ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
COLLEGE OF DEVELOPMENT STUDIES
CENTER FOR FOOD SECURITY STUDIES

COMMUNITY BASED HEALTH INSURANCE PRACTICES AND CHALLENGES IN MEKET WOREDA, NORTH WOLLO ZONE OF AMHARA REGIONAL STATE, ETHIOPIA

BY

TADESSE ABEBE ENGIDAESHET

JANUARY 2022

ADDIS ABABA, ETHIOPIA

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TADESSE ABEBE ENGIDAESHET

ADVISOR

TEMESGEN TILAHUN (Ph.D.)

A THESIS SUBMITTED TO THE COLLEGE OF DEVELOPMENT STUDIES CENTER FOR FOOD SECURITY STUDIES OF ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN FOOD SECURITY AND DEVELOPMENT STUDIES

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ADDIS ABABA, ETHIOPIA

DECLARATION

I, Tadesse Abebe Engidaeshet, hereby declare that the thesis entitled: "***Community Based Health Insurance Practices and Challenges in Meket Woreda"***, submitted by me to the award of the Degree of **Master of Science in Food Security and Development Studies**, is my own original work and has not been submitted 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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Signature: _____

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As an advisor of the thesis, I certify that I have read and evaluated the thesis prepared by **Tadesse Abebe Engidaeshet** entitled" Community-Based Health Insurance Practices and Challenges in Meket Wierda, North Wollo Zone of Amhara Regional State" and recommended for open defense as fulfilling the requirement for the **Degree of Master of Science in Food Security and Development**.

Temesgen Tilahu(Ph.D.) _____ _____

Name, Advisor Signature Date

As members of the Examining Board of this thesis open defense, we certify that we have read and evaluated the thesis prepared by **Tadesse Abebe Engidaeshet** entitled "Community-Based Health Insurance Practices and Challenges in Meket Wierda, North Wollo Zone of Amhara Regional State " and recommend that it is acceptable as a thesis required for the Degree of Master of Science in Food Security and Development Studies.

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Chairperson of the Center of Graduate Program Coordinator

DEDICATION

I dedicated this thesis to Almighty Lord for his blessing in my life and my beloved family for their encouragement.

STATEMENT OF THE AUTHOR

My educational background includes a Bachelor of Science in Agriculture and a Master of Arts in Rural Development. This is my master's thesis for the second time. First and foremost, I certify that this thesis is my original work and that all sources of information used in this thesis have been properly acknowledged. This thesis was submitted as part of the requirements for a Master of Science degree at Addis Ababa University, and it has been put in the University Library to be made available to borrowers in accordance with the library's guidelines. I solemnly declare that I am not submitting this thesis to any other school for the purpose of receiving an academic certificate. Partial quotes from this thesis are permitted without specific permission as long as the source is properly acknowledged. When the planned use of the material is in the interests of scholarship, the Head of College of Development Studies or the Dean of the School of Graduate Studies may grant permission for prolonged quotation from or reproduction of this text in whole or in part. In all other cases, however, authorization from the author is required.

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Signature: _____

Place: Addis Ababa University, Addis Ababa

Date of Submission: _____

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ABBREVIATIONS AND ACRONYMS

ANOVA:	Analysis of Variance
CBHI:	Community Based Health Insurance Scheme
CHW:	Community Health Worker
DA:	Development Agent
EHIA:	Ethiopian Health Insurance Agency
FMoH:	Federal Ministry of Health
HEW:	Health Extension Worker
ILO:	International Labor Organization
LMICs:	Least and Middle-Income Countries
MDG:	Millennium Development Goals
MWAO:	Meket Woreda Administration Office
NGO:	Non-Governmental Organization
OOP:	Out of Pocket
ORDA:	Organization of Rehabilitation and Development of Amhara
PHC:	Primary Health Care
PHCU:	Primary Health Care Unit
PHCS:	Primary Health Care System
PSNP:	Productive Safety Net Program
PDS:	Permanent Direct Support
SHI:	Social Health Insurance
SSA:	Sub-Sahara Africa
SNNPR:	Southern Nations Nationalities and Peoples Region
USAID:	The United States Agency for International Development
USD:	United States Dollar
UHC	Universal Health Coverage
WoLSA:	Woreda Office of Labor and Social Affair
WHO:	World Health Organization

ABSTRACT

The objective of this research is to examine the CBHI practice and challenges in the North Wollo Zone of Meket Woreda. An in-depth interview and open-ended questions were utilized to collect quantitative data from a simple random sample of 287 respondents (158 males and 129 females). Qualitative information was acquired from a variety of sources as well (IDIs, KIIs and FGDs). Descriptive and inferential statistics were used to assess and display quantitative data, while thematic analysis was used to evaluate and present qualitative data. Findings of this research disclosed that majority of the surveyed rural households (80.5%), prior to enrollment in the scheme, were covering their health expenses through out of pocket. Some of the reported restrictions include gaps in program design and execution, insufficient beneficiary participation in CBHI administrative activities, insufficient medical supplies, long referral procedure, and unsatisfactory service delivery by health facilities. According to the findings, the CBHI program's current practice in the research area resulted in a significant improvement in improved healthcare provision to rural families despite increased strain on health experts. Gender of the household, level of education/literacy, and family size were statistically significant at 0.05. The study would contribute to narrow research gaps, as feedback for program implementation, and functioning as a source of information or reference for practitioners -+in the study area.

Key words: CBHI Programme, Health insurance, Out-of- Pocket

CHAPTER ONE: INTRODUCTION

1.1 Background

Community-based health insurance (CBHI) is currently viewed as a transitional mechanism for achieving universal health coverage in low-income countries by major international development agencies (WHO, 2005). Access to affordable healthcare is a key concern in the developing countries, and out-of-pocket healthcare costs have become a most important source of poverty. According to Guy (2003), most rural farming communities in Sub-Saharan Africa countries are found incapable to establish strong health care facilities due to the prevalence of worldwide catastrophic healthcare costs.

Since the 1980s, most developing nations have used payment-based systems to increase the performance and accessibility of healthcare institutions (Jacobs et al., 2008). Several people are unable to seek and receive vital health treatment due to financial limits imposed by out-of-pocket[1] expenses. Community-based health insurance programs, according to WHO (2010), are becoming a promising alternate to a cost-sharing health-care system that improves health-care utilization, reduces illness-related economic uncertainties, and ultimately leads to a fully operational health-care system for a longer period.

Anagaw (2015) claimed that Ethiopia's health service is mostly relied on out-of-pocket payments and somewhat pricey healthcare costs and causes consumers to forego health-care services. It makes it more difficult for the impoverished, who live in rural areas to get and use essential health care. Health care necessitates government spending, donor contributions, and hefty out-of-pocket payments. According to the Ethiopian Ministry of Health (2014), household out-of-pocket spending increased from 33% in 2010 to 42% in 2015. Inadequate government investments and underdeveloped private-sector involvement, however, have impacted health-care finance.

According to EHIA (2015), the Ethiopian government has launched a Community Based Health Insurance scheme as a potential alternate to healthcare empowerment in the informal economy in

[1] ***Out of pocket expenditure (user fees) for healthcare services*** [1]*: defined as direct payments made by individual to health service providers at the time-of-service use; that will not reimburse and share risk.*

response to the existing out-of-pocket expenses. The demand for behavioral change and outreach programs is increasing. In 2011, the CBHI plan was implemented in numerous locations with the objective of boosting the quality of healthcare services for rural and urban residents (Hilina, 2014). Accordingly, the pilot CBHI scheme was tested in 13 districts across four regions of Ethiopia (Tigray, Amhara, Oromia, and SNNPR) with the purpose of improving access to health care services, lowering out-of-pocket expenses, and improving service quality to balance high demand for health care and low supply of medical services, primarily for rural households and people in the urban informal sector (Anagaw, 2015).

A study by FMoH (2016) stated that the designing of the Ethiopian CBHI scheme builds on the assumption of certain features including voluntary household membership, help for the economically marginalized people, a monthly-based fee, targeted financial assistance and benefit package, administration of the scheme with the participation of the community, and linkage between referrals. Rural households in the study Woreda, Meket should pay an annual fee of 180 Birr (8.57 US$) to participate in the program. All curative and preventative services that are part of the basic health care program are covered by the benefit packages. Community-based health insurance schemes have the potential to achieve universal coverage of health services by pooling risks and protecting rural households and the informal sector from high health-care costs (Jutting 2003). Many developing countries, like Ethiopia, are unfamiliar with the scheme. As a result, an investigation regarding CBHI and its impact on the health-care system is critical, as it has affected households' access to healthcare and the quality of services provided.

The aim of this research was to examine how CBHI program is implemented in Meket Woreda, as well as what challenges it encounters and what types of lessons could be learned.

1.2 Statement of the Problem

Since 2005, the World Health Organization (WHO) has urged all healthcare system to move toward universal coverage in order to improve everyone's access to appropriate and affordable health care (WHO 2010). Several high- and middle-income countries have attained universal coverage over the course of a century by implementing various health-care financing methods, such as tax-based financing and/or social health insurance programs. Low- and middle-income

countries, on the other hand, have gone some way in covering persons in the informal sector, especially poor and vulnerable families, who frequently make up the majority of the population. Furthermore, millions of people in many developing nations are currently suffering because they cannot access cheap health care services or because paying for health care causes great financial hardship or pushes them into deep poverty (USAID,2011). Findings of the World Health Organization (WHO, 2010) revealed that around 150 million individuals face catastrophic health expenditures every year, and 100 million people fall into poverty after paying for health care.

Despite the fact that health insurance has arisen as a means of supplementing financial resources available for health care as well as a means of providing services, particularly in developing countries (Hsiao 2001), health insurance is very restricted in Africa. CBHI is only used in a few countries. Although, in most poor countries, such as Ethiopia, community-based healthcare finance through schemes can be a very essential strategy in providing financial protection, access, quality, and usage of healthcare services. Ethiopia rates low even when compared to other low-income countries in terms of access to modern health care and a variety of other health metrics. The user fee charges are one of the reasons for poor performance in healthcare services (FMoH 2014). CBHI scheme becomes one approach for developing countries such as Ethiopia to address difficulties linked to access, quality, and utilization of health services.

Various studies have been conducted on the impact of CBHI on health-care access, quality, and change in healthcare-seeking behavior. Escobar et al., (2010) examined many studies from developing countries and found that seven of the ten studies evaluate the link between health insurance and access and use; nine of the ten studies find that health insurance has a positive and significant impact on access and change in health care seeking behavior. According to Jutting (2003), the majority of research (39 of 51) examine the impact of health insurance on access, usage, and quality of health care services, implying that health insurance improves access, quality, and use of health care services.

Anagaw et al., (2015) stated in Ethiopian that community-based health insurances have been advocated as a feasible alternative due to the inadequate capacity of publicly financed health care in Ethiopia to provide appropriate and affordable access to health care. Melaku, Shimeles, and Berhane (2014) conducted another study on willingness to join a community-based health insurance scheme, finding that social, economic, cultural, and awareness levels were the most

important factors in determining enrollment in a CBHI scheme, resulting in low health-care utilization. Similarly, according to an EHIA (2015) study, 72.3 % of CBHI members visited health facilities, and CBHI members were 26.3 % more likely than non-members to visit a health facility while they were sick. Hellina (2014) investigated socio-economic determinants of CBHI in Kilte Awlaelo Woreda of Tigray Region, and she concluded that cultural, economic, and social factors are pillars that determine CBHI scheme participation and health care seeking behavior. Also, Fitsum, Challi, and Belaineh (2007) conducted a study in Jimma zone on health service utilization and associated factors and found that the level of utilization was insufficient. The finding revealed that sex, marital status, household income, and distance to the nearest healthcare institution were the most relevant factors influencing study participants' healthcare consumption.

Despite the fact that there has been research on CBHI and health-seeking behavior in Ethiopia, the planning and implementation of the CBHI program has received little attention. Furthermore, the relationship between the CBHI scheme and other social protection programs (PSNP) was not well recognized. Furthermore, earlier research that focused on the health-seeking behavior of a specific geographic community were unrelated to the implementation of the CBHI scheme (Fitsum, Challi and Belaineh 2007). Other studies focused on how rural Ethiopians seeking health care in general, regardless of their socioeconomic or cultural circumstances (Anagaw 2015; EHIA 2015).

Furthermore, a number of studies on the CBHI scheme and healthcare utilizations relied on literature reviews (Escobar et al. 2010). From a public health perspective, the majority of studies used quantitative methods. The researcher was motivated to perform the study in Meket Woreda because there were no empirical works that showed the adequacy of the plan and implementation of the CBHI scheme, and the linkage between CBHI and PSNP implementation had not been explored before.

1.3 Objectives of the Study

1.3.1. General Objective of the Study

The overall objective of the study was to examine at the practices and challenges of Community Based Health Insurance in Meket Woreda/North Wollo Zone of Amhara Region.

1.3.2. Specific Objectives of the Study

In line with the general objective, the following specific objectives were formulated. These are: -

- Identify the extent to which rural households participate in the CBHI program
- Assess how participation in the CBHI scheme benefits the rural households
- Investigate the challenges encountered during enrollment in CBHI scheme
- Examine the linkage between CBHI scheme with PSNP implementation in the study area

1.4 Research Questions

The purpose of the study was to find answers to the following outlined questions:

- What is the level of participation of rural households in the implementation and management of CBHI scheme?
- What are the current practices of CBHI scheme in the study area?
- How CBHI users are received benefits from enrolling in CBHI programme?
- What type of challenges are facing during establishing the CBHI program in place?
- How is the implementation of CBHI scheme link with PSNP in the study area?

1.5 Significance of the Study

This study provides basic information about the nature of designing and implementations of the recently established alternative healthcare financing/CBHI scheme in Meket Woreda. Additionally, the study has a wide range of implications for enhancing affordable healthcare services and program formulation, which eventually contributes improvements of the health status of the community. The outcome of the study adds some insights to the existing gap in literature on community-based health practices in the study area.

Finally, this study will also serve as a way in and be helpful in initiating other researchers and local development experts who will work on the issue of CBHI scheme for further in-depth analysis. Also, it will give feedback to the responsible government bodies to address concerns.

1.6 Scope and Limitations of the Study

1.6.1 Scope of the study

This thesis analyzed the community-based health Insurance practices and Challenges in Meket Woreda. Therefore, the scope of the study was rural-based focused on the informal sector, specific to beneficiaries. Besides, this thesis analyzed the complementarities between CBHI scheme with PSNP implementation in the study area. Moreover, methodologically this thesis employed descriptive statistics using SPSS combined with various qualitative techniques.

1.6.2 Limitations of the study

This study was theoretically limited to looking at CBHI practices and limitations rather than integrating to other social assistance services. The researcher disproportionately applied the representative sample for the total number of households from three agro-ecologically diverse kebeles to the size of the entire kebeles in the Woreda, resulting in the study's first weakness: it didn't adequately represent the study area. Due to considerable staff turnover and poor recording, acquiring disaggregated data on scheme performance was also a major challenge for this research (inadequate secondary data).

