Implementation evaluation of Community Based Health Insurance in Limu Kossa District, Jimma Zone, South West Ethiopia

By Tolera Tadesse (BSc)

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June 2015

Jimma, Ethiopia

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By Tolera Tadesse (BSc)

Advisers: 1.Mirkuzie Woldie (MD, MPH)

2. Tesfamichael Alaro (BSc, MPH)

3. Gelila Abraham (BSc, MSc)

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Abstract

Background*: Community based health insurance is a method of financial protection that protect out-of-pocket health care expenditure and increase access of health cares for rural population. High income countries achieved universal coverage by using different method of social protection but in low and middle income countries, out-of-pocket payments of health care are remain high, this created constraints to utilizing essential health services. Many African countries still now face challenges in initiating, sustaining, or scaling-up community based health insurance. Limu kossa district is one of the 13 districts in Ethiopia that have been implementing this insurance as pilot program since 2012.*

The objective*: The objective of this study was to evaluate the level of implementation of CBHI in Limu Kossa district, southwest Ethiopia.*

Method*: Implementation evaluation of community based health insurance was conducted by using mixed case study design in Limu Kossa district on health institutions. Three evaluation dimension: availability, compliance and acceptability dimension with 43 indicators were used. All health institutions (six health centers and one district hospital) those have signed contractual agreements with the CBHI administration to implement community based health insurance were included in the study. Two hundred thirty one (231) members and 37 key informants of scheme were interviewed, Documents of community based health insurance were reviewed and inventory observation was conducted. The quantitative data were analyzed by descriptive statistic while qualitative data were analyzed thematically.*

Results*: The study found that the overall availability resource dimension implementation status was 60.43% which partial implemented according judgment parameter. From total health institutions 2(27%) of them had trained health workers on the scheme and 4 (57%) of them had essential tracer drugs and laboratory services. The overall implementation status of compliance dimension was 55% which were poor implemented according to judgment parameter. Community mobilization session conducted in the year was 1(25%). From total patients visited health institutions, 82% were insured patients. The result from showed that the scheme enrolment reach 49% in2015,renewed rate were 90%,drop rate were 10% and 26.24% were growth rate. The mean members' satisfaction was 3.94 which shows almost insured patients were satisfied toward the scheme. Study from qualitative data also shows that there were low community awareness to toward the schemes, shortage of medical equipment and drugs in health institutions and inactive health care finance in most health institutions.*

Conclusion*: Generally the overall the level of implementation of CBHI were in the Limu Kossa district was found to be partially implemented. Therefore the stakeholders of the scheme have to increase community awareness, fulfill essential resource for health institutions and strength health care finance in health institutions.*

Keywords*: Community based health insurance, implementation evaluation, Limu Kossa district.*

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Acronyms and Abbreviations

AFB----------Acid Fast Bacilli

BSC----------Bachelor of Science

CBHI----------Community Based Health Insurance

CDC----------Center of Disease Control

EA----------Evaluability Assessment

EHIA----------Ethiopian Health Insurance Agency

ETB----------Ethiopia Birr

FMOH----------Federal Minister Of Health

HC----------Health Center

HCF----------Health Care Finance

HCFR----------Health Care Finance Reforms

HI----------Health Institutions

HH----------Household

HIV----------Human Immunodeficiency Virus

HSDP----------Health System Development Plan

IPD----------Inpatient Department

OOP----------Out of Pocket

OPD----------Outpatient Department

PFSA----------Pharmaceuticals Fund and Supply Agency

RH----------Rhesus

SHI----------Social Health Insurance

SNNPR----------South Nation Nationality and People Region

UHC----------Universal Health Coverage

VDRL----------Venereal Disease Research Laboratory

USAID----------United States Agency for International Development

WHO----------world Health Organization

Operational Definition

Access to health services: According to this study access to health services mean when insured patient get health services like outpatient, inpatient and referral linkage without tension of health expenditures.

Availability of tracer's drugs: Availability of tracer drugs mean when all of tracer drugs are available in HI during study period. Tracer drugs include 11 drugs which are reported in HMIS of hospitals and health centers.

Availability of essential diagnostic equipment: When all of the following diagnostic equipment is available in HI during data collection. Those are including: blood pressure apparatus, stethoscope, fetoscope, examination light, adult Weight scale, cotton, glove, goose, examination Coach and delivery kit.

Availability of essential laboratory services: when all of the following laboratory services are available in HI during study period. Those are include: microscope services , hemoglobin test, Stool examination, urine analysis services, AFB services ,H pyloric test services, RH test, VDRL.HIV test, X ray and ultrasound services (for hospital).

Active Members: The HH members who can use the health services as members of CBHI during study period.

Active health care finance: When the HI were utilized its internal budget for health service improvement by following governmental rule of finance.

Compliance: Mean implementation of activities according national guideline of the insurance.

Member satisfaction: The level of member's satisfaction to ward scheme was measured using five point likert scales from ten items.

Health institutions (HI): Government health facility which include health center and district hospital.

Membership growth rate: Numbers of members in 2015 minus numbers members in 2014 dividing numbers members in 2014.

Renewal rate: Numbers of members renewing their subscriptions in 2015 dividing numbers members in 2014.

Standard judgment: Quantitative measure with cutoff point that specifies what is good or less.

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CHAPTER 1: INTRODUCTION

1: Background

According to the 2005 World Health Organization (WHO) world health assembly declaration and 2011 report to achieve the goal of universal health coverage(UHC) 'everybody should access to adequate health service at an affordable price' which mean all people should to get quality of health care without financial hardship(1).There are three main financial protection method to help to achieve the goal of UHC. Those are Social health insurance(SHI),private health insurance(PHI) and community based health insurance (2).

Community based health insurance (CBHI) is a power full tool to increase access of health care's and protection that protect out-of-pocket health expenditure and for rural population of in middle and low income countries to achieve the goal of UHC(3). It is nonprofit kinds of insurance which designed for people who live and work in rural areas in which most of them unable to access adequate public, private, or employer-sponsored health insurance(4). It is the mechanisms in which people who are in similar risk of a certain event contribute a small amount (premium) towards a health insurance fund. This fund is then used to treat people who become ill(5). The pooling of resources in the schemes allows for cross-subsidies between those who are healthy and those who are sick and between rich and poor (6). Evaluation conducted in Nigeria shows CBHI can increase health care utilization by 15% and reduce OOP health care expenditures by 40%and can increase the household income by 16% (7).

The key advantage of CBHI are decreasing OOP expenditures by increasing prepayment and risk sharing for poor people than others types of insurance(8). To improve affordability of membership, the enrolment follows harvest time during probability that households have cash (9). CBHI have some weakness like limitation on protection of members of the HH, it does not cover all kinds of health service, unless supported by government sustainability is under question, it's benefit is limited to the poorer part of the population, adverse selection due to voluntary membership, moral hazard, fraud, abuse and cost escalation. Because of this CBHI fail in many developing countries to access the people to health care and reduce OOP expenditures(10). To overcome the problem enroll all HH, make copayment, additional payment those don't follow referral system, continuous follow up and reinsurance the schemes in other insurance(11).

1.2: Statement of the Problem

World Health Organization in 2010 identified three interrelated problems that limit universal coverage: limited availability of health resources, direct payments at the time people need care and inefficient and inequitable use of resources(4). Globally about 150 million people suffer from financial catastrophe. Because OOP payment for health services around 100 million are pushed below the poverty line annually and from this 11% of suffering by severe financial hardship and 5% them forced into poverty each year. Around 1.3 billion people lack of access to effective and affordable drugs, surgeries, and other interventions in the world due to weak health care financing system(12).According to the International Labor Organization (ILO) more than half the world's population not have any type of formal social protection. These problems is more severe in low income countries where there is low coverage of functional health insurance (13).

Developed countries have been achieved universal coverage by using tax based, social and private insurance but low-income countries unable achieve universal coverage by using both this types of insurance(14). Over a third of the world's population resides in low income countries, where about 70% of people live in rural areas and work informal sector (6). In low- and middle-income countries OOP payments around 30%-85% of total health expenditures(15). High OOP are creating constraints to utilizing essential health services and pushing families deeper into poverty in low income countries (16).

Community based health insurance has been introduced in Africa over the past two decades, many countries still now face challenges in initiating, sustaining, or scaling-up CBHI the exception in Ghana and Rwanda(17).The potential of CBHI to be scaled up to reach UHC is limited. There are several key reasons for this: Enrolment rates are often very low, for example in SSA it cover two million people in Africa, out of an estimated population of 900 million, generate little revenue and are not financially viable in the long-run, Premiums are usually charged at a flat rate and CBHI schemes have small risk pools(3,17).

For this reason many scholars and practitioners try to investigating the effectiveness and sustainability of CBHI schemes, the challenges face during implementation of the schemes and the solutions for this problems (6,24).In Sub-Saharan Africa, formal and well functioning

health insurance schemes exist for the very few employees in the formal sector. Majority of them highly exposed to OOP expenditure(19).

Ethiopia access to affordable health care and to achieve universal health coverage (UHC) remains challenge among in the informal sector (20). In Ethiopia outpatient health care utilization rates remain among the lowest in sub-Saharan Africa (21) and direct OOP payments about 37% of the total health expenditure (22). FROM has identified different challenge for under coverage of schemes: scalability of the schemes due to huge fiscal implications and inadequate readiness of facilities to provide quality service in pilot schemes district(23).

In jimma zone ,limu kossa district most of the population around 89 % living in rural area which all of them are farmers, There is high burden of malaria morbidity and mortality in this area due to community exposed to high OOP health care payments(24). To address these problem pilot CBHI launched in limu kossa district in 2011(25). Since there is no evaluation conducted in this district on the way CBHI has been implemented, the aim of this evaluation paper is to evaluate if the scheme is implemented as intended and determine the barriers that affect the implementation of the schemes.

1.3: Significance of the Evaluation

This finding will be used by stakeholders for program improvement. The finding of this study will be crucial for program designers and donors for designing, planning and formulating policy. The result of this evaluation will be used as for developing effective intervention and strategies of scheme during schemes scale up it as national program. It also will be used as crucial inputs for strengthening implementation of the schemes and informed decision making and resource allocation. The findings of this evaluation will be baseline for conducting other research and impact evaluation.

CHAPTER 2: DESCRIPTION OF THE PRORAM

2.1: Program Background

In 2010 Federal Minister of Health (FROM) draft health insurance strategy which with objectives of to reduce the burden of OOP spending and increase access to quality health services(23). In 2010 the government of Ethiopia introduces two types health insurance: social health insurance and community-based health insurance. Social health insurance will cover employees in the formal sector while community-based health insurance will cover the rural population and informal sector in urban area(22).

In June 2011 thirteen Districts from four pilot regions (Tigray, Amhara, Oromiya and SNNPR) have been selected to implement the CBHI as pilot program. Household level monthly premiums range between Ethiopian Birr (ETB) 10.50 to ETB 15.These premiums amount to about 0.5% of household monthly income. To enhance affordability the central government subsidizes a quarter of the premium, and district and regional governments are expected to cover the costs of providing a fee waiver to the poorest 10% of the population (22).

The scheme covers both outpatient and inpatient health care services in public facilities which have signed contractual agreements with the CBHI administration. Utilization of care from private providers is not permitted unless a particular service or drug is unavailable at a public facility. When they seek care, scheme members are first expected to visit a health center and can subsequently access higher level care at district or regional hospitals as long as they have referral letters from the health center. Members who visit hospitals without referral letters need to cover 50% of their costs(14).

2.2: Program Stakeholders

Stakeholders are individuals, groups, or organizations that can affect or are affected by an evaluation process or its findings(26). Stakeholders participation in program evaluation will ensure the utilization of findings (27). During Evaluability assessment stakeholders of CBHI in limu kossa district have been identified and discussed on their role in the program and evaluation. The evaluation question and evaluation judgment criteria were agreed with key stakeholders.

Table1: Stakeholders analysis matrices in implementation evaluation of CBHI in Limu Kossa, district, 2015

S/N	CBHI Stakeholders	Role in the program	Interest or perspective on evaluation	Role in the evaluation	Ways of Com.	*Level of Importance*
1	Oromia CBHI Offices	Monitoring &Evaluation Supportive supervision Policy formulation	Know challenges meet during evaluation For program improvement Lesson learned for scale up	Source of information Interpreter and user of evaluation finding	Phone Email	High
2	USAID and HCFR	capacity building for Health workers on CBHI Technical and financial support	For program improvement Get information on about weakness and strength the scheme	user of evaluation finding	Phone Email	*Medium*
3	Jimma Zone CBHI Office	Monitoring & Evaluation Supportive supervision	For program improvement Get information on about weakness and strength the scheme	Source of information Interpreting findings	Face to face discussion Phone Email	High
4	Limu kossa health Office	Planning of the program coordinating & facilitating Supportive supervision	Get information on about weakness and strength the scheme Know challenges meet during evaluation	Source of information Interpreter and user of evaluation finding Facilitate and coordinate the evaluation Establishing judgment parameters Selecting evaluation question and indicators	Face to face discussion Phone	High

	CBHI Stakeholders	**Role in the program**	**Interest or perspective on evaluation**	**Role in the evaluation**	**Ways of Com.**	***Level of Importance***
5	L/kossa Admistration offices	Political and technical support Community mobilization	To know gab for filling Get information on about weakness and strength the scheme	Interpreter and user of evaluation finding Establishing judgment parameters	Face to face discussion	*High*
6	Limmu kossa CBHI Offices	Planning of the program Implementer of the program Monitoring Supportive supervision	Evaluation is Important for share knowledge Get information on about weakness and strength the scheme Evaluation is Important for Program improvement	Selecting evaluation question and indicators Establishing judgment parameters Source of information Facilitate and coordinate the evaluation Interpreter and user of evaluation finding	Face to face discussion Phone	*High*
7	Limu kossa Health institution	Implementer of the program capacity building for Health workers on CBHI	Evaluation is Important for share knowledge Get information on about weakness and strength the scheme	Source of information Interpreter and user of evaluation finding Establishing judgment parameters	Face to face discussion	*High*
8	Beneficiary (members)	Premium contribution	Important for improving health service provided	Serving as sources of data	Face to face discussion	*High*

2.3: The Goal and Objectives of CBHI

One major policy objective of the Government of Ethiopia is access to quality and affordable health service for all citizens. For this reason the government has developed a health insurance strategy as a complementary policy to improve financial protection and achieve universal health coverage.

The Goal of CBHI

- To improve the overall health status of the people and reduce OOP payment for achieve universal health coverage in rural area and informal sectors of Limu Kossa district.

General Objective of CBHI

- To increasing access, utilization and quality health services and reduce OOP payment for the people living in rural area and informal sectors of Limu Kossa district.

