

**The Practice of Community Based Health Insurance in  
Ethiopia: The Case of Meket District in Amhara Region**

**By:**

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**Addis Ababa University**  
**College of Social Science**  
**School of Social Work**

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**Declaration**

I, Beyene Adane Endeshaw, hereby declare that the thesis entitled: “*The Practice of Community Based Health Insurance: the case of Meket District*”, submitted by me to the award of the Degree of **Master of Social Work at Addis Ababa University**, is a product of my original work and it hasn’t been presented for the award of any other Degree, Diploma, Fellowship of any other university or institution. This work has also accredited the views of the research participants. To the best of my knowledge, I have fully acknowledged the materials and pieces of information used in the study.

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This is to certify that this thesis entitled: “*The Practice of Community Based Health Insurance: the case of Meket District in North Wollo Zone of Amhara region*”, prepared by Beyene Adane and submitted in partial fulfillment of the requirements for the award of degree of **Master of Social Work** complies with the regulation of the University and meets the accepted standards with respect to originality and quality.

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## Abbreviation and Acronyms

**ANRS:** Amhara National Regional State

**CBHI:** Community Based Health Insurance Scheme

**CHW:** Community Health Worker

**FMoH:** Federal Ministry of Health

**HSFR/HFG:** Health Sector Financing Reform/Health Finance and Governance

**ILO:** International Labor Organization

**MWAO:** Meket Wereda Administration Office.

**NGO:** Non-Governmental Organization

**OOP:** Out of Pocket

**SHI:** Social Health Insurance

**USAID:** The United States Agency for International Development

**WCA:** West of Central Africa

**WHO:** World Health Organization

**SSA:** Sub-Sahara Africa

**SNNP:** Southern Nations Nationalities and peoples

**EHIA:** Ethiopian Health Insurance Agency

**UHC:** Universal Health Coverage

**PHC:** Primary Health Care

**PHCU:** Primary Health Care Unit

**PHCS;** Primary Health Care System

**USD:** United States Dollar

**MDG:** Millennium Development Goals

**ETB:** Ethiopian Birr

**PSNP:** Productive Safety Net Program

**PDS:** Permanent Direct Support

**ORDA:** Organization of Rehabilitation and Development of Amhara

**WoLSA:** Woreda office of Labor and Social Affair

**LMICs:** Least and Middle Income Countries

## Abstract

*The issue of Community Based Health Insurance is an emerging and promising concepts to access affordable and effective health care services in Low and Middle income countries. The aim of the introduction of Community Based Health Insurance is to mobilize additional resources to the health sector. Accordingly, the main objectives of this study was to assess the practice and challenges of CBHI in the rural area of Ethiopia; particularly in Meket District, North Wollo Zone of Amhara region. To conduct this study; mixed research approach was employed to gather data from 173 respondents (60.7% male and 39.3% female households) for household survey and informants of IDIs, KIIs and FGDs. The quantitative data were analyzed and presented using descriptive statistics such as table, percent and graphs in SPSS version 21. Primary data have been collected qualitatively through open-ended questions like, in-depth interview from purposively selected beneficiary households, KII from four CBHI employed staffs and woreda administration head and FGD from kebele council, CBHI beneficiaries, health extension workers, kebele managers and DAs. The result of the study shows that, the majority of household respondents (82.7%) cover their health expenses before enrolling CBHI were through OOP, limited beneficiaries sense of belongingness and ownership in managing, administering and decisions about the scheme. Kebele/village administration forced households to pay the premium. The findings also indicated that, there were gaps in design and implementation of the program, in adequate supply of medicines, lack of adequate supply of laboratory equipment, long process to refer to the contracted health facilities, poor delivery of service by health facilities, Lack of skilled man power in health facilities, professionals didn't provide equal services and threatened indifferently to member of CBHI and non- member beneficiaries. A number of households didn't have membership ID even they paid the premium, long process of refund of money to the beneficiaries, delay in renewal of membership ID and households not bring full family registration. Finally, the study provides an implication to different actors like; program and policy, social work Education and implementation to research. The governments should provide holistic awareness to the community on CBHI, improve and shorten the referral processes, should provide comprehensive and quality health services to the members, CBHI should provide adequate supply of medicine and medical equipment by working in collaboration with Ethiopian Pharmaceutical Fund Supply Agency (PFSA) and participating members in decision making process to provide trust and sense of ownership to the communities.*

**Key words:** Household, subsidy, indigent, CBHI, Beneficiaries, Enrollment, Out Of Pocket

## CHAPTER ONE: INTRODUCTION

### 1.1 Background of the Study

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 Sub-Saharan Africa (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 ( Guy, 2003).

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 (WHO, 2005).

Based on the 2014 national health account around 20.77 USD were spending per person. Compared to the World Health Organization standard which estimated around 114 USD per person per annum is much higher than the national health accounts. Thus spending for health expenditure are so low and the expenditure are 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 reforms, among them health sector reform is a part of it. Currently, the government is introducing various tools to finance health sector programs among them Community Based Health Insurance (CBHI) is for the informal sectors & those lead their lives on agricultural sectors; where as Social Health Insurance (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).

Accordingly, the pilot CBHI scheme was tested in 13 Districts located in four regions (Tigray, Amhara, Oromiya, and SNNPR) of the country in 2011 aimed at improving access to health care services, reducing the burden of out of pocket expenditure, increasing quality of services to balance high demand of health care and low supply of medical services basically for rural households and people in urban informal sector (FMoH 2010; Anagaw 2015).

A study by FMoH (2011) stated that the designing of the Ethiopian CBHI scheme builds on the assumption of certain features (parameters) such as, membership for enrollment is done voluntary on a household basis; to reduce the possibility of adverse selection, financing the very poor (indigents), regular premium, targeted subsidy , benefit package, community involvement in management and administration of CBHI scheme and line of referral are considered main features in the designing of CBHI scheme. In the pilot districts, households

who join the community-based health insurance are expected to pay 180 Birr (8.57 US\$) annually as a premium. Community Based Health Insurance covers a wide variety of health insurance arrangements or benefit packages. The benefits packages of CBHI in Ethiopia include all curative and preventive care that are part of the essential health package in Ethiopia ( FMoH 2011).

Community Based Health Insurances scheme brought a potential to achieve universal coverage of health services through risk pooling and protect rural household and informal sector population from costly health care expenditure (Jutting 2003). The scheme is new for many developing countries particularly for Ethiopia. So, an investigation about CBHI and its contribution in the health care system is imperative, as it changed households access for healthcare service, improve healthcare seeking behavior and quality of service provisions.

Consequently, this study examined the practice, challenges, house hold participation, knowledge and awareness of communities in Community Based Health Insurance schemes for rural house hold particularly in Meket District in North Wollo Zone of Amhara Regional State and contribute to the improvement of implementation of the schemes in the District.

## **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 (WHO, 2010). 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, 2013)

Poor health care financing remains a major challenge for the health system of Ethiopia (WHO, 2010). It leaves households vulnerable to impoverishment from catastrophic health expenditures, and slows progress towards health improvements such as the Millennium Development Goals (MDGs) by limiting access to essential health services among the poor. Important barriers to improve 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 (WHO, 2010).

Study that was 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.

Adane (2013) studied on willingness to pay for CBHI among households in the rural community of Fogera District, North West Ethiopia. The study concluded and recommended that willingness to pay for the CBHI was encouraging. However, they indicated that 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.

Hilina (2014) conducted research on Socio Economic Determinants of Community Based Health Insurance the Case of Kilte Awelaelo District, Tigray Regional State in his study a logistic 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.

Nair (2015) conducted research on Determinants of Enrollment in Comprehensive Health Insurance Scheme and Implementation Challenges: A Study in Kerala, South India 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. The researcher conclusion indicated that poor 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 studies conducted (case of Ethiopia) when the program was implemented in CBHI implementation woredas. But currently CBHI practice in

Ethiopia is expanded and rolled out in its full that beyond the first 13 identified pilot woredas. Since the challenges encountered on CBHI enrollment before the pilot woreda schemes & after may not be the same. The employed majority of the researcher's employed the quantitative approach especially logistic inferential statistics.

Apart from these the above studies were conducted with limited factors and did not include factors that affect CBHI enroll like aptitude of insured House Holds and perceptions of health care providers about CBHI scheme. What is more; most studies previously made focused on willingness of the HH to pay to CBHI.

Hence, these studies would fill these gaps that exist in the previous studies which were concluded mainly using methodology; more of either qualitative or quantitative. But this study conducted to the new area that has not been re-targeted for research by identifying the gap and the challenges of CBHI practice and I used mixed approach (both qualitative and quantitative). The reason that inspires me to select the topic was that six years back from now I was in Meket Woreda (the study area) to provide awareness training about CBHI. The community members were raising a number of issues like premium issue ( from family member one to five pay the same amount), service delivery issue e.g private institution provide better service than public, referral system etc.... Their question were very impressive & relevant and I understand that it is vital to conduct a research in the areas of the practice and challenges of CBHI.

### **1.3 Objectives of the Study**

#### **1.3.1. General Research Objectives**

The general objective of this study is to examine the practice, house hold participation, knowledge and awareness of communities on CBHI schemes in Meket Woreda.

### 1.3.2. Specific Research Objecti

Specifically, this study intends:

- To identify the household's level of knowledge & awareness they have on the concept of Community based health insurance.
- To investigate implementation challenges encountered in enrolling of CBHI program in both demand side & supply side problems.
- To identify the enrollment status of CBHI in the district.
- To assess the households' participation level on CBHI practice and utilization
- To identify strategies/practices help to overcome implementation problems.

### 1.4 Research Question

This study will intended to answer the following research questions:

- What is level of society's knowledge & awareness on CBHI program?
- What are the implementation status of CBHI in Meket district?
- What are demand & supply side challenges faced by Meket woreda on practicing the CBHI scheme
- How CBHI beneficiaries express their experience of participation on CBHI implementation?
- What are ways used to overcome the challenges facing the CBHI in Meket district?

### 1.5 Significance of the Study

The issue of CBHI is not studied in Meket District. Thus, this research will intended to make a contribution to the woreda filling this gap. First, the findings of this study will have a tremendous significance in identifying the challenges of CBHI in the study area, and responses

of the government or non-government organizations in addressing the challenges of CBHI in the study area. Second, it creates awareness to the government, NGOS, and anyone who is interested to solve the challenges of CBHI.

Third, this research will create insight for further research to be investigated on the study area for further solution. Fourth, the study is crucial in making positive impact on providing an input to policy makers in understanding where policy gap is and brings adjustment to accommodate such unaccommodating issues to policy and development.

Fifth , it creates insight for the responsible government bodies of Meket Woreda particularly who are employed in Health Sectors to evaluate and correct how their duty addressed challenges of community as well as initiated to narrow such gaps among the community on CBHI implementation.

## 1.6 Scope of the Study

This study focused on Health Insurance schemes 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.

The study area (Meket Woreda is selected due to its good performance & some challenges during implementation. The District Performance last year is 74.8% which is the highest as compared with other schemes woreda (EHIA, 2015).

## 1.7 Limitation of the Study

It's hard to imagine for a study of this kind will possibly be without limits. The fact that this study is planned to be conducted in Meket Woreda, North Wollo Administration of Amhara Regional State, raises the key question of representation for a bigger image. The first limitation of the study may be regard to sampling; the researcher determined sample size for the total number of households from the selected kebeles that will not fully represent the study District due to resource constraints. It also faces some challenges like time constraints & respondents were not available within the time frame. Even if the researcher face the above listed challenges I have been used different techniques to cope up the problems.

## 1.7 Concepts and Terminology

### 1.7.1. Conceptual Definition

**Community Based Health Insurances:** a scheme characterized by community members to prepay for healthcare services formed based on solidarity and voluntary collective pooling of their resources to share the financial risks of health care services and entitle to own the scheme and control its management (Wiesmann and Jutting 2000)

**Household:** is defined as a person or group of people related or adopted legally, who live together and share a common pot of food (Jutting 2003).

**Traditional Medicine:** is the sum total of Indigenous knowledge, skills, and practices, based on the world views and experiences to different cultures, used in the prevention, diagnosis, maintenance or improvement of physical and/or mental illness.

**Universal Coverage:** access to adequate health care for all at an affordable price (WHO

2005).

**Kebele/Village:** is the smallest administrative unit established in management and administration of CBHI scheme

**Indigents:** are people (10% from the total population of the District) who are poor of the poor and are unable to afford premium payment of CBHI scheme.

**General Subsidy:** central government of Ethiopia provided 10% of the premium collected in CBHI implementing woredas.

**Risk Pooling:** A means of resource sharing for health care through cross subsidizations for sick and poor, from healthy and wealthy.

**Healthcare Institutions:** health oriented organizations that established formally including health posts, health centers, clinics, pharmacy and hospitals working in the study area.

**Woreda:** one of the portions in to which an entire state or country divided for judicial, political or administrative purpose (Black's Law Dictionary).

**Region:** Areas that broadly divided by physical characteristics (physical geography), human impact characteristics (human geography) and the interaction of human and the environment (Black's Law Dictionary).

## CHAPTER TWO: LITERATURE REVIEW

This chapter presents reviews of literature on Community Based Health Insurance practice, challenges, participation of House Holds and knowledge and awareness of communities on CBHI. The literature review shows that theoretical as well as empirical literatures.

### 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).

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 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 (Steven R.2005).

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).

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 CBHI 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. As Anagaw (2015) in his study 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 (Anagaw, 2015).

CBHI 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 (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 Strength of CBHI

Besides providing financial protection from the economic consequences of illness, health insurance is meant to improve equitable and affordable access, and reduces the cost of health care and thereby, promotes health care seeking behavior (Chen *et al.* 2007; Hsiao 2001). Chen *et al.* (2007) stated that it is precisely the most vulnerable (low income and rural) population groups who benefit most from CBHI scheme; by removing their financial barrier at the time of illness.