It would be crucial to use regression analysis to assess the use of accessible health care services in relation to various socio-demographic characteristics. However, no data on a specific predictor of health-care consumption was found, and the association could not be measured.

1.7 Conceptual Definition and Terminology

Community Based Health Insurance: a scheme in which community members prepaid for healthcare services based on solidarity and voluntary collective pooling of resources to share the financial risks of health care services and to be entitled to own and govern the scheme (Wiesmann and Jutting 2000).

General subsidy: the central government of Ethiopia provided 10% of the premium collected in CBHI implementing woredas (CBHI guideline, 2010).

Healthcare Institutions are healthcare service-oriented institutions that have been formally established in the studied area, including health centers/clinics, pharmacies, and hospitals.

Household is defined as, according to Jutting (2003), a person or group of persons who are formally connected or adopted and reside together again and shared a pot of food.

Indigents are poorest of the poor and found unable to afford the annual premium payment of CBHI scheme, directly supported (10% from the total population of the Woreda).

Insured Household: household who share the same membership in community-based health insurance card or are dependents of the same principal member.

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

Risk Pooling: is a method of sharing health-care resources by providing cross-subsidies to the sick and impoverished from the healthy and rich (CBHI guideline, 2010).

Traditional Medicine: is the total of traditional practices, abilities, and knowledge based on diverse cultures' world perceptions and perspectives, and applied in the protection, treatment, care, and level of physical and/or mental disorder (EHIA,2015).

Universal Health Coverage: access to adequate health-care service for all at an affordable price (WHO, 2005).

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

1.8 Organization of the Thesis

This thesis was organized into five chapters. Chapter one introduced and set out the background information, statement of the problem, research objectives, research questions, significance of the study, scope and limitation, concepts and definitions of terminology, and organization of the study. Chapter two stated a review of related literature (theoretical and empirical evidence). Chapter three explained to introduce a description of the study area, research methods, and materials such as location, the socio- demographic profile of the study area; research design, sampling size determination and approach; types and sources of data; sampling techniques, and data collection tools; techniques of data collection and ethical consideration. Chapter four described result reports and related discussions. Chapter five summarize the finding and suggested relevant recommendations.

CHAPTER TWO: LITERATURE REVIEW

2.1 Concept of Community Based Health Insurance

Health insurance is a means of boosting the financial risk coupled with the unpredictability in individual healthcare costs by pooling spending throughout time including across individuals using risk sharing (OECD, 2004). In the face of escalating healthcare costs, health financing systems based on general taxation, or the establishments of social health insurance are often viewed as effective means to achieving national healthcare and adequate financial stability for everybody. People and corporations usually participate in social health insurance schemes through salary-based contributions, whereas in tax-funded programs, the population contributes informally through taxation (WHO, 2010).

Given the limited capability of publicly sponsored health services in underdeveloped countries to deliver effective, accessible healthcare, community-based health funding has been suggested as a potential alternative. According to the study, the ultra-poor are frequently omitted, as are markers of unfavorable shortlisting. According to Anagaw (2015), access to CBHI is linked to greater health-care consumption, especially when it comes to the use of cost-effective outpatient care rather than inpatient care. Furthermore, the programs appear to reduce devastating healthcare costs. There are substantial relationships between scheme design and success, demonstrating the importance of integrating the target group in the planning process (Adane et al.,2014).

CBHI's methodology adapts insurance principles to communities' social settings, directed by their choices and based on current institutions and processes. CBHIs can assist communities in managing healthcare expenditures and ensuring that the impoverished and other vulnerable people get access to adequate healthcare. According to Calapar(2011), the programs are particularly successful in reaching rural inhabitants and the informal economy. It includes self-employed persons who are challenging to insurance (farmers, petty-traders, and laborers). These individuals are generally unable to pay critical healthcare out-of-pocket (OOP) charges at the time-of-service provision, which, if not managed, could lead them into going bankrupt.

CBHI is often formed and administered by a local community organization (USAID, 2011). The CBHI strategy calls for the creation of a network of facilities through the negotiation of contracts with various health care providers. The majority of health-care packages include basic treatments including prenatal, labor, and childcare, as well as family planning and, in certain circumstances, hospitalization costs. CBHIs were advantageous because they enlist and engage residents, ensuring that health care services suit local requirements and creating primary healthcare available and inexpensive to members by sharing resources and complementing them with external resources (Meghan, 2010).

CBHIs are distinguished by their members' voluntary participation and contributions provided in advance to cover possible medical bills. Premiums are paid on a regular basis by members in the schemes, usually when their revenues are sufficient (Hilina, 2014). Typically, such programs are started with the assistance of non-governmental organizations (NGOs), after which the community assumes full responsibility for the program's governance and administration. Local governments may also be able to assist in the promotion and funding of such initiatives. According to Watkins (2003), the community is involved in the establishment of the system and determines on the benefit level and payment. Members must also participate actively in the management and oversight of the organization.

2.2 Fundamental Assumptions of Community Based Health Insurance Scheme

The ideal CBHI model comprises community health care finance that prepays for healthcare services and is founded on two key assumptions: solidarity and voluntary communal pooling of resources to share the financial risks of health care services. First, governments in low- and middle-income nations, such as Ethiopia, lack the funds or tax revenue to adequately fund healthcare costs for the economically marginalized people (FMoH, 2011).

The second assumption is that the poor and those who reside in the informal sector spend a substantial amount of money on health care from both public and private providers, resulting in high health-care spending, which often pushes rural families into poverty. As a result, CBHI is widely recognized as one of the potential ways to extend health-care insurance to the rural

community and low-income informal sector segment of the population, allowing households to protect against significant healthcare expenditures due to a high reliance on out-of-pocket payments (Hsiao 2005). According to an empirical study conducted by Zelalem et.al., (2015), the CBHI scheme separates the payment period for health care from the time-of-service usage, which is more appropriate to rural households due to seasonal differences in income and expenditures. Poor people are less likely than wealthy person to seek health care because they do not have the financial resources to do so.

2.3 Factors Influencing CBHIs Performance

i. Affordability of Contributions: Flat payments are common, because they penalize the poorest: flat contributions are discriminatory, with a flat-rate contribution as a proportion of income being larger for the poor than for the non-poor (Guy, 2003).

ii. Unit of Enrollment: When households, communities, businesses, or mutual benefit groups serve as the foundation of participation, achieving proper membership percentages is considerably simpler. The household was the cornerstone of enrollment in more than half of the WHO-audited programs (WHO, 2010).

iii. Distance: Membership costs are increasingly affected by the gap between the family's income position and the nearby health facility where (covered) services are available (Demiste,199).

iv. Timing of Collecting: Repayment timelines were maintained adjustable, with monthly, quarterly, semi-annual, and annual payments based on earnings. Greater flexibility was granted since very some families could manage to pay for a one-year or even six-month participation in ahead (MoH, 2016).

v. Quality of Care: One of the arguments for non-beneficiary is that the public healthcare institutions do not provide quality healthcare. However, only government health service was included under the insurance coverage program (USAID, 2011).

vi. Trust: The availability of entry in the population, such as a micro-credit program, a developmental collaboration, or other social groups, according to Krishnan (2001), may aid in the construction of CBHI. If current initiatives have gained public trust, it may be possible to implement a scheme. It's critical to take note of data from several distinct systems.

2.4 Community Based Health Insurance in Ethiopia

Most developing nations, including Ethiopia, have implemented the CBHI scheme to provide universal coverage and equitable access to health care, protecting the poor and destitute from high out-of-pocket costs. Since the late 1990s, the CBHI scheme has served as an alternate means of achieving universal coverage, primarily for people in the informal sector (Anagaw, 2015). In June 2011, as part of the Ethiopian government's health sector financing reform program, a pilot CBHI scheme was launched in 13 districts across the country's four main regions (Tigray, Amhara, Oromia, and SNNPR) in an attempt to increase access to health care and reduce household vulnerability to out-of-pocket health care costs (FMoH 2011).

According to EHIA (2015), regional administrative bodies nominated these Woredas based on Federal Ministry of Health directives. Household enrolment is voluntary after kebeles have been chosen, although it does involve active engagement in management and oversight. Enrollment is done at the household level rather than individual level to prevent adverse selection. Within areas, benefit packages, registration costs, and premium payment methods are similar, however they differ slightly between them (FMoH 2016). In the administrative referral program, the benefit package comprises both outpatient and inpatient service utilization at public and private facilities. As a result, participating households are prohibited from seeking care in private institutions unless a certain service or drug is inaccessible in a public facility. Treatment overseas, kidney dialysis, and therapies with a high cosmetic value, such as artificial teeth and plastic surgery, are not covered by the scheme (WHO,2010). Before being referred to a hospital, members must first visit a health center (district or regional). Those who do not follow the referral procedure are responsible for 50% of their medical care costs.

A survey of households in the rural community of Fogera Woreda found that 94.7 % were willing to pay for community-based health insurance, with the impoverished willing to pay up to 5% of their monthly income; this is more hopeful than experiences of other countries' experiences (Adane, 2014).

2.5 Complementarities Between CBHI Scheme with Other Social Protection Programme (PSNP)

The term "social protection" refers to government policies aimed at reducing poverty and risk, as well as protecting vulnerable people (African Union, 2008). Social security programs are seen as a better long-term alternative to sporadic humanitarian aid in addressing the core causes of poverty in developing countries. Such programs are likewise growing in popularity around the world (ILO, 2014). In practice, social protection policy covers a wide range of issues, from food security to social assistance for the poor and health care. The National Social Protection Policy emphasizes the potential for linkages between different types of vulnerabilities and urges for a coordinated set of efforts to be implemented (GFDRE, 2016).

PSNP is Ethiopia's major social protection program, with the purpose of strengthening rural households' livelihoods, food security, and nutrition in parts of the country that are chronically food insecure. CBHI, which began in 2011, is seen as Ethiopia's first step toward universal health insurance, which the Ethiopian government hopes to achieve by 2035(GFDRE 2016). The previous study examined into the collaborations that exist between PSNP and CBHI- a two key social protection programs in rural Ethiopia. CBHI operated in almost one-third of the PSNP Woredas, according to FMoH(2016). CBHI is being expanded even more, but it is still falling short of the goals set forward in the National Social Protection Strategy, which calls for an equitable geographic distribution of social protection resources and instruments to ensure that poor households have access to all of the protection they require. Nearly 22% of all PSNP beneficiary families are enrolled in CBHI in PSNP Woredas where it is operating.

Given that PSNP users are among the poorest and most food insecure households, and that health insurance might provide major benefits, the low enrollment rate among PSNP beneficiaries is concerning. The proportion of indigent households in PSNP households and other poor households is relatively similar. This implies that the selection criteria for PSNP users and CBHI indigents are slightly different. The limitation of focusing on out-of-pocket payments is that it only includes households that have incurred them — not those that have had health problems but were unable to afford treatment. As a result, it is crucial to figure out how many poor households in these chronically food insecure Woreda would potentially benefit from CBHI participation.

2.6 Limitations and Constraints of Community Based Health Insurances

Leading to inadequate use rates in some countries, community-based health insurance schemes have been hampered in their ability to recruit and integrate significant numbers of people who are expected to share the risk of sharing health-care bills (Hsiao, 2003). There is a low demand despite high expectations for people to join such schemes due to the voluntary nature of membership. The main causes for the failure of previous CBHI initiatives were administrative issues such as poor design, misuse of resources, a lack of supervisory procedures, inadequate community engagement in the scheme's management and administration, and corruption (WHO,2010).

Another issue to solve is the self-selection of people with poor health into the CBHI program, which has a negative impact on the program's long-term viability. People with chronic illnesses, as well as those with inadequate financial resources, are typically included. Furthermore, according to a study conducted in Nigeria, the following factors influenced people's decision to join the CBHI: affordability, lengthy distances traveled to the health care center, members' socioeconomic position, inadequate health care services, and cultural views and customs (Jutting, 2003). People were prevented from joining such CBHI schemes due to a lack of proper education and previous negative experiences with such schemes. There should be adequate and transparent communication and information flow between those in charge of the initiatives and those who benefit from them. A sufficient prerequisite for poor members to receive a larger share of scheme benefits has been described as adequate communication.

2.7 Conceptual and Theoretical Framework of the Study

This section provides assessments of the most common theoretical literature related to community-based health insurance practices in order to formulate frameworks for identifying gaps and guiding principles.

Access to health care service: CBHI is an emerging concept for providing financial protection against the cost of illness and enhancing access to health services for low-income rural households and those who are not covered by formal insurance (Jutting 2003). For low-income rural households and those in the informal sector who are not covered by formal insurance, the

CBHI program has become a promising model for providing financial protection against the cost of illness while also enhancing access to health services.

Quality of health care service: One of the first issues was that certain health facilities lacked the essential infrastructure (potable water and power), which hampered the delivery of high-quality health care (Anagaw, 2015). In Ethiopia, the FMoH and its counterparts made public funds available to assist catchment health facilities in meeting the essential infrastructure standards. Community-based health insurance may improve care after a significant health event, as well as routine and preventive care (Jutting 2003). Due to free access to health care at the time of service, the use of health facilities is likely to expand. Better care will raise people's expectations of getting good value for money in the event of an illness, increasing demand for insurance once more. As a result, at least some of these pooled resources could be used to increase access and improve service quality (EHIA 2015).

Health information access and awareness level: the level of education of CBHI participants and access to health information provided incentive for prevention and health-care utilization. Even if a person is a member of the scheme, the absence of signals to action will lower the possibility of preventive and service utilization (USAID,2011). On the other hand, the lack of expense at the moment of service increases the use of advanced healthcare services.

Socio-economic and demographic factors: According to WHO (2010), socio-demographic variables and attitudes, interact with economic driving factors (including family income, wealth, and service fee), CBHI membership, and distances from health care facilities to produce the conditions under which a person is or is not likely to seek healthcare when need factors such as symptoms of illness are experienced.

In general, results from the previous studies showed that most component of the framework correlated with households' use of healthcare services.