2.4: Specific Objectives of CBHI

- To reduce direct OOP health care expenditures by 40 % at the end of 2015.
- To increase health service utilization by 15% at end of 2015
- To remove financial burdens on households during illness for the people living in rural area and informal sectors of Limu Kossa district.
- Generate revenue for health institution which helps to improve the quality of health services.

2.5: Major Strategies of CBHI

- Increasing health seeking behavior of the people
- Promote prepayment by collecting contributions from households
- Ensure sustainable by enroll all household and renew their membership
- Raise sufficient funds for health institution
- Cross subside, equity and solidarity
- Community participation/empowerment)
- increases referral linkage between health institution

2.6: Program Resources and Activities

2.6.1: Program Resources

- Trained human resource and financial resource
- Facilities water, electricity, room for inpatient and outpatient, laboratory
- Medical equipment and supplies, drugs and reagent
- Guidelines and registration book and referral forms

2.7: Program Activities

- Community mobilization and enrolling members
- Capacity building for health workers on scheme
- Premium collection from member
- Fulfill essential equipment and drugs for health institution
- Provision of health service for members and referring
- Subsiding for indigent and reimbursement
- Registration and reporting

2.8: Output of CBHI

- Number of people trained on CBHI
- Numbers household enrolled into CBHI scheme
- Numbers household renewed their subscriptions
- Numbers household drop out from the scheme
- Numbers of members who take outpatient services
- Numbers of members who take in patient services
- Numbers members who get laboratory services and referral services

2.8.1: Outcome of CBHI

- Health service utilization increased
- OOP expenditure decreased

2.8.2: Impact of CBHI

- Universal health coverage achieved
- contribute in poverty reduction

2.8.3: Program Logic Model

Logical model is "a systematic and visual way to represent among program components and show how program is operate, Logic model is an important tool of evaluation(28) .

Logic model of CBHI

Problem statement: low health services utilization and high OOP health care expenditure among residents of rural parts of Limu Kossa district (32).

Goal: To achieve the goal of universal health coverage in Limu Kossa district.

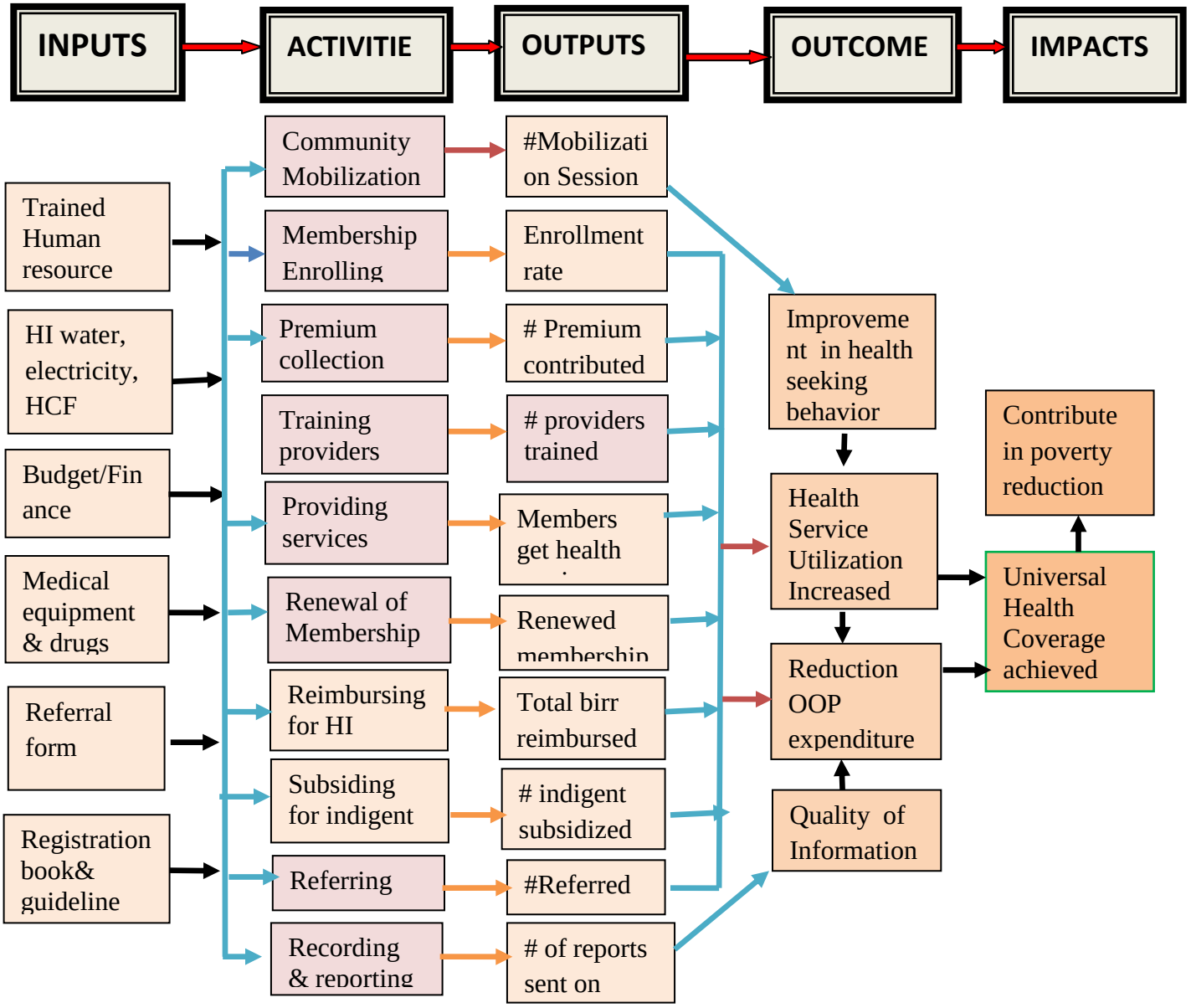

Figure 1: Logic model of CBHI in limu kossa district, Jimma zone, 2015

2.9: Stage of CBHI Development

2.9.1: Global Situation of CBHI

Health insurance was started in 17th century by industries workers as sickness funds. In 1883 chancellor of German formulated Bismarck rule of insurance by organizing industries workers. Until now 85 courtiers accepted Bismarck rule of insurance including Ethiopia(1). CBHI has been started in Africa, Latin America and Asia. CBHI has been introduced to low-income countries over the past two decades.

CBHI schemes with a variety of designs have been introduced across SSA but with generally disappointing results so far. Two exceptions are Ghana and Rwanda, both of which have introduced schemes with effective government control and support coupled with intensive implementation program. Poor support for CBHI is repeatedly linked elsewhere with failure to engage and account for the 'real world' needs of beneficiaries, lack of clear legislative and regulatory frameworks, inadequate financial support, and unrealistic enrolment requirements(10).There is strong CBHI which known as traditionally as mutuelles, mostly in West and Central Africa. Example the coverage CBHI of in Rwanda increase from 35% in 2006 to almost 85% in 2008 (29). Now time in most developing country CBHI under implementation as national programs (10).

2.9.2: Local Situation

In June 2011 thirteen Districts from four pilot regions selected based on availability of financing reforms and HCs geographically accessible (located close to a main road. In Amhara region the unit of contribution is per individual (ETB 3 per individual per month). HH become the members by paying ETB 10.50 in SNNPR,11 ETB in Tigre and ETB 15 in Oromia (30). After the pilot implementation has been reviewed Ethiopian Health Insurance Agency (EHIA) decided to scale-up to 60 districts in 2014 (25). At end of the HSDP-IV the CBHI and SHI expect to cover about 50% of the population. When CBHI scale up to all district as national program it can cover 84 % of the population of the countries(31).Limu Kossa District is one of pilot district implementing CBHI since 2011 and at the end of 2014 40 % of HH of the district population become the members of the schemes(22). Generally the stage of CBHI in this district is on the implementing stage and it's matured to generate information for process evaluation.

CHAPTER 3: LITERATURE REVIEW

3.1: Availability

Availability of trained health workers , adequacy of medical equipment and drugs in health institution are the necessary input to provide effective health services for members of community based health insurance. According Federal minister of health (FROM) 2010/2011 reports there were shortage of midwives, doctors and anesthetists, shortage and attrition of highly skilled professional and low coverage of skilled delivery and newborn care, there were shortage of drugs, medical supplies, equipment and commodities and inadequate availability of resources compared to health care needs in health institution (22). As study conducted in Debub Bench District shows among the ill 92.4% had sought treatment for the illnesses, 5% did not get treatment due to lack of money for treatment (32). According to the 2011 Ethiopian Demographic Health Survey (DHS),there were shortage of skilled delivery providers, the percentage of deliveries by skilled providers was 51% in urban areas and only 4% in rural areas(33).

Federal Ministry of Health was conducted survey in 2003 and 2004 revealed that in most health facilities, the drug budget cover only one-quarter of the year and health facilities were experiencing stock-out of essential drugs for most of the year(34). The 2009/10 Federal Minister of Health supervision data showed that only 6 percent of retained revenue was used for procurement of essential equipment and health facilities have lack of functional diagnostic equipment and vehicles because of budget shortages. Many health centers did not have a water supply or dysfunctional water system(5).

According to Federal Ministry of Health the country's expenditure on drugs had been increasing by an average of around 28% annually but the per capital government expenditure on drugs was only 32 birr or US $3.80 in 2005-2006 and households out-of-pocket payment was 47% of the total drug expenditure(35). The fee waiver system did not safeguard patients against having to pay for medicines because of the unavailability of drugs in public health facilities. Moreover, the share of employer-provided drug insurance was only 0.2% of the total drug expenditure in 2005-2006(36).

3.2: Compliance Dimension

The study conducted in Ethiopia on pilot of CBHI in 2013 shows that number of outpatient care use per insured household member (0·19) was higher by 0·074 visits than the visits per non-insured household member (37). Study conducted in Fogera District, North West Ethiopia shows 77.3% HH were not insured, 21.2% insured and the remaining 1.5% insured but not renewed(38).

Study conducted in Rwanda shows that the households that were members of the CBHI were 15 percentages higher in utilization of health care than uninsured following an illness episode. CBHI reduce OOP health expenditure by 17 percentage (39).Study conducted in Senegal shows that CBHI community-financing through pre-payment and risk-sharing reduce financial barriers to health care, A single stay of one member can lead to an expenditure that represents more than 25% of the household's annual budget (17). The evaluation conducted in Cambodia public health service the utilization of health care increased by 11% among CBHI members while only 0.2% for non-members(40).

3.3: Acceptability /Satisfaction dimension

In April 2012, about a year after scheme inception, 41% of eligible households had enrolled. At the time of the 2012 survey, 96% of the insured had indicated that they would renew their membership while 57% of the uninsured indicated that they planned to enroll in the future (41). However, actual renewal rates in April 2013 turned out to be 82% and 25% of those who had not enrolled in the first year did enroll a year later. By April 2013, enrolment stood at 48% .There is noticeable differences across regions with CBHI uptake rates ranging from 35.4% in SNNPR to 62.7% in the Amhara region. Renewal rates also vary, from 93.1% in the Amhara region to 73.5% in Tigray(41).

The study conducted 2014 on all pilot district showed that the scheme saw enrolment increase from 41% 1 year after inception to 48% a year later. An impressive 82% of those who enrolled in the first year renewed their subscriptions, while 25% who had not enrolled joined the scheme (45).

As study conducted in India shows that 82 % of the insured patients were generally satisfied with the care received. The main reasons for satisfaction were the availability of doctors and medicines and the recovery by the patient. Satisfaction was similar across socioeconomic and demographic variables. Age, gender, literacy and economic status did not determine satisfaction levels. Eight four (84%) insured were happy with the infrastructure(42).

Waiting time to see a medical professional play a substantial role in determining enrolment (43).The main reasons for satisfaction were that they received good treatment / good medicines and the main reason for dissatisfaction was the poor outcome of the therapy(42).

This Conceptual Framework for implementation evaluation of CBHI was modified after different related literature was reviewed based the theoretical model of evaluation of Santos, Hartz and Natal (Moreira & Natal, 2005) to assess level of implementation of the CBHI.

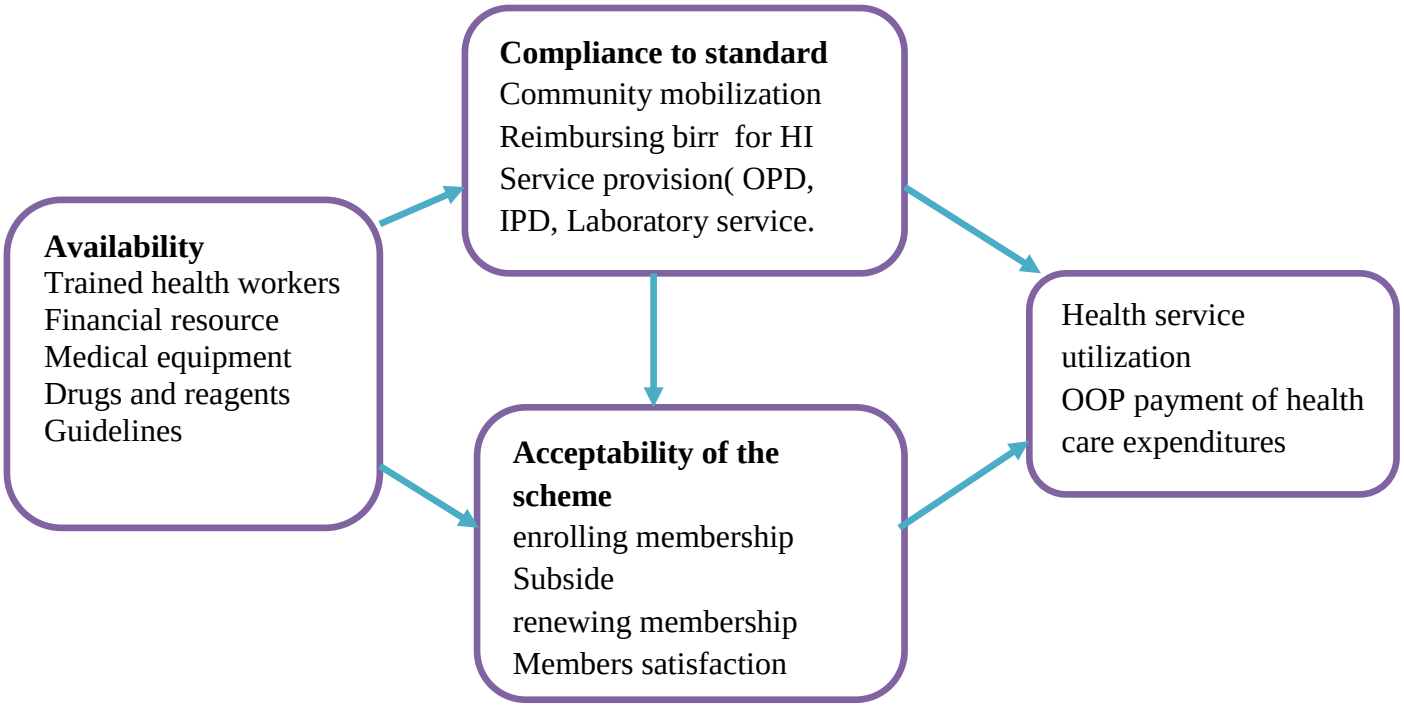

Figure 2: the conceptual framework for implementation evaluation of CBHI in Limu Kossa district. Jimma zone, 2015

CHAPTER 4: EVALUATION QUESTIONS AND OBJECTIVES

4.1: Evaluation Questions

The evaluation questions that were asked to be answered by this study were the following:

1. Are there required resources for the implementation of CBHI? If yes how? If not why?
2. Are activities in the CBHI scheme implemented according to the national guideline? If yes how? If not why?
3. Are members of the scheme satisfied with health service provided? If yes how? If not, why?

