10	6.7	6.7	100.0
<b>Total</b>	<b>150</b>	<b>100.0</b>	<b>100.0</b>	

**Source: Own computation (2017)**

From the total respondents 53.3% of them were produced grater or equal to 15 quintals of teff last year, however 26.7% of them were produced wheat beyond or equal to 7 quintal where as 13.3% & 6.7% of the respondents were produced beans & barley respectively. This show that majority of the households production capacity are good this suggests that households income is good. From total contribution made to scheme finance 30 % will be covered by the non-indigent member of the households the rest will be made by the government & donor. For this non-indigent member of household in order to get service via the scheme it is expected from them to pay the premium payment yearly to make so they should have income. Among decisive factor that make the households to reside within the CBHI is income. Majority member of CBHI is engaged on agricultural work so their only asset is crop production or animal husbandry. Hence, as the above data shows that the last year production capacity of the households on various listed crops is averagely good this have positive impact on the household decision to reside within the CBHI membership via paying the premium payment yearly.



**Fig: 4.11 Number of wild-animals that households have**

**Source: Own Computation (2017)**

Among the total respondents 46.7% of the respondents have Milk cows & oxen (>4); However, 26.7% of the respondents have 20 sheep's & the rest were 13.3%, 5.3%, 6%, 2% of the respondents have 25chicknes, 3 horses, 5 donkeys & 4 mules respectively. Among income generating activates in agricultural activity is animal husbandry; regarding this majority of the respondents were asked number of animals they have. Hence, majority of the respondents relatively have a number of listed animals including cattle. This has positive impact on the CBHI enrolment or to stay within the scheme by renewing their membership yearly.

#### **4.3.3. CBH, its challenges & benefits**

##### **Table 4.10: Response on: when you started enrolling in CBHI**

As part of its health care financing strategy in general and its health insurance strategy in particular, the Government of Ethiopia endorsed and launched community-based health insurance (CBHI) schemes in 13 pilot woredas in Amhara, Oromia, Southern Nations, Nationalities, and Peoples (SNNP), and Tigray regions in 2010/11 to provide risk protection mechanisms for those employed in the rural and the informal sectors. Three years on, the government has decided to scale up CBHI, with schemes in 161 woreda, (EHIA, 2013).

After three years of piloting, the government decided to expand CBHI schemes to 161 woredas of the country. Aleltu is among districts found in Oromiya that selected for scale up of CBHI. In Aleltu district the CBHI was launched in 2014. In this regard beneficiaries were asked when they started enrolling in the scheme & the initiating factors behind introducing the scheme.

Major initiating factors behind introducingthe CBHI in the woreda; according to the employees & official the reason for launching of CBHI in the Aleltu district is.

„federal government by being with Oromiya regional state it identified & decided the first expansion woreda“s based on some criteria such as population density, the regions performance during the pilot enrollment & pre woreda assessment so based on this criteria Aleltu district was selected as among the first expansion districts on CBHI & major initiating reasons behind CBHI the previous achievements on pilot woreda scheme enrollment was good & the government highly give emphases on CBHI enrollment as the data assessed in pilot woredas shows there is

high demand & interest by the households to enroll in the CBHI. Currently, CBHI identified as good finance mobilization in health care to bearing the universal access to health care (UAHC) or rendering the health service in affordable cost to different class of the society living in the rural side of the country.

Interview was conducted with CBHI officials regarding the enrollment rate of your district. & employees answered that.

„Currently, our district is among the good enrolled CBHI districts during 2006(E.c) the enrollment rate is (59%), in the 2007(E.c) (59.9%), in 2008(E.c) (62.4%), 2009E.c (75%). These data shows the enrolment rate of CBHI in Aleltu district is showing good rate & it is increasing from year to year by this rate the next year enrollment rate will excised 75% since they are working awareness creation & other promotion activity in the local households.“

The following table demonstrates respondents report on the when you started to enroll in the CBHI hence analysis & interpretation is made.

	<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
Valid Before 1 years	40	26.7	26.7	26.7
Before 2-3 years	110	73.3	73.3	100.0
<b>Total</b>	<b>150</b>	<b>100.0</b>	<b>100.0</b>	

**Source: Own computation (2017)**

From the total respondents 73.3% of them are enrolled in CBHI before 2-3 years since the starting of the CBHI in the woreda that is since the 2014. Whereas the rest of respondents or 26.7% of them being enrolled before one year. This shows that majority of the respondents beingenrolled since the starting time of the CBHI at Aleltu that is since 2014.

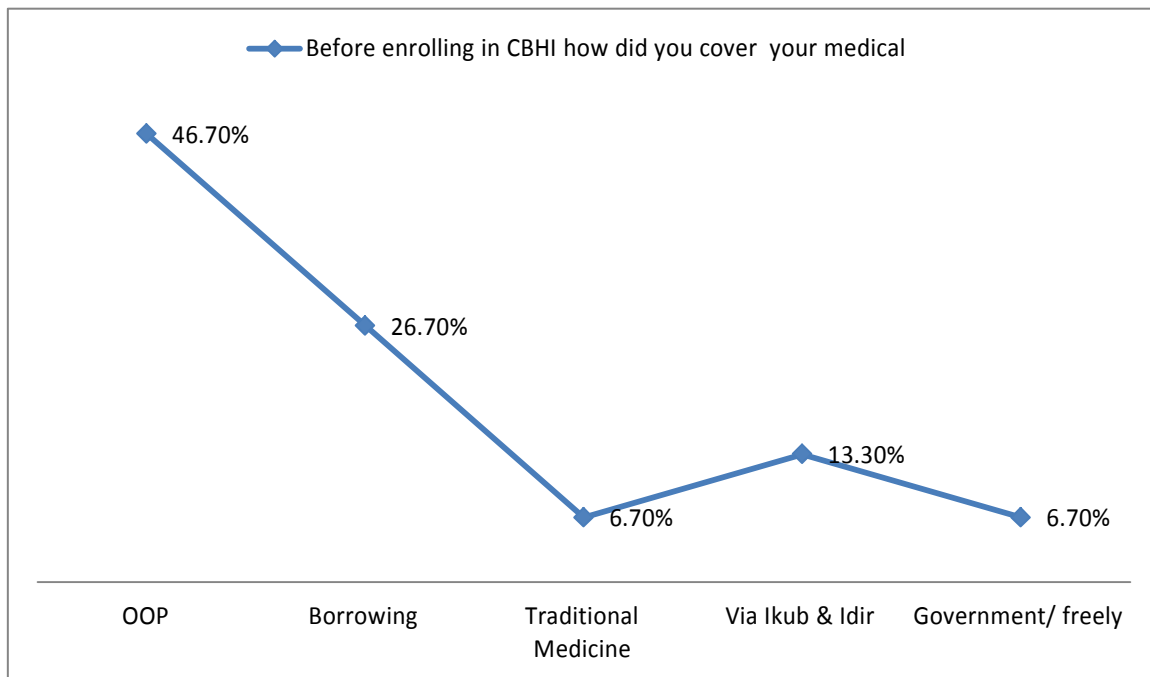
The introduction of the health insurance in Ethiopia is infinity. In Aleltu district it has the age of three years. So it needs initiation & cross-sectoral cooperation in order to make the scheme successful enough & taking the roots of the ground. The above survey data shows that the enrollment of CBHI in Aleltu is very successful enough on enrollment during its launching time

73.3% of the respondents have been the member of CBHI during the launched year of the CBHI in the woreda this was the result of good awareness creation & acceptance of the policy by the society.

**Response on: Before enrolling in CBHI how did you cover your medical expense?**

According to Meghan, (2010), more than half of health expenditure in poor countries is covered by out of pocket (OOP) payments incurred by households. An increase in such expenditure can have catastrophic effects and may deplete a household’s ability to generate current and future income and have inter-generational consequences as households may be compelled to incur debt, sell productive assets, draw down buffer food stocks, or sacrifice children’s education.

Here questions was raised for beneficiaries regarding the previous history of health cost coverage in order to compare the dependency ratio of OOP & borrowing to cover their health cost coverage. Regarding this the following table reveal the insured households report on their previous history of health cost coverage before they insured in the community based health insurance. The result of the report is interpreted & analyzed as follows.



**Fig: 4.12 before enrolling in CBHI how you covered you medical expense.**

**Source: Own computation (2017)**

Concerning the health cost coverage of households before enrolling in CBHI 46.7% of respondents used the out-of pocket payment (OOP) to cover their health expense before they enrolled in CBHI; whereas 26.7% of the respondents borrowed from others persons to cover their health cost. But 13.3% & 6.7% of them covered their expense via Ikub & Idir, & government/ free health service respectively. This shows that majority of the households were using the OOP in order to cover their health cost coverage. As the result of the introduction of the CBHI district many people's become saved from OOP, borrowing & others means of financing to health expense. As bulk of studies conducted shows that in majority of less developed countries health cost converge is through OOP & borrowing this number will be high in Ethiopia by which More than 80% of total private health expenditure in Ethiopia is in the form of out-of-pocket payments. This suggests that majority of the people relies on Out of pocket payment in order to cover the heath expense this is very traditional way of health expense coverage.

**Table 4.11: Response on: Our health status is improved after enrolling in CBHI**

To calculate the point for each critical factor two considerations were taken in to account: the score for each significant element of the factor, and the weight for each significant element. A score of „5“ (strongly agree) would yield a full mark of 5 towards that element; a score of „4“ (agree) would yield a mark of 4 towards that element; a score of „3“ (neutral) would yield a 3 mark whereas score of „2“ (Disagree) would be „2“ mark the last would be „1“ (Strongly disagree) & would yield „1“ mark.