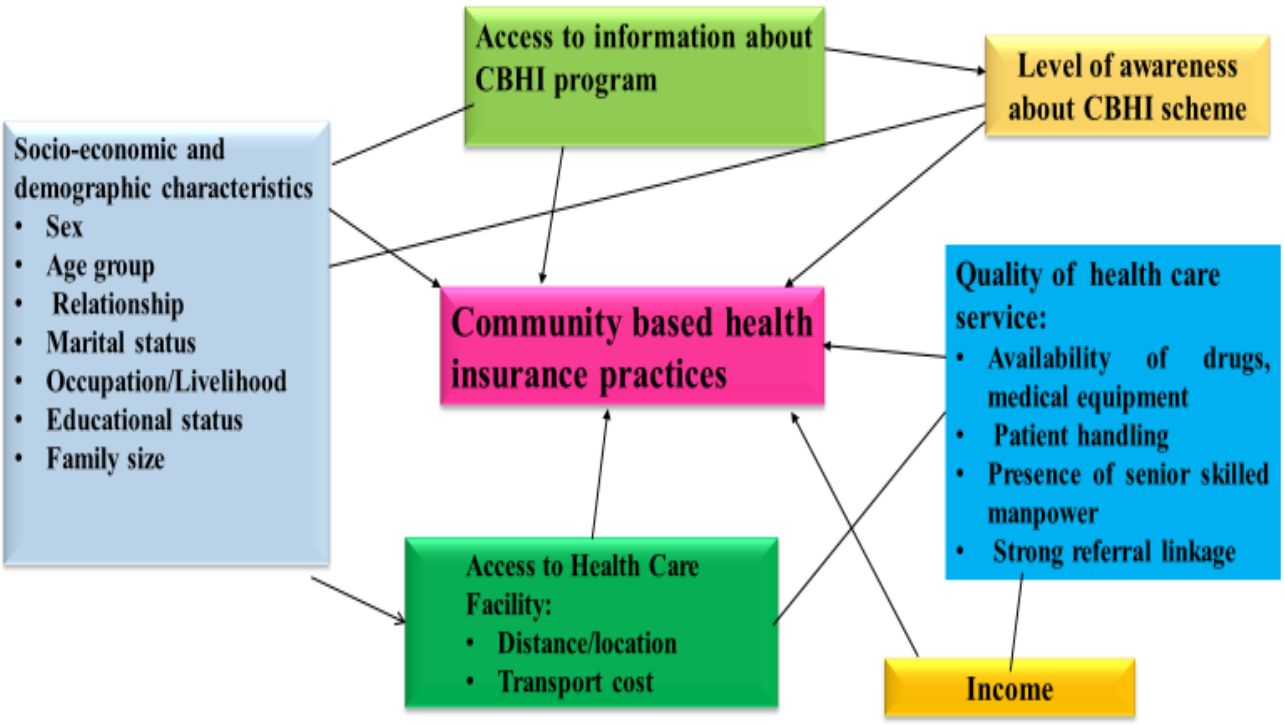

FIGURE 1: Conceptual framework (adopted from USAID, 2011)

CHAPTER THREE: RESEARCH METHODOLOGY

The research methodology section covers the following topics: study area description, research design and strategy, data collection tools and methods, sample and sampling procedure, data collection procedure, data processing and analysis, and ethical issues.

3.1 Description of the Study Area

Meket Woreda is located in the North Wollo Administration Zone of the Amhara region. It is 670 kilometers north of Addis Ababa, 222 kilometers from Bahirdar, and 145 kilometers from the zonal town (Woldia). It is bordered to the north by Bugna and Lasta Woreda, to the south by Wadla Woreda, to the east by Gidan and Gubalafto Woredas, and to the west by Lay-and Tach Gayint Woredas (Woreda Administrative Office, 2018). Geographically, it is located between latitudes $11^{o}30'$-$12^{o}10'$N and longitudes $38^{o}30'$-$39^{o}30'$E, according to Meket Woreda Administration Office (2018). The altitude ranges from 1,458 to 3,460 meters above sea level, with agro-ecology zones of kola (25%), Woina Dega (55%) and Dega(20%). According to Woreda Agriculture Office (2018), the total area is 191,148 hectares with varied land use classifications (cultivated land 49,450 ha, pasture 15,152 ha, forest and shrubs 54,000 ha, built-up area 39,528 ha, degraded or eroded land 8,659 ha, valleys and rugged topography 8,659 ha, and grassland 15,700 ha).

A total of 217,044 people live in Meket Woreda (107,899 male and 109,145 females). A total of 26,095 people live in the two urban kebeles (males 12,760 and females 13,335) of the Woreda (Woreda Administration Office,2018). Meket Woreda has a total of 36 kebeles (34 rural and 2 urban kebeles). The main source of livelihoods in the study area are subsistence agriculture and small-scale trading. On average, a 0.5 ha of farmland is owned by a family of five people. The principal crops grown are teff, barely, wheat, bean, sorghum, and soya bean. Winter irrigation is also used to produce a variety of cereals and fruits in this location (Meket Woreda GTP1 Report, 2016). When it comes to animal husbandry, it is also popular in the research area. More than half of the population, according to the Woreda Administrative Office (2018), is illiterate, meaning they are unable to read or write. Despite the fact that there are 36 health posts (one for each kebele), eight health-care centers, and a newly constructed primary district hospital (Shedeho Meket), facilities and supplies are still in short supply.

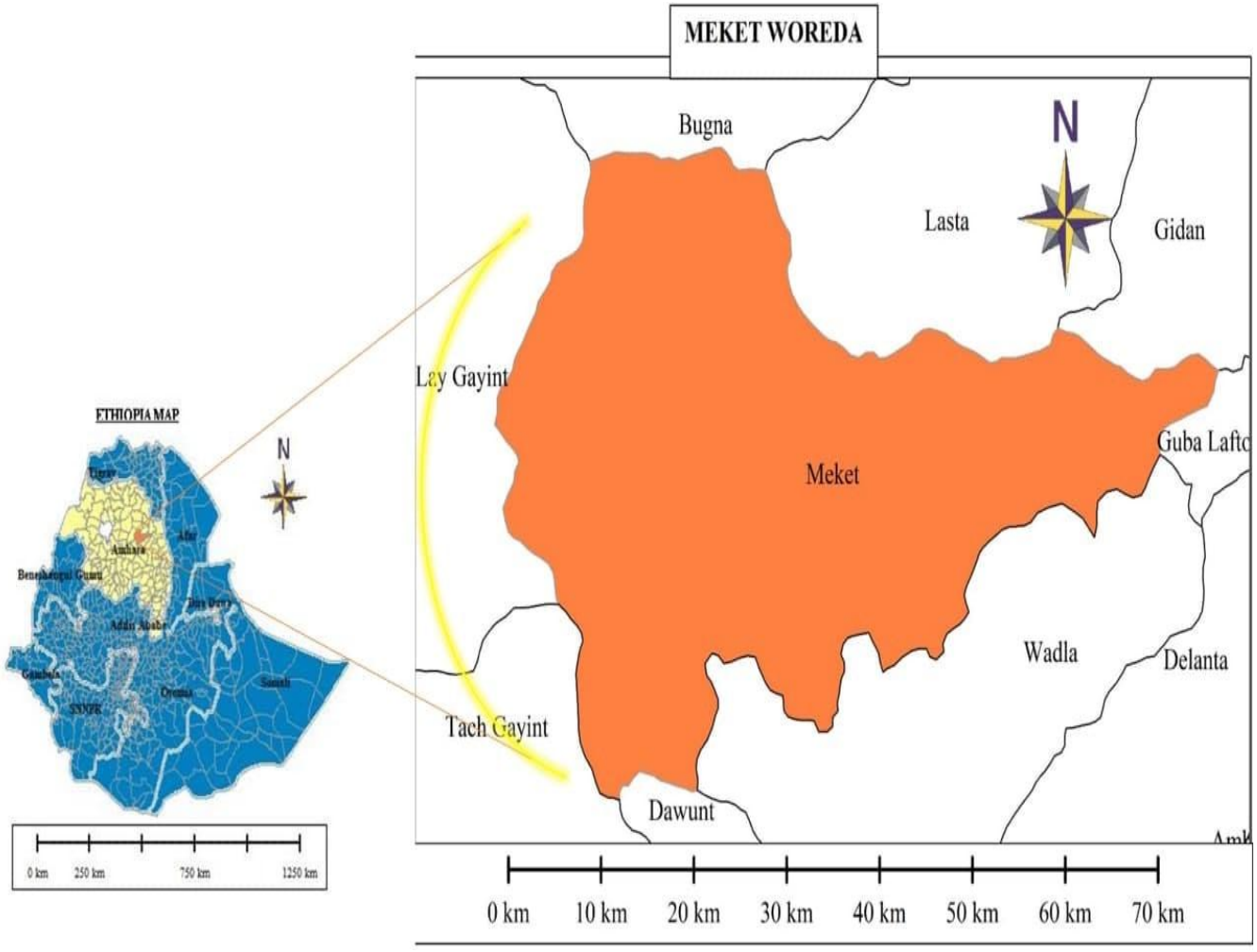

FIGURE 2: Location of the study area (Source: Ethiopian Mapping Agency, 2020)

3.2 Research Design and Approach

The actual data was collected from 287 household heads (respondents) and randomly selected informants using a cross-sectional study approach. The design of the study was the best for stimulating responses to the research question (Diriba, 2014). The major survey tools used to gather qualitative data includes focus groups, key informant interviews, in-depth interviews and observation, and questionnaires were taken as instruments to collect quantitative data for this study.

This study employed mixed research approach; it included both qualitative and quantitative approaches. Mixed approach encompasses both quantitative and qualitative data helps to comprehensively understand a research problem and address the issue under study in holistic

perspective (Kothari, 2004). The triangulation method allows for the extraction of quantitative data from a representative household survey, while CBHI scheme participants and health care professionals can probe or investigate qualitative data for more in-depth information. A household survey was conducted to collect quantitative information on the CBHI scheme's practices and health-care utilization. On the other hand, qualitative data was gathered through in-depth interviews, key informant interviews, and focus group discussions to supplement quantitative data on the issue under study. Furthermore, one of the key sources was secondary data, which was gathered through a review of published and unpublished sources (evaluation checklists, government official documents and performance reports).

3.3 Eligibility Criteria

3.3.1 Inclusion criteria

The study included all beneficiaries over the age of 18 who had joined and benefited from the CBHI scheme in Meket Woreda since 2014 and had signed an informed consent form indicating their willingness to participate.

3.3.2 Exclusion criteria

Non-beneficiaries of the CBHI scheme and beneficiaries who refused to participate in the interview were among the exclusion criteria. Children under the age of 18 were also not allowed to participate.

3 4 Method and Tools for Quantitative Data Collection

3.4.1 Household survey

Simple random sampling was considered relevant to collect quantitative data from a representative sample using a semi-structured questionnaire that includes close ended questions supplemented with open-ended questions in order to give each respondent within the population an equal and/or measurable chance (Saunderes et al., 2009). The purpose of the survey of sampled heads of households was to examine into scheme practices, implementation challenges, service quality, and so on. The Woreda's diverse agro-ecology was represented using a multistage stratified sampling technique. An updated list of CBHI member households was used as a sample frame for selecting sample head of households for the study.

3.4.2 Study population and sampling design for household survey

A multistage proportionate stratified random sampling technique was used to select participant heads of households based on the proportion of each subgroup in the overall population, with a simple random sample selected within each subgroup. The main sampling units were called kebeles. Thirty-four rural kebeles in the Meket Woreda were also divided into three agro-ecological zones to account for variations in CBHI implementation. To obtain representative samples from each community, three ecological zones (Kola, Woyina Dega, and Dega) were considered. Because the numbers of kebeles are quite small and lottery is applicable, sample kebeles from each ecological Zone were selected for representation to each agro-ecological zone.

Then three kebeles were chosen at random, one from each ecological zone: kebele 012 (Arabal) from ten kolla kebeles, kebele 03 (Kurisa) from fourteen Woyina Dega kebeles, and kebele 029 (Warkaye) from ten Dega kebeles. In addition, there were 200 payer insured households in kebele 012 (Arabal), 348 payer insured households in kebele 03 (Kurisa), and 477 payer households in kebele 029 (Warkaye). The total number of paying households in the three kebeles is then (N) = 1,025. Sample size of the study was calculated using simplified proportion sample size estimation formula, to determine the required sample size at a confidence level of 95 %, and a 5% margin of error (Yamane, 1967). The sample size was then calculated using the 95% confidence interval and a 5% margin of error as follows:

$$n = \frac{N}{1+Ne^2}$$

Where,

n is the sample size to be selected

N is the population size of the study = 1,025

e is the margin of error (acceptable sampling error) = 5% (0.05)

Accordingly, applying Yamane's sample size calculation,

$$n = \frac{N}{1+Ne2}$$

$$n = \frac{1{,}025}{1+1{,}025\ (0.05)^2} = \mathbf{287}$$

Following the determination of the sample size, the samples (287 head of households) were allocated into proportions for each kebele using the formula (nk= (NK*n)/N); where, nk= sample for each kebele, NK= total number of paying insured household in the population for each kebele, N=total population (paying insured households for three kebeles) *=sign for multiplication. As a result, 77 sample households from Arabal(012) kebele, 87 sample households from Kurisa(03) kebele, and 123 sample households from Warkaye(029) kebele were selected.

A non-response is a failure to gather information from a targeted individual for any reason (death, absence, or refusal to respond) in a sample survey, and the non-response rate is the proportion of such individuals in the sample aimed at. As a result, 10% of the 287 household heads are considered contingency (which is 29 HHs).

3.5 Method and Tools for Qualitative Data Collection

Qualitative research is a method of investigating and comprehending the meaning that individuals or groups attribute to a social occurrence they are witnessing (Creswell, 2009). The quality of health care services, as well as the attitudes of frontline health care workers about the CBHI system, were investigated using a qualitative approach.

i. In-depth Interview (IDI)**:** It is a sort of interview that helps a researcher to develop a full understanding of the respondents' viewpoints on the subject being investigated (Saunders et al., 2009). Insured patients were interviewed to generate narratives about how they respond to service utilization and quality. Along with probing questions, open-ended questions were prepared to allow participants to be as flexible as possible. The researcher had conducted five in-depth interview and acquired data from scheme users for triangulation purpose.

ii. Key Informant Interview (KII)**:** A guide designed expressly for this purpose was used to perform KIIs as part of the qualitative survey. Participants(experts) who had a better grasp of how the CBHI plan was implemented were interviewed, with a focus on key components (EHIA,2015). Key informant interviews with people who know what's going on in the specific area, who have first-hand knowledge of the problem at hand, who can provide insights into the nature of the problems, and who can offer recommendations for solutions. In order to acquire

information from various perspectives, four key informant interviews had conducted with the Woreda CBHI Coordinator, Kebele managers, Woreda Administrator, Head of Woreda Health Office, and Woreda PSNP Coordinator.

iii. Focus Group Discussions (FGDs)**:** Focus group discussion (FGD) used to better understand communities' perspective and consensus regarding the CBHI scheme practices and how people benefit through receiving quality of services that the participant provides and acquire wider scope of validity data. FGD is vital to use when the goal is to better understand how people think about an experience, idea, or event, according to Freitas (1998), because the discussion in the meetings is effective in delivering information about what people think. Accordingly, in each study kebele, one FGD was conducted. FGDs were formed with the participation of selected heads of households to ensure that all parts of the community were represented (male, female, youth and elder). Considering the study homogeneity of participants in terms of income status and awareness (education) level, the researcher conducted five focus groups: three mixed gender FGDs with eight participants, and two female FGDs with six participants. Participants were from kebele CBHI task forces, beneficiaries, Health Extension Workers/HEWs, and Agricultural Development Agents.