4.2: Evaluation Objectives

4.2.1: General Evaluation objectives

- To evaluate the level of implementation status of CBHI in Limu Kossa district, Jimma Zone, 2015

4.2.2: Specific Evaluation objectives

1. To identify the availability of resources for implementation of CBHI.
2. To evaluate if CBHI implemented according to pre designed national guideline.
3. To determine the level of member's satisfaction on health service provided for members of the schemes.
4. To identify barriers that can affect the implementation of CBHI.

Chapter 5: EVALUATION METHODS

5.1: Study Area

Limu Kossa is one of the district from jimma zone which found 75 km from jimma town and 425km from the Addis Abeba. It is bounded by Seka chokorsa district at North, Chora botora district at south, Limu seka district at east and at West- Goma district. Climatic condition of the district is woyna dega. Economically they depend on farming cash crop like coffee and fruit. The district administratively structured 36 rural and 4 urban kebeles. District has 1hospital, 7 health centers and 36 health posts, 2 medium clinics, 12 small clinics 7 drugs store and 6 drug venders. There are 237 health professionals. The district has 163,612 total populations with 29118 households; from this 14278 are household members of CBHI.

5.2: Evaluation Period

EA was conducted from November 10-30, 2014 while the actual evaluation data collection was carried out February 23 – March 20, 2015.

5.3: Evaluation Approach

This evaluation was conducted during program implementation by involving stakeholder to answer evaluation questions important to modify an intervention and provide program improvement(44). Therefore formative form of evaluation approach was used in this evaluation.

5.4: Evaluation Design

The aim of this study to evaluate if CBHI implemented as intend by integrating both qualitative and quantitative data from variety of source for triangulation. Therefore mixed method case study design was employed.

5.5: Focus of Evaluation

The focus of program evaluation was dependent on program and stakeholder priority, availability of resource and financial(45).Depending on purpose of the evaluation and stakeholders priority: hence the focus of this evaluation was process.

5.6: Evaluation Dimension

The evaluation dimensions have been selected with stakeholders based evaluation the focus and those can answer the evaluation question(44). These dimensions help to determine the level of

the implementation of CBHI in Limu Kossa district. Dimensions of evaluation assessed in this evaluation are availability, compliance and acceptability /member satisfaction.

5.6.1: Availability Dimension

The dimension of availability assessed the availability of: human resource, budget, expenditures, essential diagnostic equipment, essential Laboratory service, essential (Tracers) drugs, registration book and guideline and technical resource in health institution that are important for implementation of CBHI scheme and it include 13 indicators.

5.6.2: Compliance Dimension

The dimension of compliance refers the extent the CBHI has been implemented with pre stated standard design. It includes health services provided as pre set program standard, follow up and supportive supervision conducted and community awareness and it include 15 indicators.

5.6.3: Acceptability/satisfaction/ dimension

Acceptability/satisfaction/ dimension include enrollment and renewal of the HH to the schemes and members satisfaction.

In this evaluation this dimension determines level of member's satisfaction. It includes 10 indicators.

5.7: Indicators used for implementation evaluation of CHHI

Table 2: list of Indicators for implementation evaluation of CBHI in Limu Kossa district, 2015

Dimension	Indicators
Availability	Number of HI with that had at least one trained provider on the schemes
	Number of HI with CBHI guidelines
	Number of HI with members registration book
	Number of HI with Waiting area for clients
	Number of HI with Separated adult and under 5 OPD room
	Number of Hi with admission room for severe ill insured patients
	Number of HI with essential diagnostic equipment
	Number of HI with essential laboratory services

	Number of HI essential(tracer drugs) in HI
	Number of HI with functional water supply
	Number of HI with functional latrine
	Number of HI with electricity
	Number of HI active health care finance
Compliance	Number HI got supportive supervision from district scheme office in previous six months
	Number review meeting conducted with HI and kebele leaders
	Number community mobilization session conducted
	Number HI sent report on time for scheme
	Total birr contributed by members (premium contributed)
	Total general subsided birr by government
	Total target subsided birr
	Total reimbursed birr for HI
	Proportion of members who got OPD services
	Proportion of members who got laboratory services
	Proportion of members who got drugs from private pharmacy
	Proportion of members who got admission services
	Proportion of members who were referred to hospital
	Proportion of members who were who got surgery services
	Number of HI got payment (reimbursement) on time
Acceptability /satisfaction	Enrolment rate
	Membership growth rate
	Renewal rate
	Drop rate
	Proportion of members satisfied on medical record service
	Proportion of members satisfied on availability of health worker on time
	Proportion of members satisfied on time spend on waiting
	Proportion of members satisfied on politeness of health workers
	Proportion of members satisfied on clarity of health worker communication
	Proportion of members satisfied on the way assessing health problem

	Proportion of members satisfied on counseling on health problem
	Proportion of members satisfied on laboratory services
	Proportion of members satisfied on getting drugs from HI
	Proportion of members satisfied on overall health services provided

5.8: Populations and Sampling

5.8.1: Source population

Source populations were including:

- All health institution found in district
- All health workers in district
- All members of CBHI in district
- Documents and registrations book found in health institutions.

5.8.2: Study population

The study population were including:

- All health institution have signed contractual agreements with the CBHI administration to implement CBHI were selected.
- Health workers who were assigned on OPD, IPD, Pharmacy and Laboratory and all health institution head in selected HIs
- All insured members of the schemes were came to selected his during data collection
- Program documents and registrations book of schemes found selected HIs

5.8.3: Study units

Study units of this study were selected members of CBHI whose age were greater than 18 years and those were came to health institution for any illness during data collection. Hospital director and manager ,HC head, selected health workers who were assigned in OPD, IPD, Pharmacy and Laboratory department, CBHI coordinator , private pharmacy head. CBHI document and registration books

5.8.4: Sample Size and procedures

For health institution

All health institution that had agreement with CBHI administration selected purposely. Seven Health Institution (six health centers and one hospital were included in the study. Ambuye HC, Babu HC, Limu Genet HC, Limu Genet hospital, Cime HC, Gale HC and Jimate HC were the selected HI.

For in depth interview: From per each department (from OPD, IPO, pharmacy and laboratory) the department head were selected purposely based information richness. Totally 28 health workers were participated in the study. CBHI coordinator and all head of the selected health institution were participated in the study. One CBHI office coordinator, one private pharmacy head were included. Total 37 key informants were participated in depth interview.

For members exit interview: All insured patient whose age were greater 18 years and came to health institution for any illness in the study period consequently included. Total 231 members of the scheme were participated in the study.

Documents and records review: All registration book and documents of the scheme found in selected HI and CBHI office were reviewed from Octobers 1, 2013-January 30, 2015.

5.8.5: Inclusion and Exclusion Criteria

Inclusion criteria

Active members HH who his/her name was there in list of their subscription and whose age was greater than 18 years were included.

Exclusion Criteria

The participant who was critically ill and unable to speak was excluded.

5.9: Data collection

5.9.1: The data Collection methods

In order to address the evaluation question both qualitative and quantitative data collection techniques were used. Case study research favors the use of multiple data sources and methods of analysis (46).In this study both method of data collection were employed. The following data Collection technique were used:

- Documents and records review
- In depth interview
- Exit interview
- Resource inventory observation

5.9.2: Development of Data Collection Tools

For Quantitative Data

Document review template: Template for records and documents review and resource inventory observation was adapted from CDC 2000 program evaluation checklist(45).

In-depth interview guide: In-depth interview guide for key informants in-depth interview were developed after assessment of the program by using checklist.

Semi structured and structured question; Questionnaire for member exit interview were adapted WHO 2000 satisfaction questionnaire with little modification(47).

5.9.3: Data quality control

Questionnaire prepared in English language was translated to local language (Afan Oromo) and back to; it was translated to English to validate its consistency. All data collection tools used in the study were pre-tested on 5% of sample in similar population Goma district, which recently started implementing CBHI. During pre-test, we checked sequential problem, understandability and clarity of questions and then modified accordingly.

The data collectors and supervisors were trained on the tools to be used and the overall purpose of the evaluation research and how to interact with and keep the right and the safety of the respondents prior to the data collection. For supervisors additional one day training was given on how to supervise the data collectors. The data collectors and supervisors were participated in pretest which helps for experience and adaptation.

During data collection, data collectors were strictly followed by supervisors. Data were checked for completeness, error and consistency by the supervisors and principal investigator every day. If there any ambiguity and problems during data collection was addressed to supervisors and principal investigator. After completion of data collection, all the raw data were handled by principal investigator and stored in SPSS and MS words.

5.9.4: Data Collectors and procedures/field work

Four clinical nurses who were perfect in local language and know community's norm were employed from nearby district (Limu Saka) as data collectors, Two BSC nurse were employed from Limu Saka based on their supervision experience. Member's exit interview were conducted by data collectors face to face at health facilities after health service was provided and not agreed members replaced by immediate members. In depth interview with key informant and resource inventory observation was carried out by principal evaluator using in-depth interview guide and check list and note taking was done carefully during in-depth interview. Record and document review conducted by data collectors.

5.10: Data Management and Analysis

5.10.1: Data entry

After cleaning and checking of data for accuracy and completeness, quantitative data were entered in to SPSS version 21 by principal investigator. For qualitative data from field notes were transcribed then thematized.

5.10.2: Data cleaning

Data cleaning and checking was done at field and repeated after entry. Coding error and missing values was checked and errors were removed and missing value was completed.

5.10.3: Data analysis

To determine members satisfaction: Ten items used to measure members satisfaction were measured on five point likert scale: (1)very dissatisfied, (2)dissatisfied, (3)undecided, (4)satisfied and (5)very satisfied. Two hundred thirty one (231) members were asked to rate their satisfaction after health service was received. The result of these items was ranged from 1 to 5.The mean score and standard deviation of for each item was computed by descriptive statistics. The proportion of members who were satisfied for each items were computed by categorizing (4) satisfied and (5) very satisfied as satisfied.

Reliability of each items determined individually by Scale if item deleted test, accordingly, the test result of all items had coefficient more than 0.4 and collectively items reliability was tested and had Cronbach's Alpha value 0.89. It is within the range of recommended alpha value, greater than 0.7(48).

Data from document and review were computed accordingly. Qualitative data from fair note were thematized in to thematic area. Qualitative data analyzed by using Within-case analysis technique. Detailed case study was prepared for each HI. The finding of each HI was compared and the possible reason for their difference and similarities were identified. Finally based on the finding of each HI, final case report was prepared for district. The analysis of implementation of program was done by using judgmental value to determine the level of program implementation.

5.10.4: Matrix of Analysis and Judgment

Criteria and standards are the tool by which the ways of implemented program is measured and dictated (29). A criteria-referenced test is an objective test in which a pre-set cut-off score indicate acceptable/unacceptable performance. It is a measure against carefully written objective for a specific program (42*).*

- Based on these facts, stakeholders with principal evaluator prepared cut-off points for each indicator, dimension, and overall implementation of program.

Finally, to make evaluative judgment on the implementing CBHI program, the sum of the achieved value in each dimension were compared with overall ways of implementation judgmental criteria then we decided on overall ways of implementation CBHI program.

5.11: Ethical Consideration

The ethical approval and clearance letter was obtained from JU college of Public health and Medical science Institutional Review Board (IRB).Official permission letter was obtained JU, Oromia Health Beauro and Jimma zone Health office and Limu Kossa district health office to HI. Informed consent was obtained from the study participants after explaining the purpose of the study. During data collection all respondents were asked their permission. The informants informed that they have the right to stop responding or refuse giving any information. Confidentiality of participants ascertained by no data disclosed without their full willingness.

5.13. Evaluation Dissemination Plan

The findings of this study will be presented in a final defense to Jimma University College health sciences for HSM department and M &E unit. After approval of the findings by the university, the result of an evaluation will be disseminated to Regional CBHI department. Zonal CBHI Department, District CBHI Offices, hospital and health centers. All of them will be provided with clear, simple and summarized soft copy of the report while Jimma University and District CBHI office will be provided with both softcopy & hard copy of the report.

CHAPTER 6: RESULT

Socio Demographic of participated CBHI members

From 231members included in study, majority of them were women 138 (59.8%) and 223 (96.5%) were farmers. Most of the members insured in 2012 (47.6%) and next in 2015 (22.1%).From 231 members exit interviewed: 78 (34%) from Limu Genet hospital, 41(18%) Limu Genet HC, 26 (16%) from Ambuye HC, 24 (10%) from Babu HC, 21 (9%) from Cime HC, 17(7%) from Jimate HC and 14 (6%) from Gale HC.

Table: 3 socio-demographic related information of study participant in evaluation of CBHI in Limu kossa distict, 2015

Variables	Categories	Frequency	Percents
Age	20-30 years	32	13.85
	30-40 years	48	20.78
	40-50 years	70	30.3
	50-60 years	50	21.65
	>60 years	31	13.42
Sex	Male	93	40.26
	Female	138	59.74
Educational status	No education	188	81.39
	Only read and write	25	10.82
	Elementary (Grade 7 & 8)	14	6.06
	Secondary school and above	4	1.73
Place of residence	Rural	214	92.6
	Urban	17	7.4
Religion	Muslim	215	93.07
	Orthodox	13	5.63
	Protestant	3	1.3
Ethnicity	Oromo	215	93.07
	Amhara	11	4.78
	Others	5	2.15
Number of HH	two-four	26	11.25
	four -six	79	34.2
	six -eight	99	42.86
	more than eight	27	11.69

2.1: Availability dimension

❖ ***Trained Health Providers***

Numbers of health facilities with trained health provider on the scheme were 2 (27%).Only Limu Genet HC and Limu Genet hospital had trained health providers on schemes while Other HC did not have it.