One of its key strengths is community ownership and involvement in the setup, governance and management of the scheme. Given CBHI's participatory decision-making and management structures, it is said to improve the transparency and accountability of the scheme. It also has the potential to enhance community empowerment and allow the voicing of community members' concerns and expectations in the management of local health systems. It can also build trust and encourage familiarity with the concept of insurance (WHO 2010).

### 2.3 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 (Angaw 2015)

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 (Anagaw, 2015).

### 2.4 Types of Community Based Health Insurance

As to Krishnan & Tenkorang, cited in Anagaw, (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 are:

- 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 CBHI Models	Types of CBHI		
	Community prepayment health organizations	Provider based health insurance	Government-run community-
Design features	<p>Financed by contribution from members</p> <p>All 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</p>	<p>Designed by governments as part of the health financing system</p> <p>Often includes both primary care and hospitalization</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</p>

Organizational and institutional features	The provider is not involved in the administration of the scheme The schemes may sign contractual agreement with local providers to obtain preferential prices and insure quality of services	Providers administer the schemes and collect premiums from scheme members Providers may obtain technical assistance From the	Governments are strongly involved in the design, implementation, and evaluation of the scheme.
Role of government and NGOs	NGOs often provide technical assistance and provide start-up funds, Governments provide legal recognition and encourage their	NGOs and governments may improve the facility of the providers	Government and NGOs may subsidize the scheme and provide exemption from premium payment for
Role of the community	Pay premiums all round community involvement in design, implementati	Pay premiums Provide feedback on Quality	Pay premiums Communities may be involved in design and
Strong side of the scheme	Trust and feeling of ownership	Does not require management and technical skills from the community	The possibility of subsidized premiums Large size of scheme and enhanced sustainability
Weakness Of the scheme	Small size in nature and low ability to pool enough resources Lack of technical and managerial skills about health	Limited scale Relative low power of the community to influence benefit	Limited feeling of community-ownership Potentially high administrative costs

Source: Krishnan and Tenkorang., Cited by Anagaw (2015)

#### 2.4.1. Community Prepayment Health Organizations

According to Tenkorang as cited by Anagaw (2015) these types of health organizations are characterized by voluntary membership and payments 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.

#### 2.4.2 Provider Based Health Insurance Schemes

According to Tenkorang as cited in Anagaw (2015) 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.

### 2.4.3. Government Runs Community-Involved Health Insurance

As Krishnan, (2001) stated 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. 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 (Anagaw, 2015).

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 (Anagaw, 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 (Anagaw, 2015).

## 2.5. 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)

Meghan (2010) 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 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 (Abebe, 2010).

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).

## 2.6 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 (Jutting, 2000).

Furthermore, different studies (Angaw,2015) 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.

## 2.7. Performance Criteria

### Enrollment

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 while

alive” is gaining attraction as the Ethiopian government pursues its goal of providing universal health coverage (EHIA, 2015).

In July 2011, the Government of Ethiopia launched a pilot Community-Based Health Insurance (CBHI) scheme, with the aim of enhancing access to health care and reducing the burden of OOP expenditure. The scheme, which caters to rural households and urban informal sector workers, was rolled out in 13 districts located in four main regions (Tigray, Amhara, Oromiya, and SNNPR) of the country (Zelalem, 2015).

The scheme was introduced by Ethiopia’s Federal Ministry of Health (FMoH) in collaboration with USAID, Abt Associates Inc. (2013) and CARE Ethiopia, and 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)

Now more than 9.3 million 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 (USAID, 2018)

## 2.7.1 Exploring Factors that Influence Performance

### *2.7.2.1 Factors Influencing Membership*

1. **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).

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 (Guy, 2003).

**2. Unit of Enrollment:** 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 (Guy, 2003).

**3. 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 (Guy, 2003).

**4. Timing of Collecting:** 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, payment schedules were held flexible, with monthly, quarterly, semi-annual and 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 (MoH 2015).

**5. 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).

**6. 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 (Guy, 2003)

## **2.8. Health Sector in Ethiopia**

Ethiopia is developing with a promising rate to join middle income countries in a decade (FMoH 2015). 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).

Achieving Universal Health Care (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 (FMOH, 2014)

Ethiopia is developing PHC (Primary Health Coverage) through Health Extension Programme (HEP) and PHCU (Primary Health Care Unit) 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. (FMOH, 2014)

### 2.8.1 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 (EHIA, 2015).

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).

According to the study of EHIA (2015) 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.

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 (EHIA, 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 woredas population conducted by HSFR (Health Sector Finance Reform) during the design phase as well as the assessment of readiness of facilities in the pilot woredas 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 level as opposed to the household level. Associated Kebeles form a larger woreda-wide scheme (EHIA, 2015).

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, (EHIA,2015).

#### *2.8.1.1. 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 (EHIA, 2015).

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 level, there was no pressure by either the community or the kebele administration during the enrollment process (EHIA2015).

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) (EHIA, 2015).

#### *2.8.1.2. 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 (EHIA, 2015).

#### *2.8.1.3 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 (EHIA, 2015).

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 (EHIA, 2015).

According to the CBHI design, there are two types of government subsidies to the schemes: targeted and general subsidies, 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 (EHIA, 2015)

#### *2.8.1.4. 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 (EHIA, 2015).

#### **2.8.2. 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 (EHIA, 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 9.3 million 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 (USAID, 2018).

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 Health Financing and Governance (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 all over Woreda’s in Ethiopia 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(EHIA,2015).

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.

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.

## Summary

The above section presents reviews of literature on Community Based Health Insurance practice, House Hold participation, knowledge and awareness of the communities. 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 Meket district & its Kebeles /local villages.

Theoretical and empirical literature also clearly defined in this section and most of the previous research focusses on the willingness of households to pay for CBHI, the service given by the health sectors to meet the National Health Coverage and Economic analysis for CBHI. The empirical literature stated that the experience of different Nations in the world especially in Africa and South East Asian Region shows that the implementation of CBHI is still challenging

## CHAPTER THREE: RESEARCH METHODS

### 3.1. Research Design

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

The main survey instrument for this study was Questionnaire, Focus Group Discussion (FGD), interview and observation. The use of the survey allows the collections of large amount of data collected from large population in highly economic way as Saunders et al (2009) cited in Diriba, (2013). The data analyzed quantitatively & qualitatively using descriptive.

### 3.2. Research Strategy

The study employ a combination of quantitative and qualitative approaches. These days mixed method is considered as a tool to triangulate the result of single approach through multiple methods (Johnston, 2010). Therefore, this study considered these two methods in order to make the study more reliable through triangulation to obtain data from different sources, of the finding and eases data collection .The qualitative approach is more appropriate for understanding process questions, understanding the “how’s” and “what” regarding what is going on in practice in relation to implementation CBHI. Moreover, the quantitative approach used to identify factors affecting enrollment of CBHI.

### 3.3 Types of Data and Data Collection Technique

#### 3.3.1 Data Type and Sources

The study employed both quantitative and qualitative types of data. The quantitative data used to gather information using questionnaire while the qualitative data were collected using semi-structured questionnaire, FGD, KII and in-depth interview with structured checklists.

##### *3.3.1.1 Primary Data Sources*

To achieve the objectives of the study, primary data sources were collected from firsthand information. The sources of primary data were members of CBHI through a questionnaire and employee through open ended questions. Furthermore, key informant interviewee including wereda CBHI coordinator, Wereda health center heads, DAs, Woreda and Kebele CBHI board members and nurses. Focus Group Discussion including kebele/village CBHI board members, beneficiaries and Health extension worker were participated in the discussion.

##### *3.3.1.2 Secondary Data Source*

In this study, information from the secondary sources of data were 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 CBHI implementation they were used as inputs of main sources of secondary data.

### 3.4. Sample and Sampling Procedure

The participants for sources of primary data were questionnaires, interviews and FGD with beneficiaries/ households of Meket Woreda & employees of community based health insurance found in Meket woreda. The participants for the questionnaire selected by using purposive sampling and beneficiaries are select from local villages by using simple random sampling

technique. The five local villages selected out of twenty one villages 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 during the preliminary assessment among those villages include Kolla Warkaye, Dega Workaye, Sisseye, Gulge and Agew wuha are selected. From these five villages; the three villages are selected on their good performance on enrollment of community based health insurance, those are Kolla Warkaye, Dega Workaye, Sisseye. Whereas Gulge and Agew wuha villages are among the less enrolled villages on Community Based Health Insurance implementation.

The total study population is 755 and drawing using appropriate sample frame & sample size determination as mentioned below (MWAO, 2018). Meket woreda is selected due to it is among the good enrolled woredas in Ethiopia (MWAO, 2018) & I have been worked for many years in the study area and trained a ToT on the strategy of CBHI and also participated in community awareness on CBHI. So I have seen some limitations in awareness about CBHI and not research was carried out in the district. The villages as indicated in the above is selected from the two strata's good enrolled & less enrolled village.

### **3.5 Sample Design**

#### **3.5.1 Sample & Sample Size Determination**

The rule of thumb cited in Kevin Durrheim, (2006) cited in Guttema (2017) was used 30% of sample size for small population up to 1000.

According to the data from woreda CBHI office the total number of House Holds in the selected kebele /villages are 755, among them those households enrolled above one year were 577 HHs. Hence, purposively I excluded those households enrolled less than one year in order to get very

depth information from those who have good enrollment & stay with long time on schemes. Thus the researcher randomly selected 173 respondents for the data collection through the questioner, in-depth interview and KII from the households.

**Table 3. 1 Population and sample selection of the study**

N/o	Name of villages	Total population	No. of respondents
1	Dega workaye	208	62
2	Kolla Workaye	63	19
3	Sisye	139	42
4	Gulge	86	26
5	Agew Weha	81	24
<b>Total</b>		<b>577</b>	<b>173</b>

### 3.5.2. Sampling Design and Sampling Frame

Household is the unit of analysis in this study, in which, household heads were contacted to fill up the questionnaire. The study was conducted using simple random sampling of probability sampling technique. Simple random sampling is a probability sampling technique in which sample kebele/ local villages are selected from a list and all subjects have equal probability of selection.

### 3.6. Data Collection Instruments

**Questionnaire:** This method employed to cover five villages that consists of 173 participant (10% contingency will be in consideration) household heads. To collect data, semi-structured

questionnaires (both open ended and close ended questions) developed in English language and translate in to Amharic. Five (5) experienced data collectors were recruited based on their proficiency in the train on the data collection techniques and on the content of questionnaire by the student researcher.

**In-depth interview:** The student researcher has been collected data through in-depth interview from CBHI beneficiaries and woreda CBHI board members for triangulation purpose. Respondents contacted for the in-depth interview selected purposively by the researcher of the study as key informants on the basis of their closeness to the implementation of community based health insurance.

**Key Informant Interview:** As part of the qualitative survey, KIIs were carried out using a guide developed for this purpose and attached as Annex. People (expertise) who are responsible for implementing CBHI scheme. Participants who have better understanding of CBHI scheme implementation in particular on key issues such as design and implementation, management and governance, regulatory framework, sensitization, capacity building, and CBHI scheme parameters (premium, benefit packages, general and targeted subsidies, etc.). Key informant interviews were undertaken with community based health insurances official, *kebele* leaders and health professionals from health facilities and District health office, in order to get diverse perspectives.

**Focus Group Discussion/FGD:** This method used to triangulate the data collected through survey and interview. Focused Group Discussion conducted with *kebele*/village CBHI board members, beneficiaries, *kebele* employee, *kebele* administrators, Health extension worker and DAs participated in the discussion. Focus group discussion (FGD) used to better understand communities perspective and consensus regarding benefit package, quality of services provision

and health services utilization. “FGD is particularly suited to be used when the objective is to understand better how people consider an experience, idea, or event, because the discussion in the FGD meetings is effective in supplying information about what people think, or how they feel, or on the way they act” (Freitas 1998).

### 3.7. Data Processing and Analysis

The researcher applied both qualitative & quantitative data analysis methods depending on the nature of the data collected. The data gathered through structured questionnaire has been processed via SPSS version 21 (Statistical Package for Social Science) in order to get 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 analyzed via categorization or type of the question item as putted in the questionnaire & interview.