Here, respondents were asked whether their health status is improved after enrolling in CBHI.

The following table presented the frequency of respondents report. Under the table necessary analysis & interpretation is made according to the question in this part.

	Frequency	Percent	Cumulative Percent	Mean	Standard deviation
Valid Neutral	10	6.7	6.7	4.07	0.443
Agree	120	80.0	66.7		
Strongly agree	20	13.3	<b>100.0</b>		
Total	100	100.0			

**Source: Own computation (2017)**

Regarding the health status of the households after enrolling in the CBHI as the data in the above table (4.11) shows that only 6.7% of them become neutral regarding the health status of the household after enrolling in the CBHI where as 13.3% of the believed that they strongly agree with the question & their family health status is improved after enrolling in the CBHI, others 80% of the total respondents reported that their health status is improved due to the CBHI. This show that majority of the respondents (93.3%) of them reported that their health status is improving after they ensured. This suggested that CBHI is not only improving the health expense (health finance) of local households it also improving the health status of the households.

The mean result is 4.07 & standard deviation is 0.443 which shows the respondents health is improved after they are enrolling in the CBHI.

In the open indeed question in part of questioner ensured members of the households stated that „at any time we are visiting our nearest health institution when we are ill so we can get treatment even if we haven’t any money at our hand” (Beneficiaries responses Open ended question).

Community based health insurance schemes are promising alternatives for a cost sharing health care system which hopefully also leads to better utilization of health care services, and eventually lead to a sustainable and fully functioning universal health care system. The benefits includes both inpatient and outpatient services. All types of essential health services that would be covered through out-of-pocket spending at time of sickness are covered by CBHI schemes. This suggested that people worry on how to cover their health cost is get answer by CBHI they can get health service immediately before the disease become chronic on them. Hence, the people health become improved & safe since CBHI reduce illness related income sock.

In regarding the cost coverage „currently the CBHI is working with the commercial bank of Ethiopia & the payment is made via cheque payment. When the patients got refer from the hospital the payment will be made to them immediately via cheque payment so they can withdrew the cash money from the commercial bank of Ethiopia” (Employees & official).

### **Type of Membership**

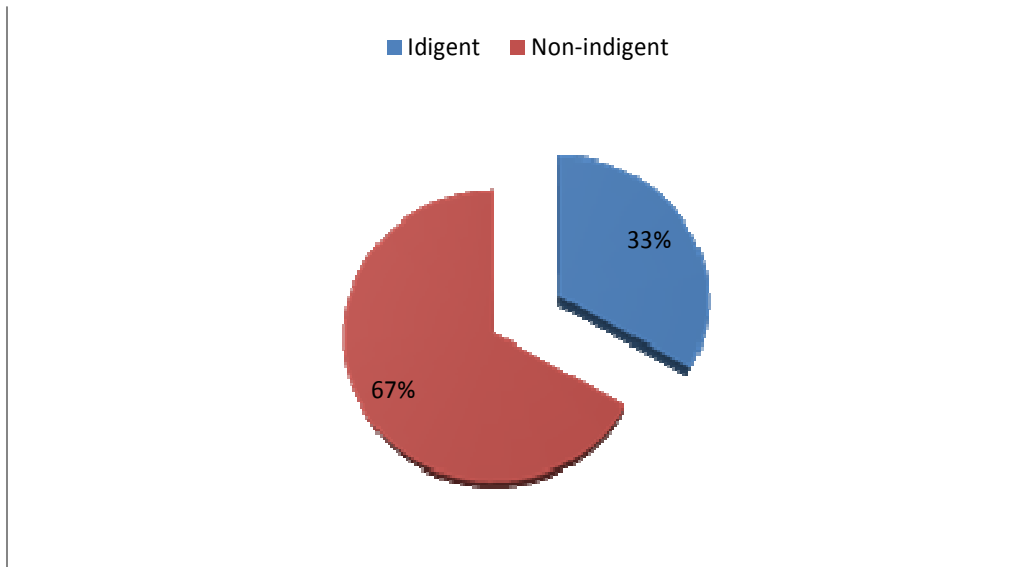
Interview was conducted with employees on identifying total number of indigent & non-indigent households enrolling in CBHI & respondents report that:

There are 1455 indigent type of member where as non-indigent type of members are 6798. This shows that since 2006 E.C/ 2014 G.C the total households enrolling the Aleltu district with 23 Gandas/ local villages were 8,253 both indigent & non-indigent member of the CBHI still the enrollment is not satisfactory as we compare the total population of the district’s 69,847 (data of 2016) from this by excluding the number of public servants in the district the number of households participating on the informal sector is 62,862. From this amount of population only 8,253 are enrolled in CBHI”.

„For the current year our office is planned to enrollee 1417 households from that till today (March, 2017) 758 households fully enrolled in the CBHI. In order to make the non-members households enrolled in the CBHI the office is working with different stakeholders like workers of health extension, kebele administration (managers of village), Woreda health bureau, farmer’s development army, religious leaders therefore, they are helping us on bringing continuous & rigorous awareness creation & behavioral change on the households,”(Employees & official).

This shows that beyond half percent is achieved by the office on enrolling the new households & the current performance & activity of the office can make to achieve its goal.

The following fig shows the beneficiaries feedback regarding the type of their membership & necessary interpretation & analysis is provided under the fig 4.13.



**Fig: 4.13 Type of membership**

**Source: Own Computation (2017)**

Among the total respondents as indicated in the above fig 4.13; 33.3% of them are indigent type of member they are getting the health services freely or without any payment this is the category of very poor households, But 66.7% of them are non-indigent member of households this category of households is getting health service via paying the premium yearly. This shows that the scheme is giving the service to the poor households without any payment. The sources of income for the scheme are government, its members & donors. The number of paying group should exceed the number of non-paying member in order to make the financial capacity of the scheme strong. From the three sources of finance the donors is unrealistic & it is situational as money countries experience like Rwanda shows that in order to make the scheme strong enough they focused on the immediate sources of finance should be the premium payment collected from the member & with support from the government. As we see from the survey data in fig (4.13) the number of the paying member exceed the number of non-paying group this is good for infant CBHI in order to make it strong enough in terms of scheme package. The increased and improved cash flow has had a positive effect on the availability of drugs and other supplies, which in turn has improved the quality of health services the facilities provide.

**Table 4.12: Response on: Do you renew your membership ID timely**

The literature suggests that there are four factors that are most likely to influence renewal rates: the quality of care on offer, health status, and affordability of insurance and information failures. The last issue includes a lack of understanding of insurance and insufficient information on how to use the insurance policy. High dropout rates clearly threaten the sustainability of such schemes, even if initial uptake is high Angaw, (2015). Regarding this beneficiaries were asked whether they are renewed or not their membership insurance on time. The following table presents beneficiaries report. Accordingly analysis & interpretation is made under the table.

	<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
Valid Yes	140	93.3	93.3	93.3
No	10	6.7	6.7	100.0
Total	<b>150</b>	<b>100.0</b>	<b>100.0</b>	

**Source: Own computation (2017)**

The above data in the table (4.12) shows that from total respondents only 6.7% of them are not yet renewed their membership Id of CBHI however 93.3% of them are renewed their membership Id on time. This show that majority of the respondents have good trend on renewing their membership ID timely. ID renewal means that specific household expressing his/her loyalty to continue its membership of CBHI. Dalliance on renewing the membership ID is among challenges reasonable for droop out of the member from the scheme that suggest less enrollment of the CBHI. Among total respondents majority of them has been renewed their membership Id on time this is good thing for the scheme in regarding the controlling members droop out mainly the non-indigent members.

**Table 4.13 Responses on: I haven't get any advantage in enrolling in CBHI**

To calculate the point for each critical factor two considerations were taken in to account: the score for each significant element of the factor, and the weight for each significant element. A score of `5" (strongly agree) would yield a full mark of 5 towards that element; a score of "4 "" (agree) would yield a mark of 4 towards that element; a score of „3" (neutral) would yield a 3

mark whereas score of „2“ (Disagree) would be 2 mark the last be „1“ (Strongly disagree) & would yield 1 mark.

The following table holds respondent’s response (report) on their attitude/ feedback towards I haven’t get any advantage enrolling in the CBHI.

	<b>Frequency</b>	<b>Percent</b>	<b>Cumulative Percent</b>	<b>Mean</b>	<b>Standard deviation</b>
Strongly Disagree	120	80.0	80.0	1.400	0.941
Valid Disagree	20	13.3	93.3		
Neutral	10	6.7	100.0		
<b>Total</b>	<b>150</b>	<b>100.0</b>			

**Source: own computation (2017)**

The survey data collected in the above table (4.13) shows that; among total respondents majority of the respondents or (93.3%) of them are getting benefit from the CBHI.

As the figure of mean 1.400 & standard deviation 0.941 shows that respondents are strongly disagree with the questions raised (I haven’t get any advantage enrolling in the community based health insurance).

- On Open ended (question No.9) beneficiaries were asked to list benefit they get from the CBHI scheme includes: „Our family health become improved, we start to save our money since we are freely getting services via CBHI by paying once a year, when we bought any prescribed medicines from private pharmacy through the medical prescription we can claim the money from the CBHI though the receipt, we stop to worry when we become sick where to go, how to finance the cost because we have insured from CBHI, When the our disease is beyond their capacity they will write refer to federal hospitals, at any time for whatever disease we are immediately went to the health centers, before enrolling in the CBHI we are paying high money for private hospitals & government hospitals even to a single diagnosis but now that all expenses is over“.