28 years health worker from Ambuye HC said:

"...I have worked in this institution for one and half years, but during this duration, I did not get any training on insurance, we only give service for members by checking only their membership identification card. "

32 years HC head said: *"...previously trained health providers who have been trained on the scheme turn over from health facilities and now most of health facilities are filled by newly graduated health workers who do not trained on the scheme and this health providers were left without taking training due to lack of budget."*

❖ *Essential Diagnostic Equipment*

Numbers of HI with essential diagnostic equipment were 57 %.Cime, Gale and Jimate HC did not have functional Blood pressure apparatus, stethoscope and thermometer while Babu, L/Genet HC and Hospital had it.

❖ Essential laboratory services

Numbers of health facilities with essential laboratory services were 4 (57%). Gale HC, Cime HC and Gale HC did not have any laboratory services while L/Genet Hospital, Ambuye HC and Babu HC had essential laboratory. Most of the laboratory technician explains that there was lack of serological test machine in all health centers. In L/Genet Hospital there was no chemistry test.

One Laboratory's health professional from Limu Genet hospital said: *"…As district hospital there is no chemistry test in this hospital, due to this patients were referred JUSH"*

- Essential (Tracers) Drugs

Numbers of health facilities with essential (tracers) drugs were 4 (57%).There was high shortage of drugs in Cime HC, Gale HC and Jimate HC. 27 years old pharmacy's health professional said*: "... most of time there is shortage of drugs in this HC due to stock out especially drugs like ant pain and GIT drugs and due to this we referred patient to private pharmacy."*

33 years old health institution head explain about shortage of drugs*:" when we want to buy drugs from PSFA, we do not get essential drugs in large amount especially ant pain and to buy this drugs from private pharmacy, health care finance in this institution is not always active."*

Numbers of health facilities with guidelines and manuals of the scheme were 1(14%) only Limu Genet Hospital had it. All of health institution 7 (100%) had waiting area near the OPD room and separated adult OPD and under five OPD room. L/Genet HC, Cime HC, Jimate HC and Gale HC did not have admission room while L/Genet Hospital, Ambuye HC and Babu HC had separated admission room.

Numbers of health facilities with pipe water were 4 (57%). Cime HC, Jimate HC and Gale HC did not have pipe water in the facility while L/Genet Hospital, L/Gene HC, Ambuye HC and Babu HC had pipe water.

Numbers of health facilities with electricity were 5(71 %).Jimate HC and Gale HC did not have electricity in the facility while L/Genet Hospital, L/Gene HC, Ambuye HC, Cime HC and Babu HC had electricity,

Numbers of health facilities with active health care finance were 4 (57%). Cime HC, Jimate HC and Gale HC did not have active health care finance in the facility while L/Genet Hospital, L/Gene HC, Ambuye HC and Babu HC had active health care finance.

Generally the availability of resource per each HI was summarized on the following table.

Table 4: Summary result of availability resource per HI in evaluation of CBHI in Limu Kossa district, 2015

Name of Health Institutions	Trained HW	Guideline	Registration Book	Waiting area	Separated OPD	IPD Room	Essential diagnostic equipments	Essential Laboratory	Essential [tracer]drugs	Water supply	Functional latrine	Electricity	Active health care finance
Babu HC	*No*	*no*	*yes*	*yes*	*yes*	*yes*	*yes*	*Yes*	*yes*	*yes*	*yes*	*yes*	*yes*
Ambuye HC	*No*	*no*	*yes*	*yes*	*yes*	*yes*	*yes*	*Yes*	*yes*	*yes*	*yes*	*yes*	*yes*
L/Genet HC	*yes*	*no*	*yes*	*yes*	*yes*	*no*	*yes*	*Yes*	*yes*	*yes*	*yes*	*yes*	*yes*
L/Genet Ho.	*yes*	*yes*	*yes*	*yes*	*yes*	*yes*	*yes*	*Yes*	*yes*	*yes*	*yes*	*yes*	*yes*
Cime HC	*No*	*no*	*yes*	*yes*	*yes*	*no*	*no*	*No*	*no*	*No*	*yes*	*yes*	*no*
Gale HC	*No*	*no*	*yes*	*yes*	*yes*	*no*	*no*	*no*	*no*	*No*	*yes*	*no*	*no*
Jimate HC	*No*	*no*	*yes*	*yes*	*yes*	*no*	*no*	*no*	*no*	*No*	*yes*	*no*	*no*
Number of yes	*2*	*1*	*7*	*7*	*7*	*3*	*4*	*4*	*4*	*4*	*7*	*5*	*4*
In percents	29	14.29	100	100	100	42.86	57.14	57.14	57.14	57.14	100	71.42	57.14

Generally the implementation level of availability dimension when compared with judgmental parameter it was partially implemented. Implementation of each indicator was presented in the following table.

Table 5: Availability dimension level of implementation of CBHI scheme compared with judgmental criteria at Limu Kossa district, 2015

Indicators	**Expected In Number**	**Weight**	**Observed value**	**Value achieved**	**Judgment Level**
Number of HI with that had at least one Trained provider on the schemes	7	3	2 (28 %)	0.86	
Number of HI with CBHI guidelines	7	2	1 (14 %)	0.29	
Number of HI with members registration book	7	1	7 (100 %)	1	
Number of HI with Waiting area for clients	7	1	7 (100 %)	1	
Number of HI with Separated adult and under 5 OPD room	7	2	7 (100 %)	2	
Number of Hi with admission room for severe ill insured patients	7	2	3(43 %)	0.86	
Number of HI with essential diagnostic equipment	7	3	4 (57 %)	1.71	
Number of HI with essential laboratory services	7	3	4 (57 %)	1.71	
Number of HI essential(tracer drugs) in HI	7	3	4 (57 %)	1.71	
Number of HI with Pipe water	7	2	4 (57 %)	1.14	
Number of HI with functional latrine	7	2	7 (100 %)	2	
Number of HI with electricity	7	3	5 (71 %)	2.14	
Number of HI active health care finance	7	3	4 (57 %)	1.71	
Over all Availability Dimension		***30***		***18.13***	**Partially implemented**

NB: ≥ 25 Very Good Implemented, 20 – 25 % Good implemented, ***15– 20 partially implemented, 10****-15 % poorly implemented and < 10 not implement*

6.1: Compliance Dimension

Number of HI got supportive supervision from district scheme office in previous six months was 4 (57%). Number of review meeting conducted with HI and kebele leaders was 1 (25%). Number of community mobilization session conducted was 1 (25%). Numbers HI sent report on time for scheme were 7 (100 %). As raised by most of key informants: the supervision was not conducted on the scheme for health institution from District or zone or regional scheme office in previous six month. All health institution got reimbursement on time. The review meeting was conducted only one time in this year. Community mobilization was not conducted in many times at community level on the scheme.

- Financial viability of the schemes

2,785,731 birr was collected from members and 450,752 birr was got from government general subsidies and 280,000 birr was target subsides. District scheme has been reimbursed 3,198,108 birr for health institutions.

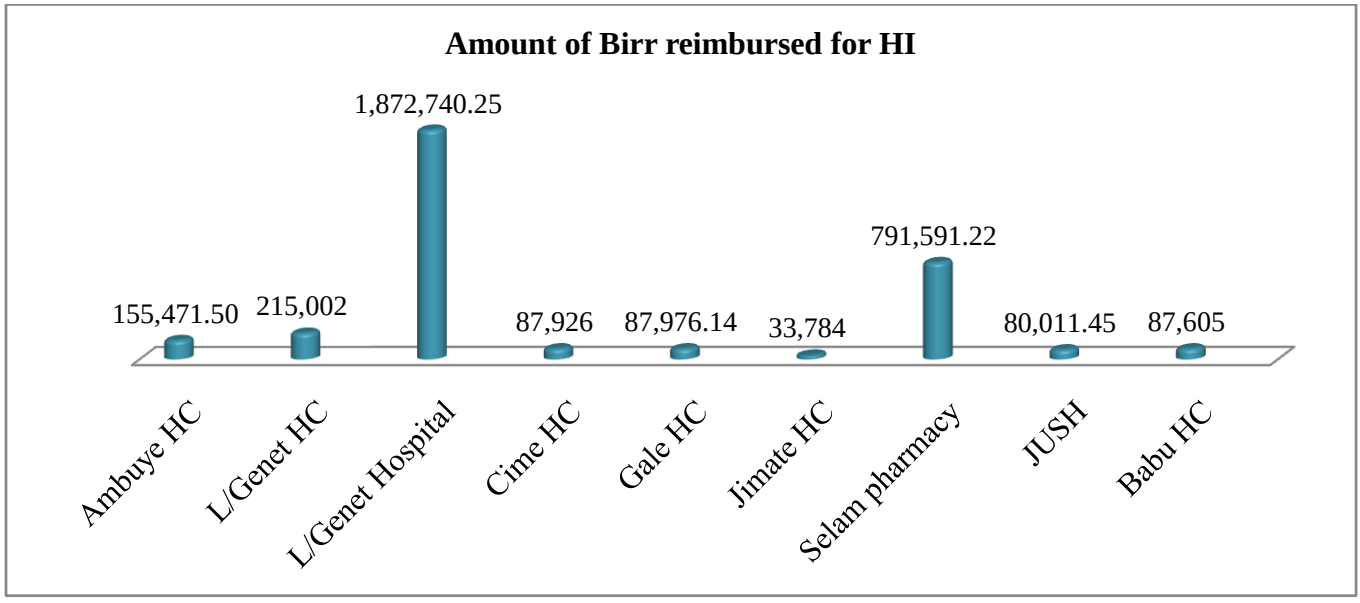

Figure 3: Reimbursed birr by the scheme for each health institutions in Limu Kossa CBHI.2015

Limu kossa CBHI coordinator said:"*…the amount of birr collected from members was less than amount of birr reimbursed for HI due to high utilization of health service by the members."*

- *Health service utilization*

  From total patient visited HI 59,020 (82 %) were the members of the insurance. From total insured patient visited the HI 11828 (22 %) of them were got laboratory services? 178 (3.3%) members were got IPD services. 15447 (26 %) members were got drugs from private pharmacy. from 678 patients were referred to hospital 86 patients were got surgery services in hospital. From Total visited HI more than half of 29671 (55.2 %) of the members were visited Limu Genet hospital then Limu Genet HC14331 (26. 67 %) and the least was Jimate HC 2154 (4%).There were poor referral linkage between HC and hospital. Limu Genet hospital accepted self referred insured patient without referral paper and without asking 50 % the price of the health service cost.

31 years pharmacist from hospital said:

"…the insurance increase the health seeking behavior of the community but most insured patient do not effectively utilize the prescribed drugs ,because of this most of the patient very risky for drugs resistances.“

From insured patient visited HI 11447(22 %) of patient were referred to private pharmacy due to stock out. District scheme had agreement only with one private pharmacy which found Limu Genet town. There was poor referral linkage between health facilities. Insured patient were gone to hospital without referral papers.

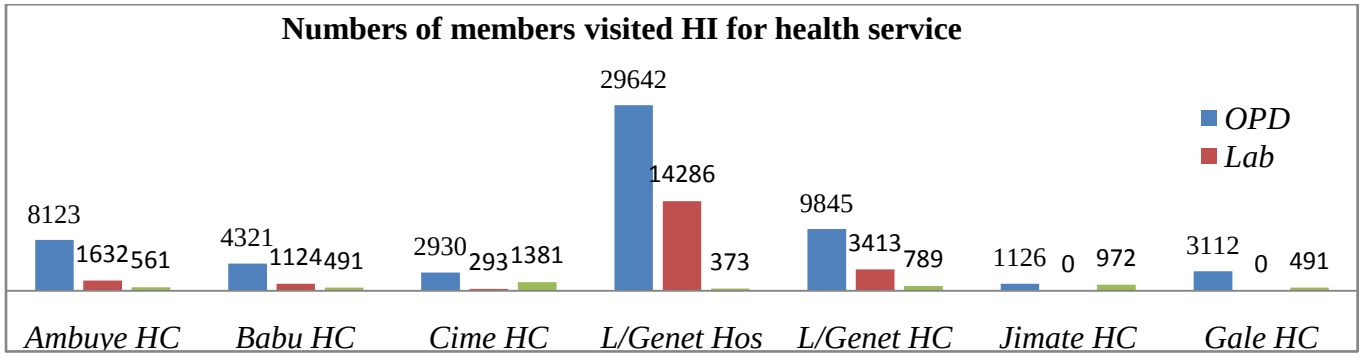

Figure 4: Summary Increase in the membership for CBHI by year in Limu Kossa district, 2015

Generally the implementation level of compliance dimension when compared with judgmental parameter it was poorly implemented

Table 6: Over all the parameters of compliances dimension in implementation evaluation of CBHI in Limu Kossa District 2015

Indicators	**Expected In Number**	**Weight**	**Observed value**	**Value achieved**	**Judgment Level**
Number of HI got supportive supervision from district scheme office in previous six months	4	2	3 (42.86%)	0.86	
Number of review meeting conducted with HI and kebele leaders	4	2	1 (50%)	1	
Number of community mobilization session conducted	4	2	1 (50%)	0.5	
Number HI sent report on time for scheme	7	2	7 (100)	2	
Total birr contributed by members (premium contributed)	4,955,000	3	2,785,731(56%)	1.69	
Total general subsided birr by government	1,500,000	3	450752 (30 %)	0.90	
Total target subsided birr	3000,000	3	280,000 (93 %)	2.8	
Total reimbursed birr for HI	3,276,000	3	3,198,108(97.6%)	2.93	
Proportion of members who got OPD services	65484	3	53,720 (82 %)	2.46	
Proportion of members who got laboratory services	53,720	3	11828 (22 %)	1.66	
Proportion of members who got drugs from private pharmacy	16116	3	15447 (95.65%)	2.86	
Proportion of members who got admission services	5372	3	178 (3.3%)	0.10	
Proportion of members who were referred to hospital	2686	3	678 (25%)	0.76	
Proportion of members who were who got surgery services	537	3	86 (16%)	0.48	
Number of HI got payment (reimbursement) on time	7	2	7 (100 %)	2	
Over all compliance dimension		**40**		**22**	***Poorly implemented***

*NB: ≥ 35 Very Good Implemented, 30 – 35 % Good implemented, 25– 30 partially implemented, 20-**25 % poorly implemented** and < 20 not implemented*

6.2: Acceptability Dimension

6.2.1: Acceptance of the schemes

- Enrollment Rate (49%)

As the scheme implemented in 2012 the enrollment rate was 24%, in 2013 it was 34 %, in 2014 it was 40 % and in 2015 it was reached 49 %.