3.6 Data Processing and Analysis

The researcher employed both qualitative and quantitative data analysis approaches, depending on the nature of the data. Before being analyzed, quantitative data was cleaned, encoded, and ready for entry. The analysis was carried out using the statistical package for social science (SPSS) version 23. Descriptive statistics were utilized to describe the socioeconomic and demographic features of the respondents' using percentages, graphs, and tables. As Yilma et al., (2015) claimed that statistical tests and models are based on assumptions.

Following that, each outcome variable was examined, with a 95% confidence interval assumed. The significance of the findings was determined using the $P \leq 0.05$ significance level. More importantly, a T-Test and One-Way ANOVA (Analysis of Variance) was used to examine if any statistically significant differences (or correlations) existed between the means of independent groups of socio-demographic characteristics, as well as between independent and dependent variables.

The formulas for one-way ANOVA are as follows:

F = MS between/**MS**within; **MS**between = **SS**between/**df**between; and MSwithin = SSwithin/**df**within.

Where: F stands for f- distribution/value

MS stands for Mean Sum of Squares (Variance)

SS stands for Sum of Squares

df stands for drees of freedom, an estimation of sample size

The purpose of qualitative data analysis was to organize information, break it down into manageable pieces, synthesize it, analyze for trends, and determine what was important and what needed to be taught (kothari,2004). Then, based on the closeness of the themes, qualitative and quantitative data were integrated concurrently based on themes in sequences of the study's objective.

3.7 Ethical Consideration

Data collection was timely begun with submitting a formal letter of support request written by Addis Ababa College of Development Studies/Center for Food Security addressing to the Meket Woreda Administrative Office. Following that, the Woreda Administration issued a formal letter to each study kebele and Woreda CBHI Coordination Office. Those eligible participants were randomly selected from the existing lists after obtaining approval from each kebele administration, and administrative facilitation was provided throughout the data collecting period.

Respondents and informants were given a brief explanation of the purpose of the study and the problem of privacy by the researcher and trained data collectors. People should be assured that their comments wouldn't be used against them, and also that they will not be compelled to write their names or any other personal information. The respondents and informants gave their informed verbal consent, which resulted in an oral agreement. The researchers and data collectors encouraged the respondents to give honest responses in open areas to avoid any disruptions after getting their consent. The information was gathered in a way that did not affect the safety or privacy of the participants. The researcher hired four data collectors with experience

in the CBHI scheme, two of whom have a M.Sc. Degree in Agro-economics and Development Studies, whereas others were attending their Post-Graduate Degree in Public Health at Wollo University. They were trained and familiarized with the research procedure. Finally, the actual data collection process was undertaken from 17 to 27 March 2020. Quantitative and qualitative data were collected at the same time. The researcher collected data from KIIs and IDIs, while the researcher collected data from FGDs with the help of a professional facilitator.

3.8 Explanation of the Study Variables

The variables employed in the analysis, as well as their theoretical knowledge of how they relate to the CBHI scheme. As stated below, these variables were generated based on the reviewed literature and experience:

Dependent variable: the dependent variable for this research is CBHI scheme practice.

Independent variables: based on literature review and past experience, the following factors are expected to influence the practice of CBHI scheme in the study area.

***Age of the heads of HHs*:** Older household heads are expected to participate in the CBHI scheme as one of the independent variables assumed to influence the scheme's practice. As household heads gets older, it is assumed that they will require security, in the form of health insurance, in order to protect themselves from the biggest financial risk.

Sex of the heads of HHs: Households headed by women are more vulnerable to health issues. Last but not least, the household's economic status is on their shoulders, and as more load is placed on their shoulders, they prefer to be a member.

Education level: If family heads received educational opportunities that enabled them to read and write, they would be more likely to participate in the scheme.

Household size: Households with more active family labor would be eligible for the CBHI program. Because a family is more likely to be made up of people in their working age group, there is a greater chance that they will engage in labor work.

Distance to the nearest health center: The distance between the nearest health center and the participation of heads of the households in the CBHI scheme is also an important factor. They

will be motivated to participate in the scheme since a health facility is within their reach. The proximity of a health facility will encourage them to engage in the CBHI.

Participate in PSNP: family members who participate in productive safety net programs will have a positive impact on CBHI involvement.

Attend local meeting: Different meetings in kebeles and Woreda will have a positive impact on the scheme's practice and management. These gatherings are successful in disseminating health insurance program information to the local population.

Out-of-pocket payment: This is because, despite being members, program beneficiaries are required to pay for health services out of pocket. This will have a negative impact on their future enrollment, as well as those who are already enrolled, as they may not continue or drop out.

3.9 Data Quality Assurance

Reliability of the research ensures that the findings of the study would be replicated if the process or instrument were used in another investigation (Creswell 2013). The tool was tested for internal consistency and reliability with 15 interviewees from the three study kebeles. Validity of findings or data, on the other hand, is defined as the accuracy or precision of study findings. Furthermore, the pilot study was utilized to improve the quality of the questions, as well as the formats, arrangements, scales, and language employed, so increasing the data's validity.

Various methods were used to ensure the quality of the qualitative data. Building a good relationship with respondents, explaining the research objectives to them, approaching respondents in a nice manner and gaining trust, and honoring the cultural values of the participants were only a few of the procedures used to improve the data's trustworthiness. Furthermore, verify with colleagues to see who is presenting the data to the colleague. To prove the data's dependability, triangulating the data acquired through several methods of data collecting was also used. The initial version of the questionnaire was translated into local language (Amharic version) by health professionals to ensure the instrument's validity. A colleague from the statistics department confirmed the consistency of the statistical measurements. Following that, the translation was carefully examined in order to avoid any ambiguity.

CHAPTER FOUR: RESULTS AND DISCUSSION

The major findings of the study are presented, analyzed, and interpreted in this chapter, based on data gathered through household survey, in-depth interview, key informant interview, and focus group discussion. To incorporate all of the necessary material gathered from the field, the chapter is divided into five sections with several sub-sections. Secondary data from several sources was also used to enhance the source data.

4.1 Socio-demographic Characteristics of the Respondents

A total of 287 household respondents (see Table 4.1 below) were interviewed with a 100% response rate, males accounting for 55.1 % and females (including housewives) 44.9 %. And 66.2 % were between the ages of 18 - 48, 27.5 % were between the ages of 49 - 69, and 6.3 % were beyond 70, according to the age distribution. This indicates that the majority of households responding are made up of people between 18-69 years old aged. Male-headed households accounted for 55.1% of all respondents, followed by mothers (42.5%) and other family members (2.1 %).

According to the findings, marital status is an important factor in continuing to practice CBHI and renewing membership on a regular basis in order to reap the benefits of the program. As a result, 79.8% were married, 2.1 % were still single, and 8.4 % and 9.8 %, respectively, were widowed and divorced. Married households make up a large portion of the scheme's participants. Single-person households require more security and insurance than families with children and grandchildren.

Considering the interviewee employment categories, 71.4 % are farmers, 11.6 % are housewives, 13.2 % are traders, and 1.7 % are daily laborers. The results clearly demonstrated that the CBHI scheme's primary focus is on the rural participants. 54.7% of those polled were illiterates (unable to read and write), 28.6% were literates, 11.8% had completed secondary school, and 4.9% had not completed their middle-schooling. As a result, education had a positive impact on the CBHI scheme's enhanced understanding.

According to the responses given by the respondents, 78.4 % had between one and five people, 17.8 % had between six and eight members, and 3.8 % had more than eight members. The majority of the respondents were registered and actually participated in the programme with one to five family

members. Furthermore, 88.5 % had children under the age of 18 years, compared to 44.6 % who had children over the age of 18.

TABLE 1: Background Characteristics of Respondents **(N=287)**

Characteristics of respondents (socio-economic and demographic)		**Percentage (%)**
Sex of respondents	Male	55.1
	Female(including housewives)	44.9
	Total	100
Age group (years) of respondents	18 – 48	66.2
	49 – 69	27.5
	Above 70	6.3
	Total	100
Relationship of respondents	Father	55.1
	Mother	42.5
	Child	2.1
	Others (parent siblings and child-in-law)	0.3
	Total	100
Marital status	Married	79.8
	Single	2.1
	Widowed	8.4
	Divorced	9.8
	Total	100
Occupation	Farming	71.4
	Housewife	13.6
	Petty-trading	13.2
	Daily laborer	1.7
	Total	100
Educational status	Illiterate (can't read and write)	54.7
	Can read and write	28.6
	Grade 1- 8	11.8
	Secondary school (grade 9 – 12)	4.9
	Total	100
Family size of the respondents (Including children)	1 –5	78.4
	6 – 7	17.8
	Above 8	3.8
	Total	100

Source: sample survey (2020)

4.2 Designing CBHI Scheme in Meket Woreda

According to Jutting (2003), community-based health insurance is emerging as an innovative and attractive approach to achieving public healthcare that has caught the interest of governments, particularly in developing countries including Ethiopia. There were a few inconsistencies in the way some design elements were applied. People's choice involvement, benefit categories inclusion, prior payment, a not-for-profit purpose in forming the program, community-based program administration, and possibly some level of risk sharing is all given high priority in most CBHI initiatives, which can be easily verified (EHIA,2015). The CBHI scheme in Ethiopia, according to USAID (2011), has important features such as membership choice and enrollment status, level of involvement, support for the very poor, annual payment, general subsidy, and services payment system.

Scheme registration has been done on a household-by-household basis rather than on an individual basis to minimize the potential for inappropriate selection, according to the Meket Woreda CBHI Coordination Office Report (2018/19). The Woreda then identifies suitable homes after Kebeles examine applications based on pro-poor eligibility criteria. All registered outpatient and inpatient services at the health-care centers would be covered by the insurance plan, with the exception of dental implants, eyewear, cosmetic operations, and dialysis. If they get a referral from a health facility, individuals can now go to hospitals without incurring a charge.

4.2.1 Awareness Level and Membership Condition

Programme participants were interviewed how underrating regarding the CBHI scheme. When asked, "*Do you know about Community Based Health Insurance*?" 92 % replied Yes, whereas 8% of respondents claimed that they had inadequate awareness on what CBHI meant. Accordingly, the data revealed that majority of participants had a well understanding on the concept and objective of the program. This is due to Woreda's conviction that they were doing a better job of spreading awareness in the rural county.

Respondents were also asked about their overall knowledge and understanding of the CBHI program. According to the responses, 19.5 % of recipients have a good understanding of the CBHI program, while 63.1 % have a fair understanding. On the other hand, 17.1 % indicated they were less aware of the scheme.

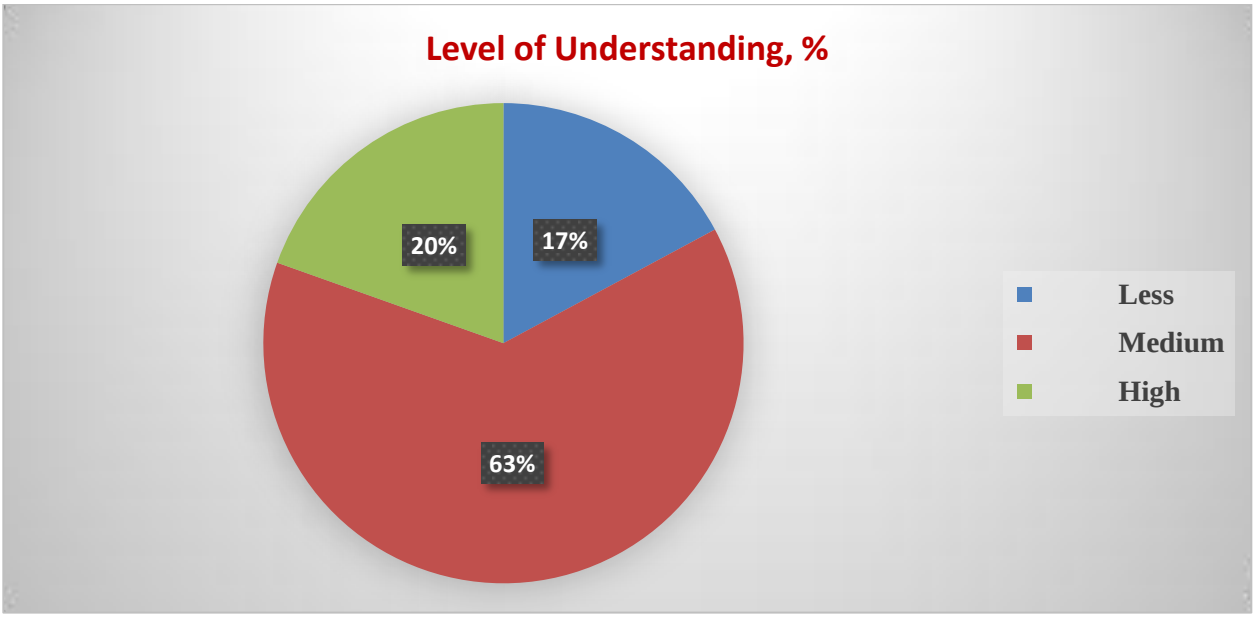

FIGURE 3: Level of understanding of responders regarding CBHI scheme

Furthermore, a FGD participant (male, 50 years old, 029 Kebele) bolstered the idea by saying, "*Creating awareness among the public is one of the numerous elements that lead to an enhanced level of participation in CBHI." This enables the program to cover a greater number of rural populations, minimize member dropout, and keep individuals in the scheme even during poor harvesting period*.'

4.2.2 Sources of information on CBHI scheme

Beneficiaries were asked how they learnt about CBHI at the outset of the program's implementation. As a consequence, 17.4 % claimed they learnt regarding CBHI via their neighbors, while 1% stated they heard about it from their locally formed groups (idir and equb). The majority of responders (76.7%), on the other hand, got their information from government personnel. The remaining 4.9 % learned about the program from their local religious bodies (church). As a result, it has been determined that local government officials played a significant role in raising awareness and encouraging action.

When asked about the terms of participation in the CBHI program, the majority of respondents (83%) responded it was voluntarily, whereas the others 17% claimed that it was somewhat influenced by local administration and government bodies.