**Table 4.14: Response on: I decided to resign my membership from CBHI**

According to the office data „the drooping rate of households in 2015 is (40.3%), in 2016 (37.5), where as in 2017 (24%) (Half year data) this data shows that the drooping rate is decreasing from year to year. This is very good performance the enrollment rate of the woreda is increasing whereas the drooping rate is decreasing from year to year. So the Aleltu district is on the good truck”, (Employees & official).

Different activities have been performed by the office in order to handle the membership dropping rate. „We are working with different responsible body’s; health posts, health centers, government hospitals (mainly with those inter in to contract), improving health service quality provision, we are dealing on solving both demand & supply side problems, discussing with the households, filling/recording clear & full information of members of the CBHI while registering them, we are doing performance assessment among employees,” (Employees & official).

To calculate the point for each critical factor two considerations were taken in to account: the score for each significant element of the factor, and the weight for each significant element. A score of `5” (strongly agree) would yield a full mark of 5 towards that element; a score of “4 ” (agree) would yield a mark of 4 towards that element; a score of „3” (neutral) would yield a 3 mark whereas score of „2” (Disagree) would be 2 mark the last be „1” (Strongly disagree) & would yield 1 mark.

The following table holds reports of respondents regarding whether they decided to stay within their membership of CBHI, with the frequency, percent & cumulative, mean & standard deviation by supporting it with analysis & interpretation.

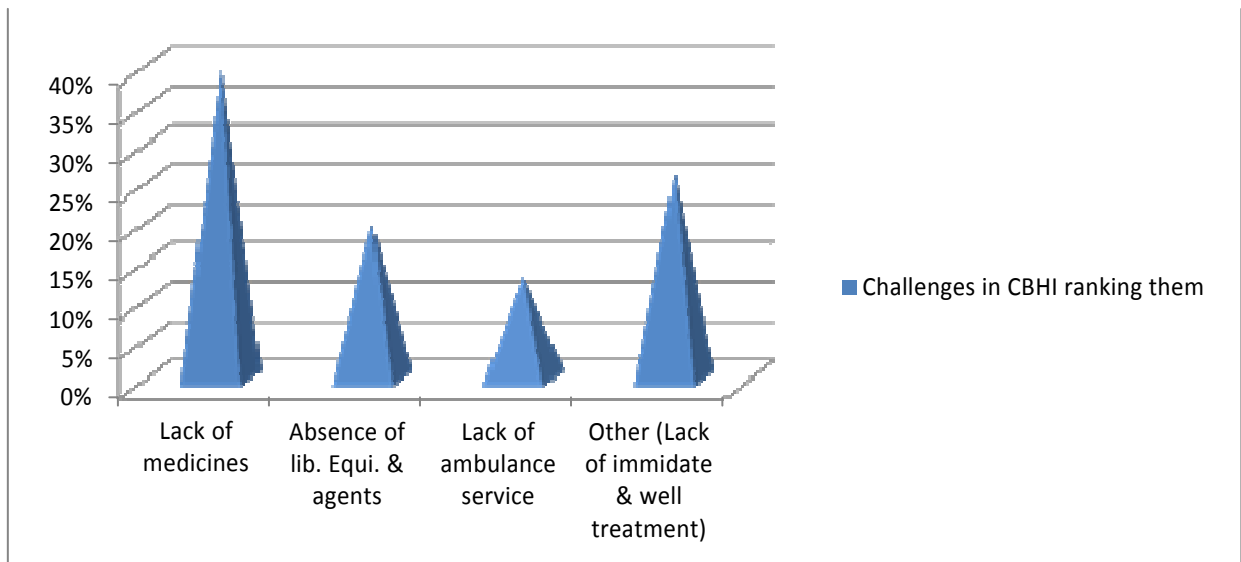
	<b>Frequency</b>	<b>Percent</b>	<b>Cumulative Percent</b>	<b>Mean</b>	<b>Standard Deviation</b>
ValidStrongly disagree	90	60.0	60.0	1.400	0.491
Disagree	60	40.0	100.0		
<b>Total</b>	<b>150</b>	<b>100.0</b>			

**Source: Own computation (2017)**

Relating to the decision on resigning/ existing within the CBHI as data in the above table (4.14) indicated that the respondents show their loyalty to stay within their membership. Hence, the issue of droop rate is not as such significant & tragic issue for the Aleltu CBHI schemes in enrollment. When the members of CBHI decided to stay with their membership it has positive impact on the sustainability of the scheme & enrollment rate. The data result suggests that the people started to understand the benefit they are getting from the CBHI as their membership as the result they decide to stay with their membership of CBHI that make achieving adequate membership rate.

The mean result is 1.400 which supports the above explanation; meaning the scale shows in between strongly disagrees & disagrees so they prefer to stay within CBHI rather than resigning their membership.

**Fig: 4.14 Challenges in CBHI**



**Source: Own Computation (2017)**

Regarding the major challenges encounter on the CBHI as indicated in the above fig (4.14); from the total respondents 40% of them identified & ranked the lack of availability of medicines as primary challenges they are facing in the health institution, whereas 26.7%, 20% & 13.3% of them identified less treatment & immediate service during refer, lack of laboratory equipments

&agents, & lack of immediate ambulance service ranked respectively as major challenges of health institution. This indicated that the existing supply side problems from the CBHI side. One of the reasons for non-membership invoked was the fact that members did not have access to better quality care at mission health facilities. This will suggest that if the service provided is not satisfying the majority it have negative impact on households not to continue their membership of CBHI mainly for non-indigent member despite it will affect the CBHI enrollment & membership rising.

Regarding, the problems (both supply & demand side) faced in the practice of CBHI the interview were conducted with employees of CBHI. The employees were asked to identify& list both demand & supply side challenges affecting the practice of CBHI within their district. listed supply side problem was; Lack of skilled man power in handling the CBHI in the woreda, Lack of budget to perform the enrollment rate of CBHI in different villages of Aleltu, Absence of available nearest government hospitals at the district level even as Oromiya level because the major referral cases (services) rendered at the federal hospitals, lack of enough man power because under one scheme only three person is assigned for one district CBHI (coordinator, accountant & data encoder), Absence of digital camera in order to take the photo of households during their membership, Absence of enough computers & printers (In order to encode the data of each members), the office is not covenant (narrow in size), the government health service is not satisfactory like the private health sectors therefore peoples prefer to a place where good service is provided. These are major problems raised within the office of CBHI.

Major problems raised from the beneficiary"s/ensured household side (Demand side) are; during registration time they will not bring required things (For instance Photo graphs, incorporating of necessary data"s), during the claim of money (after refer time) they will forget the receipt for the payment they made at the referral hospitals, During the writing of membership form they will not tell necessary information, Dalliance on Id renewal, during registration time they will not bring their family member. These are major problems raised from the beneficiary"s side.

***Major mechanism's used by the office in order to solve the problem that effect on practice of CBHI.***

According to the woreda CBHI workers Some of the problems can be solved in short period of time while other problems need long period of time so we are using different mechanism in order to handle the problems among controlling mechanism that the office currently use are: „for the demand side problem still the office are working with community & village administration in order to increase the households awareness, during the claim of the money we are telling them not to forget bringing the payment receipt, for now we haven't camera to take photo of members so we are giving them sufficient time to bring their photo after filling the form of CBHI.“

According to the respondents „In order to deal with inside office (supply side) challenges we are doing with the generally assembly committee (Consists of three person per Gendas/village, woreda cabinet, health bureau managers, district insurance coordinator, district administrator) we are discussing together in order to solve both supply & demand side problems since this problems is cross sectional it is not one side problem, general assembly help us in order to solve this challenges among the mandate of this assembly deciding contractual agreement with government referral hospital, increasing the CBHI scheme packages (Service) provided, deciding the time (due date) frame for newly enrolled (registering ) households & deciding the premium level of the CBHI.

**Table 4.15: Response on: Am happy with Current premium & timing of collecting**

Major factors influencing performance of CBHI; Affordability of contributions, Unit of enrolment, Distance, Timing of collecting, Quality of care & Trust,(Guy, 2003: 14-15).

Regarding factors determining the CBHI performance in this sub section of the study insured members of households were asked about the current premium level (affordability contribution) & timing of collecting which is one of the top determinants of CBHI performance.

From the WHO Study, it was observed that schemes in urban areas were more inclined to establish monthly or quarterly contributions so as to match the income patterns of urban informal sector workers, (ibid:16).

To calculate the point for each critical factor two considerations were taken in to account: the score for each significant element of the factor, and the weight for each significant element. A score of `5" (strongly agree) would yield a full mark of 5 towards that element; a score of "4 "" (agree) would yield a mark of 4 towards that element; a score of „3" (neutral) would yield a 3 mark whereas score of „2"" (Disagree) would be 2 mark the last be „1"" (Strongly disagree) & would yield 1 mark

The following table shows the report of the respondents regarding the question & necessary interpretation & analysis is made.

	<b>Frequency</b>	<b>Percent</b>	<b>Cumulative Percent</b>	<b>Mean</b>	<b>Standard deviation</b>
Valid Agree	55	36.7	36.7	4.63	0.484
Strongly Agree	95	63.3	<b>100.0</b>		
<b>Total</b>	<b>150</b>	<b>100.0</b>			

**Source: Own computation (2017)**

According to the survey data in the above table (4.15); from the total respondents 63.3% of themis strongly support that the current premium level of payment & timing of collecting; as well as 36.7% of the respondents are happy with current premium payment. This implies that the total respondents are happy with the premium payment & timing of collecting for CBHI schemes.