**Table 3. 2 profile of interviewee (employee & beneficiaries)**

No. of interviewee	Sex	Education	position/ status
1	M	BA	CBHI Coordinator
2	M	Bsc.	Medical Auditor
3	M	Bsc.	Nurse
4	M	Bsc.	Woreda Adm. Head
5	M	7 <sup>th</sup> grade	Beneficiary
6	M	5 <sup>th</sup> grade	Beneficiary
7	M	Read and write	Kebele council/beneficiary
8	M	Read and write	Village leader/ beneficiary

### 3.8. Site Selection and Description of the Study Area

The study area Meket Woreda is found in Amhara region, North Wollo Administration Zone 667 kms north of Addis Ababa and 220 kms from Bahardar capital of the region and 140kms from Woldeya capital of North Wollo zone. Its boundary is connected to Bugna and Lasta Woreda in the North, in the South Wadla Wereda, East Gazzo wereda, and West Taychgaynt and Laygaynt wereda which is 60 kms southern to St.Lalibela ancient rock hewn churches. Geographically it is located between longitude 38°30'-39°30'E, and latitude from 11°30'-12°10'N. The altitude varies from 1458m-3460m above sea level, with kola 25%, woyina dega 55%, and dega 20% agro ecology zone. The total area coverage is 191,148 hectare with different land use land cover such as cultivated land 49,450 hectare, pasture 15,152 hectare, forest & shrubs 54,000 hectare, building

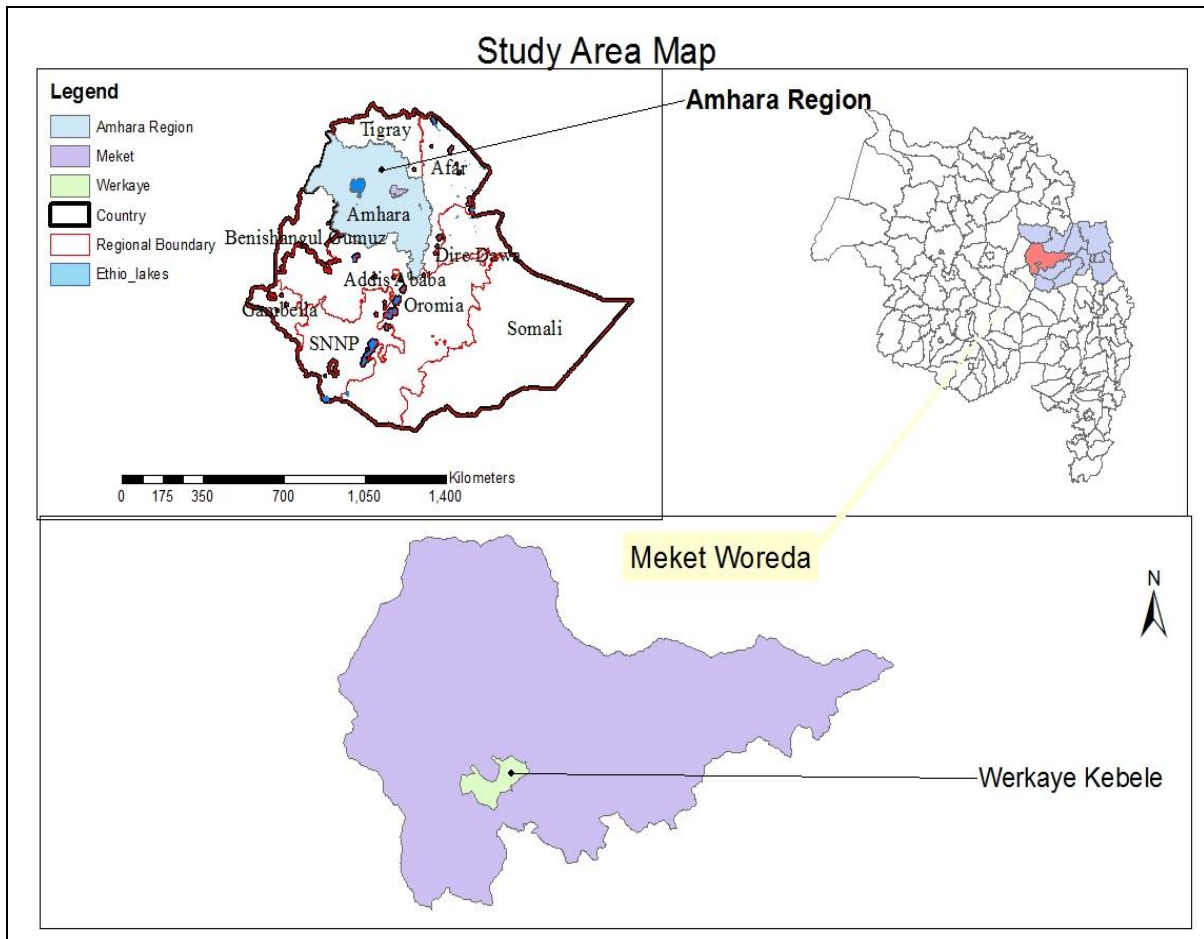
of house 39,528 hectare, degraded or eroded land 8,659 hectare, valleys and rugged topography 8,659 hectare, grass land 15,700 hectare (MWAO,2018).

The total number of population of Meket wereda is 217044. From these 107899 were males and 109145 were females. From these 12760 male 13335 female total 26095 live in the two urban kebeles. Agriculture is the most dominant means of livelihood of the population of the district. There are also a considerable number of people engaged in selling livestock, petty trading, livestock products and firewood selling (MWAO, 2018).

Meket Woreda has 34 rural Kebele and 2 urban Kebele, the livelihood of Meket *wereda* is dominated by subsistence agriculture and engaged on small trade. Average size of cultivated land owned by household with five family sizes is about 0.5 hectare. Teff, barely, wheat, bean, sorghum, and soya been are the major crops grown and raising livestock product, engaged in many activities irrigation in the winter season to produce different grains and fruits in this area (Meket wereda GTP1 Report, 2016).

The researcher has been selected the study area because of his prior knowledge and familiarity in the area. There were higher incidence of diseases and lower economic condition of the people; on the other hand the wereda has best achievement in CBHI with compared to other eastern Amhara region weredas.

**Figure 3. 1 Location of the study**



Data source: Ethiopian Mapping Agency (2019)

### 3.9. Ethical Considerations

Throughout the research, the researcher upheld and respected the participants' right to privacy, anonymity, fair treatment and to protection from discomfort and harm (Neuman, 2003).

The researcher took a formal letter from School of Social Work from Addis Ababa University, to approach different offices. The privacy of participants have abided by the rule of confidentiality. Audio-tape recording has made after obtaining the consent of the participants and notes being taken during the interviews and the FGD. Before starting the interview or the FGD, the purpose of the discussion clearly explained to make sure that the participants and discussants understand the topic to be addressed. Both the interviews and FGD held in Amharic and at convenient times for the participants.

In order to insure confidentiality, the participants were not required to write or tell their names. Furthermore, the researcher assured participants that their responses for the interview and focus group discussion are used only for the intended purpose and after completing the research, the researcher wiped out the participants' responses as no more required.

## CHAPTER FOUR

### DATA PRESENTATION AND ANALYSIS

#### 4.1 Introduction

In this chapter, the major findings of the study are presented, analyzed and interpreted. In order to collect the primary data questionnaire were distributed to CBHI beneficiaries, Interview were conducted with CBHI beneficiaries and that were selected purposefully with concerned Woreda staffs of CBHI and Head of Meket Woreda Administration office and FGDs were made with the selected CBHI members and Kebele council. The results are presented and analyzed in a sequential order in line with the specific objectives stated under the first chapter of the study using tables, pi-chart and graphs to show frequency, percentage and Statistical descriptions such as mean and standard deviation. Narrative descriptions were made for the interview data. Secondary data triangulation were made to support the explanation.

#### 4.2 Backgrounds Characteristics of the Respondent

The background section consists of the demographic characteristics of respondents which includes sex composition, age group and relationship of the family, marital status, occupation, education level and family size of the households.

##### 4.2.1 Sex Composition of the Respondents

Of the total head of respondents 68 (39.3%) of them were female beneficiaries of the CBHI in Meket district. The males were 105 (60.7%) which is the largest number of the total respondents. This shows that the majority household head of the selected kebele CBHI members are male households than female households.

#### 4.2.2 Age Composition of the Respondents

Regarding the age distribution of the respondents 58.4% of the respondents are within the age of 18-48; 32.9% are within the range of 49-69 years old. Whereas, the rest 8.7 % of them are above 70 years age. This implies that the majority of the respondent households fall in the range between 18 and 70 years old.

#### 4.2.3 Respondents Relation to the Family

Regarding the respondent's relation to the family as indicated in Table 4.1 below; among the total respondents 106 (60.7%) of them were the head of the family (fathers) to that particular family. Whereas 61 (35.8%) of them were mothers, the rest 6 (3.5%) of them are son/daughters of the family. This suggested that those families headed by the male is more than those of female headed families. This also supports the above data indicated the sex of the respondents; male respondents are more enrolled than female respondents which is true in terms of head of family.

#### 4.2.4 Marital Status of the Respondents

Concerning marital status of the respondents, as it can be seen in Table 4.1, 146 (84.4%) of them are already married respondents, 10 (5.8%) and 12 (6.9%) of them were divorced and widowed respectively, whereas 5 (2.9%) of them are not married/bachelor. This shows that among the majority of the respondents (97.1%) of them are not bachelor. From this 5.8% are divorced and 6.9% of them are widowed/ lost their wife or husband and not married again and are currently living with their children. As the data shows marital status is an important factor for practicing CBHI and renewing membership to stay within CBHI. This means that majority of the respondents are currently married households enrolled in the CBHI. This also suggested that

households having their own family need to be secured than those of who have not their own family. This indicated that marital status is one of the factors to stay in and practice CBHI.

**Table 4. 1 Demographic characteristics of respondents**

<b>Demographic Characteristics of Respondents</b>		<b>Frequency</b>	<b>Percentage (%)</b>
<b>Sex of the respondents</b>	Male	105	60.7
	Female	68	39.3
	<b>Total</b>	<b>173</b>	<b>100.0</b>
<b>Age group of Respondents</b>	18-49	101	58.4
	50-69	57	32.9
	Above 70 years	15	8.7
	<b>Total</b>	<b>173</b>	<b>100.0</b>
<b>Respondents relation to the family</b>	Father	105	60.7
	Mother	62	35.84
	Son/ Daughter	6	3.46
	<b>Total</b>	<b>173</b>	<b>100.0</b>
<b>Marital Status of Respondents</b>	Married	146	84.39
	Single	5	2.89
	Divorced	10	5.78
	Widowed	12	6.94
	<b>Total</b>	<b>173</b>	<b>100.0</b>
<b>Occupation of the respondents</b>	Agriculture	136	78.6
	Housewife	20	11.6
	Trade	17	9.8
	<b>Total</b>	<b>173</b>	<b>100</b>
<b>Educational status of he Respondent</b>	Illiterates	88	50.87
	Read and write	50	28.9
	Primary Education (1-8)	22	12.72
	Secondary Education	13	7.51
	<b>Total</b>	<b>173</b>	<b>100.0</b>
<b>Family size of the respondents</b>	1-5	145	83.8
	6-7	26	15
	8 and above	2	1.2
	<b>Total</b>	<b>173</b>	<b>100.0</b>
<b>Number of children</b>	Under 18	156	90.2
	Above 18	17	9.8
	<b>Total</b>	<b>173</b>	<b>100.0</b>

**Source: Sample Survey (2019)**

#### 4.2.5 Occupational Status of Respondents

Regarding the occupational status of the respondents; as Table 4.1 above illustrates 78.6% of them are engaged in Agricultural activities. About 11.6% of the respondents are housewife,

whereas 9.8% are involved in trade. This shows that out of the total respondents 78.6% of them are leading their lives by engaging in agricultural activities. This clearly shows that the primary focus of CBHI is the rural people who are engaged in informal sectors of the economy.

#### **4.2.6 Educational Status of Respondents**

Regarding the educational status of the respondents, as it can be seen in Table 4.1 only 13 (7.5%) of them have completed secondary education level and 22 (12.7%) of them are elementary school (1-8) attendants whereas 88 (50.9%) of them couldn't read and write and the rest 50 (28.9%) of them can read and write. The figure below shows that 49.1% of the respondents were not illiterate and have better level of understanding and knowledge about CBHI. The impact of education is positive to have better understanding and awareness on CBHI than those who are illiterate.

#### **4.2.7 Family Size of the Respondents**

Table 4.1 above illustrates the family size of the respondents. 145 (83.8%) of the respondents have one to five family members; whereas 26 (15%) and 2 (1.2%) of them have number of families that ranges 6-7 and above 8 respectively. This shows that majority of the respondents or 83.8% of them have five and below family members.

The data from IDIs supplements the above arguments "Some number of households reduce their family size in order to reduce the premium and include family members those who are recurrently have health problems. For example, family members from 1-5 pays 240 birr, family members from 6-7 pays 290 birr and households have more than 8 family members pay 340 birr".

#### **4.2.8 Number of Children in the Household**

Regarding the number of children's both less than 18 and above 18; Table 4.1 above shows that the majority of the respondents 156 (90.2%) of them are having children under the age of 18;

whereas, 17 (9.8%) of the respondents have children above the age of 18. According to CBHI strategy/design, children under the age of 18 can be included as family member of the program. On the other hand, children above 18 years old and who have their own income sources should be registered separately as a household. But in the table below suggested that 9.8% of the respondent households register their children's above the age of 18 years included like that of under 18; because households who have 8 and above family members pay the same amount of money (i.e.340 birr) per year.

### 4.3 Beneficiaries (members) Response on CBHI

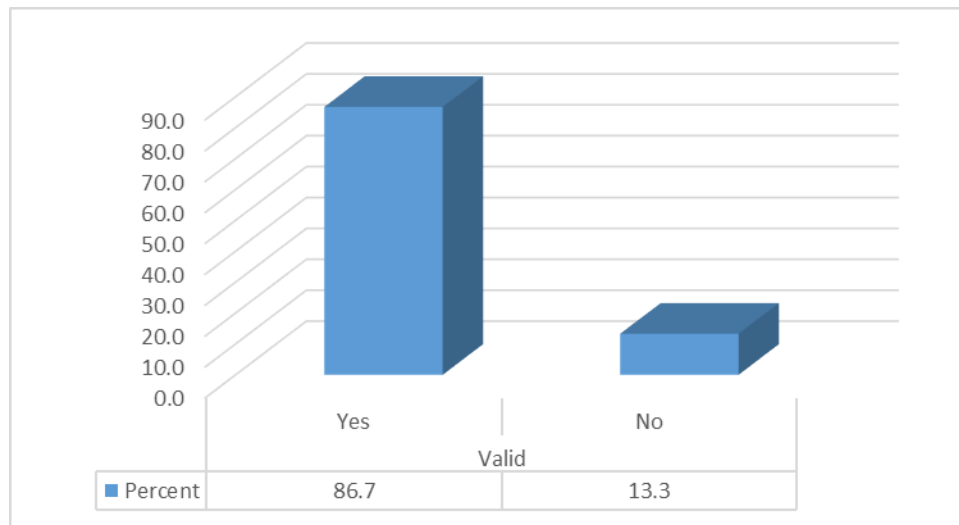
#### 4.3.1 Awareness Level of the Community on the Concept of Community Based Health Insurance.

In this sub section the data were collected through open ended questions for qualitative data collection. Questionnaire and relevant secondary documents that are related with awareness and understanding level of the community on CBHI practice were also employed to gather quantitative data.

##### *4.3.1.1 knowledge of Community Based Health Insurance?*

Regarding this, the beneficiaries were asked about their awareness on CBHI program and their response is presented and interpreted as follow.