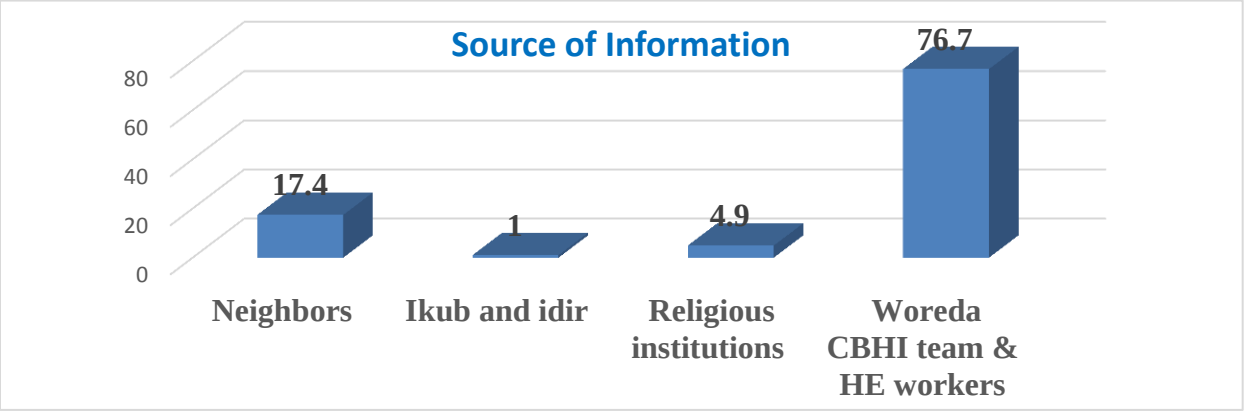

FIGURE 4: Sources of information regarding CBHI scheme

Participants in the FGD agreed with the above statement, saying that members were occasionally forced to pay premiums even if they did not want to. Kebele leaders pushed members to pay both the premium and other payments together unless they refused to take other payments (land tax, fertilizer) unless the CBHI program was paid first. This type of mechanism for collecting payments for the scheme caused suspicion; some people assumed the CBHI scheme was a way for the government to collect revenue (taxation). Despite the fact that membership in the scheme is supposedly voluntary, according to data from surveys and focus groups, there are conditions in which households in the study area are forced to pay the premium payment.

4.3 Current Practices and Benefits of Enrollment in the CBHI Scheme

4.3.1 Time of enrollment in the scheme

The region began piloting the program in 2010/11 within some targeted Woredas, according to the ANRS CBHI report (2017) claimed by Woreda CBHI Coordinator, with the purpose of establishing community–based risk safeguarding mechanisms among rural communities. Meket has been found as one of the potential areas to cascade the scheme since 2014. As a result, the region has opted to expand the initiative into further areas.

Meket Woreda Administrator was offered open-ended questions on the program's key driving factors. As a result, he was quoted as saying:

> "*The regional administration took the lead and decided to undertake a prior field work based on the selection requirements (high population size, Woreda Council's competence to successfully implement programs, and repeated drought occurrence). The program was to be implemented across all kebeles, benefiting 35% of all rural HHs. The region funded 70% of the cost of poor people, with Woreda contributing 30%. Then, it was decided that the program would launch in 2014, and execution commenced following all of the requisite criteria."*

Furthermore, the CBHI Coordinator claims that Meket is becoming a good scheme performing Woreda in the region. At the beginning of 2014, it was predicted that 35% of all HHs would participate. It is, however, progressing by reaching 64.5 % of Woreda's total population (2020). The target is to achieve 90% of the people by the end of the year (2020). When asked when they initially started engaging in the CBHI program, 86.8% of the respondents replied that it had been more than three years. Only 13.2 % claimed they had been registered in the CBHI system for less than three years.

4.3.2 Medical coverage of beneficiaries prior to enrollment

Respondents were asked about their previous medication spending experience before being invited to participate in the CBHI system. As a result, 80.5 % of interviewees paid for their medical costs with their own money, while 9.1 % borrowed money from family or friends. Furthermore, they pay for health-care expenses in 7.3%, 1.7 % and 1.4 % of cases by employing traditional therapies, which are funded by local groups and provided for free by government, respectively.

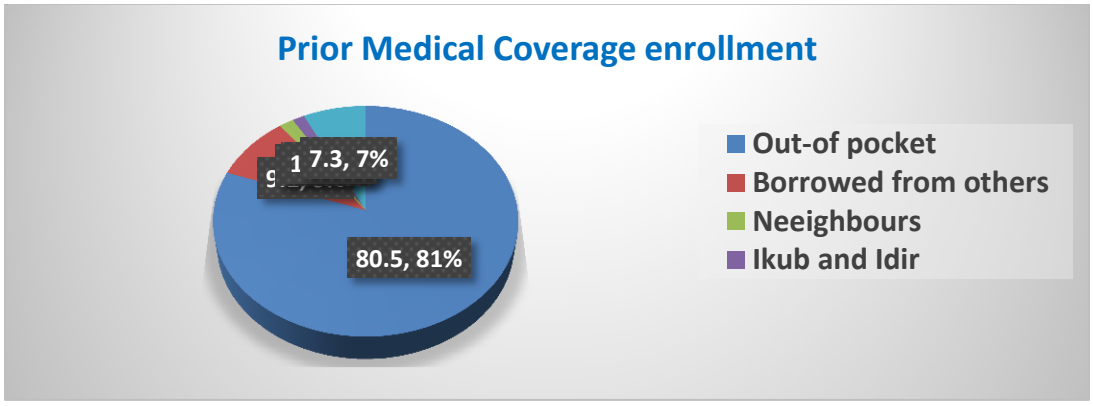

FIGURE 5: Medical Expense of Respondents Prior to Scheme Enrollment

Furthermore, a Warkaye kebele resident (male, 45) bolstered the case by saying, "*Prior joining the CBHI program, I was charged Birr 890 for a one-time medicine at a private clinic." If extra finances were needed, though, selling out animals on the marketplace took longer. We'll have had to await a long before we have sufficient funds. We came to the treatment center that after illness had deteriorated to something like a chronic stage.*"

A female FGD participant (age 50, Kebele 03) supplemented to the above information as

> "*We used to avoid attending the healthcare center if we were extremely sick prior joining the CBHI plan.* We *had gone to a church and consumed holy water or were baptized while we had illnesses (a headache or a common cold). We used either traditional treatments or white eucalyptus leaves as a fumigan*t.'

4.3.3 Health-care services received being membership

When asked if they had ever used the CBHI package while sick, 79.4% of the participants said yes. Despite paying their premiums on time, 21.6 % of those interviewed have yet to use their benefits. When asked why they have not started utilizing packages because there is not a condition in the family, 17.8% said there isn't one, and 2.8 % said it is because of poor prescription and customer service at healthcare centers.

> "*Some people prefer to travel to private clinics for better medical services, even though members pay an annual fee,*" FGD participants said. *"Due to the scarcity of qualified personnel, insufficient medicine supplies, an underequipped laboratory, and maladministration, the government health facility is unable to provide the required health care." The residents were pushed by officials from the Kebele to pay the fee, and we ended up paying for extra services from the local government. Despite paying the price, some persons have not received membership cards. They had no idea whether they were members or not."*

Also the female focus group discussant (kebele 03, Kurisa) witnessed and supported the above statement during home-to home visiting in March that few programme beneficiaries (17) are still not yet received their membership identification cards though they had paid the premium.

4.3.4 Health status improvement after enrolling in the CBHI programme

Beneficiaries were asked *Do you agree that your health status is improved after enrollment within the CBHI scheme*? Accordingly, 1.1 % and 53.3 %, respectively responded as they are strongly agreed and agreed that their wellbeing and health condition was found good after joining in the scheme. However, 27.2 % of them were neutral, feeling it was difficult to tell whether or not

conditions had progressed. Also, they responded that no illness faced since their enrollment in the scheme). A total of 8% of respondents disagreed, with one participant strongly disagreeing, implying that nothing has changed since he or she enrolled in the program. As a result, the majority of respondents said their health was improving and that they were aiding families in reducing healthcare spending.

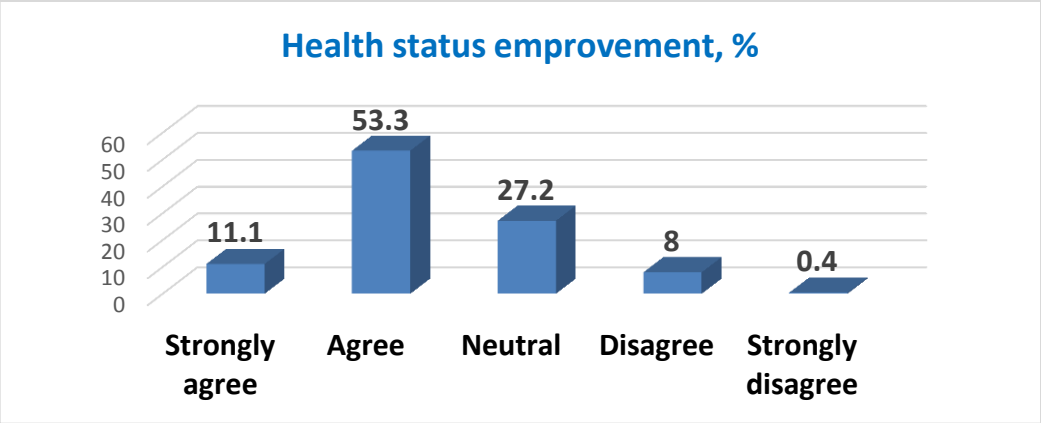

FIGURE 6: Health statuses of respondents observed after enrollment

> *'Program users are increasingly attending their local treatment center to assess their health status and receive medical advice, including for mild to moderate pain that they usually addressed with medicinal herbs*,' FGD participants said at 03 kebele(kurisa). *However, it has been proven to be creating a burden on the health facility, as health experts have highlighted*."

4.3.5 Types of CBHI scheme membership

A key informant discussion was made with Woreda CBHI staffs focused on the procedures used to categorize rural HHs as poor and better-off members. Among the total registered 33,089 enrollees in Meket Woreda, there are 4,935 impoverished people (poor or unable to pay a premium) and 28,154 non-indigent users (covering the premium). According to the CBHI rules, underprivileged people should make up roughly 10% of the recipient Woreda's total household population. As a result, the total number of households (including poor and non-indigent) was 33,089, accounting for 64 %. With supplement to the premium paid by better-off members, the region subsidizes 10% of the total sum collected. By 2020, the Woreda intends to increase engagement from 64.5% to 90% of all HHs (from 33,089 to 39,973 HHs). In this circumstance, the Woreda CBHI Coordination Office has determined to work with a wide range of stakeholders to engage in and making campaign possible.

'What type of membership do you want to join for?' beneficiaries were questioned. As a result, 48.4 % of them were classified as poor (freely treated), while 51.6 % were categorized as economically better-off HHs. The number of non-indigent participants must exceed the number of impoverished HHs (90% paying and 10% poor) in order for the program to be financially realistic.

4.3.6 Time of membership renewal

According to information from the Woreda CBHI Coordination Office, several factors influence regular membership renewals. Poor harvest, insufficient awareness raising and information sharing, HHs health status, premium pricing, fees charged for various reasons at the same time (land tax, fertilizer purchase, and local festivity cost), and a lack of income sources are among the challenges.

Members were asked if they had renewed their membership in a timely manner. As shown in the graph below, 95.1 % have said they had kept their participation on time, while 4.9 % have said they did not. As a result, the majority of respondents had an outstanding track record of renewing their membership in the scheme.

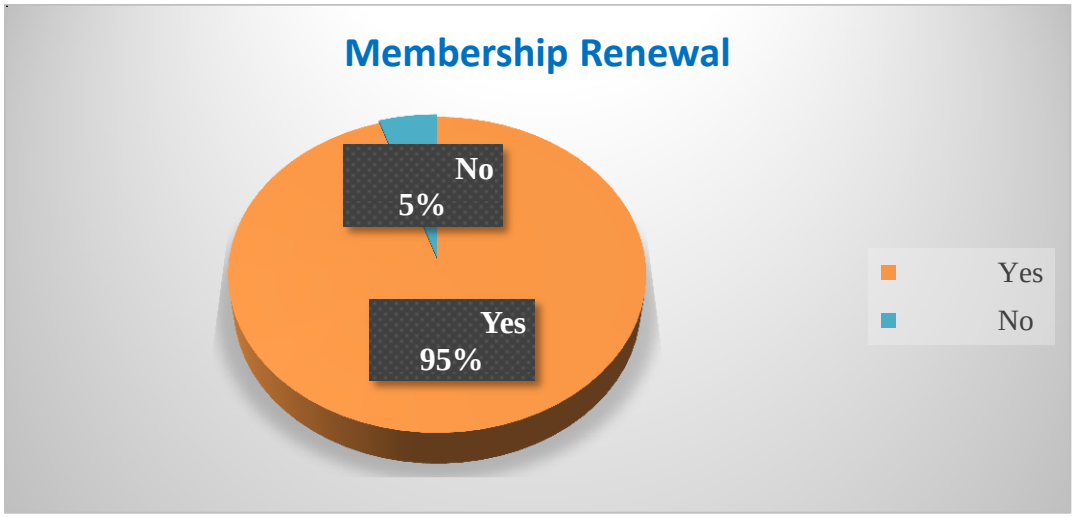

FIGURE 7: Membership renewal of respondents

"*Renewal of membership involves being insured until next year's healthcare service*," one of the FGD participants (male, 39 years old, 029 Kebele) adding to the preceding information. *If we don't extend our membership on time, we won't be able to access the necessary medical services (from January to February). In conjunction with the relevant parties in the vicinity, payment and ID renewals were completed at same time. Individuals who do not make the payment within the specified period may be penalized with a postponed service."*

4.3.7 Resignation from CBHI membership

With the exception of delayed payments, the proportion of dropping out of beneficiaries from the scheme over the last few years has indeed been null, as per evidence from Woreda CBHI coordinator. The fact that a majority of clients pay and extend their membership on time confirms to this. This showed that the program's participants were dedicated to remaining in it and earning from it. Despite the fact that participants had paid their premiums, service providers sometimes handled CBHI participants and non-beneficiaries unevenly, as female FGD participants (03 Kebele) witnessed.

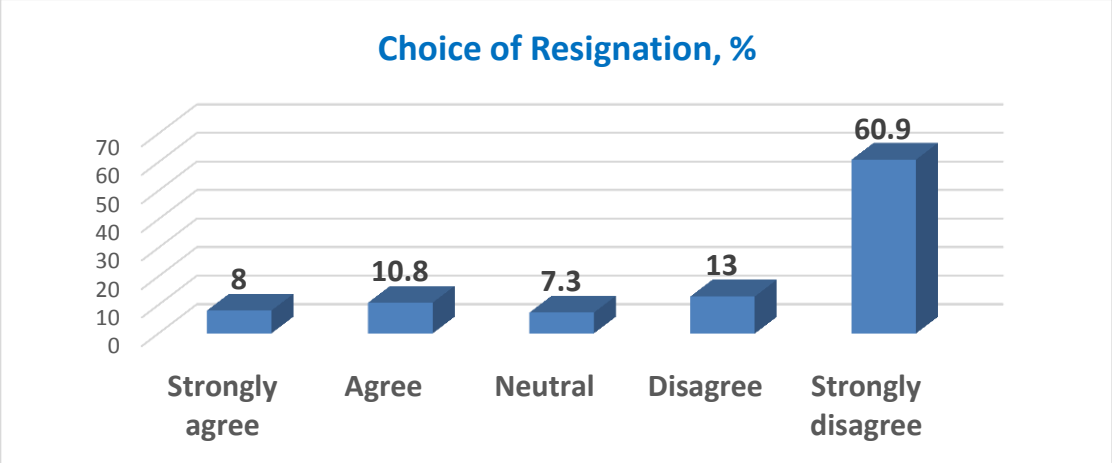

FIGURE 8: Choice of Respondents Whether to Resign or Stay in the Scheme

According to the above figure, 8 % strongly agree and 10.8 % agree to withdraw from the CBHI program, respectively. 7.3% stated they were uncertain about resigning. Whereas the majority of respondents (73.9%) who disagreed or strongly disagreed were committed to remaining members. As a result, dropping is not a concern for the program, which helps to ensure its long-term success.