As indicated in the above table (4.15) the mean value is 4.633 which are beyond the good scale (4) that suggested that respondents believed that employees they are happy with the current premium payment.

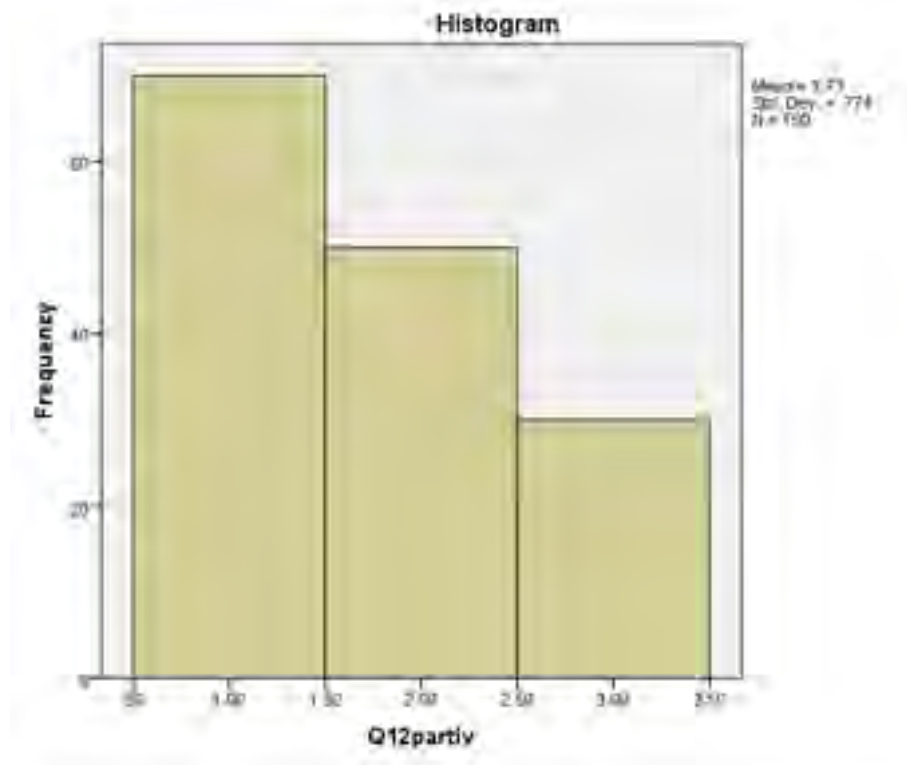
Affordability of premiums or a contribution & timing of collecting are often mentioned as one of the main determinants of membership further a number of schemes in the WHO Study had addressed the issue of affordability & timing of collecting. For instance in the Nkoranza scheme in Ghana, the estimated cost of contributions varied from 5 to 10% of annual household budgets. In case of Ethiopia it differs from the region to region.

As the response of employees regarding the timing of collection they are using the premium collection during the harvest time that mean at the end of the year which is convenient time for the households to pay the premium since it is time they have cash at their hand.

The premium payment sated/designed by Oromiya regional state is Birr 180/core family members (father, mother, and children under 18) and Birr 36 /additional noncore family member (to those become greater than 18 years old). The premium payment is constant for all non-indigent member of the CBHI. When the premium payment is fixed by the authority it should considered the family income status it should not be flat sum that is disadvantage for the poor group of the people. The current Ethiopian premium payment is not considering the income status of the households. But survey data showed that the households are happy with the current premium payment they are paying now. This suggested that the current premium level of the insurance is affordable.

**Respondent's response on: How is health facility utilization in health institution you are getting service via CBHI?**

To calculate the point for each critical factor two considerations were taken in to account: the score for each significant element of the factor, and the weight for each significant element. A score of ``4'' (Very good) would yield a full mark of 4 towards that element; a score of ``3'' (Good) would yield a mark of 2 towards that element; a score of ``2'' (Satisfactory) would yield a 2 mark whereas score of ``1'' (Poor) would be 1 mark.



**Fig: 4.15** how is health facility utilization in health institution you are getting service via CBHI?

**Source: Own computation (2017)**

According to the survey data in the above fig (4.15) from the total respondent's majority of them which accounted 66.7% reported that the health facility utilization is poor.

As the fig (4.15) shows that the mean value is 1.733 & standard deviation is 0.774 this implies that the mean value is beyond the average scale (2) that suggested that the overall health facility utilization in health institution is poor in provision of health services via CBHI.

The health facility utilization used by the health institution in providing the health service is low. Access to better health service is determinant factor in the practice of the Community based health insurance. In the provision of better health service, health facility utilization is back bone of the health institution for instance as data of WHO shows that in Ethiopia in 2009, the number of hospital beds per 10,000 people was 2 (while the average availability for Sub Saharan African

(SSA) region was 9), the number of nurses and midwives per 10,000 population was 2 (11 for SSA) and that of physicians (generalist and specialist medical practitioners) was only 0.4 (2 for SSA), (WHO, 2010).

Those health institutions have good health facility utilization it enables them to provide good health service. The response that provided by the employees is support the beneficiary's response among stated problems in health institution; lack of laboratory agents & lack of medicines are among the shortage faced in the health institution.

Further, employees were asked about the availability of Laboratory equipment & medicines.

„Yes, there is lack of availability of laboratory equipment's & medicines especially lack of laboratory agents & absence of very essential medicines (such as medicines for blood pressure, diabetic, DNS flood & other drugs) so the absence of these things has impact on the service rendered to the patients"" (Employees & official).

**Table 4.16: Response on: The nearest conventional health institution to you**

Different literatures identified that distance is one of the determinants of community based health insurance practice. Studies conducted by Desmet et al (1999:928). As cited by Guy, (2003: 15-16) shows that Membership rates are often determined by the distance of the household's home from the nearest health facility where (insured) services are provided.

Further, Schneider and Diop (2001: 25) in the Rwandan Project Study, it was also found that households who lived less than 30 minutes from the participating health facility had a much larger probability to enroll in the CHIs than those who lived farther away,(Guy, 2003: 15-16 ).

So, here beneficiaries were asked in order to answer the nearest conventional health institution to their home. Accordingly the following table forwarded the feedback of the respondents.

As data got from the scheme officials shows that the scheme service is given to the insured households at their nearest conventional health institution since there is deal with this health intuitions.

	<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
Health center	70	46.7	46.7	46.7
Valid Health post	80	53.3	53.3	100.0
<b>Total</b>	<b>150</b>	<b>100.0</b>	<b>100.0</b>	

**Source: Own computation (2017)**

Regarding the respondents response on the nearest conventional health institution table (4.16) shows that among the total respondents 46.7% of them are nearest to the health center where as 53.3% of them are near to the health post. This shows that majority of the local households are getting immediate (Primary) health service from the health post it is their nearest conventional health institution to their house. According to Desmet, Chowdury & Islam (1999:928),as cited by Guy, (2003) Membership rates are often determined by the distance of the household's home from the nearest health facility where (insurance) services are provided. In the provided survey data no households are far from the health institutions in which the service is rendered as the data showed majority of the households are using the nearest health post so they can access the health service easily from the health post without the distance.

CBHI official was asked with which government hospitals signed agreement for CBHI referral hospitals. „Previously we have agreed with „Yekatit 12“ government hospital but due to weak service provision our binding agreement is stop so currently yet now there is no any hospitals enter in to binding agreement with us in order to provide health service to the community based health insurance members.“ (CBHI Finfine branch manager)

**Table 4.17: Are you getting medicines prescribed to you timely (especially very essential drugs)**

One of the reasons for non-membership invoked was the fact that members did not have access to better quality care at mission health facilities, (Guy, 2003: 17).

Among the better quality care; getting medicines from the health institution on time is among determinant factors for customer satisfaction. Since absence of better quality care (such as absence of available medicines) can have negative impact on the practice of CBHI. For this

matter ensured member of the households were asked to identify whether they are getting medicines prescribed to them or not. Hence the following table contains the report of the respondent's feedback regarding the question & analysis with interpretation provided below the table.

		<b>Frequency</b>	<b>Percentage</b>	<b>Valid Percent</b>	<b>Cumulative percent</b>
<b>Valid</b>	<b>Yes</b>	30	20.0	20.0	20.0
	<b>No</b>	120	80.0	80.0	100.0
<b>Total</b>		<b>150</b>	<b>100.0</b>	<b>100.0</b>	

**Source: Own computation (2017)**

As survey data in the table shows that among the total respondents majority number or (80%) of them report that they are not getting medicines prescribed to them on time where as 20% of the respondents report that they are getting medicines prescribed to them. This suggests that majority of the households are not getting medicines prescribed to them from the government health institution so there is lack of available medicines at the woreda health centers, health post & governmental hospital that results poor quality of health service provision.