**Figure 4. 1 Do you know Community Based Health Insurance?**



**Source: own computation (2019)**

The above Fig 4.1 illustrated that 86.7% of the respondents’ knowledge of the CBHI. 13.3% of the respondents were mostly indigent members who did not know what CBHI means. This indicated that most of the members of CBHI are well aware of the CBHI program. It is generally understood that Meket Woreda performed well in creating awareness to the community about CBHI.

The above data are supplemented by the interview made with “among factors contributing for good enrollment of CBHI is creation of awareness to the community in regarding the program. This contribute more for the sustainability of the program by reducing the drop out of the members. A greater understanding and knowledge of the households on CBHI is expected to support to stay long in the program”.

The above data indicated that Meket Woreda is doing well with regard to awareness creation of the community in CBHI.

#### 4.3.1.2 From Whom You Heard Information on CBHI?

The below Table shows how households have heard about CBHI. The responses of the respondents have seen below.

**Table 4. 2 From whom your about CBHI**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Neighbors	11	6.4	6.4	6.4
	Eder or Ekub	4	2.3	2.3	8.7
	religious institutions	16	9.2	9.2	17.9
	CBH employees/health extension workers	142	82.1	82.1	100.0
	Total	173	100.0	100.0	

**Source: own computation (2019)**

As Table 4.2 shows beneficiaries were asked about how they came to know about Community Based Health Insurance and 8.7% of them said that they heard the information regarding CBHI from their neighbors and from *Idir* and *Equb*. However, majority of the respondents have heard the information about CBHI from the employees of the Woreda’s CBHI Office, Kebele manager and health extension workers which accounted 82.1%. The rest 9.2% of the respondents became aware via religious institution/i.e. the church. This indicates that the Woreda CBHI employees in collaboration with health extension workers and kebele manager have engaged in creating awareness on CBHI to the community.

#### 4.2.1.3 Practicing in Community Based Health Insurance Has Advantage?

The below table illustrated that; beneficiaries were asked to answer whether enrolling in Community Based Health Insurance have benefit/advantage. Accordingly the following data is the feedback of members towards the use of CBHI.

**Table 4. 3 Practicing in Community Based Health Insurance has advantage**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly Agree	36	20.8	20.8	20.8
	Agree	102	59.0	59.0	79.8
	Neutral	35	20.2	20.2	100.0
	Total	173	100.0	100.0	

**Source: own computation (2019)**

Based on the survey findings of the above table (4.3) majority of the respondents (79.8%) of them believed that engaging in CBHI program has advantages. Whereas the rest of the respondent households have neutral idea regarding the advantages in practicing Community Based Health Insurance. This also indicates that majority of the respondents are enrolled with understanding of the program benefits. One of the participants indicates its benefit as follow: *“we are secured from unconditional health costs, our health status have got improved, our health risks are reduced and we are productive than before, reducing medical costs/having the health service through minimum contribution to all family members”*.

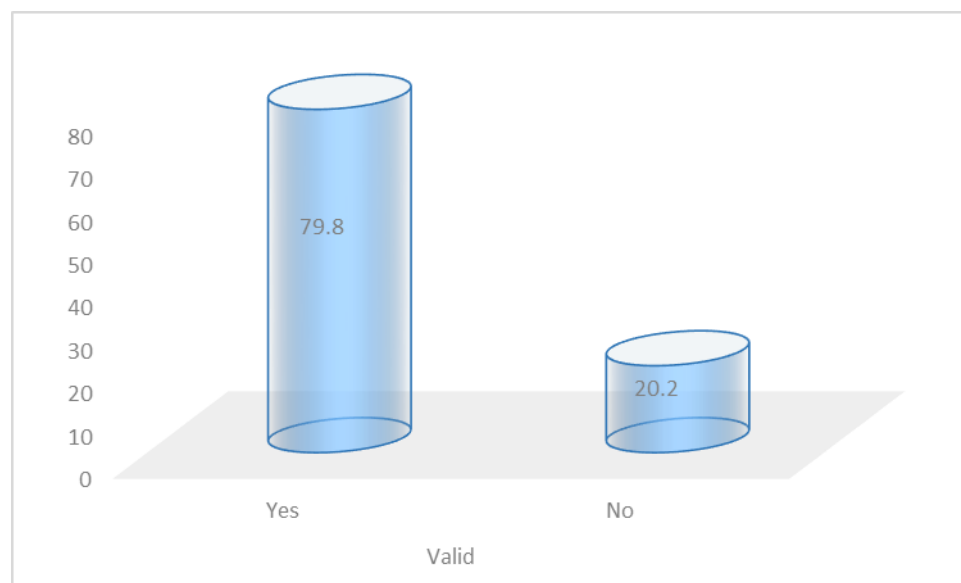
The data from KIIs (Medical Auditor) emphasized that “CBHI covers basic health service packages given by health institutions. The service includes out- patient, in-patient, surgery and laboratory services prescribed by health experts in all agreement signed health institution from health center to specialized hospitals. Members of the scheme reduce their out of pocket health costs, reduce their health related risks and get the services with least cost”.

#### 4.2.1.4 Have You Started Getting Health Services Via Your Insurance?

Beneficiaries were asked whether they have started to get the health service through their membership to the insurance or not.

The beneficiary's report is presented in this table and it is analyzed and interpreted as follows.

**Figure 4. 2 have you started getting health services via your insurance**



**Source: Own computation (2019)**

From the total respondents 138 (79.8%) of them are actively using and benefiting from the CBHI package when they became ill. And 35 (20.2%) of the respondents so far have not being using the CBHI even if they have paid their premium. The reasons why they didn't still started using the program/CBHI/ have been discussed in the FGDs. And the main reason individuals not using the service yet is supported by male FGD participants:

Even if members paid annual premium, some individuals prefer private clinics/ to get better service. The government health institution lacks good health provision/ lack of skilled man power, in adequate supply of medicine, lack of adequate laboratory equipment and have poor service delivery. The community forced to

pay the premium by kebele officials and we paid in order to get other kebele services. Some individuals also didn't have membership cards even if they paid the premium. They didn't know whether they are member or not. I have got 52 households who paid the annual premium, but have not membership ID to get the service. Then I help them to have the ID and started to get the eligible health services. This shows that still some members of CBHI lack trust on the scheme and prefer to use Out Of Pocket (OOP) for their health expenses and some individuals lack awareness on their rights to get membership cards as soon as they pay the premium. These problem may have negative impact on the sustainability of CBHI in the district and may cause drop out of members from the program.

The female FGD participants also reported that *“13 households were found during home to home awareness creation visit who have been paid the annual premium, but, still have not membership ID to get the service”*.

#### 4.2.1.5 Level of Awareness and Understanding of Beneficiaries on CBHI

Table 4.4 shows the respondents' level of awareness and understanding on CBHI. In general, beneficiary's understanding helps the successful achievement of the program.

The study measured the understanding level of participants based on the parameters of low, medium and high.

**Table 4. 4 level of awareness and understanding**

Items		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low	46	26.6	26.6	26.6
	Medium	101	58.4	58.4	85.0
	High	26	15.0	15.0	100.0
	Total	173	100.0	100.0	

**Source: Own computation (2019)**

The result of the above table (4.4) shows that among the total respondents 15% of them have high understanding on CBHI program. However, majority of the respondents (58.4%) have medium/average understanding on the program. Whereas the rest 26.6% of the respondents reported that they have low understanding with regards to Community Based Health Insurance program. This finding refers that there is no equal understanding among the members regarding the CBHI program.

#### 4.3.2 Community Based Health Insurance Practice and its Challenges

##### 4.3.2.1 *When You Started enrolling in CBHI?*

In 2010/11 Amhara region started to pilot CBHI in three woredas to maintain risk protection mechanisms for rural informal economic sector communities. After three years of piloting, the Ethiopian government as well as Amhara region decided to scale up the program in to other woredas and Meket woreda was one of the woreda's of Amhara National Regional State selected to scale up CBHI program in 2014(CBHI Coordinator).

Open ended questions were asked to CBHI officials and Woreda Administrator's about major initiating factors behind Community Based Health Insurance in Meket Woreda. According to Woreda Administrator the initiation factors for launching of CBHI in Meket Woreda was:

The primary initiation was came from the regional government with the criteria of high population density, capacity of Woreda Council hold to implement the program, the woreda is moisture stress and highly vulnerable to disease and woreda pre assessment before starting the actual program. Based on these criteria Meket Woreda was selected to scale up the program. During that time out of the total households of the woreda (35%) of the households including indigent should be member of the program to start CBHI. Costs of indigent covered 70% by regional government and 30% by woreda Administration. Indigent member covers

10% of the total households of the woreda's. By full filing all the criteria Meket woreda launched and started to implement CBHI program in the year 2014.

One of the key informants (CBHI coordinator) reported that “Currently the district is one of the most CBHI practicing woreda in the region. In the first year of 2007 E.C. the enrollment rate of CBHI was 35% but now in 2011E.C. have tremendous improvement to 74.5% of the total households. We are planned to the 90% of population to be member of CBHI in the year 2012E.C”.

The following table demonstrates that respondents’ response for the question “when you started getting practice in CBHI?”

**Table 4. 5 When You Started Practicing in CBHI**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2-3 Years Before	142	82.1	82.1	82.1
	Before Five Years	31	17.9	17.9	100.0
	Total	173	100.0	100.0	

**Source: Own computation**

The above table demonstrated that 82.1% of the respondents were enrolled in CBHI before 2-3 years since CBHI started in the woreda in 2014. The rest of the respondents (i.e. 17.9%) got enrolled before five years during the CBHI starting time of the Wereda. According to the information from KIIs in Meket Woreda CBHI has the age of five years. This indicated that the program is still in an infant stage. Even though the above survey data shows some achievements of the Wereda in the CBHI research attention has to be given in order to explore the success of the program and sustainability issues.

#### 4.3.2.2 Before Enrolling in CBHI How Did You Cover Your Medical Expense?

Question was asked to beneficiaries regarding the previous history of health cost coverage of the respondents. The following table reveals the households report on their previous history of health cost coverage before they got enrolled in the Community Based Health Insurance. The result of the report is interpreted and analyzed as follow.

**Table 4. 6 Before enrolling in CBHI how you covered your medical expense**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Out Of Pocket	143	82.7	82.7	82.7
	Borrowing	13	7.5	7.5	90.2
	Traditional Medication	8	4.6	4.6	94.8
	Ekub or Edir	5	2.9	2.9	97.7
	Government/Free	4	2.3	2.3	100.0
	Total	173	100.0	100.0	

**Source: Own computation (2019)**

Regarding the health cost coverage of households before enrolled in CBHI, 82.7% of the respondents used the Out Of Pocket (OOP) payment modality to cover their health expenses whereas 7.5% of the respondents reported that they cover their medical costs by borrowing from others. Furthermore, 4.6%, 2.9% and 2.3% of them cover their health expenses through the use of traditional medicine, support from *iqub/ Idir* and through government free health service provisions respectively. This illustrated that the majority of the respondents (i.e. 82.7%) used Out Of Pocket in order to cover the costs of their health coverage. As a result, one can imply people from Meket District have saved money by enrolling in CBHI which requires members paying only once in a year to cover for the health care needs of all members of the family.

In addition to the above variable, participants from IDIs (Male, age-48) strengthen the arguments as follow: *“Before practicing CBHI in the kebele I was paid 890 ETB for one medication only for me. It take time (at least 3-5) days to get money even to sell chattels. We went to health center after the illness became chronic/serious/”*.

Another IDI participant on the other hand said that *“before enrolling in Community Based Health Insurance we were not went to health center unless we sick seriously. When we sick like headache, Mich and common cold we went to take holy water/metemek/ and tried to take traditional medicines/damakesie, fumigated with eucalyptus and haregesa”*

#### 4.3.2.3 Do You Think Your Health Status is Improved After Enrolling in CBHI?

To calculate the points 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 the mark of 4 towards that element; a score of “3” (neutral) would yield 3 mark; a score of “2” (disagree) marks 2 and 1(strongly disagree) yields 1 mark.

The respondents answer to the question; whether their health status is improved after enrolling in CBHI or not is illustrated in the following table.

**Table 4. 7 Do you think your health status is improved after enrolling in CBHI?**

		Frequency	Percent	Cumulative Percent	Mean	Standard Deviation
Valid	Strongly Agree	15	8.7	8.7	2.06	0.48
	Agree	132	76.3	85.0		
	Neutral	26	15.0	100.0		
	Total	173	100.0			

**Source: Own Computation (2019)**

Regarding the health status of the households after enrolling in CBHI, as the data in the above table shows, only 15% of them are neutral. Of the total respondents, 8.7% of them strongly agreed that their family's health status is improving after enrolling in CBHI. The majority (76.3%) of the total respondents reported that their health status is improved after enrolling. This can show that 85% of them have benefited from CBHI with the improvement of health status of their family. This can also imply that CBHI is the program not only reducing health expenses of the household but also improves the health status of the households.

The mean of the above data is 2.06 and the standard deviation is 0.48 which means that the majority of the respondents give the score "4" to the above question and reported that the health status is improved.

During the discussion with open ended questions (FGD, male age-48), member of CBHI households stated that: *"In any one of the nearest health institutions visiting to check the health status is in increasing rate even for simple pain like common cold, head ache, mich (local name) that we previously treated with traditional medicines. Members early treatment of their illness before became serious improve their health status"*.

#### **4.3.2.4 Types of Membership**

Key Informant Interview was conducted with CBHI employees on how to identify indigent and non-indigent households enrolling in CBHI.

The data from KIIs (CBHI Coordinator) stated that; there are 4935 indigent types of membership and 28154 non-indigent types of memberships in Meket District. Among the total population indigent types of members consists almost 10% of the total population. The total number of households (both indigent and non-indigent) were 33089 which is 74.5% of the total 44415 households of the woreda since the data collected at the end of March 2019. This shows

approximately ¼ of the total population is still not enrolling CBHI in the district. This means that the Woreda needs additional effort to create awareness to the non CBHI members of the community.

In Amhara region in addition to the premium collected from non-indigent members; the government provides 10% of the total amount of collected money as a general subsidy.