35 years old doctor said: "*...half of the HH do not become the members of the scheme and they believe that as do not get quality service from public health institution"*

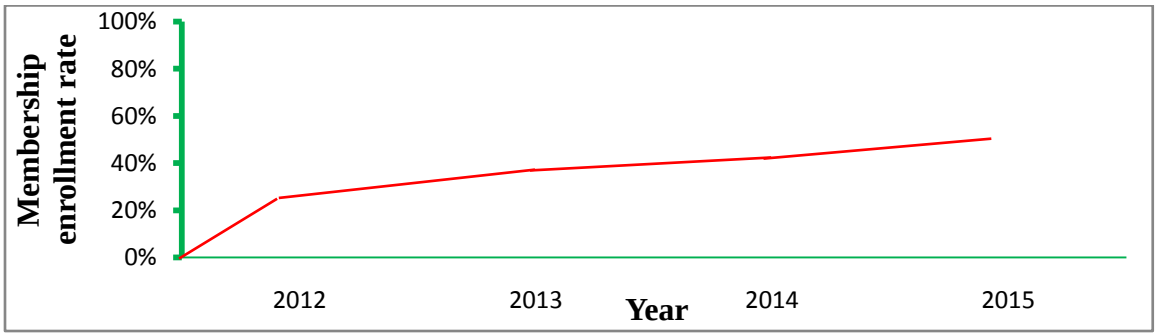

Figure 5: The growth of enrollment rate per each year in evaluation of CBHI in Limu Kossa district.2015

About half of the households in the district were being members of the CBHI scheme, from this 10% were poor households paid for by the district administration.

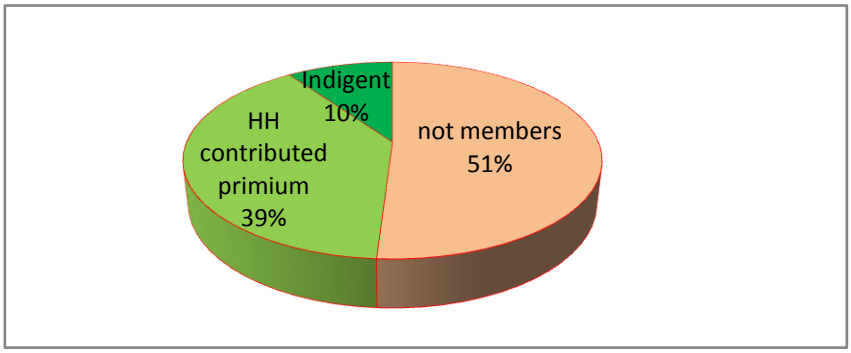

Figure 6: Proportion of HHs who had membership in the CBHI scheme, Limu Kossa district, 2015

❖ Membership growth rate (22.57%)

In 2014, 11649 HH were being the members of the schemes, in 2015, 14278 HH were being become the members of the scheme. From 14278 of members of the scheme 2629 HH (22.57%) become the members of the scheme for first time in 2015.

❖ Renewal rate (90 .41%)

From 11649 HH were being the members of the scheme in 2014, 10532 (90 .41%) of the HH were renewed their membership ID in 2015.

❖ Drop rate (9.59%)

From 11649 HH were being the members of the scheme in 2014, 1117 (9.59%) HH were dropped out from the schemes in 2015.

❖ Information from members participated in exit interview

From the finding of exit interview conducted on 231 members. The traveling time of most members by foot was between 60-120min. Most of members were spent 30min -60min on waiting time to get health service. Most of members 224 (96.6 %) got health providers at work place. Around 68 (29.3 %) the member got laboratory service and 176 (75.9 %) of the members got prescribed drugs in the institution while 55 (24.1 %) of the members were referred to private pharmacy for stock out. Detail health system related information presented in the following table:

Table 7: Information related from members participated in exit interview in implementation evaluation of CBHI in Limu Kossa district, 2015

Variables	**Response**	**Frequency**	**Percents**
Distance traveled in minute	Less than 30min	31	13.4
	30-60min	79	34.1
	60-120min	90	38.8
	120-180min	25	10.8
	Greater than 180 min	6	2.6
Waiting time in minute	Less than 30 min	68	29.3
	30min -60min	97	41.8
	60 min -90min	64	27.6
	90min - 150min	2	0.9
Got laboratory services	Yes	68	29.3
	No	163	70.7
Got drugs in the institutions	Yes	176	75.9
	No	55	23.7
Years of enrollment	2012	110	47.6
	2013	47	20.3
	2014	23	10.0
	2015	51	22.1
Reason for joining	To get better health service	72	31.2
	To reduces OOP	124	53.7
	To reduce stress related to expenditure	34	14.7
	I do not now advantage of the insurance	1	0.4
Are you renewed you subscription for next year	Yes	217	94
	No	14	6

❖ **Determining members satisfaction to service provided**

Mean satisfaction score and distribution of members by level of satisfaction with items used to measure members satisfaction. Over all mean of members satisfaction was 3.94 over five point likert scale with 1 (very unsatisfied), 2 (unsatisfied) ,3 (undecided) , 4 (satisfied) and 5 (very satisfied). Time spend on waiting, politeness of health workers, getting laboratory services and getting drugs in HI had highest mean satisfaction score 3.95-4.47. Medical record service and ways of Health workers assessed their health problem had lower mean satisfaction score 3.71(SD =0.786) and 3.75 (SD = 0.772) respectively.

On laboratory services 41.2 % of the members were satisfied, 55.9 % were very satisfied and 0.9 % were very satisfied, with the mean of 4.47 and 0.782 SD. The level of members satisfaction on the availability of health worker on time, 80.1% of members were satisfied, 11.3 % were very satisfied, 7.8 % were dissatisfied, 0.4 % were undecided and 0.4 % were very dissatisfied with the mean of 3.94 and 0.4683SD.The level of members satisfaction on time spend on waiting was 92 .6% of members were satisfied, 3.5 % were very satisfied, 3.5 % were dissatisfied and 0.4 % were undecided with the mean of 3.96 and 0.420 SD. The level of members satisfaction on the politeness of health workers, 91.3% of members were satisfied, 5.6 % were very satisfied, (2.2 %) were dissatisfied, 0.9 % were undecided with the mean of 4.00 and 0.390 SD.

On clarity of health worker communication, 83.1% of members satisfied 6.1 % were very satisfied, 2.2 % were undecided, 8.7% were very dissatisfied with the mean of 3.87 and 0.642 SD. Members satisfaction on ways of health workers assessing their health problem, 78.8% of members were satisfied, 5.6 % were very satisfied, 14.7 % were dissatisfied and 0.9 % undecided with the mean of 3.75 and 0.772SD.

The level of members satisfaction on ways of health workers counseling on their health problem:78.8% of members were satisfied, 5.6 % were very satisfied, 12.6% were dissatisfied, 3.0 % were undecided with the mean of 3.77 and 0.735 SD. Most of members were satisfied on the variable getting from HI. Accordingly 76 .6% were satisfied, 10.8% were very satisfied, 7.8 % were dissatisfied with the mean of 3.95 and 0.664 SD. The detail information of member's satisfaction in each variable was presented in the following tables

Table: 8 Mean satisfaction score of members per each item on five point likert scale in evaluation of CBHI in Limu Kossa district, 2015

Satisfaction on the items	**N**	**V.dissatisfied (1)**	**Dissatisfied (2)**	**Undecided (3)**	**Satisfied (4)**	**V.satisfied (5)**	**Mean**	**SD**
Medical record service	231	1 (0.40%)	33 (14.3%)	6 (2.6 %)	183 (79.2%)	8 (3.5 %)	3.71	0.786
Availability of HW on time	231	1 (0.40%)	18 (7.8 %)	1 (0.40%)	185 (80.1%)	26 (11.3%)	3.94	0.4683
Time spend on waiting	231	0	8 (3.5 %)	1 (0.40%)	214 (92 .6%)	8 (3.5 %)	3.96	0.420
Politeness of health workers	231	0	5 (2.2 %)	2 (0.9 %)	211 (91.3%)	13 (5.6 %)	4.00	0.390
clarity of health worker communication	231	20 (8.7%)	0 %	5 (2.2 %)	192 (83.1%)	14 (6.1 %)	3.87	0.642
Assessing health problem	231	0 %	34 (14.7%)	2 (0.9 %)	182 (78.8%)	13 (5.6 %)	3.75	0.772
Counseling on health problem	231	0 %	29 (12.6%)	7 (3.0 %)	182 (78.8%)	13 (5.6 %)	3.77	0.735
Getting laboratory services	68	2 (0.9 %)	0 %	0 %	28 (41.2%)	38 (55.59%)	4.47	0.782
Getting drugs in HI	220	0 %	18 (7.8 %)	0 %	177 (76 .6%)	25 (10.8%)	3.95	0.664
Over all health services provided	231	0 %	10 (4.3 %)	3 (1.3 %)	195 (84 .4%)	23 (10 %)	4.00	0.536
Over all		**2(0.93%)**	**16(7.5%)**	**3(1.4%)**	**175(81.8)**	**18(8.4%)**	**3.94**	

Generally satisfaction score from five point likert scale items were computed to get proportion of members generally satisfied and dissatisfied. Very satisfied and satisfied were computed as satisfied and dissatisfied and very dissatisfied were computed as dissatisfied. Almost all of (66) 97.05% of members were satisfied on getting laboratory services, Most of members 224 (96.97%) of them were satisfied on politeness of health workers while 2(0.87%) un decided. proportion of members satisfied on time spend on waiting were 222 (96.1%) while1 (0.43 %) un decided .Most of members 202 (91.81%) were satisfied on getting on drugs in HI.

Member's satisfaction on availability of HW on time at work place 211 (91.34 %) were satisfied while 1(0.43%).The level of member's satisfaction on clarity of health worker communication: 206 (89.18%) of them were satisfied while 5(2.16%) of them were undecided. Most of members 195(84.41 %) were satisfied on the way HW were counseled on health problem while 7(3.03%) of them were undecided. The level of members satisfaction on medical record service: 191(82.68%) of members were satisfied and 6(2.62%) were undecided.

Table 9: Total proportion of member's satisfaction in evaluation of the implementation of CBHI in Limu Kossa district, 2015

Satisfaction on the items	**N**	**Dissatisfied**	**Undecided**	**Satisfied**
Medical record service	231	34(14.7%)	6(2.62%)	191(82.68%)
Availability of HW on time	231	19(8.23%)	1(0.43%)	211(91.34 %)
Time spend on waiting	231	8(3.46%)	1(0.43 %)	222(96.1%)
Politeness of health workers	231	5(2.16 %)	2(0.87%)	224(96.97%)
clarity of health worker communication	231	20(8.66%)	5(2.16%)	206(89.18%)
Assessing health problem	231	34(14.72%)	2(%0.87%)	195(84.41 %)
Counseling on health problem	231	29(12.55%)	7(3.03%)	195(84.41 %)
Getting laboratory services	68	2(2.94%)	0(%)	66(97.05%)
Getting on drugs in HI	220	18(8.18%)	0(%)	202(91.81%)
Over all health services provided	231	10(4.33%)	3(1.3%)	218(94.37 %)
Total		18(8.4%)	3(1.4%)	193(90.2%)

The over judgment parameter of Acceptability /satisfaction dimension as 23.93 which was good implemented

Table10: of over acceptability/satisfaction dimension in implementation evaluation of CBHI in Limu Kossa district, 2015

Indicators	**Expected**	**Weight**	**Observed value**	**Value achieved**	**Judgment Level**
Enrolment rate	29104	3	14278 (49%)	1.47	
Membership growth rate	11649	3	3746 (26.24%)	0.68	
Renewal rate	11649	2	10532 (90 .41%)	1.81	
Drop rate	0	2	1117 (9.59%)	1.8	
Medical record service	216	2	191 (82.68%)	1.65	
Availability of HW on time	224	2	211(91.34 %)	1.83	
Time spend on waiting	222	2	222(96.1%)	1.92	
Politeness of health workers	224	2	224(96.97%)	1.94	
clarity of health worker communication	221	2	206(89.18%)	1.78	
Assessing health problem	209	2	195(84.41 %)	1.69	
Counseling on health problem	206	2	195(84.41 %)	1.69	
Getting laboratory services	66	2	66(97.05%)	1.94	
Getting on drugs in HI	202	2	202(91.81%)	1.84	
Over all health services provided	218	2	218(94.37 %)	1.89	
Overall Acceptability/ satisfaction dimension		**30**		**23.93**	***Good implemented***

NB: ≥ 25 Very Good Implemented, ***20 – 25 % Good implemented****, 15– 20 partially implemented, 10-15 % poorly implemented and < 10 not implemented*

6.3: Qualitative Data (In-depth Interview) finding

6.3.1: Barriers to effective implementation of the schemes

Barriers to effective implementation of CBHI were identified by in-depth interview of key informants and their responses were summarized under the following thematic areas.

- ✓ Low awareness of community to words the schemes.
- ✓ Shortage of resources (budget, medical equipment, drugs and reagent) in HI.
- ✓ Poor knowledge and skill of health workers on the scheme
- ✓ Poor performance building for health worker and supportive supervision.
- ✓ Low quality of health service provided by HI.
- ✓ Poor referral linkage between HC and hospital

1. Shortage of resources

The shortage of human resources in HI was the major problem as raised by many informants at facility level especially in Pharmacy room. There was high load work on pharmacy professional due to the health professional assigned in the pharmacy was delighted to registrar the members of the scheme in the registration book additional to dispensing drugs. The work load in the Pharmacy was very high and cannot be managed by one person. Only Limu Genet hospital that was assigned other health providers for the registration of the members but in all HC there was health workers assigned for this works.

31 years old who was the head of HC said:

"*After the insurance was implemented there was high load of work on health workers assigned in dispensary room. They check the name of members whether available in membership identification card, estimate the cost of the drugs, registrar the prescribed drugs on scheme book registration additional to dispensing drugs, therefore in HC one health worker was needed for this work….*"

Another problem raised with shortage of human resource was there was high patient load on the OPD due to high turnover of health workers.

Regarding shortage of medical equipment, drugs and reagent facility informants claimed that there was shortage of medical diagnostic equipment like blood pressure apparatus, stethoscope, and thermometer in most of health facility. In most of HI there were drugs stock out due to this patients were referred to private pharmacy. As many health workers assigned on laboratory there was shortage of reagent and hemoglobin centrifugal machine. As responded by some facility head there was shortage of drugs and regents in HI due to lack of drugs and reagents in PSFA. Another health facility head was responded as the shortage of this resource due to inactive functional health care finance in the institution.