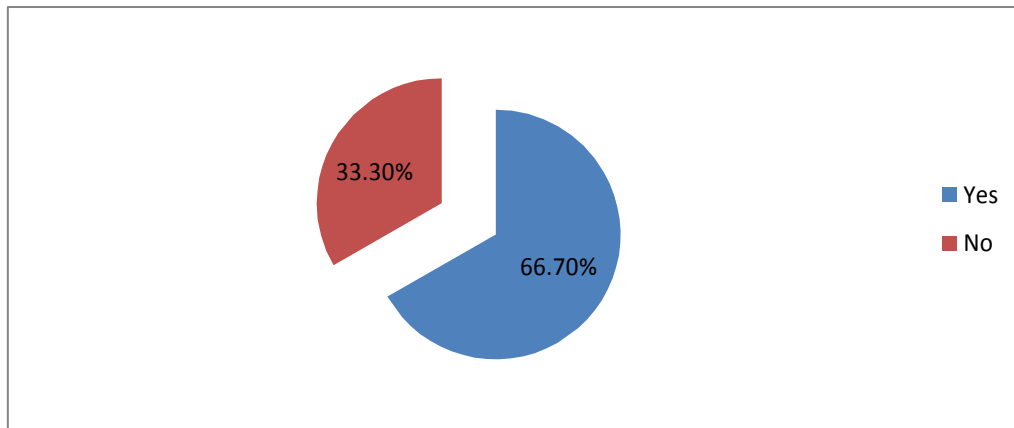
Absence of medicines in one health institution is implication of poor service provision in that specific health institution. This have negative impact on the enrolment rate of CBHI suggests that if the people can't get good service they will be dissatisfied with the service this can cause drop out from the scheme through long run. As the response of households on open ended question suggested that „during referral time they are not getting medicines prescribed to them so they forced to purchase from private pharmacies. When they ask to take receipt for their purchase they refuse to give the receipt. So they face challenges to claim the money with that receipt.“ (Beneficiaries on open-ended questioner)

#### **4.3.4. Participation in CBHI programs**

Strong community participation can facilitate health education and sensitization of members in order to promote healthy behavior and the use of preventive services, as the members share a common interest in keeping the costs of health care low, (Jutting, 2000:12).

Ethiopian community based health insurance model is top down approach in which any decision about the matter of the scheme is decided by the government the government is scheme initiator, implementer & controller. The community hasn't any direct participation on the decision making affairs of the scheme (such as deciding on meters of scheme package, premium payment & hospital identification or signing contractual agreement for referral cases) such matters will be decided by the government. The community has indirect participation in the CBHI & they will be represented in the general assembly committee of the CBHI via two people which are selected from the community. The community has passive participation than active.

Towards this beneficiaries were asked what type/level of participation they have/poses in the community based health insurance as membership.



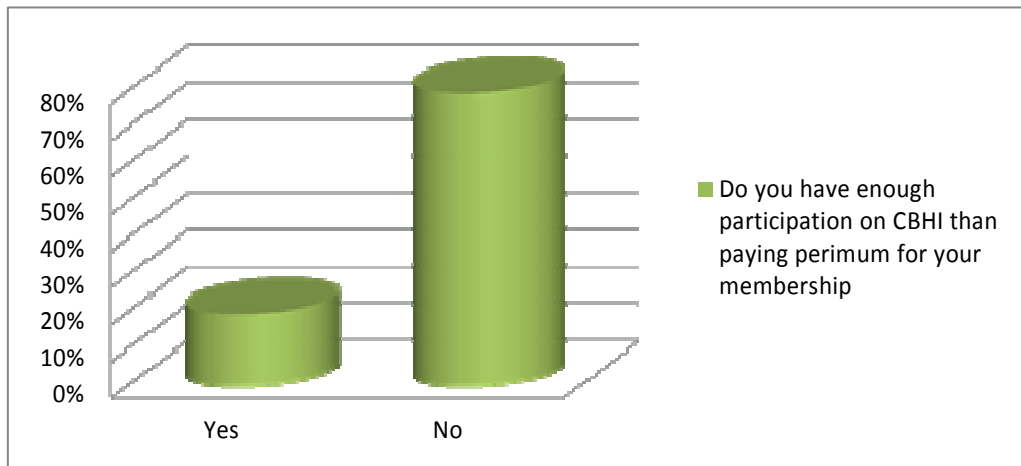
**Fig: 4.16 have you get opportunity to discuss with responsible body from the Woreda/federal health insurance agency?**

**Source: Own computation (2017)**

As fig (4.14) above shows that from total respondents only 33.3% of them haven't get the opportunity of discussing with responsible CBHI officials from the woreda or head office where as majority of respondents or 66.7% of them got the opportunity to discuss with assigned officials from woreda CBHI & federal health agency. This shows that the woreda CBHI & federal health agency are giving the stage to discuss with the society on CBHI matters this will caret an opportunity to households in order to raise various issues & questions regarding the CBHI directly to the responsible body.

There are various types of community based health insurance such as Community prepayment health organization, provider based health insurance schemes & government runs community-involved health insurance among the scheme the Ethiopian community based health insurance share the nature of government runs community-involved in which have the with the objective of creating access to a universal health care system. The government (national or regional) plays a substantial role in initiating, designing and implementation of such schemes. Governments in co-operation with donor agencies may provide reductions in premium and fee waivers for the poorest segments of society while retaining a universal benefit package. It is top down approach by which participation of the community is very less & it may not be sensitive to local needs. In case of Ethiopian CBHI it is top down approach every decision regarding the scheme come from the top.

Even if the model of CBHI in our country is top-down approach the government is using different mechanism in order to give room to the community since the insurance strategy is new & infant among this mechanism the government is arranging meeting & discussion with the society . As the above data shows that (fig 4.16) majority of the respondent“s respondents (66.7%) has got opportunity to discuss with responsible body/officials of CBHI.



**Fig: 4.17 Do you have enough participation on CBHI than paying the premium for your membership.**

**Source: Own Computation (2017)**

From the total respondents in the survey data of the above fig (4.17) 80% of them believed that their participation level is till the paying premium of CBHI where as 20% of the respondents putted that they have good participation beyond paying the premium payment as CBHI membership.

One of the disadvantages of the government runs community-involved health insurance is the schemes may lie in the government & donor countries design and implementation features. Since such programmes are the result of a top-down approach, they may not be sensitive to local needs. Limiting the role of community participation in awareness-raising, decision-making and supervision probably robs such schemes of a sense of ownership which in turn may hamper sustainability. As the data provided in the above fig(4.17) suggested that the households have insignificant role in the matters of the CBHI. This suggested that the community does not have decision making power on the matter of the CBHI for instance deciding the premium payment, the scheme packages & Making deal with the Federal hospitals for the case of referral cases.

#### **4.4 Discussion of the result**

This sub part deals with discussing the result of the findings putted in the above tables & figs.

##### **4.4.1 Practice/enrollment of Community based health insurance**

The study has found that the enrollment of community based health insurance in Aleltu woreda since the initiation time of the scheme is showing its robust progress. Meanwhile there are some challenges responsible for not full sized the scheme across the all Ganda"s (Local villages). As indicated in (interview Q. No.7) the enrolment rate of the district in 2014 were 59%, in 2015 it become 59.9% where as in 2016 it reached 75% this data shows that year to year the enrollment rate is improving & showing good progress. In the woreda the number of indigent member were 1,455 while the number of non-indigent households were 6,798 (Data of 2017). The total number of households living in the Aleletu district accordingly the number is 69,847 by deducting the number of public servants (10%) from the total population 62,862 of them become the number of households engaged in the informal sectors of the economy. Out of these total households only 8,253 people were enrolled in the community based health insurance both as indigent & non-indigent member of the society. Majority of the households participated in this study has been enrolled since the introduction of the insurance in the woreda (Table 4.10).

In order to increase the enrollment rate the woreda office is working with various stakeholders on raising the awareness of the society such as: Ethiopian health insurance agency, regional health bureaus, local village administrators, elders & religious father, workers of health extension"s, traditional local institution like Ikub & Idir, public meeting, model households on enrollment making them share their experience to other households.

#### **4.4.2 Challenges faced on enrolling the Community based health insurance**

Major challenges that have impact on practices of the scheme can rise from both demand & supply side problems. Major demand side challenges encounter for less enrollment of the insurance are; during registration time households will not bring required things (For instance, Photo graphs, families necessary data"s), during the claim of money payment during the refer time they will forget the receipt for the payment they made at the referral hospitals, During the filling membership form they will not tell necessary information, dalliance on ID renewal, during registration (form registration they will not bring their family member. These are major problems raised from the beneficiary"s side. Whereas from supply side the study come across the following major challenges; Lack of skilled man power in handling the CBHI in the woreda, Lack of budget to perform the enrollment rate of CBHI in different villages of Aleltu, Absence of available nearest government hospitals at the distract level even as oromiya level because the major referral cases/ services rendered at the federal hospitals, lack of enough man power because under one scheme only three persons is assigned for one district CBHI (coordinator, accountant & data encoder), Absence of digital camera in order to take the photo of households during their membership, Absence of enough computers & printers (In order to encoding the file of each members), the office is not covenant (narrow in size), the government health service is not satisfactory like the private health sectors therefore peoples prefer to a place where good service is provided. These are major problems raised due to the office of CBHI.

On service delivery major problems exist in the health centers providing service in the agreed insurance (fig. 4.14) are as ranked by the respondents according to their severity; Lack of medicines, other (lack of immediate & well treatment at government hospitals, during refertime), Lack of laboratoryequipment"s& Agents, Lack of immediate ambulance service. In addition to

this the beneficiaries are not treating equally & in good manner while they went to government hospitals for referral case.