For the year 2012 E.C. our office planned to enroll 90% of the total households of the Woreda in to CBHI. The current number of households including both indigent and non-indigent as mentioned above is 33089 households. The current plan is to reach the total beneficiaries from 74.5% to 90% which means from 33089 to 39973 beneficiaries from the total households of 44415. In order to achieve the plan to make non-member households enrolled in CBHI; the office of CBHI working in collaboration with different stakeholders like woreda health office, kebele health extension workers, kebele administration, local village leaders, Woreda and kebele agricultural offices religious leaders and Woreda labor and social affairs (CBHI coordinator).

The above point shows that all the stakeholders make commitment to create awareness and understanding to the non-member households regarding the benefits of Community Based Health Insurance to achieve the planned goal.

**Table 4. 8 Types of Membership**

Item		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Indigent	25	14.5	14.5	14.5
	Paid	148	85.5	85.5	100.0
	Total	173	100.0	100.0	

**Source: Own Computation (2019)**

From the total respondents as indicated in table 4.8, 14.5% of them are very poor households /indigent types of beneficiaries getting health service without being charged any payment. The majority of the respondents (i.e. 85.5%) are economically better /non-indigent households who are getting health services by paying the premium once in a year. This shows that the program is

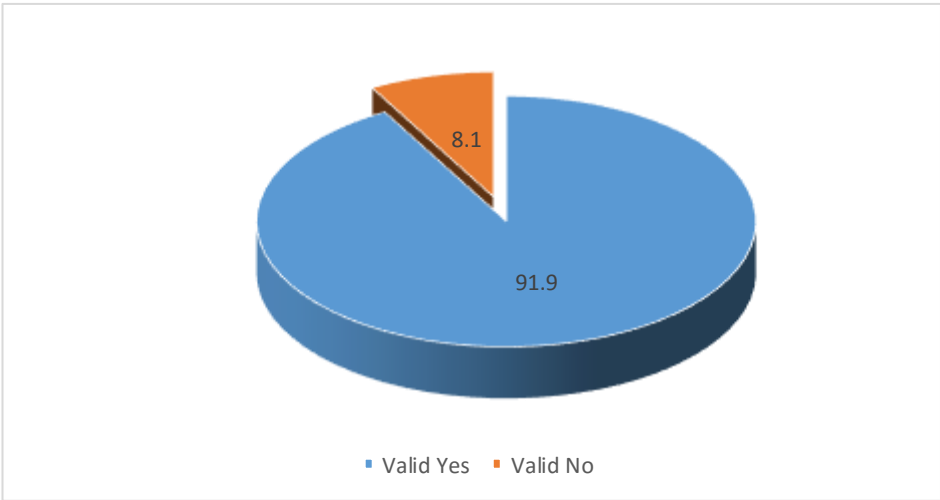
giving the health service to the indigent members freely without paying any costs. All the costs to the indigent members are covered by the government (70% by regional government and 30% by Woreda administration). As indicated in the above table, the number of non-indigent beneficiaries exceeds many times than indigent to make the program financially strong and insures the sustainability of the program where the standard is 90% to be no indigent and 10% to be indigent.

**4.3.2.5 Do You Renew Your Membership ID Timely?**

There are factors that are most likely to influence renewal rate of membership: some of these are the quality of service provided, health status of the member, affordability of payment, a number of payments at once(land tax, fertilizer, sport fee and contribution for Amhara Development Association) and information failure. The last factor includes lack of understanding of the program and insufficient awareness and information on how to use the program (IDIs, male).

Regarding this beneficiaries were asked whether they have renewed or not their membership insurance on time. The following table presents the beneficiaries report.

**Figure 4 3 Do you renew your membership ID timely?**



Source: Own Computation (2019)

The above data (Figure 4.3) shows that from the total respondents only 14 ( 8.1% ) of them did not renew their membership ID of CBHI on time while 159 (91.9%) of them have renewed their membership ID of CBHI on time. This indicated that the majority (more than 90%) of the respondents have good trends on renewing their membership ID on a timely basis.

One of the participants of FGD (Male) reported to complement the above data with:

Renewing membership means getting health insurance to the next one year. Unless they renewed their membership on the right time (in the case of Meket Woreda the time for paying the premium and renewal is February and March) members can't get access to the service. Time of payment and renewal was fixed on the dual agreement between the members and Woreda council. Members paying their premium after February and March they will be forced to wait one month to get the service.

#### *4.3.2.6 I Decide to Resign My Membership From CBHI*

Based on the data from Key Informant Interview with CBHI coordinator the dropping rate of members from the program in the past few years was 0% (there has not been any drop out) except for a few delay of paying the premium within the time frame. This is also supported by the above Figure 4.3; currently in the year 2011 E.C until March (when data collection for this current study took place), 91.9% of the respondents have paid the premium and renewed their CBHI membership ID. This can show the commitment of members to stay in the program.

Despite, the scheme have some challenges, one of the participants of FGD (Male), even though some challenges/issues like poor service delivery by service providers/not given equal treatment to CBHI members and others, inadequate supply of medicine, inadequate laboratory equipment, and long process of referral linkage and shortage of well-trained / skilled man power from health institutions beneficiaries have prefer to stay within the program.

One of the participants of Key Informant Interviews (CBHI coordinator) complement the above data: “the dropping rate of members from the program in the past few years was 0% (there was/is no drop out) unless a few delay of paying the premium within the time frame and also the self- supporting culture of the societies were increase from time to time. Regarding to minimize drop out Meket Woreda have a very good performance in creating awareness and increasing understanding of beneficiaries to stay in the program and we strongly working in collaboration with Woreda office of Labor and Social Affairs(WoLSA) and Organization of Rehabilitation and Development of Amhara (ORDA) to reduce the delay of payment and renewal of membership ID of Productive Safety Net Program beneficiaries of Permanent Direct Support (PDS) clients who are permanently benefiting from the program as pension”.

To calculate the points to what extent the respondents agree, 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 “1” (strongly agree) would yield a full mark of 1 towards that element; a score of “2” (agree) would yield the mark of 2 towards that element; a score of “3” (neutral) would yield 3 mark; a score of “4” (disagree) marks 4 and 5(strongly disagree) yields 5 mark.

The following table shows the reports of respondents regarding whether they decide to stay within CBHI or not presented with frequency, percent, mean and standard deviation by supporting it with analysis and interpretation.

**Table 4. 9 Decide to resign my membership from CBHI**

Item	Frequency	Percent	Cumulative Percent	Mean	Standard Deviation
Neutral	17	9.8	9.8	4.0058	0.45106
Disagree	138	79.8	89.6		
Strongly Disagree	18	10.4	100.0		
Total	173	100.0			

**Source: Own Computation (2019)**

Pertaining to the decision on resignation/ existing from CBHI, as data in the above table (4.9) indicated, 9.8% of the respondents were neutral regarding the decision to resignation from CBHI; whereas 90.2% of them showed to stay within the membership. Hence, the issue of dropping is not the concern for Meket Woreda CBHI program and this can have positive impact on the sustainability of the program.

The mean result is 4.0058 and the standard deviation 0.45106, the items Disagree and strongly disagree means respondents have no intension to resign from the program and shows a commitment to stay within CBHI.

**4.3.2.7 Being enrolled in community based health insurance?**

The following Table presented the responses of beneficiaries in regarding the question of Community Based Health Insurance have not advantage. The response of the respondents are presented and analyzed as follow.

**Table 4. 10 I haven't got any advantage enrolling in community based health insurance**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	10	5.8	5.8	5.8
	Neutral	25	14.5	14.5	20.2
	Disagree	63	36.4	36.4	56.6
	Strongly Disagree	75	43.4	43.4	100.0
	Total	173	100.0	100.0	

**Source: Own Computation (2019)**

Based on the above table among the total household respondents only 5.8% of them were not get the benefits of Community Based Health Insurance. On the other hand 14.5% of the respondents were neutral whether they are benefited or not. Whereas 79.8% of the majority of the respondents

were benefited from the service given by the scheme. This means the majority of the respondents highly benefited with reducing Out Of Pocket health expenditures and cover their health expenses with minimum premium payment to all family members, reduce health risks, improve the health status of their family and increase labor productivity of the family by investing more time to produce asset rather staying in the house with illness.

One of the participants of FGD (Male) reported that: a number of households not benefiting from the scheme. This is because of poor service delivery by health facilities, boring of beneficiaries in waiting long time to get service from the scheme, in adequate supply of medicines, lack of skilled man power in the government contracted health facilities and poor handling of patients. Due to this individuals prefer private health clinic to get better services even they pay much amount of expenses.

#### 4.2.3.8 I am Benefited From CBHI

Table 4.11 illustrates the benefits of Community Based Health Insurance to the targeted members and analyzed and presented as follow.

**Table 4. 11 Benefits of the CBHI to the respondents**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Reduced in medical expense	101	58.4	58.4	58.4
	Improved Health	44	25.4	25.4	83.8
	Increased in Labor Productivity	8	4.6	4.6	88.4
	Other	20	11.6	11.6	100.0
	Total	173	100.0	100.0	

**Source: Own computation (2019)**

The above Table explains that, more than half (58.4%) of the respondents reported that they have benefited from the program by reducing Out Of Pocket (OOP) medical expenses. On the other hand, 25.4% and 11.6% of the respondents have got different benefits like reduced health risks, insuring/securing all the family members etc. The rest 4.6% of them have reported that after enrolling in CBHI program their labor productivity have increased.

This indicated that the objectives of Community Based Health Insurance have been achieved by insuring/guarantying the community's health with a minimum or no cost for their health services. Members of the program highly benefited through reducing Out Of Pocket (OOP) medical expenses, improve health status of the family by checking their health condition thoroughly, reducing health risks in securing with insurance and increasing the productivity of people by increasing working time and reducing waiting at home by illness. Beneficiaries have chance to get services from health post to referral and specialized hospitals through keeping the process of referral linkage.

In addition to the above explanation; one of the participants from FGD (Male) strengthen the arguments as follow.

“In our kebele there was an individuals who have members of CBHI. The scheme covers all eligible expenses of his health services 12500birr. If this individual was not members of the scheme; he couldn't went to the health facilities, unless he tried to take traditional medicines or waiting until he died. So, CBHI have many benefits like ‘Yediha Majet’(in Amharic),highly reduces Out Of Pocket expenses, getting health services Via small amount/contribution of money to all family members for a year. However, some health service providers think that we get the service freely and also thinks that no one is came here to health centers if, directly pay for the services. We consider that, CBHI have many benefits to the members.

**4.3.2.9 Affordability of the Current Premium Collection**

In this section of the paper, members of the households were asked about the current premium level (affordability of the contribution) and its timing of collecting which is one of the determinant factors to the performance of CBHI.

To calculate the points 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 the mark of 4 towards that element; a score of “3” (neutral) would yield 3 mark; a score of “2” (disagree) marks 2 and 1(strongly disagree) yields 1 mark.

The following table shows the report of the respondents regarding the question with necessary interpretation and analysis.

**Table 4. 12 Are you happy with current premium collection?**

		Frequency	Percent	Cumulative percent	Mean	Standard Deviation
Valid	Strongly Agree	43	24.9	24.9	4.106	0.421
	Agree	119	93.7.	93.7.		
	Neutral	11	6.3	100.0		
	Total	173	100.0			

**Source: Own Computation (2019)**

According to the survey data in the above table 4.12, from the total respondents 6.3% of them were neutral in deciding whether it is affordable or not. The majority (93.7%) of the respondents have indicated that the current premium is affordable for the service they got from the contracted health facilities.

As indicated in the above table 4.12), the mean value is 4.46 and standard deviation is 0.421 which is score above “4” means that respondents are happy with the current premium and timing of collection.

According to responses from IDIs, employee and official timing of collection of the premium was decided by the members during harvesting season from February to March which is convenient time to get cash for households to pay the premium.

The data from IDIs supplements the above data by arguing that “we renew our membership with the general payments of the government (land tax, fertilizers, Amhara Development Association/ADA/, Sport fee) when we get better income in February and March. The amount of payment was decided by the government based on the number of the family (family members from 1-5= 240birr 6-7= 290birr and above 8= 340birr. If we don’t pay; we didn’t have to get the services. So we pay earlier to get the services as we want”.

One of the KII participants(Head of Woreda Administrator) said that “Regarding to the amount of payment; the central government decided by considering the current capacity of households to pay( using economic parameters, current costs of medical facilities) in reference to the number of family size in the household. Throughout the region the amount of premium is equal depending on the family size of the household. Unless the central government fixes standard payment (if payments are different across the region) it makes a problem of good governance”.

Generally the current amount of premium and time of collecting the premium have been accepted by the majority of the households and which implies that it is affordable to the beneficiaries and the timing of the collection is suitable.

#### *4.3.2.9.10 How Do You Evaluate the Service Delivery of CBHI?*

Good health care service delivery increases the sustainability of Community Based Health Insurance and at the same time the trust of beneficiaries to the scheme also increases. The

beneficiaries' sense of belongingness and ownership highly depends on the quality of services given by the contracted health care facilities.

The table below answers the question how the beneficiaries evaluate the service given by the scheme. The data in the table is analyzed and presented below as follow.

**Table 4. 13 How do you evaluate the Service Delivery of CBHI?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Good	6	3.5	3.5	3.5
	Good	52	30.1	30.1	33.5
	Satisfactory	49	28.3	28.3	61.8
	Low	66	38.2	38.2	100.0
	Total	173	100.0	100.0	

**Source: Own Computation**

The above table (4.13) shows that the responses to the question how do they evaluate the service delivery of CBHI at the health facilities. More than half (i.e. 56.5%) of the respondent households said that the service given by the health facilities are either satisfactory or low. Especially 38.2% of the total respondents evaluated the service provision whereas, only 3.5% of them have got very good services from the scheme. The rest of the respondents (30.1% of them) have rated the services from the scheme as 'good'. Over all the above data illustrated that the service delivery from the scheme have not satisfied the beneficiaries.