2. Knowledge and skill of Health workers

As raised by many key informants of health facilities most of health workers not trained on the scheme, the previously trained health worker turn over and HI were filled by newly graduated health workers. This health worker did not have knowledge on the rule of the insurance due to this the health workers not give some health information about the advantage of the scheme those for those who do not know about the schemes.

Regarding the skill of the health workers, some informants claimed that all health workers did not have equal knowledge the way of assessing patient's problem, treating and counseling the patient. Due to this insured patient go to HI those had skilled health professionals like Limu Genet hospital or Limu Genet HC.

3. Low Awareness of Community to Words the Schemes

As raised by many key informants of health facilities, many the patient come to HI do not know about and the use of insurance due to this most of the community still do not enrolled.

28 years old of health facility head said*:*

"...most of members come to health facility due to only being the members of the schemes without medical problem and one day from one HH, four members of this HH come to health center for treatment but finally when we assess their problem only one child has illness..."

Some key informants responded that some insured patient after takes drugs from one HI, if there is no improvement from their illness with short day especially with one day, they go to other

institution like Limu Genet hospital without finishing previously prescribed drugs; this condition will cause drugs resistance in the futures.

4. Capacity building

As raised by many key informants, most health professionals did not obtain review meeting and training on scheme due to this most of health workers did not familiar with rule of CBHI. There is poor data recording and reporting. Another problem raised under capacity building was lack supportive supervision for health institution from district, zonal or regional scheme office. There was no scheduled supportive supervision and written feedback for HI.

Summary over all dimensions *Evaluation of the implementation of CBHI*

Table 11: over all dimensions of the Evaluation of the implementation of CBHI program at Limu Kossa district, 2015

Dimensions	Indicators No.	Value given	Value achieved	Percentage achieved	Level of implementation	Judgment criteria
Availability	13	*30*	*18.13*	*60.43 %*	Partially Implemented	≥85% *Very Good* Implemented 75-85 *Good Implemented* **60- 75%** Partially Implemented 50 - 60 Poorly Implemented < 50 % Not Implemented
Compliance	15	40	22	55 %	Poorly Implemented	
Acceptability / satisfaction	14	30	23.93	79.77 %	Good Implemented	
Over all implementation status	**42**	**100**	**65.7**	**65.7**	**Partially Implemented**	

CHAPTER 7: DISCUSSION

The over implementation of the program was determined based on the overall all value of each dimension judgment parameters. The over the level of implementation of the program was 65.7 which partially implemented according to judgment parameter. This level of implementation was lower than standard of pre set judgment parameters value.

7.1: Availability Dimension

Over all, the availability of many resources was inadequate as compared to standards guideline of the scheme and standard judgment parameters. Generally the availability dimension had judgment value 60.43 % which was partially implementation according preset judgment criteria.

The study found the the availability of trained health provider was 2(28 %) of HI had trained health workers on the schemes. Only Limu Genet HC and Limu Genet hospital had trained health provider while others health institution did not have. This result is lower than with national scheme guideline recommend that service must provide by trained health care worker in each health institution (4).The reason for lack of trained health workers were due to high turnover of health workers. If there was no trained health workers on the scheme the heath workers could not implement according to standards of the scheme.

From the seven health facility, three of them did not have essential diagnostic equipments like B/P apparatus, stethoscope, and thermometer. Cime HC, Gale HC and Jimate HC did not have essential diagnostic equipments while Babu HC, L/Genet HC and Hospital had it. This result was lower than standard guideline. This was due to poor health care finance system in this institution.

There were no any laboratory services in two health institutions and in most of health institution there was shortage of essential laboratory service and reagents. Jimate HC and Gale HC did not have any laboratory service due to lack of electricity and reagents. This result was inconsistence to CBHI guideline which says that HI that had agreement with the scheme must to fulfill essential laboratory services (39).

In most of health institution there was high stock out of drugs especially drugs like ant-pain and GIT drugs due to poor health care finance in facility and shortage of drugs in PSFA. This study similar survey conducted by FMOH in health institution which shows there was shortage of drug in health institutions and health institutions were experiencing stock-out of essential drugs

many times (29).If there no shortage of drugs in HI, the member could not get drugs and if members did get the members will not renew their membership ID. This will affect sustainability of the program.

7.2: Compliance dimension

Generally the compliance dimension which has 15 indicators, had judgment value 55 % which was poorly implemented according to judgment parameter. This dimension was the lowest when compared to others dimension and most of its indicators need improvement.

The study also revealed 3(42.86%) of the HIs have received supportive supervision from the scheme as per the standard and from the received supervision only 2(28.57 %) were with written feedback. This finding was less than standard judgment parameters and scheme guide line (4). This may due to lack of resource) budget in district CBHI office.

Community mobilization was conducted only one time in 2014 (25%); these results shows there were poor community mobilization to on the schemes. This study was lower than study conducted in rural Nigeria, community mobilization on the scheme was conducted four times in the years(49).The difference may due to in Nigeria community mobilization was conducted by HI rather than the scheme. This low community mobilization cause low community awareness on the scheme. This study revealed from the members of the scheme 2,785,731 birr collected and 3,198,108 birr was reimbursed for health institutions. When compare revenue generated from members and reimbursed birr, the reimbursed for HI higher than revenue generated. This result shows to financing viability of scheme to cover its expense for long time was poor. This results his inconsistence with insurance guideline which said reimbursed birr for HI can be less than revenue generated. This difference was due to high utilization of health service by members and poor referral linkage between HI.

This study found from total patients visited HI for any illness, 82 % of them were the members of the scheme. This result was slightly higher than study conducted in Ghana from total patients visited HI,76 % of insured patient (41).

This difference was due to strong referral linkage between HC and hospital. As result from qualitative finding, there were over utilization of health service by insured members. This results similar with the evaluation conducted in Cambodia shows there was over utilization of health

care by insured patient(increased by 11% among CBHI members) (46).From total insured patients visited HI as OPD , 22 % of them did not get drugs in the HI due to stock out of drugs. These results were higher than guideline which 10 % of can referred to private pharmacy for stock out drugs in HI (39). This may due to poor health care finance in HI.

There were poor referral linkage between HC and hospital. Limu Genet hospital accepted self referred insured patient without referral paper and without asking 50 % the price of the health service. This is inconsistence with CBHI guide line which said if patients come to Hospital without referral paper they have to pay 50 % price of health service prices and if patient have referral paper from HC they have to get health service without any payment in hospital. This difference was due to low awareness of the members on the referral linkage. This condition cause over utilization health services by members and high reimbursement.

7.3: Acceptability/satisfaction Dimension

The overall acceptability/ satisfaction dimension was good judgment parameter. This dimension was scored best judgment parameter value when compare with other dimension.

This study found that from total HH 49 % of them enrolled in the schemes. This study lower than study conducted in Rwanda in 90 % of HH enrolled in the schemes. The difference is due to in Rwanda scheme was high financed by the governments and the scheme was implemented as national program (6). This study found out that 10 % insured were indigent. This result consistence to standard of CBHI guideline which says 10% HH from district must selected as indigent (8). These results similar with Rwanda 9.7 % of members of the scheme were indigent(7).

This study found that from 90 % of members were renewed their subscription and 10 % of them were dropped from the scheme. This result was consistence with national guide line. This study result was lower than study conducted in Nouna district scheme in Burkina Faso dropout rate of 30.9% in 2005 and 45.7% in 2006.Ths due to the low quality of care in Nouna district. This study found that 21.57% membership growth rate. This result was lower than pre set standard parameters and guideline of the schemes (8).This may due to poor community mobilization on the schemes.

This study found that the mean of members' satisfaction 3.94 over likert scale these represent members were satisfied on health service provided. The low mean satisfaction score was medical records service in which members less satisfied. This may be shortage of health providers at medical units.

Time spend on waiting, politeness of health workers, getting laboratory services and getting drugs in HI had highest mean value in most of members satisfied on it. This result similar to study conducted in Ethiopia CBHI pilot study which show availability of medical equipment, laboratory test and waiting time to see a medical professional, played a large role in satisfaction. For instance, the availability of blood testing equipment at the nearest health center was increase satisfaction by 30 % (14). This study also similar to study conducted in India shows that 82 % of the insured patients were generally satisfied with the availability of doctors and medicines and the recovery by the patient and received good treatment / good medicines. Age, literacy and economic status did not determine satisfaction levels(42).

The level of satisfaction was in very high in Limu Genet HC and Ambuye when compare others institutions due most of members were stayed less than 40 minutes on waiting area in this HI and got drugs from HI.

7.4: Limitation of the Evaluation

- Because of resource and time constraint the study did not include barrier that affect acceptability of the scheme at community level from those non members of scheme.
- The trained health workers and HI managers' turnover from health institution and this made difficulty to get more rich information about the program.

CHAPTER 8: CONCLUSION AND RECOMMENDATION

8.1: Conclusion

Generally the overall the level of implementation from the three dimensions (availability of resources, compliance to guideline &acceptability/satisfaction) were felt below the standard agreed up on with the stakeholders for the judgment of implementation status. As a result, the implementation status of a CBHI in the Limu Kossa district was found to be partially implemented.

Specifically:

- The finding of the study on availability dimension showed there was inadequacy of resources (shortage of trained health workers, medical equipment, drugs and reagent in HI) that needed for implementing CBHI. The intended activities were not performed according to the guide line and there was no compliance to guideline.
- The finding of the study on compliance dimension showed community mobilization on the schemes, supportive supervision, the training health workers on the scheme were below the expected standard. There was poor referral linkage between HI and high reimbursement birr than revenue generated.
- The result from acceptability/satisfaction showed the enrolment rate and members growth rate were below the expected standard. The level of members satisfaction were good on the variable time spend on waiting, politeness of health workers, getting laboratory services and getting drugs in HI.
- The finding of the study from qualitative data showed there was low awareness of community to words insurance, over utilization of health service by the members (moral hazard) and inactive heath care finance in HI.

8.2: Recommendation

To Health workers and Institution.

- Health worker have to give health education on the utilization of health service.
- Health institution has to fulfill essential medical equipment, drugs and laboratory service.
- Health institution have to strength health care finance in the facility
- Strength referral system and follow the rule of referral on the schemes.

To District CBHI office and Health office

- Create community awareness continuously on the schemes.
- Give training for health workers on rule and regulation of the scheme.
- Conduct supportive supervision for health institution.
- District health office integrates with others concern sectors allocate budget for the scheme and secure electricity for HI did not have the electricity light.

To Zonal CBHI Office and health Department

- Zonal CBHI office has to facilitate as health institution fulfill essential laboratory machine and medical equipment.
- Zonal CBHI office have to conduct supportive supervision for District CBHI
- Zonal CBHI office has to give training for health workers on rule and regulation of the scheme.
- Zonal CBHI office has to prepare meeting review with District CBHI office.

To Oromia Regional Health Bureau and CBHI department

- Develop CBHI manual guide line and make it as available at health institution.
- Facilitate source of budget for district CBHI office.
- Recruit and training health workers on CBHI.
- Send general and target subsides on time for CBHI office.
- Conduct supportive supervision for District CBHI.

CHAPTER 9: META EVALUATION

Evaluation has Meta evaluated to ensure quality and credibility of findings. This means, meta-evaluation has done alongside the evaluation itself to make sure uncertainties identified and corrected during the planning, implementation and analysis of information of the evaluation. Meta-evaluation was done by taking account the 30 standards encompassed within four attributes:

9.1: Utility

To insure the utility of evaluation we thoroughly identified and involved important stakeholders during evaluability assessment for indicator selection and included their interest necessary for program improvement. Moreover, we were made to involve them in each stage of evaluation, we were reported the result easily understandable way to the stakeholders, and we were present when it is necessary in timely manner.

9.2: Feasibility

"Feasibility standard of the evaluation was conducted in a natural by opposing to laboratory, setting and consume valuable resources" (44). In order to fulfill the standard, case study strategy was used and it was operated in field setting with pre-determined resources that necessary to address the evaluation question and the needs of stakeholders.

9.3: Propriety

Propriety is about protection and respecting of the right of subject were studied. This attribute was addressed in ethical consideration part and in addition to that, before conducting evaluation the data collectors was trained to respect the decision of participant to be involved or not in the study.

9.4: Accuracy

To maintain the accuracy standards; we were reviewed appropriate program documents and records and we was e discussed with stakeholders to understand the program. Training will be provided to the data collectors to collect valid, credible and reliable information with different data collection methods from defensible sources in order to prepare valuable judgment and feasible recommendations.

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Annexes 1: Evaluation Tools

1. Consent form

For key informant of CBHI

Name of health institution_____

Dear Sir/Madam

Good morning! My name is _____and I am a member of evaluation team that evaluate implementation program at limu kossa district and the evaluation conduct with the collaboration of Jimma University. We are tending to conduct evaluation on the way CBHI implemented in order to find the best practice and the weakness that need to improvement, and at the end, we will provide feedback that important for input to improve the CBHI program. I am interested to ask you some questions to know the weakness and strength in the way program was implemented. To assure your confidentiality I am not record your name and individualize information what you give.

Please give me your willingness to continue; do you:

1. Agree

2. Not, agree

Data collector name: _____Signature_____ date__/__/__

Supervisor name: _____Signature_____ date__/__/__

Notes to the interviewer:

If the participant agrees to continue, acknowledge his/her decision and proceed with the

If s/he does not agree, respect his/her decision to decline and go to the next Participant.

Consent form for member of the CBHI

Name of health institution_____

Dear Madam/Sir

Good morning! My name is _____ and I am a member of an evaluation team that evaluate the implementation of CBHI, and the evaluation executed in collaboration with Jimma University. We proceed to conduct process evaluation of CBHI scheme in order to find the best practice and to identify the weakness of CBHI services. Then finally, we will give feedback to service provider and program manager based on information what you provided us honestly and what we are seeing practically, which is input to improve the insurance program. To assure your confidentiality I am not tending to record your name and individualize information what give me. If you are voluntary to participate, I am interested to ask some questions to know your satisfaction level on service get on being member of the insurance services provided.

Please give me your willingness to continue; do you:

1. Agree

2. Not, agree

Data collector name: _____Signature_____ Date__/__/__

Supervisor name: _____Signature_____ Date__/__/__

Notes to the interviewer:

If the participant agrees to continue, acknowledge his/her decision and proceed with the Interview. If s/he does not agree, respect his/her decision to decline and go to the next Participant.