> "*The dropping rate of members from the program in the previous few years was essentially null unless a few delays in paying the premium within the timeframe and also the self-supporting culture of the societies were increasing from time to time*," the Woreda CBHI Coordinator complemented to the above information.

4.3.8 Benefits of enrollment in the CBHI scheme

Out of pocket payments (OOP) by individual families cover more than half of health expenditure in underdeveloped countries (Meghan, 2010). The program reduced out-of-pocket expenses for 62.7 %, as seen in the graph below. 18.8% of those polled said their health has improved as a result of

joining up for the insurance (checking their health status at a nearby health center). Following participation in the plan, respectively 3.5 % and 15% of respondents were observed gaining benefits (through enhanced labor productivity with a greater number of working days per year) and reducing health risks. (insured family members can go to the health facility at any time if they are ill).

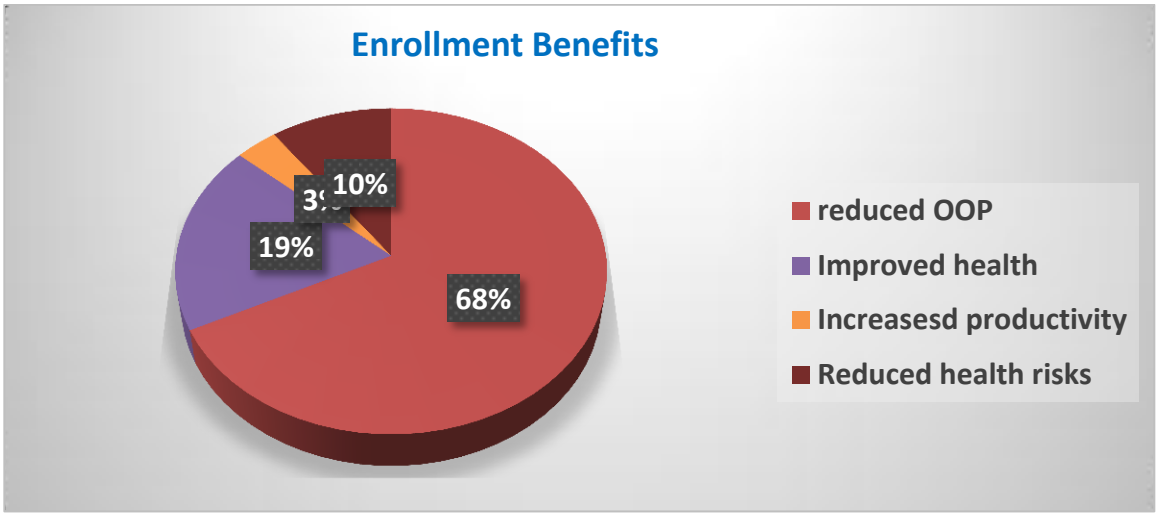

FIGURE 9: Benefits received from enrollment

> "*We are somewhat secured from costly care delivery, our health status has improved while risks had already reduced, that we are more productive than it was before; we were also allocating so much time and labour on agricultural production tasks than ever, so we were able to minimize expenditure and achieve health treatment by having paid a minimum amount to all family members*," said one of the FGD participants (Female HHs, age 53, 029 Kebele).

Additionally, in-depth interview with 029 kebele (Warkaye) Manager complemented the above information as:

> *'The insurance fee is relatively cheap, and I believe that individuals can handle the premium payment and benefiting from it, I was hospitalized three months ago at Shedeho Meket Primary Hospital. The doctor suggested me to immediately travel to Dessie Specialized Hospital for further treatment after an assessment. However, an expert was summoned to obtain the essential medications, and a diagnostic was made utilizing an X-ray machine and a laboratory analysis at a privately held facility. Despite the fact that I did not have any pocket money, I acquired the appropriate treatment and was hospitalized for 7 days of impatient service. I was relieved but the total payment came to Birr 12,500 birr, which was far too much for me. However, the money made at Dessie was refunded to me after I talked with the Woreda CBHI Coordination Office. Thanks to the CBHI system; I eventually received my money."*

The following statements have been also underlined by a key informant (medical auditor) from the Woreda CBHI Coordination Office: "*The CBHI encourages health-care providers to offer basic health-care packages to their beneficiaries. All Woreda-signed treatment contracts comprise outpatient, hospitalization, surgery, and diagnostic facilities, which are all recommended by healthcare practitioners. The scheme's participants are advised on a regular basis on how to lower their direct healthcare expenditure and some other health-related difficulties, as well as how to obtain the best medical care at the cheapest cost*."

4.3.9 Affordability and premium collection time

Respondents were asked about the price of the insurance and the payment schedule in this area. Both of these variables were found to be important drivers of CBHI success. When calculating the points for each vital component, the rating and weighting factors for each element were taken into account. A score of "5" (strongly agree) will get you a full 5 for that element; a score of "4" (agree) will earn you a 4; a score of "3" (neutral) will earn you a 3; a score of "2" (disagree) will earn you a 2; and a score of 1 (strongly disagree) will earn you a 1. The table below illustrates how participants answered questions and how they were grouped.

TABLE 2: Beneficiaries Response on the Current Premium Level

Responses	Percent	Cumulative Percent	Mean	Standard deviation
Strongly agree	19.9	19.9	4.106	0.241
Agree	47.0	66.9		
Neutral	27.9	94.8		
Disagree	4.5	99.3		
Strongly disagree	.7	100.0		
Total	**100.0**			

Source: Own Computation (2020)

According to the results shown above, 19.9% and 47% of participants respectively, were evaluated as strongly agree and agree, suggesting that the existing payment is viewed reasonable and that the essential collecting period was used to obtain the requisite healthcare. In the meantime, 27.9% of them were neutral about the affordability of the scheme, and its payment collection time. This is because of the area is prominently know by drought reoccurrence and high rate of poverty, as a

result beneficiaries had requested the government to include all their family members or subsidize it. The remaining 4.5 % and 0.7% respectively, indicated dissatisfaction and significant disagreement with the cost and timing of the premium. Respondents are happy with the current premium and collection schedule, with a mean score of 4.106 and a standard deviation of 0.241. The collecting of premiums has been recommended in coordination with beneficiaries for the months of February and March, as per Woreda CBHI employees, because farmers may more readily pay the premium using cash.

> "*Whenever we have fantastic cash in February and March, we pay and extend our membership as well as other payment accruals*," the aforementioned statement was backed up by an in-depth interview. *The government decided the payment rate based on family size (families of 1-5 members pay Birr 240, families with 6-7 members pay Birr 290, and families with greater than 8 received Birr 340). We have no right to receive CBHI assistance if we can't charge. As a result, we pay upfront for the products we need."*
>
> "*In deciding the amount of payment, the central government could take into consideration rural households' payment capacity, family size, and medical costs*," Woreda Administrator witnessed about his CBHI pricing perspective. *HH's payment could be the same across the region, irrespective of family size. He asserted that the federal government had the right to provide consistent payments across the country. It would be difficult to manage effectively if remuneration differed across the region."*

4.3.10 Satisfaction level of beneficiaries on the CBHI service delivery

Good health-care service delivery improves the program's long-term survival. The quality of service offered by contracted health care businesses has a significant impact on the recipients' responsibility and participation (EHIA,2015). The research findings revealed that 2.1 % and 23.7 %, respectively, thought medical services provided by health institutions were very good and good. In contrast, 28.6% of beneficiaries indicated they were dissatisfied. Health-care service delivery by health-care centers, on the other hand, was rated unsatisfactorily by 45.6 %. Overall, the findings revealed that, in order to satisfy program users, service delivery must be considerably enhanced.

> "*The quality of health-care services offered by private clinics is clearly better to that supplied by public institutions*," an IDI participant (male, 50 years old, Kebele 029) contributed to the aforementioned data. *We were driven to seek prescribed drugs from private firms at excessive costs because they were not accessible in the government-run pharmacy. Clients taught that government had affiliations to a specific private clinic and drug store, leading the medicines to be scarce at a fair price."*

4.3.11 Health institution nearest to residence of the beneficiaries

According to the research findings, respectively, the government-owned health centers and hospital (*Shedeho* Meket Primary Hospital) could serve 17.1 % and 33.8 %. Privately managed clinics are used by 8% of the interviewees. Health-care services are provided by health posts accounting for 41.1 % of beneficiaries. However, according to discussions with Woreda health experts and HEWs, the majority of clients receive the required healthcare services from the primary hospital via referral linkages but travel long distances for medical advice and additional examination.

> *'Health posts are largely considered to give assistance on family planning as well as other health extension services*,' according to Woreda Administrator's statement. *Health centers and hospitals, on the other hand, are commonly referred towards for medical service delivery. Two referral hospitals (Bahirdar and Dessie Hospitals), three general hospitals (Woldia, Boru, and Debre Tabor), three primary hospitals (Shedeho Meket, Lalibela, and Nefas Mewucha), and nine health centers have already signed contracts with the Woreda CBHI Coordination Office*."

4.3.12 Socio-demographic characteristics (predisposing factors) and scheme practices

This study used a One-Way ANOVA ("analysis of variance") to compare the means of two independent study populations to see if there was statistical evidence indicating they were significantly different (kothari,2004). With a 0.05 threshold of significance, there's a 5% possibility of detecting a difference when none occurs. The T-test and a One-Way ANOVA were used to compare the two groups. Male and female-headed households were compared using the T-test to check if there was a statistically significant difference in CBHI scheme enrolment or activities. According to the results of the test, the test statistics are significant at 0.01. The results of the test indicated that in the previous three years, men and women headed HHs had different practices/enrollment status.

TABLE 3: Respondents' socio-demographic characteristics and scheme practices

			CBHI practices/enrollment status	
Pre-disposing factors		**Percentage (%)**	**Test statistics**	**Significances at**
Sex of respondent HHs	Male	55.1		0.001*
	Female	44.9		
	Total	**100**		
Marital status	Married	79.8	One-way ANOVA (F-test)	0. 188**
	Single	2.1		
	Widowed	8.4		
	Divorced	9.8		
	Total	**100**		
Educational status of HHs	Illiterate (can't read and write)	54.7	One-way ANOVA (F-test)	0.034*
	Can read and write	28.6		
	Grade 1- 8	11.8		
	Secondary school	4.9		
	Total	**100**		
Family size of the respondents	1 - 5	78.4	One-way ANOVA (F-test)	0.002*
	6 – 7	17.8		
	Above 8	3.8		
	Total	**100**		

*** significant at P≤ 0.005, significant ** at P≤ 0.001**

Source: sample survey (2020)

A one-way ANOVA was employed to analyze the major socio-demographic variables and evaluate group variances in CBHI practices. As a result of the study, the gender of the household, the level of education/literacy, and the size of the family were found statistically significant at 0.05. Due to differences in family size and education, the test statistic revealed that varied levels of CBHI enrolment were observed for each group.

4.3.13 Community meeting and discussion framework with key local partners

According to EHIA (2015), strong participation of the local community in the CBHI program's planning and implementation could assist in achieving with greater levels. The research findings revealed that, correspondingly 7.7% and 3.1 % of respondents indicated they had the opportunity to discuss with Woreda/Zonal officials and experts regarding the scheme plan and rules/regulation. Whereas 38 % of interviewees responded in a conversation in which service delivery was a top priority, with 27.5 % of those who took part emphasizing premium payment. 23.7 % participated other types of gatherings (local election, good governance, paying event fees and other development issues). Thus, the higher percentage of people who responded witnessed that delivering proper healthcare services was remained a major question for the program.

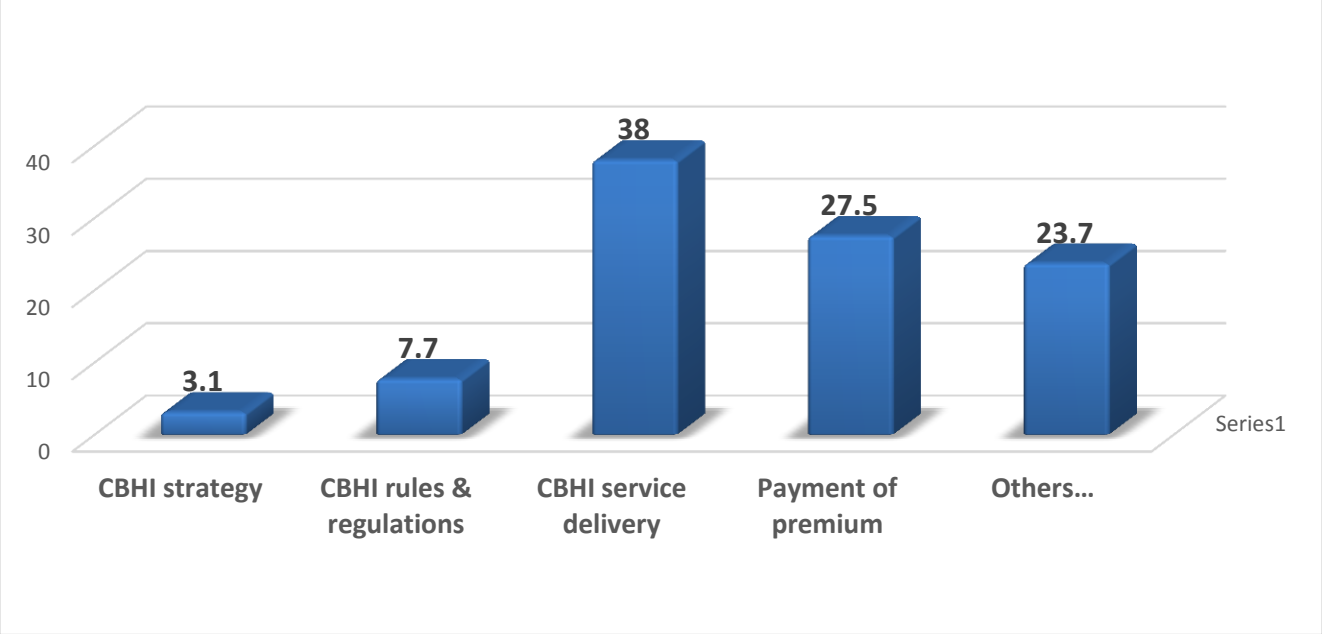

FIGURE 10: Opportunity of respondents for discussion with officials

> *'Holding multiple levels of meetings at the kebele level*, according to focus group participants (kebele 029), *helped to promote awareness and enhance community knowledge of the program intervention. They also witnessed how participatory debate may assist in the provision of timely answers to challenges, the development of ownership rights, and the long-term survival of the program."*