The data from IDIs, male age-66 supplement the above data with the argument that:

Health service delivery from the private health care facilities are better than the service given by the government owned health institutions. Even the prescribed medicines were not available in the government owned pharmacy and we forced to buy out side in a costly price. The employee from the government have linkage to the

private clinic and tell the patients to buy medicines from the identified private pharmacy.

#### 4.3.2.11 Responses on: the Nearest Conventional Health Institutes in Your Home

In the next table the respondents’ answers for the question about the nearest conventional health center to the beneficiaries home are presented.

**Table 4. 14 The nearest conventional health institutes to your home**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Health Centre	49	28.3	28.3	28.3
	Health Post	27	15.6	15.6	43.9
	gov't hospital	97	56.1	56.1	100.0
	Total	173	100.0	100.0	

**Source: Own Computation (2019)**

According to Table 4.14, 28.3% of the respondents are nearest to the health center and 15.6% of the respondents have covenant to the health post. The majority of the respondents (i.e. 56.1% of them) are served at “Anchim Primary Hospital” in Meket Woreda. This shows that majority of the respondents are getting health services from Meket Anchim Primary Hospital in the anticipation to get better services.

The data from KIIs (Woreda Head Administrator) revealed that:

Most of the time health posts located in the Kebeles provide family planning and health extension package services. To get medication services beneficiaries went to health centers and hospitals by keeping referral linkage process. Farther more, Agreement was signed between CBHI office and health institutions in two referral hospitals (Felegehiwot Hospital in BahirDAR, and Dessie hospitals), three general hospitals ( Woldia, Boru and Debire Tabor), three primary hospitals

(Meket Anchim, Lalibela and Nefas Mewucha hospitals) and 9 health centers inside and outside of the woreda serving CBHI beneficiaries.

### 4.3.3 Level of Participation of the Community in CBHI

#### 4.3.3.1 Participation Level of Respondents in Local Meetings Concerning CBHI.

The data collected from questionnaire, interview and FGD related with the study is presented and interpreted in detail.

The survey respondents have reported to answer the question regarding what type of participation they have in CBHI.

**Table 4. 15 Participation level of respondents in local meetings concerning CBHI.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	CBH Strategy	14	8.1	8.1	8.1
	CBHI Rules and Regulation	13	7.5	7.5	15.6
	service Delivery	86	49.7	49.7	65.3
	Payment Issues	60	34.7	34.7	100.0
	Total	173	100.0	100.0	

Source: Own Computation (2019)

As Table 4.15 shows from the total respondents 8.1% of them have attended local meetings that focused on the agenda of CBHI strategy. Regarding rules and regulations of the program 7.5% of the respondents reported to have participated in local meetings at least once in last few years. Almost half of (49.7%) the respondents have a chance to discuss health service delivery of the program whereas the rest 34.7% of them have discussed in the agenda of payment in their life in CBHI. This shows that all the respondents have participated at least once in the local meetings regarding CBHI.

One of the participants from the FGD revealed that arranging different local meetings to discuss about the implementation of the program is very important to create awareness and improve the level of understanding of beneficiaries on CBHI. This can help to increase the sustainability of the program by reducing the challenges and create sense of ownership to the members.

**4.3.3.2 On Which Agenda You Get the Opportunity to Discuss Freely On CBHI with Responsible Body/ Stakeholders From Woreda and Above?**

Strong community participation in the designing and implementation of CBHI program can promote the scheme in to a higher level.

Pertaining to the question of the agenda on which survey respondents get the opportunity to discuss with different stakeholders is presented in the following table.

**Table 4. 16 On which agenda you get the opportunity to discuss freely on CBHI with responsible body/ stakeholders from the Woreda and above**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	CBH Strategy	9	5.2	5.2	5.2
	CBHI Rules and Regulation	9	5.2	5.2	10.4
	service Delivery	145	83.8	83.8	94.2
	Payment Issues	10	5.8	5.8	100.0
	Total	173	100.0	100.0	

**Source: Own Computation (2019)**

As the above Table 4.16 shows from the total respondents 5.2% of them have got the opportunity to discuss with experts and officials from the Woreda and higher structures in the agenda of CBHI strategy. Regarding rules and regulations of the program 5.2% of respondents reported to have participated in discussing with experts and officials at least once in last few years. The majority (83.8 %) of the respondents have a chance to discuss in health service delivery of the program

whereas the rest 5.8% of them have discussed in the agenda of payment in their life in CBHI. This indicated that, one of the major challenges of the program is the delivery of health service to the program beneficiaries and for that matter the maximum number of respondents discussed with woreda and above level in the hope of solving the problem of service delivery.

#### 4.3.3.3 How do you evaluate your participation on?

Participation of beneficiaries in Community Based Health Insurance and their evaluation of participation were discussed in the next table. Analysis and presentation of the data also presented as follow.

**Table 4. 17 How do you evaluate your participation on CBHI?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Payment	82	47.4	47.4	47.4
	Informing Others who are not CBH members	47	27.2	27.2	74.6
	Experience sharing	24	13.9	13.9	88.4
	Others	20	11.6	11.6	100.0
	Total	173	100.0	100.0	

**Source: Own Computation (2019)**

The above table 4.17 indicated that the majority of the respondents 47.4% of them still evaluate themselves only in payment of the premium and not engaged in other activities to contribute to the scheme. On the other hand, 41.1% of the respondents are participating in creating awareness and sharing their experiences to the non-members of the community to be part of the program. The rest 11.6% said that they have not participated in all aspects of the program including paying the premium (indigent members). This shows that, the majority of the respondents participating in the minimum requirement to be member of CBHI only by paying the annual premium. But

members are expected to participate in all aspects of the program including providing information to others to be member of the program, experience sharing to others, participating in meetings, participating in decisions, evaluating implementation of the program etc.

Further, the above explanation supported by the FGD (Kebele Manager) reports that:

The community has limited roles in decision making processes (no power to decide on health packages given by the program, amount of premium payment, in contractual agreement between health institutions in referral case). The only represented community members (kebele administrator, representative from women & youth and the selected religious father are part of the woreda CBHI general assembly and involved in some areas of decisions, like in fixing the time of payment of the premium, participating in the awareness creation session and experience sharing to the non-member communities to enroll in the program.

The information from KIIs (CBHI Coordinator) revealed that for example, CBHI provides up to 71000 birr for one beneficiary by covering all the eligible health expenses from health center to referral hospitals through referral processes and another non CBHI member individual costs 14000 birr by comparing these two individuals CBHI office used this occasion to create awareness for non-member communities.

#### **4.4 Demand and Supply Problems**

The major challenges that have impact on the implementation of the scheme came from the unbalance of demand and supply.

The scheme designed to provide the health care services of Inpatient, Outpatient, surgery and laboratory services to the beneficiary by showing the renewed membership ID from the contracted health facilities. However, Eye glass and contact lens provision, artificial teeth implantation,

Medical costs covered by other insurances, transportation costs, Dialysis and Foreign medical services were not given by the scheme (KII).

In line with the research question the challenges from the scheme divided in to two.

**1. Demand side challenges:** some of the challenges from the demands sides such as delay of paying the annual premium, an increasing intension of beneficiaries to have injections rather than oral tablets and kebele leaders forced households to pay the premium.

One of the participants from FGD support the above arguments by reporting that “The **demand side challenges** are: limited understanding and awareness of beneficiaries to Community Based Health Insurance, low sense of belongingness and ownership of members to the scheme(limited participation in decision making processes), beneficiaries intension to have medication of injection rather prescription of oral tablets, even if they pay the premium; a number of households have not membership ID, delay of paying the premium, Kebeke/village leaders forced households to pay the premium; this violated the principle of voluntary membership and some household members didn’t bring all family members to register in CBHI.

**2. Supply side challenges:** Regarding the supply side challenges, some of the listed were long process of referral system, in adequate availability of prescribed medicines in government pharmacies and poor service delivery of the service providers.

One of the participants from FGD reported that, the supply side challenges were “poor delivery of service by the health facilities, in adequate supply of medicine from the contracted health institutions, in adequate supply of laboratory equipment, long process of referral system from one health facility to another health facilities, in some health facilities lack skilled man power to the required level, some service providers lack professional ethics; serving indifferently between program beneficiaries and non-members, lack of enough man power because at Woreda level the scheme designed to

have four staff members ( Coordinator, Accountant, Medical auditor and cashier),the office is not covenant (narrow), shortage of office furniture (lab top, camera)”(FGD).

## 4.5 Overall C challenges of the program

### 4.5.1 Challenges from CBHI

Different studies show that, the degree of community participation in the design and running of CBHI can vary of widely and is usually greater if funds are owned and managed by the member themselves than if the schemes are run by health facilities to avoid moral hazards (Jutting, 2003). However, different to the above study, this study revealed that, there were gaps in the design and implementation of CBHI in the study area.

#### **1. The Scheme not Provide Comprehensive Health Services**

Despite, beneficiaries pay their premium in order to get eligible health services that was designed in the scheme; practically the service did not satisfied the beneficiaries to the required level. Regarding the service provision of CBHI, this study identifies the gaps of; households who have better income sources prefer private clinics to get quality services using **out of pocket** for their health expenses, refund of money from CBHI to beneficiaries’ takes long process, inadequate supply of medicine, lack of adequate supply of laboratory equipment and long process of referral linkage to different contracted health facilities.

#### **2. Gaps in Creating Awareness to the Community and Service Providers**

Before launching the scheme to the district awareness creation to the communities about CBHI were expected from the government. The government was the designer, implementer as well as controller of the program. This study tries to show the gaps from awareness creation to the communities: Kebele/village administrator force households to pay the premium and enrolling new members to the program, which means the existing principles of premium collection on a

voluntary bases are violated, health service providers/professionals/ lack professional ethics in some contracted health facilities (gives dis respect to CBHI members, treats indifferently to member and non-member and even they are not happy when saw ID cards of members of CBHI).

#### 4.5.2 Challenges from Members

##### 1. Limited Awareness to the Scheme

Awareness of the community is a critical factor for the sustainability of the scheme. This study found the gaps in regarding awareness of the community to CBHI. These are Even though, the households registered to benefit from the scheme, a number of households still didn't receive membership IDs to serve from the program, Delay in membership ID renewal, Households will not bring full family members to CBHI (register frequently ill family members) and lack of awareness on their rights to get membership cards as soon as they pay the premium.

##### 2. Limited Participation in Decision Making Processes

The community has limited roles in decision making processes (no power to decide on health packages given by the program, amount of premium payment, in contractual agreement between health institutions). The community sense of belongingness and ownership in managing and administration of the scheme is limited to kebele administration and district officials.

#### 4.6 Strategies Help to Overcome the Challenges of CBHI

The Woreda Council planned to address the above listed bottle neck of CBHI implementation by working with different concerned stakeholders.

The data from KIIs (Head of Woreda Administrator) reported that: primarily the office of CBHI by working in collaboration with woreda's administration/ council and different stakeholders of

the program identify the gaps and challenges of the scheme. These challenges are divided in to two: Woreda level issues and Region and Federal issues.

The identified woreda level gaps and challenges are: Limited Awareness of beneficiaries to the CBHI

These are Even though, the households registered to benefit from the scheme, a number of households still didn't receive membership IDs to serve from the program, Delay in membership ID renewal, Households will not bring full family members to CBHI (register frequently ill family members) and lack of awareness on their rights to get membership cards as soon as they pay the premium. The second one is Limited Participation of beneficiaries in Decision Making Processes. These challenges are the community has limited roles in decision making processes (no power to decide on health packages given by the program, amount of premium payment, in contractual agreement between health institutions). The community sense of belongingness and ownership in managing and administration of the scheme is limited to kebele administration and district officials.

To address these gaps/challenges the woreda officials in general and CBHI office in particular working with different stakeholders to increase the level of understanding and awareness of the program beneficiaries, kebele/local leaders and health professionals through training, experience sharing ( videos and from better performed Woredas) and demonstrations. The woreda also planned to increase the decision making powers of the beneficiaries by participating and making suitable environment when decision required.

Whereas, issues like poor delivery of comprehensive health services (inadequate supply of medicine, inadequate supply of laboratory equipment, long process of referral system and poor delivery of service by service providers needs further discussion with regional government and

Ethiopian Health Insurance Agency to solve the problem permanently and to insure the sustainability of the scheme.

## CHAPTER FIVE: DISCUSSION, CONCLUSION AND IMPLICATION

This chapter presents three things: discussion, conclusion and implication of the study.

### 5.1 Discussion

The ultimate goal of the study was to examine and assess the practice and challenges of CBHI in rural Ethiopia: particularly on Meket District in North Wollo Zone of Amhara region.

The issue related to this topic of the study are multifaceted, the study set up to examine the following specific objectives: understand the household level of awareness the research participants have on the concept of Community Based Health Insurance, challenges and implementation status of CBHI in the district, assess the households level of participation on CBHI practice and utilization, challenges encounter on enrolling of CBHI program both in demand and supply side and exploring strategies/ practices that help to overcome implementation problems.

Mixed research approach was used to gather data from 173 household respondents (60.7% male and 39.3% female) through household survey and informants of IDIs(5 in number), KIIs(4) and FGDs(1). Accordingly, primary data were collected from the aforementioned respondents and informants to address the objectives of the study. Secondary data were used; research documents, CBHI strategy document and guide line and reports of the woreda CBHI implementation.

This section has been presented in sequential order in line with the research questions.

#### **1. What is Level of Society's Knowledge and Awareness on CBHI Program?**

The sensitization of program by CBHI schemes officials was continued on community mobilization efforts since scheme was established. In order to increase the enrollment rate, the Woreda CBHI office is working with different stakeholders on raising awareness of the

community, such as: Ethiopian Health Insurance Agency (EHIA), Regional Health Bureau, local leaders and elders, traditional institutions like *idir* and *ikub* and public meetings on enrollment to participate in making experience to the non-member households.