2. Data Collection Tools

A. Checklist for documents and records review *for General health institution*

Name of health institution _____

Table 1: Observation checklist for Documents and records review for General health institution for evaluation of implementation of CBHI in limu kossa District, 2015

		yes	No	YES it's Quantity
A1	Are there CBHI guidelines in health institution?			
A2	Are there CBHI agreement contract in the institution			
A3	Is there HO or Nurses trained on CBHI who work on OPD/IPD?			
A4	Are there Pharmacist trained on CBHI in the institution?			
A5	Are there laboratories trained on CBHI in the institution?			
A6	Is there with Waiting area in the institution?			
A7	Are there Separated OPD rooms in the institution?			
A8	Are there Separated IPD rooms in the institution?			
A9	Are there separated under 5 OPD room in the institution?			
A10	Are there Laboratory services in the institution?			
A11	Are there Essential (tracers) drugs in the institution?			
A12	Is there Pipe water in the health institution?			
A13	Is there electricity power in the institution?			
A14	Is there functional health care financial?			
A15	If yes A14, Are there active management committee?			
A16	Are there reporting forms of previous quarterly?			
A17	Are there CBHI members referral form to hospital for HC			

B. Checklist for observation of IPD/OPD department

Table 2: Observation checklist for Documents and records review checklist generally for IPD and OPD department for evaluation of implementation of CBHI in limu kossa District, 2015

		yes	No	YES it's Quantity
B1	Are there enough beds in admission room?			
B2	Are admission rooms are clean?			
B3	Are there IV standards in admission rooms?			
B4	Are there antiseptic agents in OPD and emergency OPD rooms?			
B5	Are there forceps and scissors in OPD rooms?			
B6	Is cotton in emergency in OPD rooms?			
B7	Is there goose in emergency OPD rooms?			
B8	Are there disposal glove in emergency OPD rooms?			
B9	Are there surgical glove in emergency OPD rooms?			
B10	Is there lido cane in emergency OPD rooms?			
B11	Are there safety boxes in OPD rooms?			
12	Are there MUACs in fewer than 5 OPD rooms?			
B13	Is there pamphlet in fewer than 5 OPD rooms?			
B14	Is there plan B under 5 OPD rooms			
B15	Are there functional adult Weight scales in OPD?			
B16	Are there functional BP apparatus in OPD rooms?			
B17	Are there functional stethoscopes in OPD rooms?			
B18	Are there functional child Weight scales in OPD rooms?			
B19	Are there Examination Coaches in OPD rooms?			

C. Checklist for observation of pharmacy department

Table 3: observation Checklist Documents and records review checklist for pharmacy department for evaluation of implementation of CBHI in limu kossa District, 2015

	Essential drugs	yes	No	YES it's Quantity
C1	Are there amoxicillin 500mg 0r 250 mg capsule in pharmacy/store?			
C2	Is there amoxicillin 250mg/5ml or125mg/5ml syrup in pharmacy/store?			
C3	Are there amphicilin500mg or 250 capsules in pharmacy/store?			
C4	Is there amphicilin125mg/5ml or 250mg/5ml syrup in pharmacy/store?			
C5	Are there cotrimozathole480 or 960 mg tablet in pharmacy/store?			
C6	Is there cotrimozathole 240mg/5ml syrup in pharmacy/store?			
C7	Are there 500mg or 250mg ciproflaxin in pharmacy/store?			
C8	Are there metrodazole 500mg or 250mg capsule in pharmacy/store?			
C9	Are there metrodazole 250mg/5ml or 125mg/5ml syrup in pharmacy/store?			
C10	Are there mebendazole or albendazole tablet in pharmacy/store?			
C11	Is there third generation anti biotic like ceftrizone in pharmacy/store?			
C12	Are the ant pain drugs tablet (parasitamol or ibuprofen or indometacin or diclfena) in pharmacy/store?			
C13	Are there anti pain injection (diclofena or dipron) in pharmacy/store?			
C14	Are there cloxacilin 500mg or 250mg capsule in pharmacy/store?			
C15	Are there cloxacilin 250mg/5ml or 125mg/5ml syrup in pharmacy/store?			
C16	Is there gentamacin injection in pharmacy/store?			
C17	Is there pensilin or benzatine injection in pharmacy/store?			
C18	Is there dermatology cream in pharmacy/store?			
C19	Are there iron sulphates tablet in pharmacy/store?			
C20	Are the anti acid syrups or omeprazole tablet in pharmacy/store?			
C21	Are the ORS sachets in pharmacy/store?			
C22	Are there Normal saline for Iv fluid in pharmacy/store?			
C23	Are there a coartem in pharmacy/store?			

D. Checklist for observation of Laboratory department

Table 4: observation Checklist for Documents and records review checklist for Laboratory department for evaluation of implementation of CBHI in limu kossa District, 2015

	Essential laboratory services and equipment	yes	No	YES it's Quantity
D1	Are there functional microscopes in the laboratory?			
D2	Are there microscopic slides in the laboratory?			
D3	Is here hemoglobin centrifugal machine in the laboratory?			
D4	Is there Stool examination service in the laboratory?			
D5	Are there urine analysis services in the laboratory?			
D6	Are there AFB services in the laboratory?			
D7	Is there H pyloric test services in the laboratory?			
D8	Is there RH test in the laboratory?			
D9	Is there HCG test in the laboratory?			
D10	Is there hemoglobin test service in the laboratory?			
D11	Is there VDRL test service in the laboratory?			
D12	Is there X ray test for hospital in the laboratory?			
D13	Are there ultrasound services for hospital in the laboratory?			
D14	Is there HIV test in the laboratory?			
D15	Is there essential reagent in the laboratory?			

Part 2: document and record review

F. Checklist for documents and records review on CBHI service

Name of health institution _____

Table 5: Documents and records review checklist on review on CBHI service given from may 2014 to may2015

S/N	Activities and services	plan	Achieved		Remark
			No	%	
E1	# Active members in CBHI schemes in institution catchment?				
E2	# Birr reimbursed by scheme for health institution?				
E3	# Members get OPD services in health institution?				
E4	# Members get IPD services in health institution?				
E5	# Members get laboratory services by the health institution?				
E6	# Members get referral to hospital in health institution?				
E7	# Members get surgery services in hospital?				
E8	# Birr generated by the institution?				
E9	# Birr utilized by the institution?				
E10	# of health institution sends report on time?				
E11	# HF gets payment on time by scheme?				
E12	# Review meeting conducted with HF on CBHI?				
E13	# Review meeting conducted with community on CBHI?				
E14	# Community mobilization conducted with community on CBHI?				
E15	# of supportive supervision conducted by district CBHI office?				
E16	# Members referral to private pharmacy for drugs from institution?				

Part 3: Exit interview

F. Exit interview questions for members of CBHI

Name of health institution _____

F1. Age of members_____

F2. Sex 1 Male 2 Female

F3. Educational status: *1.Illiterate 2 Read and write only*

3. Elementary (grade 7&8) 4.Secondary and above (above 9th)

F4. What is your work or occupation? *1. Farmers 2.Mixed crop and animal producer*

3. Small merchandant 4. Daily laborer

*5. Other, specify*_____

F5. Place of residence 1 Urban 2 Rural

F6. Religion 1.Muslim 2.Orthodox 3.Protestant 4.Catholic

F7. Ethnicity 1.Oromoo 2.Amara 3.Dawuro 4.Walayita 5.Tigre 6.Other specify_____

F8. Numbers members of your HH: 1.two-four 2.four -six 3. Six -eight 4.more than eight

F9.When the first time your HH become the members of the insurance?

1. 2011 2. 2012 3. 2013 4.2014 5.2015

F10. How you/your family become the members of the schemes?

1. Knowing the advantage of the schemes 2.By only kebele influence

3. We know the advantage of the insurance after starting using insurance 4. To get better health service 5. To reduce OOP payments

F11. How far is your home from health center? (In minutes)?

1. Less than 30min 2.30-60min 3.60-120min 4.120-180min 5. Greater than 180 min

F12. How much time do you spend waiting area to get health services?

1. Less than 30 min 2. 30min -60min 3. 60 min -90min 4.90min - 150min 5. Greater than 150min

F13. Are health providers available at work place time? 1. Yes 2. No

F14. If No for question F13 why the health provider not available

1. Shortage of health provider in this institution 2. Health provider not available on work place or absents 3. Health providers are on meeting or training 4. Health providers want to kebele for supportive supervision 5. I don't know

F15. Is health provider assessing your problems (including physical examination)?

1. Yes 2. No

F15.Is health provider explanation about health services has provided for you?

1. Yes 2. No

F16. Are you getting laboratory services?

1. Yes 2. No

F17. If No for question F16 why did not you get

1. Laboratory services was not needed for my illness 2.there is no laboratory health providers

3. No laboratory services in the institution 4.i don’t know it's the reason

F18.Are you get all prescribed drugs in this institution

1. Yes 2. No

F19.If no for F18 why you did not get all prescribed drugs in this institution?

1. There are no enough drugs 2. Many drugs stock out 3.private pharmacy have more drugs than this institution 4.the dispenser room was closed 5. Don't know

F20.Are you plan to renew your insurance members ID in the next year

1. Yes 2.no

F21.If no for F20 why you will not renew your insurance members ID in the next year

1. Lack of money 2. I don't happy to health service that provided by health institution

3. The health institution don't have essential drugs 4.I did not get laboratory services 5. If other specify_____

G. Satisfaction related information

In these parts of questions we interested to know your level of satisfaction in health care service

Please indicate your level of satisfaction with each of the following characteristics.

Table 6: Satisfaction questions for members of the insurance for evaluation implementation of CBHI in limu Kossa District, 2015

S/n	Measurements	Very dis Satisfied (1)	Dis satisfied (2)	Un Decided (3)	Satisfied (4)	Very Satisfied (5)
G1	How much you satisfied on medical record service	1	2	3	4	5
G2	How much you satisfied on availability of Health worker on time	1	2	3	4	5
G3	How much you satisfied on time spend on waiting	1	2	3	4	5
G4	How much you satisfied on politeness of health workers	1	2	3	4	5
G5	How much you satisfied on health worker experience	1	2	3	4	5
G6	How much you satisfied on assessing health problem	1	2	3	4	5
G7	How much you satisfied on counseling on health problem	1	2	3	4	5
G8	How much you satisfied on laboratory services	1	2	3	4	5
G9	How much you satisfied on counseling on drugs taking	1	2	3	4	5
G10	How much you satisfied on overall health services provided	1	2	3	4	5

G11.Are there problem related on the implementation of CBHI? If yes what are this problem?

What is the solution for the problem?

_____
_____
_____
_____
_____
_____
_____

G12.Do you have any other comments that you would like to share?

_____

Data collector name: _____Signature_____ Date__/__/__

Supervisor name: _____Signature_____ Date_

KUTAA 3

Gaaffii Heeyyamaa Kan misensa Insurance fayyaa hawaasa

Ashamaa? Maqaan koo _____ jedhama.Ani garee Qorannoo Insurance fayyaa hawaasa kessaa tokkoodha. Qorannoon kun University Jimmaatti waliin tahuun kan gaggeefamudha.Kaayyoon qorannoo kanaas haala hojii irra oolmaa Insurance fayyaa hawaasa qorachuun sadarkaa hojii irra oolmaa isaa murteessssuu,ciminaa fi hir'ina jiruu addaa baasuudhaan foyyaa'insa sagantaa kanaf gumaachaa gochuu akkasumas bu'aan qorrannoo kana tarsiimoo insuransii fayyaa hawaasa gara fulduratiif diriirsuuf fayyadu kan dandahuu dha.

Odeeffannoon isiin gaafadhu haala tajajiila fi ittigammadinsa Insurance fayyaa hawaasa isiin argataan faana kan wal qabaatuu yoo tahuu odeeffannoon nuti isin irraa argannu kun isin dabalatee hawaasa naannoo keessan jiraniif baay'ee kan fayyaaduu dandahuudha. Odeeffannoon kun iccitiin kan qabamuudha. yeroo keessan xinnoo fudhachuu yoo ta'e malee odeeffanno kana waan kennitaniif wanti isin miidhamtan hin jiru.Gaaffii fi deebiin kana irratti Hirmaachuu fi diduu irratti mirga guutuu qabdu ykn gidduutti addaan kutuu ni dandeessu.Haala fedhii keessan isaa armaan gadii keessa tokkoo filaadha.

1. Eeyyamamaa dha 2. Eeyyamamaa miti

Maqaa ragaa funaanee_____ mallattoo_____ guyyaa_____

Maqaa superviyiizeraa _____mallattoo_____ guyyaa_____

F.Formii Oddoffannoon waligalaa kan Miseensa Inshuuransii Fayyaa Hawaasa

Maqaa Dhaabbataa Fayyaa_____

S/N	**Oddoffannoon waligalaa**	
F1	Umurii_____	
F2	Saala: 1 Dhiiraa 2 Dhalaa	
F3	Sadarkaa barnootaa: 1.Gonkumayyuu hin baranne 2. dubbisu fi barreessuu qofa 3.sadarkaa tokkooffa 4. sadarkaa lammaffaa fi isaa oli	
F4	Maal hojjeettuu ykn maal hojjeetani jiraatu? *1*.Qotee bulaa 2.Qotee bulaa fi horsiisee bulaa 3. Daldaalaa 4. Hojjeetaa humnaa 5. Kan biroo yoo tahee ibsi_____	
F5	Bakka jireenya keessaan eessaa? 1. magaalaa 2. Baadiyyaa	
F6	Amantaan isiin hordooftaan maalii ? 1.Musliima 2.Ortoodoksii 3.Prootestaantii 4.katoolikii 5. waaqeeffataa	
F7	Sabni keessaan kami ? 1.Oromoo 2.Amaaraa 3.Daawuuroo 4.Waalayitaa 5.Tigiree 6.Kan biroo _____	
F8	Baayinni miseensa maatii keessani meeqa ? 1.lama hang afurii 2.Afurii hanga jahaa 3. jahaa hanga saddeetii 4.sadeetii ol	
F9	Yoomii maatiin keee yeroo jalqabaaf miseensa insuransii kan tahee ? 1. 2004 2. 2005 3. 2006 4.2007	