#### **4.4.3 Major benefit the society is getting from enrolling in CBHI**

The societies health status is improving by the community based health insurance (Table 4.11), they start getting any treatment with less/no cost , their family health status become improved, They start to save their money since they are freely getting services via CBHI by paying premium once a year, when they bought any prescribed medicines from private pharmacy through the medical prescription they can claim the money from the CBHI though the receipt, they stop to worry when they become sick where to go, how to finance the cost because have insured from CBHI, When our dieses is beyond their capacity they will write us refer to federal hospitals, at any time for whatever dieses we are immediately went to the health centers, before enrolling in the CBHI they were paying high money for private hospitals & government hospitals even to a single diagnosis but now that all expenses is over.

## Chapter Five

### 5. Conclusion & Recommendation

#### 5.1. Introduction

This study was conducted with the purpose of assessing Community based health insurance practice/enrollment & challenges: the case of Aleltu district. For the case the descriptive survey research method was used in order to conduct the survey. Data was collected using data collection tools such as questioner & interview. For the literature review, a number of books have been used. The data collected was organized, analyzed & discussed. This section deals with, conclusion & recommendation by putting the research topic & research questions into the attention. In the earlier chapter four findings have been presented as they are using descriptive statistics specifically frequency tables. Hence this chapter provided the following recommendation & conclusion based on the findings of the study.

#### 5.2 Conclusion

Ethiopian is planning to make universal access to health mainly to the rural communities among the tools that the country used on meeting the UAH is health insurance strategy. Thus introduction of health insurance strategy in Ethiopia Economy contains two parts those are Community based health insurance & social health insurance. The focus of this study was Community based health insurance that deals with those peoples engaged on informal sectors of the Economy & excluded the public servants.

In Ethiopia, there is an old tradition called *idir* or *kire* of community organizations providing financial help to families for emergencies, like funerals. But a new form of “idir/kire” nicknamed “idir/kire while alive” is gaining traction as the Ethiopian government pursues its goal of providing universal health coverage. That scheme is community based health insurance or CBHI. CBHI is health insurance that pools members’ premium payments into a collective fund, which is managed by the members, and covers basic health care costs at local health centers when a member is sick. The insurance is even accepted at hospitals when a member is referred by the lower level health facilities.

CBHI primarily covers essential health service packages at the health center level. The benefits includes both inpatient and outpatient services. All types of essential health services that would be covered through out-of-pocket spending at time of sickness are covered by CBHI schemes. Due to CBHI's initial success, the Ethiopian Health Insurance Agency (EHIA) decided to scale up CBHI to an additional 161 districts, with technical support from the HFG Project while the CBHI schemes in 13 districts are under evaluation.

Aletu district is among the newly scale up districts. The enrollment of CBHI In this district started in 2014. For the purpose of this study Aletu district was taken as study area. In doing so the researcher, has collected primary data through self-administrated questioner from selected respondents and in depth interview with purposively selected individuals from the district CBHI bureau & Ethiopian health insurance agency finfine branch manager for cross check of the interview. The questioner was distributed & completed by 150 beneficiaries of the CBHI and was analyzed using SPSS version 21 in order to get descriptive statistics.

The results of the survey have yielded useful findings relating to the enrollment of CBHI & challenges encountered that become good input for the woreda CBHI scale up. The study have dazzlingly revealed that there are tragic issues that need immediate rejoinder from all concerned body in order to scale up the enrolment rate of CBHI in the woreda unless the scheme will be come under risk.

Major initiating reasons behind CBHI enrollment is the previous achievements on pilot woreda scheme enrollment were good & the government highly gives emphases on CBHI enrollment. Currently, CBHI identified as good finance mobilization in health care to bearing the universal access to health care (UAHC) or rendering the health service in affordable cost to different class of the society living in the rural side of the country.

In short, the study has reached a conclusion that the Enrollment/practice of CBHI on having new members is good; the office is working on boosting its members but there is solemn problem while the health institution render the service to this insured people mainly during higher referral case to the government hospitals households justified that there is problem on implementation of the scheme on service delivery. The office should not work only on the enrollment of the CBHI

it should also work on the satisfaction of the households from the scheme this can't solved alone it need the cross sectional cooperation with responsible stakeholders such as health institution's, banks, drug suppliers & other institution in making the service provided via the scheme is good. Merely focusing on the collection of money from the new & permanent members of the CBHI will leads to drop out of the member from their membership of CBHI. Therefore, unless immediate corrective action's takes place by the responsible body to readdress the challenges mainly the supply side challenges the sustainability of the scheme will be under the question.

### **5.3 Recommendation**

Based on the research findings, the study has produced the following recommendation to improve the CBHI enrollment & solve the problem of CBHI (Both demand & supply side).

The enrollment rate of CBHI in Aleltu woreda is increasing from year to year. This is good performance to scale up the insurance & reducing the out of packet based people & achieving universal access to health. Beside this the office is working on reducing the drop rate of permanent members. So we can say the CBHI in Aleltu woreda is on good track on scale up the enrollment & minimizing the drop out.

The supply side problems; such as availability health facilities in quality & quantity should be considered the beneficiaries of CBHI raised that they are not getting medicines, quality service & equal treatment mainly during referral cases. Even if the agency is working with drug suppliers such as PFSA in order to solve the shortage of medicines it is not enough. Even people are not happy with the health service they are receiving from agreed federal hospitals. Formerly the office was entered contractual deal with Yekatit 12 referral hospital due to complain raised by the patients the Agency is forced to cut off the contractual agreement with this Yekatit 12 Hospital & the society is getting the health payment by calming via cheque. This is temporary solution but in order to solve the problem permanently the agency should work on with different stakeholders ( such as federal hospitals & ministry of health) while signing binding agreement beside thisthere should be a work of awareness creation to the employees of the agreed hospital while this people come with their membership ID they should treated equally as the other patients getting the service via OOP since the CBHI is new to our country especially those living in the city may have know-how about it.

Family size for under age is not limited on getting service from the scheme in Oromiya regional state but in SNNP regional state there is family size (quota ) those have beyond six children"s they will pay additional payment in addition to the premium yearly. This trend should be used in Oromiya regional state because the scheme is not financially enough so through long run the family size has impact on the shortage of finance & limited health service like outpatients only.

Among the factors responsible for dalliance during CBHI registration is that; household is not bring their photograph on time so they will not get their membership Id timely since it is rural area the farmers may not accesses photograph house therefore, the researcher recommend the office to have its own camera to take the photo of household during the registration time.

From the problems encountered on the enrolling of CBHI is lack of skilled man power & lack of enough man power in order to solve this problem the agency should recruit new man power from the market & it should capacitate the exiting employees via giving education opportunity & training to this employees. Beside this problems such as absence enough office computer & printers, & the office is not covenant (small in size). Absence of enough office computer & inconvenient office will encountered to improper handling of the data for the members of the CBHI the office size also leads to improper working environment.

The premium payment is regardless of considering the households income & family size (those of under 18 years old) the premium payment should have the level (scale) according to their income for instance low income (Low produced household), Middle income & high produced house hold. Such kind of categorization should be there among indigent group of the households. In Aleltu woreda there is no such kind of classification households are paying the premium payment yearly without any classification/categorization among the households. It is better if there is premium bracket (Division) based on their income or among the households in order to make the insurance premium fair.

## **Bibliography**

Abebe, S. (2010). Community Based Health Insurance Schemes in Africa: the Case of Rwanda. Development Research Department of the African Development Bank. 1-.

Adane K. et al . (2013). Willingness to pay for community based health insurance among household in the rural community of Fogera District North west of Ethiopia. International journal of Economics finance & Management , 1-80.

Adebayo et al. (2015). A systematic review of factors that affect uptake of community-based health insurance in low-income and middle income countries. BMC health service research , 15-543.

Yilm et al (2015). Impact Of Ethiopian Community Based health insurance on household Economic welfare. International Reserach for Economics & Management , 10-30.

Angaw, D. (2015). Essays on evaluating a community Based health insurance scheme in Rural Ethiopia. International institute of social studies , 5-.

Calapar, T. (2011). Improving financial Access to health service to the poor. Jounal For equity in health , 1-.

David M. Levine et al. (1999). Statistics for Managers Using Microsoft Excel, 2nd Edition. New York.

Demste, C. &. (1999). 'The Potential for Social Mobilization in Bangladesh: The Organization and Functioning of Two Health Insurance Schemes'. Soical Science & Medicine , 925-938.

Diriba, A. (2013). Roles and challenges of NGOS in poverty alleviation and women empowernment in kelem Wolega Zone.

EHIA. (2015). Evaluation of Community Based Health Insurance Pilot Schemes In Ethiopia Final Report. Addis Ababa: EHIA.

Ethiopian Herald . (2015). Ethiopian scale up Community Based Health Insurance. Addis Ababa. . Addis Ababa: Ethiopian HErald News Paper, English Version .

FMOH. (2009). Health Insurance Strategy. Addis Ababa: FMOH.

FMOH. (2014). Quarterly Health Bulletin. Policy and practice Information for action. Addis Abab: Federal Ministry Of Health .

FOMH. (2008). Health Insurance Strategy . Addis Ababa: Federal Ministry of health planning & program department .

Guy, C. (2003). Community based health insurance in developing countries: facts, problem & perspectives World Health Organization. World Health Organization conference (pp. 20-70). Geneva: World Health Organization.

Habiyonizeye, Y. (2013). Implementing Community-Based Health Insurance schemes Lessons from the case of Rwanda.

Haile. (2014). Willingness to join community based health insurance among rural households of Dehub Bench District, Bench Maji Zone, and Southwest Ethiopia. . BMC Public health , 14-51.