Regarding the concept of CBHI, 150 (86.7%) of the households have knowledge about what CBHI mean, of all the household members 142 (82.1%) have primarily heard the information from CBHI employee and health extension workers

Different studies show that, the degree of community participation in the design and running of CBHI can vary widely and is usually greater if funds are owned and managed by the member themselves than if the schemes are run by health facilities to avoid moral hazards (Jutting, 2003). However, different to the above study, this study revealed that community sense of belongingness and ownership in managing and administration of the scheme is limited to kebele administration, district officials and employee, kebele experts (DAs, Managers and Health Extension Workers). This study revealed that, there were gaps in the design and implementation of CBHI in the study area. For example, currently the kebele/village administration plays a critical role in registering scheme members and collecting the premium. However, some kebele/village administrator force households to pay the premium and enrolling new members to the program, which means the existing principles of premium collection on a voluntary bases are sometimes violated.

## **2. What are the Implementation Status of CBHI in Meket District?**

KIIs (CBHI Coordinator) revealed that in Meket Woreda the enrollment of CBHI since the starting time of the scheme in 2014 has shown increases in coverage. The total number of households living in the informal sector of the economy are 44415. Out of these total households 33089 (74.5%) were enrolled in CBHI both in indigent and non-indigent. Despite, there are some problems the performance in the enrollment rate has increased from 35% to 74.5% in 2011 E.C. However, a huge difference across all Kebles in the district ranges from 29% to 90% performance

was recorded. Overall the woreda CBHI beneficiaries the indigent numbers are 4935 (11.1%) getting health services freely from CBHI which is more than what was designed (10%) of the total households.

In Ethiopia in general and Meket Woreda in particular, CBHI is a promising alternative for people to get the health service with a minimum expenses. The concern of Out Of Pocket (OOP) health costs have been reduced with CBHI and all eligible health service expenses are covered by the program. This means that people worry on how to cover their health cost have got the response by CBHI. Members can get health services immediately before the disease became chronic.

According to Meghan, (2010), more than half of health expenditure in poor countries are covered by Out Of Pocket (OOP) Payments incurred by households. The increment of such an expenditure can have catastrophic effects and may deplete the households' ability to generate current and future income. This also leads the household to as intergenerational consequences to debt, sell of productive assets or may scarifies invested for their children's education.

Moreover, this study have been complemented the above idea with before the introduction of CBHI, households were severely threaten by high Out Of Pocket (OOP) payments and patients were vulnerable for prolonged chronic illness that come from delay to seek treatment, result suggested that before enrolling in the scheme out of pocket expenditure of the total sampled households were 82.7% which is more than that of expenditure of the least and middle income countries.

As Helina (2014) shows that the age determinant factor for the household practicing in CBHI. As people getting older in age they need security for their life; but in my findings when people became younger ( under the age of 48= 58.38%); can easily understand and know the benefits of

CBHI in order to reduce health risk and to get health services from the health institutions through their minimum premium payment than older people.

According to CBHI design (2015), there are three types of government subsidy to the program: targeted, general and financing the program by management costs (staff salary, office and operational costs). The regional government and woreda administration financed all the health costs of indigent members.

### **3. What are Demand and Supply Side Challenges Faced by Meket woreda on practicing the CBHI Schemes?**

A study by FMOH (2011) stated that the designing of the Ethiopian CBHI scheme builds on the assumption of certain features (parameters) such as, membership for enrollment is done voluntary on a household basis; to reduce the possibility of adverse selection, financing the very poor (indigents), regular premium, targeted subsidy, benefit package, community involvement in management and administration of CBHI scheme and line of referral are considered main features in the designing of CBHI scheme.

According to the data from IDIs, KIIs, and FGDs, in CBHI strategic document the supply of health facilities: CBHI covers basic health service packages given by health institutions. The service includes out- patient, in-patient, surgery and laboratory services prescribed by health experts in all agreement signed health institution from health center to specialized hospitals and services not given by CBHI includes eye glasses, teeth implantation, dialysis, transportation cost, risks which is covered by other insurances and abroad medications are prohibited to CBHI programs are adequate to the program. Similarly, for example, a study by EHIA (2015), verify that availability of drugs and adequate diagnosis at the facility of first contact is the most

important factor for households to join/or sustain CBHI membership. If these problems are not addressed CBHI achievements might not be maintained.

#### **4. How CBHI Beneficiaries Express their Experience of Participation on CBHI Implementation?**

The community has limited roles in decision making processes (no power to decide health packages given by the program, amount of premium payment, in contractual agreement between health institutions in referral case). The only represented community members (kebele administrator, representative from women & youth and the selected religious father are part of the woreda CBHI general assembly and involved in some areas of decisions, like in fixing the time of payment of the premium, participating in the awareness creation session and experience sharing to the non-member communities to enroll in the program.

The information from KIIs (CBHI Coordinator) revealed that for example, CBHI provides up to 71000 birr for one beneficiary by covering all the eligible health expenses from health center to referral hospitals through referral processes and another non CBHI member individual costs 14000 birr by comparing these two individuals CBHI office used this occasion to create awareness for non-member communities.

Most of the Ethiopian government decision making process goes through top down approach in which the decision is made by the government. The government is initiator of the program, implementer of the program and as well as controller.

The degree of community participation in the design and running of the CBHI can vary widely and is usually grater if funds are owned and managed by the member themselves than if the scheme are run by health facilities. If members can identify themselves with “their” scheme

because they control the fund and have decision making power, they will tend less to an necessary use of health care service (Jutting, 2000).

### **5. What are Ways Used to Overcome the Challenges Facing the CBHI in Meket district?**

One of the specific objectives of this study was to investigate ways to overcome the challenges facing during the implementation of CBHI in the study area.

Based on the data from KII/Woreda officials/ firstly, Woreda council and CBHI Office and Health Office identify the challenges in to woreda levele issue and region and above issue. Some of the challenges as identified as woreda issues are Community sense of belongingness and ownership in managing and administration of the scheme, even if beneficiaries paid the annual premium a number of households still didn't receive membership IDs to benefit from the program, delay in membership ID renewal, households will not bring full family members to CBHI, still some members of CBHI lack trust on the scheme and prefer to use Out Of Pocket (OOP) for their health expenses and some individuals and lack of awareness of beneficiaries on their rights to get membership cards as soon as they pay the premium. In order to reduce these gaps the woreda officials in general and CBHI office in particular working with kebele/village leaders and other stakeholders to increase the level of understanding and awareness of the program beneficiaries to build trust to the scheme. The woreda officials also planned to reduce the challenges regarding limited awareness and understanding of health professionals (lack professional ethics and not equally treated member and non-member) and kebele/village leaders in the scheme design. Whereas, regional and federal related challenges like inadequate supply of medicine, inadequate supply of laboratory equipment, long process of referral system and poor delivery of service by service providers needs further discussion with regional government, Ethiopian Health Insurance

Agency and Ministry of Health to solve the problem permanently and to insure the sustainability of the scheme.

## 5.2 Conclusion

At different time the government of Ethiopia has been taking different reforms, among them health sector reform is part of it. In Ethiopia, there is an old tradition called idir/kire of community organizations providing financial help to families for emergencies like funeral, but a new form of idir /or kire is gaining traction as the Ethiopian government pursues its goal of providing universal health coverage through Community Based Health Insurance(CBHI). Community Based Health Insurance is defined as health insurance that pools members “premium payment in to a collective fund” managed by the members and covers basic health care costs at local health centers when is sick.

Meket woreda is among the newly scale up woreda, the enrollment of CBHI in this district started five years ago in 2014. For the purpose of this study Meket woreda is taken as the study area. The researcher has collected quantitative primary data from 173 households through self-administrated questionnaire, which was analyzed using SPSS version 21 in order to get descriptive statistics. Quantitative data were collected through In-depth Interview (5) purposively selected from CBHI beneficiaries, Key Informant Interview (4) and Focus Group Discussion (FGD) with the selected Kebele council and beneficiaries and the analysis was conducted with description and direct quote. This study identified five research questions which were addressed by the data gathering through qualitative and quantitative methods.

This study concluded with the key findings from the scheme; not provide comprehensive health services and gaps in awareness creation to the community and professionals and gaps from the

beneficiaries; low level of beneficiaries to the scheme and limited participation of beneficiaries to the decision making process

This study also provides an insight/implication to different actors like policy and programs to improve the design and implementation of the scheme, provides an implication to practice, Social Work Education to engage in the ongoing policy by identifying problems, generating policy ideas, implementing and evaluating policy and finally provide an insight to researchers to investigate further solutions to the program challenges.

### 5.3 Implication to Social Work

#### 5.3.1 Implication to Policy and Program

This study is crucial in making positive impact on providing an input to policy makers in understanding where policy gap is and brings adjustment to accommodate such unaccommodating issues to policy and development.

There were gaps in the design and implementation of CBHI in the study area. For example currently the kebele/village administration plays a critical role in registering scheme members and collecting the premium. However, some kebele/village administrator force households to pay the premium and enrolling new members to the program, which means the existing principles of premium collection on a voluntary bases are sometimes violated, CBHI office should closely work with Kebele and village leaders in order to keep the principles of the program

There is a need to improve the availability of drugs and medical supply by closely working with PFSA (Pharmaceutical Fund Supply Agency). Health facilities need to be reduce the referral process/or beneficiaries who have membership ID should have got the service from any contracted health institution without refer by providing affordable health services to members of the scheme.

It is clear that Community Based Health Insurance increases health service utilization by beneficiaries; thus there is a need to design mechanisms to address complaints by and create incentive for health workers in reference to additional work burden. So, the government should give great emphasis to work with responsible stakeholders to improve supply of medicine, supply of laboratory equipment, long process of refer and poor delivery of services by the health facilities that didn't satisfied the members to the required level.

### 5.3.2 Implication to Practice

This study will creates some insight for the responsible government bodies of Meket Woreda particularly who are employed in Health Sectors to evaluate and correct how their duty addressed challenges of community as well as initiated to narrow such gaps among the community on CBHI implementation.

Even though, the Woreda CBHI office is working with different stakeholders on raising awareness of the community, such as: Ethiopian Health Insurance Agency (EHIA), regional health bureau, local leaders and elders, traditional institutions like idir and ikub and public meetings on enrollment to participate in making experience to the non-member households, the government should give more emphasis in creating holistic awareness to make the program more sustainable and should make transparency in the utilization of the collected money from the member households; some beneficiaries were thinking as a “debit” and assumed that “the collected money is misused by the service providers”. There were also problems of registering full family of household members to the program and select frequently sick individuals. This shows lack of awareness and understanding of the scheme to the members. So, the government should create awareness and need to participate CBHI beneficiaries in management, administration, mobilization and decision making.

In reference to the data from IDIs, KIIs and FGDs, there are a number of beneficiaries who had paid their premium of membership, but still they didn't receive membership ID start to get the service provision from the program. So that, the responsible body (Woreda Administration Office, Woreda Health Office, Woreda CBHI Office and Kebele Administration) should identify these individuals and provide their ID to get the service from the scheme.

According to data from IDIs, KIIs and FGDs; despite problems on beneficiaries the intention to have injection than tablets (assumed that injection better cure the illness than oral tablets and make problem of gastric, in some health facilities health professionals (especially the newly employed) have not enough awareness and what is expected from them. Not all, but some professionals provide services differently to CBHI and non-CBHI patients by giving priority to the non-members even not treated as equally and they don't feel comfort when see the membership cards. Even some lack not only professional ethics but also professional skills. In this area the government should give high attention by recruiting skilled man power and evaluate how the service is delivered to the beneficiaries and provide refreshment training to the service providers.

Likewise, private health clinic, government health facilities should provide good services in order to attract beneficiaries. Beneficiaries were bored by waiting long time to get the services, so in order to reduce waiting time of patients to get the service, government should increase the number of contracted health facilities and make a balance between the ratio of patient and professionals.

### 5.3.3 Implication to Social Work Education

Social Workers are natural allies to public health professionals, and their experience, knowledge, and wisdom can provide added value to ongoing policy (CBHI). Given the number of social workers' engagement in health policy practice and research, these individuals can provide

meaning full guidance at all steps of the health policy process (particularly in identifying problems, generating policy ideas, implementing and evaluating policies).

Social work education needs a large scale of producing work forces for public and private organizations which should make influences to have positions on the field. There were not social workers in any one of the health facilities in the study area. Both public and private University should provide more emphasis to produce demand driven quality Social Work forces in a large scale.

#### 5.3.4 Implication to Research

This research was conducted in a single woreda of Amhara region. I suggest the need to do large scale (Country wide, Regional/Zonal based and Woreda based including most or all Kebeles) research to assess and examine the practice and challenges of the scheme.

Further researches are needed on Community Based Health Insurance linkage to other social protection and complimentary coordination to other social service for example linkage to Productive Safety Net Program (PSNP), Women and children affairs and Ministry of Labor and Social Affairs (MoLSA) especially for indigent families to get additional services like Education.

Studies in the service delivery of health service providers and health facilities to CBHI members including the referral process are needed. Because in my findings there were gaps in health professionals to provide equal services to members and non- members. Members can't went to all the contracted health facilities unless they keep the referral processes. So, studies how to improve and shorten the long process of the referral system is needed.

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## Annex

### Introduction

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. Above 70 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. Widowed  D. Divorced
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 the house hold?
  - 1-5: Male  Female
  - 6-7: Male  Female
  - above 8: Male  Female
8. Number of Child Age (<18) -----  
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 heath 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?

A .No illness ----- B. Poor Medication ----- C. Poor laboratory facilities-----

D. poor client handling-----

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

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

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

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

A. Before 2-3 years ago----- Before 2-3 years ago-----

B. Before5yearsago-----

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?

- A. Poor Quality of their service   
B. Absence of Medicine   
C. Lack of medical equipment (Lab digenesis)

D. Cost of premium is not affordable

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

A. Reduce OOP  B. Improve health

D. Increase productivity  E. Reduce risks

10. Which challenges you are currently identifying as beneficiary?

A. Absence of availability of medicine

B. Absence of laboratory equipment (agents)

C. Lack of ambulance service

D. Poor service delivery

11. Are you very happy with current premium level?

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

E. Strongly Agree

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

A. Health center  C. Health Post

B. Clinic (Private)  D. Hospital (Government)

#### Part IV. Participation in CBHI programs

1. In which part do you attend in any local meetings concerning CBHI?

A. CBHI Strategy----- B. Rul & regulation of CBHI----- C. Service delivery

D. Payment of premium -----E. others -----

2. On which part you get the opportunity to talk (discuss) freely on CBHI with responsible body/stakeholders from woreda & above?