4.3.14 Role of beneficiaries in the management of the CBHI scheme

Finding of this research revealed that 42.5 % of those interviewed revealed that they were greatly involved on paying the mandatory premium. Whereas 29.6% and 19.9% of individuals were actively engaged in awareness creation for non-beneficiaries and sharing experiences, correspondingly. Only 1% of participants were CBHI board members active in kebele decision-making, while 7% of users were recognized as engaging in various locally organized rituals and assemblies. In addition to the previously mentioned information, it was revealed that program participants meet the basic membership criteria by contributing the membership fee. On the other hand, according to EHIA (2015), programme beneficiaries were required to engage in all components of the program, including circulating information, capacity building via experience and awareness raising for non-beneficiaries, attending gatherings and decision-making occasions, assessing program intervention and give advice, and so on

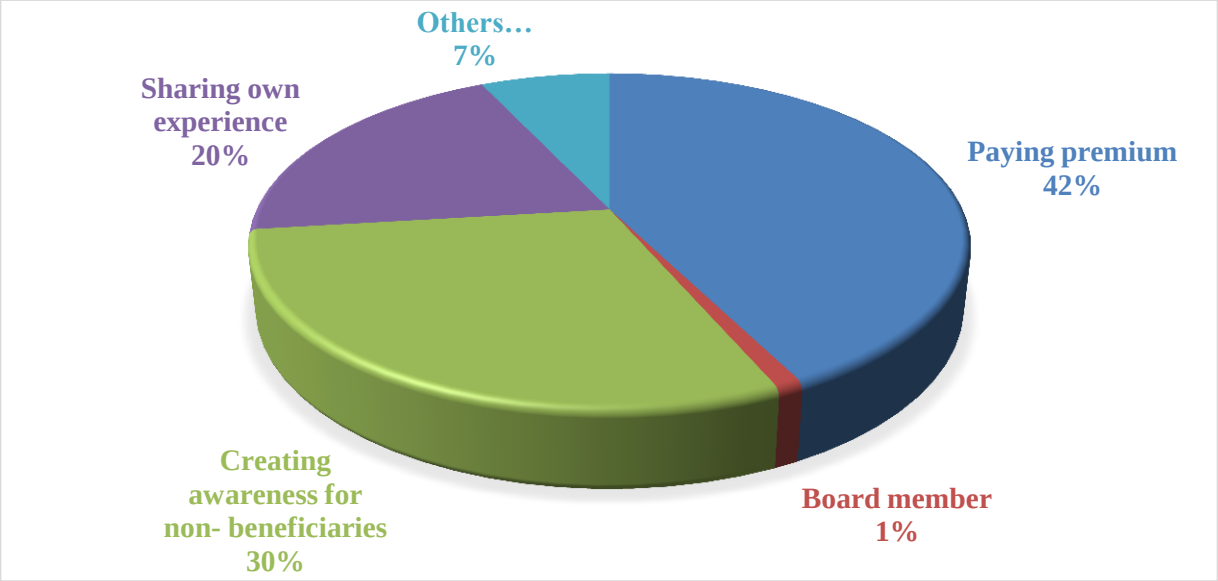

FIGURE 11: Participation of beneficiaries in running the CBHI program

> Moreover, one of the informant among the KIIs (Manager, 029 kebele) strengthened the preceding claim, saying: "*In terms of the types of health services that should be provided, the community has minimal influence on the program's decision-making processes. A kebele manager/administrator, religious leaders, women, and youth's advocates are among the members of the CBHI taskforce. They could entail a variety of decision-making processes, such as negotiating premium payments, mobilizing the community, increasing awareness, and exchanging experience.*"

4.4 Challenges of Implementing the CBHI Programme

4.4.1 Challenges raised from the program perspective

Serious challenges related to uneven demand and supply have hindered the operation of the CBHI program (USAID,2011). The program was established to provide the recipient with essential health-care services (in-patient, out-patient, surgery, and laboratory assessment), as well as timely membership renewals. According to Jutting (2003), community participation in the CBHI scheme design and implementation varies significantly and is usually more if funds are administered and possessed by program participants themselves rather than by health institutions in order to reduce moral threats.

a) The program does not cover all aspects of healthcare

Beneficiaries paid payments in order to get appropriate healthcare services from hired health institutions, but many were disappointed when they did not receive the service. Despite being members, some people with better income sources prefer to go to private clinics and pay for their health care from user free payment. CBHI then took a lengthy time to refund the funds to the recipients. According to the data collected through FGDs and KIIs, the study area faces a number of challenges including a lack of proper laboratory equipment and limited pharmaceutical supplies.

The above statement complemented by one of the KIIs(health experts at Filakit Healthcare center) as:

> *"Regarding drug supply, in our health center drug stock out become limited especially in each quarter year due to high utilization, patients come frequently but they did not use the drug properly. Some patients even through it away because they are not interested to take drug rather prefer to get injections. More importantly, contracted health facilities, especially in hospitals, experience drug stockouts and so patients often must buy items from outside private retailers. Limited stockouts in Pharmaceutical Fund and Supply Agency (PFSA) hubs have been the major reason that brought drug shortages."*

One of the KII (health professional at *Shedeho* Meket Primary Hospital) stated the laboratory services as follows:

> *"The number of instruments available for laboratory services is minimal. The majority of the instruments we had in the past are no longer in use; they are not repaired or replaced with new ones. New equipment purchases take time and require a procedure. As a result, as service utilization rises, we must work*

harder to provide services to all rather of focusing on quality. Serving a large number of clients exhausts us and causes us to lose concentration, which has an influence on service quality."

b) Gaps in community and service provider awareness have been identified

Before initiating the CBHI scheme in the area, the regional government was supposed to provide the local administration and population with appropriate information and raise knowledge about how to operate and administer the program (EHIA,2015). In practice, however, it was revealed that the government was involved for the program's conception, implementation, and administration. According to field observations and information gather from informants, the research area exhibited the following gaps: a lack of awareness, local councils forcing rural HHs to pay a premium early (despite voluntarily gathering of the payments), and a few health centers mistreating customers.

According to one of the FGD participants(kebele 029, male) strengthened the above information as: "*Inadequate understanding and awareness of beneficiaries regarding the scheme, limited participation in decision-making processes, gaps in timely renewal of membership ID cards, some beneficiaries are delayed in paying the premium, unable to fully register the entire family members by some HHs, kebele leaders influenced some HHs paying the premium, which is contrary to the CBHI governing principle*".

4.4.2 Challenges posed by program participants

i) There is a lack of adequate awareness and understanding of the scheme

According to WHO (2010), local public knowledge is a critical aspect in managing the CBHI scheme for longer period of time. During the study period, however, it was found that the level of community participation being limited. Despite having registered for the program, some households were unable to obtain a membership card or receive health-care services covered by the program. Some limitations include membership renewal delays, an increasing number of hospital visits for common illnesses (which increased service provider workload), registering few members among large families (only including the commonly ill family members), and users' lack of understanding of their roles and responsibilities.

One of the IDIs (kebele 029, male) supplemented the above arguments as:

> "*A small number of households deliberately reduce their family size in order to save money on insurance premiums and include family members who have illnesses on a regular basis. Families with 1 to 5 members pay 240 birr, families with 6 to 7 members pay 290 birr, while households with more than 8 members pay 340 birr*."

ii) **Participation in decision-making procedure is limited**

The local community played a specific role in decision-making actions, according to focus group discussants and KIIs. Minimal participation in determining on the program's health packages, premium level and contracts made with better health institutions are among these. The administrative obligations of the scheme are only held accountable by the local administration (both kebele and Woreda).

One of the FGD participants (kebele 012, male) stated that *holding many local meetings to review the program's implementation is critical in raising beneficiary awareness and improving their level of comprehension of CBHI. This can help to boost the program's sustainability by decreasing difficulties and giving members a sense of ownership.*

In general, as described below, the research findings witnessed that lack of pharmaceuticals and poor laboratory services in government-owned health institutions were the biggest difficulties for 9.4 % and 21.6 % of families, respectively, from the supply-side hurdles described above. And, according to 32.8 %, a lack of ambulance service is a big issue (a topic that was frequently brought up by women recipients who live in rural – and remote – areas). 36.2 %, on the other hand, had said contracted health center offered poor service to its customers.

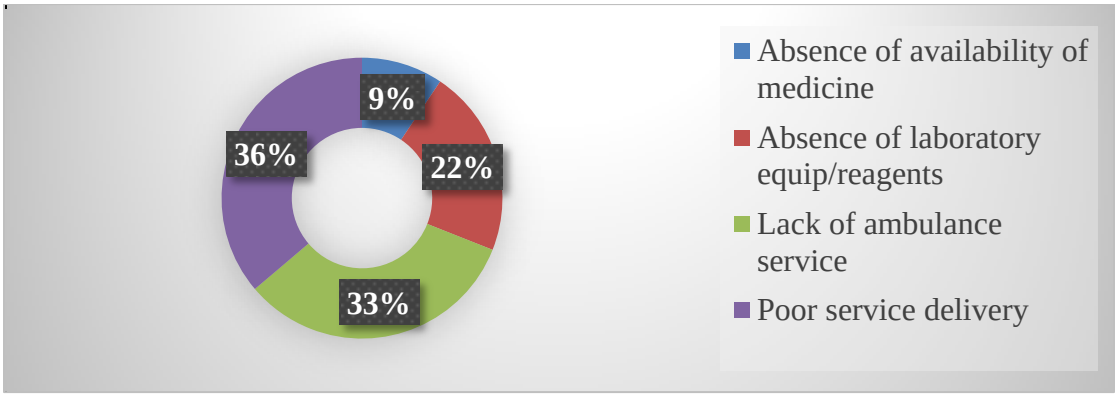

FIGURE 12: Critical challenges identified by respondents

One of the FGD participants (male, age 50, kebele 012) witnessed the following information:

> "*Inadequate delivery of healthcare service, inconsistent drug supply and availability, lack of laboratory equipment/chemicals, long referral procedure, sometimes shortage of skilled health professional to the expected level, some service providers' medical ethics are lacking., indifferently serving program beneficiaries and non-members, the Woreda CBHI coordination office has insufficient facilities with few numbers of employees*."

4.5 Linkage between CBHI Scheme with PSNP

Food security programs, social services for the vulnerable, and health care services are all covered by the National Social Protection policy. The National Social Protection Policy highlights the possibility for linkages among different forms of vulnerabilities and urges for a coordinated set of efforts (GFDRE 2016). The relationship between the Productive Safety Net Programme (PSNP) and the Community Based Health Insurance Scheme is investigated in this research. The CBHI program is aimed at rural households and urban workers who engage in the informal economy. The following are the five objectives of CBHI (WHO, 2010): (i) to make health services more affordable; (ii) to improve the quality of health services; (iii) to improve the financial viability of the health sector; (iv) to engage and strengthen community participation in health service management; and (v) to strengthen the capacities of the national health sector.

According to Woreda PSNP Coordinator information, people who are directly assisted by PSNP are also more likely to participate in the CBHI initiative. The proportion of surveyed households who were enrolled in three sampled kebeles is shown below. However, when looking at the complete sample, there isn't much of a difference in terms of PSNP client status. According to the Woreda Administration Office (2018), the CBHI program has benefited 64.5 % of the 44,415 HHs in Meket Woreda. Although there were documentation inadequacies, 48.1 % of HHs in the local area were identified to be PSNP beneficiaries. Furthermore, 72 % of the 287 CBHI users interviewed were identified to be PSNP clients, with the remainder being better-off individuals.

TABLE 4: Proportion of PSNP and CBI scheme beneficiaries in sampled kebeles

Study kebeles	PSNP beneficiaries, HHs			CBHI Scheme users, HHs		
	M	**F**	**T**	**M**	**F**	**T**
Warkaye(029)	170	140	310	360	117	477
Kurisa(03)	151	145	296	200	148	348
Arabal(08)	92	88	180	115	85	200
Total			786			1,025

Considering that PSNP beneficiaries consist of the poorest and most food insecure households who would potentially benefit significantly from health insurance, this relatively high proportion of enrollees among PSNP beneficiaries was found promising. The above result also revealed that PSNP households were considerably to participate in CBHI, despite differences among the kebeles examined. PSNP beneficiaries, according to the Woreda Administration, have been strongly advised and strictly supervised to participate in the program. They also examined whether or not the premium was being paid. As a result, more than 85 % of the total Woreda PSNP beneficiaries households were found being enrolled in CBHI scheme on average. The Woreda also claimed that Permanent Direct Support households of PSNP were all registered and benefited from the CBHI scheme (as indigent users) than Public Works households. The share of indigent households was very similar among PSNP households and other poor households. This suggested that the selection criteria for PSNP beneficiaries and for indigents in CBHI were somewhat similar.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

Community-based health insurance has the capability to enhance health care services for rural families with support from various concerned partners and improved participation of the local community in its designing and administration. An efficient and equitable health care system is an important instrument to break up the vicious circle of poverty and ill health conditions. The scheme has been found to be a valuable and innovative financial instrument in the healthcare service of Meket Woreda. The findings of this study, like those of other empirical studies, revealed that community-based health insurance has proven to be a beneficial financial tool in the health sector reform in the study area. Hence, the out of pocket for health care services have

had very limited impact because it failed to cover informal sector, who constitute the majority of the countries populations, CBHI scheme turnout to be realistic option to access health care for all, and to meet universal health coverage.

Though the CBHI program necessitates a lack of clearly defined minimum bounds for the scheme's management and administration, both the government and members played a vital part in the scheme's long-term viability and operation in Ethiopian community-based health insurance. As a result, most literatures, similar to the findings of this study, showed that actual implementation of CBHI schemes required collaborative effort so far, with the scheme's success and viability largely dependent on the government's design and management of the scheme, as well as society's full participation. More importantly, the result of the study revealed that proper design and management through community involvement and benefit package at best; complimented by quality services provision.

The key findings of this research revealed that t the scheme did not provide a holistic healthcare service, constraints in awareness raising and understanding of the community, shortages in medical supplies and laboratory facilities, inadequate community participatory decision-making process and administrative operations and so on. Also results of this research showed that more work remains to be accomplished to improve awareness and knowledges as well as better link these major social protection programs in rural Ethiopia. Despite efforts made to include and benefit all PSNP households in the scheme, many people still remain to be vulnerable to health

shocks as a result of poor productivity and increased poverty. Participation in public dialogues and assemblies has also greatly contributed to improving knowledge and perception of the scheme's principles and guidelines. As a result, attendance in local meetings is associated to boosting scheme enrolment rate.

5.2 Recommendations

Based on the findings of the study, the followings are the major recommendations as given by the researcher.

Woreda Administration Office/CBHI Task Force:

- Should communicate and work with both regional and federal government to improve the availability of drugs/medical supplies
- Should ensure the existence of active community participation and decision-making power while running the CBHI scheme
- Should ensure the complementarities between running the CBHI scheme with implementation of PSNP in the study area.