Hilina, H. (2014). Socio Economic Determinants of Community Based Health Insurance. The Case of Kilde Awelaelo District, Tigray Regional State.

Jutting et al . (2003). Are the poor too poor to demand health insurance. Proceeding of the 25 international conference of agricultural Economists (IAAE) ISBN (20). Durban, South Africa.

Jutting, D. W. (2000). The Emerging Movement of Community Based Health Insurance in Sub-Saharan Africa: experiences & lessons learned.

Kevin Durrheim, D. P. (2006). Research in practice: Applied methods for social sciences. Cape Town: Juta and Company Ltd, 2006.

Krishnan, J. &. (2001). Community involvement in health care financing a survey of literature on impact, strength & weakness .

Meghan, S. (2010). Micro Finance Health Insurance In Developing Countries. wharton Reserach scholars woking paper .

MLI, M. L. (2013). Reducing financial barriers to reproductive health care : Ethiopia Spoty Light. Addis Ababa: Aspen Global Health & health development.

Nair D. (2015). Determinants of Enrollment in Comprehensive Health Insurance Scheme and Implementation Challenges: A Study in Kerala, South India. Health Sci J.

OECD. (2004). Private Health insurance in OCEDE countries .

Ontiveros, P. J. (2013). 'Understanding and Information Failures: Lessons from a Health Micro insurance Program in India'.

Shafudah, E. (2011). Appraising Performance Management Processes: A Case of the Directorate of Customs and Excise, Ministry of Finance, Namibia. Submitted in Partial Fulfillment of the requirements for the Degree of Master of Science in the Subject Leadership and ChangeManagement at the Leeds Metropolitan University.

Tabor, Steven R. (2005). Community Based health Insurance & social protection policy. Social protection Unit Human Development Network the world Bank.

Tenkorang, A. (2001). Health Insurance for the Informal Sector in Africa Design Features, Risk Protection, and Resource Mobilization. . HNP discussion paper .

USAID. (2011). 'Ethiopia Health Sector Financing Reform: Midterm Project Evaluation'. Addis Ababa : USAID.

watkins, C. &. (2003). Health Organization in Guinea-Conakry (West Africa): What is Going Wrong?" Declining Subscriptions to the Maliando Mutual. Journal of social social science& medicine , 1205-1219.

WHO. (2010). Health System Financing: The path to universal coverage. Geneva: 15-50.

WHO. (2000). Improving Health performance. Geneva: World Hwlath Organization.

WHO. (2005). "Reporting on Ethiopian Health survey 2003". Geneva: World Health organization.

## **Annexes**

### **Direction**

Read question carefully & tick the best responses from the given alternatives & mark this sign "✓". In the provided boxes for the items that require detailed explanation, you may write your comments or suggestion in the space provided there are some possibilities to where you might choose more than one answer from the alternatives provided.

**I. BACKGROUND INFORMATION**

1. Sex : Male  Female  Woreda ----- Kebele -----2.

Age A. 18-48 years  B. 49-69 years  C. 70-90 years

3. What is the relation of the respondents to the house hold?

A. Father  B. Mother  C. Child

D. other (Parent sibling, child in law) -----

4. Marital Status of the respondents.

A. Single  B. Married  C. Windowed  D. Divorced

E. Polyandrous

5. Occupation of the respondents.

A. Farming  B. House wife  C. Trade  D. Laborer

E. Government  F. Student  G. other-----

6. Educational Status of respondents

A. Illiterate  B. Read & write  C. Grade 1-8  D. Secondary School

E. Diploma/Degree

7. What is the family size of house hold?

1-5: Male  Female

6-10: Male  Female

11-15: Male  Female

8. Number of child age (<18) -----

9. Number of working age (>=18) -----

## **II. Awareness Level on the concept of Community Based Health Insurance**

1. Do you know Community Based health insurance?

A. Yes  B. No

2. If your answer for the above question No. 1 is „Yes“ from whom/what you heard/got information?

A. From neighbor  C. Religious institution

B. Ikub & Idir  D. Woreda CBHI & workers of health extension

E. TV, Radio, news paper

3. Enrolling in the Community based health insurance has advantage.

A. Strongly Agree  C. Neutral  E Strongly Disagree

B. Agree  D. Disagree

4. Have you start to get health service via your membership?

A. Yes  B. No

5. If No why? (Please list your reason)

-----  
-----  
-----

6. What is your level of knowledge (understanding) on community based health insurance?

- A. Less  B. Medium  C. High  D. Unknown

**Part III. Household's health status, family size & income**

1. How do you rate the health status of your family?

- A. Very poor  C. Medium   
B. Poor  D. Good  E. Very good

2. Approximately, how much of these products did your house hold produced & sold during the last one year?

Maize (in birr/quintal)

Taffee (in birr/quintal)

Wheat (in birr/quintal)

Barely (in birr/quintal)

Nut (in birr/quintal)

Others (Specify)

3. How many of these animals do this household own?

Milk cows, Oxen or bulls?

Sheep

Chickens

Horse

Donkey

Mule

**Part IV. Questions related to Community based health insurance: it's Benefit & Challenges**

1. When you started enrolling in community based health insurance?

- A. Before 1 year ago       C. Before 5 month ago   
B. Before 2-3 years ago       D. Other (Specify)

2. Before you joined the community based health insurance how did you cover your medical expense?

- A. OOP       C. We were using traditional way of treatment   
B. Borrowing       D. Via Ikub & Idir      E. Government/free-----

3. Our health status is improved after we enrolled of the scheme.

- A. Strongly Agree       C. Neutral   
B. Agree       D. Disagree       E. Strongly disagree

4. Which type of member you are?

- A. Indigent Member   
B. Non-indigent Member

5. Do you renew your & family's membership **ID** timely?

- A. Yes       B. No

6. I decided to resign my membership from CBHI

- A. Strongly agree       C. Natural   
B. Agree       D. Disagree       E. Strongly disagree

7. I haven't got any advantage enrolling in community based health insurance?

- A. Strongly Agree       C. Neutral   
B. Agree       D. Disagree       E. Strongly disagree

8. If your response for the above question number „8” is strongly agree/ Agree what is your reason? Please rank it as 1<sup>st</sup>, 2<sup>nd</sup> .....

- A. Poor Quality of their service
- B. Absence of Medicine
- C. Lack of medical equipments (Lab digenesis)
- D. Cost of premium is not affordable
- E. others (Please specify)-----

9. After you joined the CBHI schemes what kind of benefits did you get?

-----  
-----

10. Which challenges you are currently identifying as beneficiary? Please Rank it 1<sup>st</sup> 2<sup>nd</sup> .....

- A. Absence of availability medicine
- B. Absence of laboratory equipment (agents)
- C. Lack of ambulance service
- D. Others (Please specify)-----

11. Am very happy with current premium level?

- A. Strongly Agree  B. Agree  C. Neutral  D. Disagree
- E. Strongly Agree

12. How is health facility utilization mechanism?

- A. Very Good  B. Good  C. Satisfactory  D. Poor

13. If it is poor please list them. (the major problem faced in the specific health institutions)

-----  
-----

14. What is the nearest conventional health institution to your home?

- A. Health center       C. Health Post   
B. Clinic (Private)       D. Hospital (Government)

15. Are you getting medicines (Especially very essential drugs) prescribed to you from your health center on time?

- A. Yes     B. No

**Part V. Participation in CBHI programs**

1. Do you attend in any local meetings/ gathering concerning community based health insurance?

- A. Yes     B. No

2. Have you gate the opportunity to talk (discuss) freely on CBHI with responsible body/stakeholders from woreda & above?

- A. Yes       B. No

3. Do you have enough participation on CBHI program than paying of the premium?

- A. Yes       B. No

**This is the end of questioner**

**Thank you very much for you**

**Participation & Cooperation!!!**

**I. Gaaffilee eenyummaa Ofii ibsan**

1. Koorniyaa : Dhi  Du  Godina----- Ganda-----

2. Umurii A. waggaa 18-48  B. waggaa 49-69  C. waggaa 70-90

3. Maatii keessaniif isin maali (Maal taatu)?

A. Abbaa  B. Haadha  C. Ilma/Intala

4. Gaa"ela /Fuudhaafi heeruma ilaalchisee

A. Kan hin fudhiin/hin-heerumiin  C. Haati warraa kan boqotte

B. Kan Fuudhe/heerumte  D. Abbaan warraa kan boqote

E. Kan wal-hiikan

5. Hojiin kessan maali?

A. Qonnaan Bulaa  C. Daldalaa

B. Hojii mootumaa  D. Hojii humnaa

E. Barataa/ttuu  F. Kan biroo

6. Sadarkaa Barnootaa

A. Kan hin baratiin  B. Duubbisuufi barreessuu  C. Kutaa 1-8

D. Barnoota sadarkaa lammaffaa  E. Dippiloomaa  F. Digirii

G. kan biro-----

7. Baay"inni maatii kessanii meeqa?

1-5: Dhiira  Dubartii

6-10: Dhi  Du.

11-15: Dhi  Du.