A. CBHI Strategy----- B. Rul & regulation of CBHI----- C. Service delivery-----

D. Payment of premium -----E. others -----

3. How do you explain your participation on CBHI program?

A. Paying premium-----

B. Board member -----

C. Creating awareness for non-members-----

D. Sharing own experience-----

Others-----

**This is the end of questioner Thank you very much for your  
Participation  
& Cooperation!!!**

መግቢያ

የሚከተሉትን ጥያቄዎች በጥንቃቄ ካነበባችሁ በኋላ ከቀረቡት አማራጮች መካከል ከፊትለፊቱ ባለው ሳጥን ወስኑ ። ”√ ” ምልክት በማስቀመጥ ይምረጡ። በተጨማሪም ተጨማሪ ማብራሪያ ወይም አስተያየት መስጠት ከፈለጉ ከስር ባለው ክፍት ቦታ ለጥናቱ ይጠቅማል ያሉትን ሃሳብ ማስቀመጥ ይችላሉ።

ክፍል1.መነሻ

1. ያታ፡ ወንድ ----- ሴት -----
2. ዕድሜ፡ ከ 18-48 ----- ከ 49 — 69 ----- ከ 70 በላይ-----
3. ወረዳ ፡----- ቀበሌ ----- መንደር -----
4. በቤተሰቡ ወስኑ ያለው ዝምድና ምንድን ነው  
አባት ----- እናት ----- ልጅ ----- ሌላ -----
5. የጋብቻ ሁኔታ  
ያገባ/ች/ ----- ያላገባ/ች/ ----- የፈታ/ች ----- ባሏ የሞተባት-----
6. የስራ ሁኔታ  
ግብርና ----- የቤት እመቤት -----ንግድ ----- የጉልበት ስራ ----- የመንግስት -----  
----- ተማሪ ----- ሌላ -----
7. የትምህርት ሁኔታ  
ያልተማረ ----- ማንበብና መጻፍ ----- 1ኛ ደረጃ ----- ሁለተኛ ደረጃ----- ዲፕሎማ/  
ዲግሪ -----
8. የቤተሰብ ብዛት  
1 — 5 ፡ ወንድ ----- ሴት -----  
6 — 7 ፡ ወንድ ----- ሴት -----  
ከ 8 በላይ፡ ወንድ ----- ሴት -----
9. የልጆች ብዛት ከ 18 ዓመት በታች -----  
ከ18 ዓመት በላይ-----

ክፍል2. በማህበረሰብ ጤና መድን ዙሪያ ያለው የግንዛቤ ደረጃ በተመለከተ

1. የማህበረሰብ የጤና መድን ምን ማለት እንደሆነ ያውቃሉ  
አወ፡ ----- አላውቅም፡-----
2. ለጥያቄ ቁጥር 1 መልስዎ አወ ከሆነ ከማንና እንዴት ለሙ  
ከጎረቤት ----- ከ ዕድር/ ዕቁብ ----- ከ ሀይማኖት ተቋማት -----  
ከወረዳ ማአጤመአገልግሎት ሰራተኞች/ጤና ኤክስቴንሽን----- ቲቪ፤ ሬዲዮ፤ ጋዜጣ-----
3. በማህበረሰብ አቀፍ የጤና መድን አገልግሎት መታቀፍ ጠቀሜታ አለው ብለህ ታስባለህ  
እጅግ በጣም----- በጣም ----- መሀከል ላይ -----  
ፍፁምየለውም----- የለውም-----
4. የማጤመስ አባል ከሆንክ ጅምር አገልግሎቱን ማግኘት ጀምረሃል ወይ  
አወ ----- የለም -----

5. ካላገኙ ለምን

ስላልታመምኩ----- በቂ የህክምና አገልግሎት ስለማይሰጥ-----

የተሟላ የመመርመሪያ መሳሪያ አለመኖር----- ጥሩ የደንበኛ አያያዝ አለመኖር-----

6. በማህበረሰብ አቀፍ የጤና መድን አገልግሎት ዙሪያ ያለውት ግንዛቤ ምን ያክል ነው

ዝቅተኛ----- መካከለኛ----- ከፍተኛ -----

ክፍል 3 የማህበረሰብ አቀፍ የጤና ምድንን የተመለከቱ ጥያቄዎች? ጥቅሙና ያጋጠሙ ችግሮች?

1. በማህበረሰብ አቀፍ የጤና መድህን አገልግሎት የታቀፍከው/ሽው መቸ ነው?

ሀ. ከ 1 አመት በፊት ----- ለ. ከ 2 — 3 አመት በፊት -----

ሐ. ከ 5 አመት በፊት -----

2. በማህበረሰብ አቀፍ የጤና መድህን አባል ከመሆንህ በፊት የህክምና ወጭህን/ሽን እንዴት ነበር የምተሸፍነው/ኛው?

ሀ. ካለው ገቢ ወጭ በማድረግ ----- ለ. በመበደር ----- ሐ. ባህላዊ ህክምና በመጠቀም -----

መ. በእቁብ/ እድር ----- ሠ. በመንግስት/ በነፃ -----

3. በማህበረሰብ አቀፍ የጤና መድህን ከታቀፉ በኋላ የጤናዎ ሁኔታ ተሻሽሏል ብለው ያስባሉ?

ሀ. በጣም ተሻሽሏል----- ለ. ተሻሽሏል ----- ሐ. መካከለኛ-----

መ. ለውጥ የለም ----- ሠ. ፍፁም ለውጥ የለም -----

4. የትኛው አይነት የጤና መድን አባል ነዎት?

ሀ. ምስኪን ----- ለ. የክፍያ -----

5. የእርስዎንና የቤተሰብዎን የማእጫም አባላት በጊዜው አድሰዋል?

ሀ. አወ ----- ለ. የለም -----

6. ከማእጫም በፍላጎትዎ ከአባላት ለመወጣት መወሰን ይችላሉን?

ሀ. እጅግ በጣም ----- ለ. በጣም ----- ሐ. መካከለኛ ----- መ . አልፏልም -----

ሠ. ፍፁም አልፏልም-----

7. ከማህበረሰብ አቀፍ የጤና መድህን ምንም ጥቅም አላገኜሁም ብለው ያስባሉ?

ሀ. እጅግ በጣም ----- ለ. በጣም ----- ሐ. መካከለኛ ----- መ . የተወሰነ አግኝቻለሁ -----

ሠ. ብዙ ጥቅም አግኝቻለሁ-----

8. ለጥያቄ ለተራ ቁጥር 7 የሰጡት ምላሽ እጅግ በጣም/በጣም ከሆነ ምክንያቱ ምንድን ነው ?

ሀ. ደካማ የአገልግሎት አሰጣት ----- ለ. በቂ የመድሃኒት አቅርቦት አለመኖር -----

ሐ. በቂ የህክምና ቁሳቁስ አለመኖር/ የላብራቶሪ ምርመራ----- መ. ተመጣጣኝ የሆነ ክፍያ አለመሆን-

ሠ. ሌላ ካለ ይገለፅ -----

9. በማእጫም ከታቀፉ በኋላ ምን ጥቅም አግኝቻለሁ ብለው ያስባሉ?

ሀ. የህክምና ወጭ መቀነስ----- ለ. የጤና ሁኔታ መሻሻል-----

ሐ. አምራች ዜጋ መሆን-----መ. የጤና ስጋትን መቀነስ-----

10. እንደ ማእጫም አገልግሎት ተጠቃሚነትዎ በአሁኑ ጊዜ ምንምን ችግሮች አሉ ብለው ለይተዋል?

ሀ. በቂ የመድሃኒት አቅርቦት አለመኖር ----- ለ. በቂ የህክምና ቁሳቁስ አለመኖር/ የላብራቶሪ ምርመራ----- ሐ. የአምቡላንስ አገልግሎት አለመኖር ----- መደካማ የአገልግሎት አሰጣጥ-----

11. አሁን ባለዉ የክፍያ ሁኔታ ደስተኛ ነኝ ብለዉ ያስባሉ?

ሀ. እጅግ በጣም ----- ለ. በጣም ----- ሐ. መካከለኛ ----- መደስተኛ አይደለሁም ----- ሠ. እጅግ በጣም ደስተኛ አይደለሁም -----

12. የጤና አገልግሎት አሰጣፎ ምን ይመስላል?

ሀ. በጣም ጥሩ----- ለ. ጥሩ----- ሐ. አጥጋቢ----- መደካማ -----

13. በእርስዎ መኖሪያ አቅራቢያ የሚገኘዉ የጤና ተቋም የትኛዉ ነዉ?

ሀ. ጤና ጣቢያ ----- ለ . ጤና ኬላ ----- ሐ. የግል ክሊኒክ ----- መደመንግስት ሆስፒታል -----

ክፍል 4. በማህበረሰብ አቀፍ የጤና መድን ዙሪያ ያለ ተሳትፎ በተመለከተ

1. በቅርብ ካሉ የመንደር ዳኞች /ባለሙያዎች ጋርስለማህበረሰብ አቀፍ የጤና መድን አገልግሎትን በተመለከተ በምን ጉዳይ ስብሰባ ተሰብስበዉ ያወቃሉን?

ሀ. ስለ ማዕጠማ ስትራቴጅ-----ለ. ስለ መዕጠሙ ህግና ደንብ----- ሐ.ስለ አገልግሎት አሰጣጥ-----መ.ክፍያን በተመለከተ----- ሠ. ሌሎች-----

2. ስለ ማከጤመ አገልግሎት ወረዳና ከዛ በላይ ከሆኑ አጋር አካላትጋር ሃሳብዎን በነፃነት የመገለፅ አድል አግኝተዉ ነበር?

ሀ. ስለ ማዕጠማ ስትራቴጅ-----ለ. ስለ መዕጠሙ ህግና ደንብ----- ሐ.ስለ አገልግሎት አሰጣጥ-----መ.ክፍያን በተመለከተ----- ሠ. ሌሎች-----

3. ስለ ማከጤመ አገልግሎት ክፍያ ከመክፈል ባለፈ ያለዎትን ተሳትፎ እነዴት ይገልፁታል

ሀ. ክፍያን በመክፈል----- ለ. የቦርድ አባል በመሆን----- ሐ.ግንዛቤ በመፍጠር----- መ. ልምድን በማካፈል----- ሠ.ሌሎች-----

## ስለ ትብብርዎ እና ስለ ተሳትፎዎ

### ከልብ አመሰግናለሁ

## Interview guide for KII interview

Date-----

Interviewer -----

Position -----

Interviewee-----

Education status-----

Duration of interview-----

Telephone-----

place-----

Woreda-----

Time of interview-----

1. When collection of premium is takes place/timing of collecting the premium/?
2. What is/ are initiating factors behind enrolling community based health insurance in the woreda?
3. What is the current total household numbers enrolling in the program? Among them how many of them are identified as indigent and non-indigent?
4. What are major problems currently you are facing while enrolling CBHI in your woreda?  
Demand side-----  
-----  
-----  
Supply side-----  
-----  
-----
5. What strategies /method's you are using in order to handle the above listed problems?
6. How you are creating and increasing level of awareness of households "especially those of not yet enroll?
7. How can you see the enrollment rate 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 drooping rate of the member?
10. With what government hospitals you are currently signed agreement for patient referral case and what is service provision/ coverage looks like?
11. Do you have any laboratory equipment and medicines available in your health center?
12. For how many number of child age is possible for households to get free health service? Please identify the number of both indigent and non-indigent?

- 13.** How many people are planning to enroll the current fiscal year? What activity is performed by your office in order to accept these households?
- 14.** Is there identified model kebeles (best performed)in enrollment of CBHI? What makes them model?
- 15.** Is there identified kebeles in less enrollment, high dropout and other performances please list their name and what activity is performed by your office in order to boost up their performance like other model kebeles?
- 16.** By what approach you introduce the premium level in a /Top-down/Bottom-up approach (in which the participation level of the society is high)? Why you prefer to follow this approach?

## Guide line for In-Depth Interview

Date: -----

Position: -----

Education status: -----

Telephone: -----

Woreda & Name of Kebele: -----

Interviewer: -----

Interviewee: -----

Duration of interview: -----

Place: -----

Time of interview: -----

1. How is your level of knowledge (understanding) on community based health insurance?
2. When you started enrolling in community based health insurance?
3. Before you joined the community based health insurance how did you cover your medical expense?
4. After you joined the CBHI schemes what kind of benefits did you get?
5. Are you very happy with current premium level?
6. When collection of premium is takes place (Timing of colleting the premium)
7. Which challenges you are currently identifying as beneficiary?
8. What is the nearest conventional health institution to your home?
9. Do you renew your & family's membership **ID** timely?
10. I decided to resign my membership from CBHI
11. How do you explain your participation on CBHI program?
12. What you recommend to increase the sustainability of the scheme

### Guide for Focus Group Discussion (FGD)

Date: -----

Position: -----

Education status: -----

Telephone: -----

Woreda & Name of Kebele: -----

Interviewer: -----

Interviewee: -----

Duration of interview: -----

Place: -----

Time of interview: -----

1. Have you got enough awareness on CBHI before enrolling? Do you know what CBHI means?
2. What are the service provisions provided to beneficiaries? If any additional services you recommend?
3. How do you explain your participation on CBHI program beside, paying the premium?
4. What are the challenges you are identifying in enrolling CBHI?
5. When collection of premium is takes place (Timing of colleting the premium)? Who fix the amount? Is it affordable?
6. How do you evaluate the sustainability of CBHI in your worwda/ kebele
7. What you recommend strategies to overcome the challenge in enrolling CBHI.