Woreda CBHI Coordination Office:

- Should work with a variety of local partners to improve the understanding of the community how to participate and benefit from the CBHI scheme.
- Should schedule with stakeholders to mobilize the community and improve the current enrollment rate of the Woreda population, considering the “voluntary-based" governing concept of the scheme.

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ANNEXES

Annex 1: Consent form

Community-Based Health Insurance Practices and Challenges in Meket Woreda

Researcher: Tadesse Abebe engidaeshet. Bole Sub city, Addis Ababa, Ethiopia. (+251)- 911-391599.

This is to be submitted in partial fulfilment of the requirements for the Degree of Master of Science in Food Security and Development Studies, Addis Ababa University Ethiopia. I _____ (Name of Interviewer). Am here to interview randomly selected beneficiaries from the list of given each kebele administration. The purpose of this interview is to obtain information on "*Community-Based Health Insurance Practices and Challenges in Meket Woreda, North Wollo of Amhara Regional State*". Now you are randomly selected to participate in this interview from the list of students. The participation in this assessment is voluntary (data collectors please leave if the beneficiaries are not willing to participate). Information and data obtained from you are considered as confidential. We are not recording any specific names. The information will be used to recommend the CBHI prcatice. You will not gain any material benefit from agreeing to conduct this interview. We would appreciate if you can provide us with the most accurate answers as you can. Are you willing to talk with us and share your experience for this assessment?

- ✓ I understand and fully agree to voluntarily take part and cooperate with the researcher after explaining to me the nature and purpose of the research
- ✓ I understand that I need to respond on the questionnaire, which asks about my demographics and CBHI current practice as well as challenges encountered
- ✓ I understand that all information obtained from me will be in strict confidence, although information gained during the study may be published
- ✓ I have read and fully understood the above conditions and for any valid reason I can withdraw my participation in this project.

Name: _____ Signed: _____ Date: _____

Annex 2: English version questionnaires

Read the questions carefully and select the best response from the options provided. In the space provided, you may post your thoughts or suggestions. There is a chance you'll pick more than one solution from the options below.

Interview Guide – Household Survey

SECTION(A): Background Information

1. Sex: A. Male B. Female
2. Age: A. 18-48 years B. 49-69 years C. > 69 years
3. What is the relationship of the respondents to the household?

   A. Father B. Mother C. Child D. Other (parent sibling, child-in-law, etc.)
4. Marital status of the respondent

   A. Married B. Single C. Widowed D. Divorced
5. Occupation of the respondent

   A. Farming B. Housewife C. Trading D. Laborer E. Government employee F. Student G. Other
6. Educational status of the respondent

   A. Illiterate B. Read & write C. Grade 1-8 D. Secondary school E. Diploma/Degree
7. Family size of the respondent(number)

   A. 1-5; Male Female

   B. 6-7; Male Female

   C. > 7; Male Female
8. Number of children

   A. < 18 years

   B. > 18 years

SECTION(B): Awareness Level on the Concept of CBHI

9. Do you know community-based insurance? A. Yes B. No

10. If" yes", from whom/what do you got/heard the information?

    A. Neighbors B. Ikub and Idir C. Religious institutions D. Woreda CBHI and HE workers E. TV, Radio, News Paper

11. If yes, enrolling in the Community Based Health Insurance has advantage?

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

12. Have you start to get health service through your membership?

    A. Yes B. No

13. If No, why?

    A. No illness B. Poor medication C. Poor laboratory facilities D. Poor client handling

14. How is your level of knowledge(understanding) on Community Based Health Insurance?

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

SECTION(C): Questions Related to CBHI; its Benefits and Challenges.

15. When you started enrolling in Community Based Health Insurance?

    A Before 2-3 years B. Before 5 years

16. Before you joined the Community Based Health Insurance, how did you cover your medical expense?

    A. Out of Pocket B. Borrowing C. We were using traditional treatment techniques D. Using Ikub and Idir E. Government/free

17. Do you agree that your health status is improved after enrolled within the CBHI scheme?

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

18. Which type of member you are?

A. Indigent member B. Non-indigent

19. Do you renew yours and family membership ID timely?

A. Yes B. No

20. Do you agree if you are asked to resign from CBHI membership?

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

21. Do you agree that enrolling in CBHI scheme have no advantage?

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

22. If your response is "Strongly agree/Agree", what is your reason?

A. Poor quality of service delivery C. Lack of medical equipment/lab. Diagnosis

B. Absence of medicine D. Cost of premium is not affordable.

23. What kind of benefits you get after joining the CBHI scheme?

A. Reduce OOP B. Improve health C. Increase productivity D. Reduce risks

24. Which challenges you are currently identifying as beneficial?

A. Absence of availability of medicine

B. Absence of laboratory equipment/agents

C. Lack of ambulance service

D. Poor service delivery

25. Do you agree with the current premium level?

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

26. How do you get the CBHI service delivery?

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

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

A. Health center B. Clinic(private) C. Health Post D. Hospital(gov't)

SECTION(D): Participation in CBHI Scheme

28. In which part do you attend in any of the meetings concerning CBHI?

A. CBHI strategy B. CBHI rule/regulation C. CBHI service delivery D. Payment of premium E. Others

29. On which CBHI scheme part you get the opportunity to discuss freely with responsible body(stakeholder) at Woreda or higher level?

A. CBHI strategy B. CBHI rule & regulation C. Service delivery D. Premium payment E. Others

30. How do you explain your participation in CBHI programme?

A. Paying premium B. Board member C. Creating awareness for non-beneficiaries D. Sharing own experience E. Others

Interview Guide – 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 besides, paying the premium?
4. What are the challenges you are identifying in enrolling CBHI?

5. When is collection of premiums takes place (timing of colleting the premium)? Who fixes the amount? Is it affordable?
6. How do you evaluate the sustainability of CBHI in your Woreda/ Kebele?
7. What you recommend strategies to overcome the challenge in enrolling CBHI?

Interview Guide - KII

Date---------- Interviewer ----------

Position ---------- Interviewee----------

Education status--------- Duration of interview----------

Telephone---------- Place----------

Woreda---------- Time of interview----------

1. When is collection of premia 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----------

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5. What strategies /method's you are using to handle the above listed problems?
6. How you are creating/increasing level of awareness of households "especially those of not yet enroll?
7. How do you see the enrollment rate the Woreda? (Very Good, Good, Satisfactory, Poor) why? How?
8. What is the level of drooping rate of the households from the program in your Woreda? What is the immediate reason for it?
9. What activity is performed by your office 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 numbers 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 to accept these households?
14. Is there identified model Kebele (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 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?

Guideline – 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 is collection of premiums 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 timely renew your and family's membership identification card (IDs)?
10. I decided to resign my membership from CBHI?
11. How do you explain your participation on CBHI program?
12. What you recommend increasing the sustainability of the scheme

Annex 3: Amharic version questionnaires

መግቢያ

የሚከተሉትን ጥያቄዎች በጥንቃቄ ካነበባችሁ በኋላ ከቀረቡት አማራጮች መካከል ከፊትለፊቱ ባለዉ ሳጥን ዉስት "" ምልክት በማስቀመጥ ይምረጡ፡፡ በተጨማሪም ተጨማሪ ማብራሪያ ወይም አስተያየት መስጠት ከፈለጉ ከስር ባለዉ ክፍት ቦታ ለጥናቱ ይጠቅማል ያሉትን ሃሳብ ማስቀመጥ ይችላሉ፡፡

ክፍል1.መነሻ

1. ፆታ፡ ወንድ -------- ሴት --------

2. ዕድሜ፡ ከ 18-48 --------- ከ 49 — 69 ---------- ከ 70 በላይ----------

3. ወረዳ ፡-------- ቀበሌ ---------- መንደር ----------

4. በቤተሰቡ ዉስት ያለዉ ዝምድና ምንድን ነዉ

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 መፃፍ ---------- 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 ያለዉ የግንዛቤ ደረጃ በተመለከተ

11. የማህበረሰብ የጤና መድን ምን ማለት እንደሆን ያዉቃሉ

አዎ፡ ---------- አላዉቅም፡----------

12. ለጥያቄ ቁጥር 1 መልስዎ አዎ ከሆነ ከማንና እንዴት ሰሙ

ከጎረቤት ---------- ከ ዕድር/ ዕቁብ ---------- ከ ሀይማኖት ተቋማት ----------

ከወረዳ ማአጤመአገልግሎት ሰራተኞች/ጤና ኤክስቴንሽን--------- ቲቪ፤ ሬዲዮ፤ ጋዜጣ----------

13. በማህበረሰብ አቀፍ የጤና መድን አገልግሎት መታቀፍ ጠቀሜታ አለዉ ብለህ ታስባለህ

እጅግ በጣም---------- በጣም --------- መሀከል ላይ ----------

ፍፁምየለዉም---------- የለዉም----------

14. የማጤመአ አባል ከሆንክ ጅምሮ አገልግሎቱን ማግኜት ጀምረሃል ወይ

አዎ ---------- የለም ----------

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15. ካላገኙ ለምን

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

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

16. በማህበረሰብ አቀፍ የጤና መድን አገልግሎት ዙሪያ ያለወት ግንዛቤ ምን ያክል ነዉ

ዝቅተኛ---------- መካከለኛ--------- ከፍተኛ ---------

ክፍል 3 የማህበረሰብ አቀፍ የጤና ምድንን የተመለከቱ ጥያቄዎች ጥቅሙና ያጋጠሙ ችግሮች

17. በማህበረሰብ አቀፍ የጤና መድህን አገልግሎት የታቀፍክዉ/ሽዉ መች ነዉ

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

ሐ. ከ 5 አመት በፊት ---------

18. በማህበረሰብ አቀፍ የጤና መድህን አባል ከመሆንህ በፊት የህክምና ወጭህን/ሽን እንዴት ነበር

የምተሸፍነዉ/ኝዉ

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

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

19. በማህበረሰብ አቀፍ የጤና መድህን ከታቀፉ በኋላ የጤናዎ ሁኔታ ተሻሽሏል ብለዉ ያስባሉ

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

መ. ለዉጥ የለም ---------- ሠ. ፍፁም ለዉጥ የለም ----------

20. የትኛዉ አይነት የጤና መድን አባል ነዎት

ሀ. ምስኪን ---------- ለ. የክፍያ ----------

21. የእርስዎንና የቤተሰብዎን የማአጤመ አባለነት በጊዜዉ አድሰዋል

ሀ. አወ ---------- ለ. የለም ----------

22. ከማአጤመ በፍላጎትዎ ከአባለነት ለመዉጣት መወሰን ይችላሉን

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

ሠ. ፍፁም አልፈልግም----------

23. ከማህበረሰብ አቀፍ የጤና መድህን ምንም ጥቅም አላገኜሁም ብለዉ ያስባሉ

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

ሠ. ብዙ ጥቅም አግኝቻለሁ----------

24. ለጥያቄ ለተራ ቁጥር 7 የሰጡት ምላሽ እጅግ በጣም/በጣም ከሆነ ምክንያቱ ምንድን ነዉ

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 ----------

25. በማአጤመ ከታቀፉ በኋላ ምን ጥቅም አግኝቻለሁ ብለዉ ያስባሉ

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

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

26. እንደ ማአጤመ አገልግሎት ተጠቃሚነትዎ በአሁኑ ጊዜ ምንምን ችግሮች አሉ ብለዉ ለይተዋል

Annex 4: Statistical findings

Table 1. Socio -demographic characteristics

Characteristics of respondents (socio-economic & demographic)		**Frequency**	**Percentage (%)**
Sex of respondents	Male	158	55.1
	Female	129	44.9
	Total	287	100
Age group of respondents(years)	18 – 48	190	66.2
	49 – 69	79	27.5
	Above 70	18	6.3
	Total	287	100
Relationship of respondents	Father	158	55.1
	Mother	122	42.5
	Child	6	2.1
	Others (parent siblings, child-in-law, etc.)	1	0.3
	Total	287	100
Marital status of the respondents	Married	229	79.8
	Single	6	2.1
	Widowed	24	8.4
	Divorced	28	9.8
	Total	287	100
Occupation	Farming	205	71.4
	Housewife	39	13.6
	Petty-trading	38	13.2
	Daily laborer	5	1.7
	Total	287	100
Educational status	Illiterate (can't read & write)	157	54.7
	Can read & write	82	28.6
	Grade 1- 8	34	11.8
	Secondary school (grade 9 – 12)	14	4.9
	Total	287	100
Family size of the respondents (including children)	1 –5	225	78.4
	6 – 7	51	17.8
	Above 8	11	3.8
	Total	287	100

Table 2: Beneficiaries responses(n=287)

Variables		**Response status, %**	**Remark**
Beneficiaries' awareness	Less Medium High	17 63 20	
Source of information	Neighbors Local groups Religious institutes Government personnel	17.4 1 4.9 76.7	
Time of enrollment	Before 2-3 years Before 5 years	13.2 86.8	
Medical coverage prior to enrollment	OOP Borrowing Traditional ways Using local groups Gov't free service	80.5 9.1 7.3 1.7 1.4	
Improvement of health status after enrollment	Strongly agree Agree Neutral Disagree Strongly disagree	11.1 53.3 27.2 8 0.2	
Membership type	Indigent Non-indigent	48.4 51.6	
Timely renewal of membership	Yes No	95.1 4.9	

Resign from membership	Strongly agree Agree Neutral Disagree Strongly disagree	8 10.8 7.3 60.9 13	
Benefits of scheme enrolment	Reduce OOP Improve health Increase productivity Reduce risks	62.7 18.8 3.5 15	
Challenges of implementation	Unavailability of medicine Lack of laboratory facilities Ambulance service Poor client handling	9 22 33 36	
Attending local meetings	Scheme strategy Rules and regulations Service delivery Premium payment Others	3.1 7.7 38 27.5 23.1	
Participation	Paying premium Board members Creating awareness Sharing experience Others	20 1 30 20 7	

Table 3: Testing the association of variables with scheme enrollment

			CBHI practices/enrollment status	
Socio-demographic factors		**Percentage (%)**	**Test statistics**	**Significances at P≤ 0.05 * Or**
Sex of respondent HHs	Male	55.1		0.001*
	Female	44.9		
	Total	**100**		
Marital status	Married	79.8	One-way ANOVA (F-test)	0. 188**
	Single	2.1		
	Widowed	8.4		
	Divorced	9.8		
	Total	**100**		
Educational status of HHs	Illiterate (can't read and write)	54.7	One-way ANOVA (F-test)	0.034*
	Can read and write	28.6		
	Grade 1- 8	11.8		
	Secondary school	4.9		
	Total	**100**		
Family size of the respondents	1 - 5	78.4	One-way ANOVA (F-test)	0.002*
	6 – 7	17.8		
	Above 8	3.8		
	Total	**100**		

* significant at P≤ 0.005, significant ** at P≤ 0.001