8. Lakkoofsa daa'immanii umuriinsaonii hojjiif hin geenye-----  
9. Lakkoofsa daa'immanii umuriinsaonii hojjif ga'e-----

**II. Hubannoo hawaasni Inshuuraansii fayyaa hawaasaa irratti qabu ilaalchisee gaaffilee dhivaatan**

1. Inshuuraansii fayyaa hawaasaa beektuu?

A. Eyyee  B. Lakki

2. Deebiin kessan gaaffii 1<sup>ffaa</sup> eyye yoo ta'e akkamiin bartan?

A. Oolaa koo irraa  C. Afooshaa/Iddirii koo irraa

B. Namoota iqubii koo irraa  D. Waldaa irraa(Amantii)

E.Miidiyaa ( Tv, Raadiyoo, Gaazexaa)

F. Hojjettoota Inshuuraansii fayyaa hawaasaarraa

3. Miseensa inshuuraansii fayyaa hawaasaa tahuun bu'aa guddaa qaba.

A. Baay'een deggara  C. Walaba (hin degarus/hin mormus)

B. Nan-deggara  D. Baay'een Morma  E. Nan-morma

4. Tajajiila fayyaa IFH tiin fayadamuu jalqabdanitu?

A. Eyyee  B. Lakki

5. Debiin kessan lakii yoo tahe sababni kessan maali?

---

---

6. Beekumsa isin Inshuuraansii fayyaa hawaasaarratti qabdan maal fakkaata?

A. Xiqqoo  B. Giddu-galeessa  C. Guddaa

**III. Fayyaa maatii, baay'ina maatiifi galii argatan ilaalchisee**

1. Fayyaan maatii keessanii maal fakkaata?

- A. Baay'ee gadi bu'aadha  C. Giddu galeessa   
B. Gadi-bu'aadha  D. Misha  E. Baay'ee gaariidha

2. Oomishaalee armaan gaditti eeraman keessaa bara darbe isin/maatiin kessan walumaa galatti hammam oomishtan?

Boqqolloo (Qarshii/Kuntaala): \_\_\_\_\_

Xaafii (Qarshii/kuntaala): \_\_\_\_\_

Qamadii (Qarshii/Kuntaala): \_\_\_\_\_

Garbuu (Qarshii/Kuntaala): \_\_\_\_\_

Nuugii (Qarshii/Kuntaala): \_\_\_\_\_

Oomisha gosa biroo -----

3. Maatiin kessan beeyiladoota armaan gaditti tarreeffaman keessaa hangam qabu?

Sa'a Aannanii, Sangaa: \_\_\_\_\_

Ra'ee: \_\_\_\_\_

Hoolota: \_\_\_\_\_

Lukkuu (Hindaaqqoo): \_\_\_\_\_

Kan biro: \_\_\_\_\_

**IV. Gaaffilee faayidaafi rakkoolee Inshuuraansii faayyaa hawaasaarratti mudataniin walqabatan ilaalchisee**

1. Yomii kaasse Miisensaa Inusaransii fayyaa hawasuma tatani galmoftanii?

- A. Waggaa tokko dura  C. Ji'a shan dura   
B. Waggaa 2-3 dura  D. (Yoomi kaasse) -----

2. Sana dura basii mana yalaa fi qorichaaf bahuu hala kamiin basa turtanii?

- A. Kafaltii kalatii dhan  C. Yalaa/ Qorichaa Aadaa fayyadama ture   
B. Liqeefachuu dhan  D. garagara afoshaa fi iqubii dhan   
E. Tajajila toolan (Mootumma irraa)

3. Erga miisensa insuransii fayyaa hawasaa jalat galmofanee itt fayyadamu jalaqabnee kasnee fayyaan kooti fi kan matii koo foya'e jiira.

- A. Baay'een deggara  C. Walaba (hindegara/hinmormus)   
B. Nan-deggara  D. Baay'een Moorma   
E. Nan-moorma

4. Gartuu miisensa isaa kamii dha isin?

- A. Miisensa busii busuu   
B. Miisensa tolan/biilisaan yalaamu

5. Waraqaa enyuma miisensuma kessani yeroo dhan haromsitu?

- A. Eyyee  B. Lakki

6. Miisensuma koo haquuf/dhisuuf murtessera?

- A. Eyyee  B. Lakki

7. Miisensa ta"u koot fayyaaida argadhen hin qabu?

- A. Baay"een deggara  C. Walaba (hindegarus/hinmormus)   
B. Nan-deggara  D. Baay"een Moorma   
E. Nan-moorma

8. Yoo deebiin keessan gaaffi 7ffaa keessati eeye tehe sababnii keessan malii? 1<sup>ffaa</sup>, 2<sup>ffaa</sup>.... jedhaa debii kessan sadarka dhan filadha/ka"a?

- A. Tajajila qulqulina hin qabine  C. Hanqina Meshalee labratorii   
B. Hanqina qoorichaa  D. Busiin kafalamuu gudda tahusa

A. Kan biro-----

9. Waaluma galatii fayidaa akkami argatanitu insuransii fayyaa hawasuma irraa?

- a. -----b.  
-----c. ---  
-----

10. Akka fayyadamat rakoollee gurgudda insuransii fayyaa hawasumairati isiin mudatee maalfa dha? filanoo/debii keessan 1<sup>ffaa</sup>, 2<sup>ffaa</sup> jeedha sadarkaa dhan kaha

- A. Hanqina Qooricha   
B. Hanqina keeninsa tajajila qulqulu/garii   
C. Hanqina meshalee tajajila   
D. hanqina tajajila yeroo tassaa (Ambulansii)   
E. Debii hatatama kennu dhisu dhukubsatoota refiralii barbadanifi   
F. Kan bira yoo jirate-----

11. Busii amaa kafala jiruut gamada dha?

- A. Baay"een deggara  C. Walaba (hindegarus/hinmormus)   
B. Nan-deggara  D. Baay"een Moorma   
E. Nan-moorma

12. keeninisi tajajila fayyaa maal fakkata?

- A. Bay"ee garii dha  C. Qubsadha/homa hinjedhu   
B. Graii dha  D. Bay"ee gadii buu"a dha

13. Debiin kessan yoo bay"ee gadii buu"a tahee sababnii kessa taressa.

-----  
-----  
-----

14. Mana kessaniit wajjiri fayyan siinit dhiyatuu kami?

- A. Keela fayyaa  C. kilinika dhunfa   
B. Buufata fayyaa  D. Hospital Mootuma

15. Qoorichaa isiniif ajajamu yeroo dhan argatuu wajjira fayyaa mootuma irraa?

- A. Eyyee  B. Lakkii

V. **Hiirmanaa Hawassa Insuransii fayyaa hawasaa irratti.**

1. Walgayii/lenjii insuransii fayyaa hawasaa irrati hiirmatanii beektuu?

- A. Eyyee  B. Lakki

2. Qama isaa ilaltu dukaa carraa fulduratii/fuleen mari"achuu argatanitu insuransii fayyaa hawasaa ilalchise?

- A. Eyyee  B. Lakki

3. Busii kafalluti ala hiramna kan biro/gaha qabduu?

- A. Eyyee  B. Lakki

**Hirmaattuu/aa gaaffiifi deebii qorannoo kanaa ta'uu keessaniif  
galatoomaa!!!**

## Interview Guide

### Employees of Woreda CBHI

Date: -----

Interviewer: -----

Position: -----

Interviewee: -----

Education status: -----

Duration of interview: -----

Telephone: -----

Place: -----

Woreda & Name of Kebele: -----

Time of interview: -----

1. When collection of premium is takes place (Timing of colleting the premium)

-----  
-----  
-----

2. What is/are initiating factors behind enrolling community based health insurance in your woreda?

-----  
-----  
-----

3. What is the current total house hold number enrolling in the program? Among them how many of them are identified as indigent & non-indigent?

-----  
-----

4. What are major problems you are currently facing while enrolling community based health insurance in your woreda?

**Supply side (From your office side)**

-----  
-----  
-----

**Demand side (From member's or household's side)**

-----  
-----

5. What strategies/ method's you are using in order to handle the above listed problems?

-----  
-----  
-----  
-----

6. How you are creating & increasing level of awareness of the household's especially those of not yet enrolls?

-----  
-----  
-----  
-----

7. How can you see the enrollment rate of the woreda? (Very Good, Good, Satisfactory, poor). Why? How?

-----  
-----  
-----  
-----

8. What is the level of drooping rate of the household's from the program in your woreda? & what is the immediate reason for it?

-----  
-----  
-----

9. What activity is performed by your office in order to reduce even to stop the drooping rate of the member?

-----  
-----  
-----  
-----

10. With what government hospital you are currently signed agreement for patient referral cases & what is a service provision/coverage is looks like.

-----  
-----  
-----

11. Is there any insurance company/ bank you enter in to binding agreement to facilitate the insured service? Yes/ No? & how the payment is takes place?

-----  
-----

12. Do you have any Libratory equipments & medicines availability in your health center?

-----  
-----  
-----

13. For how many numbers of child aged is possible for households to get free health service? Please identify the number of both indigent & non-indigents.

-----  
-----

14. Do you think the high number of family size (underage) has impact on those have less aged children"s **Yes/No. & How?**

-----  
-----

15. How many people are planning to enroll the current fiscal year? & what activity is performed by your office in order to accept these households? (**activity like: continuous and rigorous awareness creation and behavioral change** )

-----  
-----  
-----

16. Is there identified model kebele"s (Best performed) in enrollment of community based health insurance than other woreda"s? What makes them model?

-----  
-----  
-----

-----Identified kebele"s/areas in less enrollment, high droop out & other performances please list their name & what activities is performed by your office in order to boost up their performance like other neighboring kebele"s?

-----  
-----  
-----

17. By what approach you introduce the premium level in a **top-down manner/bottom up approach** (in which the participation level of the society is high)? Why you prefer to follow such approach?

-----  
-----  
-----  
-----