F10	Haala kamiin maatii kee kan miseensa insuraansii fayyaa hawaasa tahaan ? 1. Bu'aa insuuransii waan beeknuuf 2.Caaliseen dhibbaa gandaatiin qofa 3. Erga miseensa tanee bu'aa isaa barreen booda haroomsine 4.Tajaajila fayyaa gaarii argachuuf 5.Qarshii yaalaa kiisii keessaa bahuu hambisuuf	
F11	Mana keessani kaataani hanga dhabatta fayyaa kana gahuuf daaqiqaaa meeqaa isiinitii fudhaataa ? 1.Daqiiqaa 30 gadi 2. Daqiiqaa 30-60 3. Daqiiqaa 60-120 4. Daqiiqaa 120-180 5. Daqiiqaa 180 fi isaa ol	
F12	Ogeessaa fayyaa arguuf ykn dabareen keessaan isiin gahuuf daaqiqaa meeqaa eegdaan ? 1.Daqiiqaa 30 gadi 2. Daqiiqaa 30 -60 gidduu 3. Daqiiqaa 60 -90gidduu 4. Daqiiqaa 90- 150 gidduu 5. Daqiiqaa 150 ol	
F13	Ogeessa fayyaa iddoo hojii isaatti yeroon argatanittuu ? 1. Eeyyeen 2.Lakkii	Eeyyeen => F15
F14	Gaaffii F13 yoo lakkii tahee maaliif? 1.Hir'ina ogeessaa fayyaa jira 2.Ogeessi fayyaa yeroon sa'a hojiitii hin argamne fi kan hafan 3. Ogeessi fayyaa walgahii ykn leenjii irra jiru 4. Ogeessi fayyaa ganda deeggaruuf deemu 5. Ani hin beekuu	
F15	Ogeessii fayyaa rakkoo kee sirritti sii gaafatee sii yaaleeraa? 1. Eeyyeen 2.Lakkii	Eeyyeen => F17

F16	Jajaajilli qorannoo labooratorii siif godhameeraa jira? 1. Eeyyeen 2.Lakkii	
F17	Gaaffii F16 lakkii yoo tahee maaliif? 1.Tajaajili labooratorii dhibee kootiif waan hin barbaachifneef 2.Ogeessii labooratorii waan hin jireef 3.Tajaajili labooratorii waan hin jireef 4. sababa isaa hin beekuu 5. kan biroo yoo tahee ibsi_____	
F18	Qorichaa siif ajaajame hundaa isaa dhaabatta fayyaa kana keessa argatettaa? 1. Eeyyeen 2.Lakkii	Eeyyeen => F19
F19	Gaaffii F18 lakkii yoo tahee maaliif ? 1. Dhabbataa fayyaa kun qorichaa gahaa waan hin qabneef 2. Qorichaa dafee waan dhumufi 3.Dhaabbataa fayyaa kana irraa mana qoricha dhuunfa qoricha waan qabuf 4.Mani qorichaa cufaa waan taheef 5. kan biroo yoo tahee ibsi_____	
F20	Isiin maatiin keessaa bara dhuftuuti waraqaa miseensumma insuuransi fayyaa hawaasa haroomsisuuf fedhii qabdu? 1. Eeyyeen 2.Lakkii	
F21	Lakki yoo tahee gaaffii F20 maaliif? 1.Qarshii miseensummaaf kafaluu waan hin qabneef 2. Dhabbataa fayyaan jajajila fayyaa gahaa miseensaf waan hin kennineefi 3. Dhabbataa fayyaan keessa qorichaa gahaa waan hin arganneef 4. Dhabbataa fayyaan tajaajila labooratorii gahaa waan hin arganneef 5. kan biroo yoo tahee ibsi_____	

G. Haala itti quufinsa miseensoota tajaajila insuransi fayyaa hawaasa.

Haala itti quufinsa isiin jajaajila inshuuransii fayyaa hawaasaaf qabdan waan beekuu barbaanneef jajiila armaan gadii kana irratti sadarkaa itti quufinsa kee murteessi.**Baayyee itti hin quufne** ykn **Itti hin quufne** ykn **Murteessuu hin dandeenye** ykn **Ittiquuferaa** ykn **Baayyee itti quufeeraa** jedhii tokko filaadhu

S/N	Gaaffillee	Baayyee itti hin quufne	Itti hin quufne	Murteessuu hin dandenye	Ittiquuferaa	Baayyee itti quufeeraa
G1	Ittiquufinsi isiin tajaajila mana kaardii irratti qabdaan hammami?	1	2	3	4	5
G2	Ittiquufinsi isiin ogeessaa yeroon iddoo hojii irratti argachuu kee irratt qabdaan hammami?	1	2	3	4	5
G3	Ittiquufinsi isiin yaalii argachuuf sa'atii isiiniti fudhaate irratti qabdaan hammami?	1	2	3	4	5
G4	Ittiquufinsi isiin haala isiin siimachuu fi isiin kabajuu ogeessaa fayyaa irrattin qabdaan hammami?	1	2	3	4	5
G5	Ittiquufinsi isiin haala fi afaan ifaa taheen dubatee sii yaalee irrattin qabdaan hammami?	1	2	3	4	5
G6	Ittiquufinsi isiin ibsa oggessii fayyaa qorrannoo isiinif godhee rakkoo keessaan addaa baasuuf irratt qabdaan hammami?	1	2	3	4	5
G7	Ittiquufinsi isiin qoricha isiin haalli ogeessi fayyaa rakko irratti gorsaa siif kennee irraatti qabdaan hammami?	1	2	3	4	5
G8	Ittiquufinsi isiin qoricha barbaachisaa dhabbataa fayyaa kana irra argatan irraatti qabdaan hammami?	1	2	3	4	5
G9	Ittiquufinsi isiin jajajila labooratorii jiraachuu irratti isiin qabdan hammami?	1	2	3	4	5
G10	Ittiquufinsi isiin haala walgala yaala fayyaa siif kenname irratti qabdan hammam?	1	2	3	4	5

G13. Rakkoon fi furmaata isaa insuuransi fayyaa hawaasa qabu jettee yaadduu yoo jiraatee maalii dha?

_____
_____
_____

Part 4

H. In-depth interview for health professional and manager

Name of Health institution_____

Number of workers that work in the unit _____

H1. Is there trained health worker on CBHI in this institution? If not, why?

_____
_____
_____

H2. Describe the adequacy of health workers in this institution?

_____
_____
_____

H3. Are there adequate medical supplies and equipment to implement the insurance? If not, why?

_____
_____
_____

H4.Are there essential drugs in this health institution? If not, why?

_____
_____
_____

H5. Are there enough laboratory services in this health institution? If not, why?

_____
_____
_____

H6. Are the numbers of members of CBHI come for services come increasing ? If not, why?

_____
_____
_____

H7. Have you attend on monthly/quarter meeting on CBHI and to share lessons learned? If not, why?

_____
_____
_____

H8. Are members of the scheme get essential health services when come to health institution? If not why

_____
_____
_____

H9. What are the general problems or factors related to CBHI? What is the likelihood?

Solutions?

_____
_____
_____

H10. Do you have any other comments that you would like to share?

_____
_____
_____

Data collector name: _____Signature_____ Date__/__/__

Supervisor name: _____Signature_____ Date__/__/__

J.Data collection tools used at district CBHI offices

Table 7: Documents and records review checklist for evaluation of the implementation of CBHI in limu kossa district from March 2014 to March 2015

S/N	Activities and services	plan	Achieved		Remark
			No	%	
J1	# new members updates their CBHI card				
J2	# members do not updates their CBHI card				
J3	# Active members in CBHI schemes in the district				
J4	# birr contributed by members in the district				
J5	# members get OPD services in the district				
J6	# members get IPD services in the district				
J7	# members get laboratory services in the district				
J8	# members get referral to hospital in the district				
J8	# members get surgery services in hospital in the district				
J9	# birr paid for health institution by scheme				
J10	# average cost by health institution to members				
J11	Proportion of birr health institution get from CBHI scheme payment				
J12	# HF send report on time				
J13	# HF get payment on time by scheme				
J15	# review meeting conducted with HF on CBHI				
J16	# review meeting conducted with community on CBHI				
J17	# community mobilization conducted with community on CBHI				
J18	# of supportive supervision conducted				
J19	Amount of birr the district office have cash birr				

Data collector name: _____Signature_____ Date__/__/__

Supervisor name: _____Signature_____ Date__/__/__

K .Interview guide for CBHI office staff

Number of workers that work in the CBHI office _____

K1. Is there trained health worker on CBHI in CBHI office? If not, why?

_____

_____

_____

K2. Describe the adequacy of health workers involved in implementation of CBHI service in CBHI office and health facilities

_____

_____

_____

K3. Are adequate medical supplies and equipment to implement the insurance? If not, why?

_____

_____

_____

K4.Are there adequate drugs in the institution to provide health services to members? If not why

_____

_____

_____

K5. Are there essential laboratories in health institution services for members? If not, why?

_____

_____

_____

K6.Are conducts community mobilization to increase the numbers of members? If not why?

_____

_____

_____

K7. Are the numbers of members of CBHI increasing in the district? If not, why?

_____

_____

_____

K8. Have you monthly meeting with zonal CBHI on CBHI and to share lessons learned? If not,

Why?_____

_____

_____

K9. Have you monthly meeting with HF on CBHI and to share lessons learned? If not,

Why?

_____

_____

_____

K10. Are members of the scheme get essential health services when come to health institution? If not why

_____

_____

_____

K11.Do you have enough budgets to pay for HF? If not why?

_____

_____

_____

K12. What are the general problems or factors related to CBHI? What is the likelihood?

Solutions?

_____

_____

_____

K13.are you have idea on implementation of CBHI in the limu kossa district

_____

_____

_____

Data collector name: _____Signature_____ Date__/__/_

Supervisor name: _____Signature_____ Date__/__/__

Table of judgmental metrics of availability dimension in implementation evaluation of CBHI in Limu kossa district,2015

Evaluation Question	Indicators	Data Source	Data Collection Methods	Expected	Observed	weight	results	
Is there the required resource to implement CBHI? If not why?	Number of HI with that had at least one trained provider on the schemes	HC/H	In-depth interview	7		3		*: > 25 Very Good Implemented, 20 – 25 % Good implemented, 15– 20 partially implemented, 10-15 % poorly implemented and < 10 not implement*
	Number of HI with CBHI guidelines	HC/Ho	Observation and document review	7		2		
	Number of HI with members registration book	HC/Ho	Observation and document review	7		1		
	Number of HI with Waiting area for clients	HC/Ho	Observation and document review	7		1		
	Number of HI with Separated adult and under 5 OPD room	HC/H	Observation and document review	7		2		
	Number of Hi with admission room for severe ill insured patients	HC/Hos	Observation and document review	7		2		
	Number of HI with essential diagnostic equipment	HC/Ho	Observation and document review	7		3		
	Number of HI with essential laboratory services	HC/Ho	Observation and document review	7		3		
	Number of HI essential(tracer drugs) in HI	HC/Ho	Observation and document review	7		3		
	Number of HI with pipe water	HC/Ho	Observation and document review	7		2		
	Number of HI with functional latrine	HC/Ho	Observation and document review	7		2		
	Number of HI with electricity	HC/Ho	Observation and document review	7		3		
	Number of HI active health care finance	HC/Ho	Observation and document review	7		3		
	Over all Availability Dimension			100		30		

Table of judgments matrices' of compliance dimension in implementation evaluation of CBHI in Limu Kossa district.2015

Evaluation Question	Indicators	Data Source	Data Collection Methods	Expected	Observed	weight	result	
Is CBHI has been implemented according to National CBHI guideline ?	Number HI got supportive supervision from district scheme office in previous six months	Document	Document review			2		*≥ 35 Very Good Implemented, 30 – 35 % Good implemented, 25– 30 partially implemented, 20-25 % poorly implemented and < 20 not implemented*
	Number review meeting conducted with HI and kebele leaders	Document	Document review			2		
	Number community mobilization session conducted	Records	Records review			2		
	Number HI sent report on time for scheme	Records	Records review			2		
	Total birr contributed by members (premium contributed)	Records	Records review			3		
	Total general subsided birr by government	Records	Records review			3		
	Total target subsided birr	Records	Records review			3		
	Total reimbursed birr for HI	Document	Document review			3		
	Proportion of members who got OPD services	Document	Document review			3		
	Proportion of members who got laboratory services	Document	Document review			3		
	Proportion of members who got drugs from private pharmacy	Document	Document review			3		
	Proportion of members who got admission services	Document	Document review			3		
	Proportion of members who were referred to hospital	Document	Document review			3		
	Proportion of members who were who got surgery services	Document	Document review			3		
	Number of HI got payment (reimbursement) on time	Document	Document review			2		
	Over all compliance Dimension					40		

Table 8: Table of judgment matrices for acceptability /members satisfaction dimension evaluation of CBHI scheme in limu kossa district 2015

Evaluation Question	Indicators	Data Source	Data Collection Methods	Expected	Observed	weight	results	Judgment Level
Are members of the scheme satisfied ? If not why?	Enrolment rate	Document	Document review			3		*: ≥ 25 Very Good Implemented, 20 – 25 % Good implemented, 15– 20 partially implemented, 10-15 % poorly implemented and < 10 not implement*
	Membership growth rate	Document	Document review			3		
	Renewal rate	Document	Document review			2		
	Drop rate	Document	Document review			2		
	Proportion of members satisfied on medical record service	Members	Exit interview			2		
	Proportion of members satisfied on availability of health worker on time	Members	Exit interview			2		
	Proportion of members satisfied on time spend on waiting	Members	Exit interview			2		
	Proportion of members satisfied on politeness of health workers	Members	Exit interview			2		
	Proportion of members satisfied on clarity of health worker communication	Members	Exit interview			2		
	Proportion of members satisfied on the way assessing health problem	Members	Exit interview			2		
	Proportion of members satisfied on counseling on health problem	Members	Exit interview			2		
	Proportion of members satisfied on laboratory services	Members	Exit interview			2		
	Proportion of members satisfied on getting drugs from HI	Members	Exit interview			2		
	Proportion of members satisfied on overall health services provided	Members	Exit interview			2		
	Over all accommodation/members satisfaction dimension					30		

Table of pre set judgments parameters for evaluation of CBHI in Limu Kossa District,2015

Dimension	Indicators Numbers	Value Given (X)	Value Achieved (Y)	Percentage Achieved	Quality judgment Criteria
Availability	14	30		Y/X*100	
Compliance	15	40		Y/X*100	
Accommodation/ Member satisfaction	14	30		Y/X*100	
Over Implementation				Y/X*100	≥85% *Very Good* Implemented 75-85 *Good Implemented* 60- 75% Partially Implemented 50 - 60 Poorly Implemented < 50 % Not Implemented

WORK PLAN AND BUDGET

Table 9: Work plan of the evaluation of CBHI in Limu Kossa, 2015

Activities	Responsible body	Time period																							
		January				February				March				April				may				June			
		week				Week				Week				Week				week				Week			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
EA	P. Evaluator																								
Evaluation plan development	P. Evaluator																								
Submission of first draft Evaluation plan	P. Evaluator																								
Comment incorporation	P. Evaluator																								
Proposal defense	P. Evaluator																								
Incorporating comments from the defense and advisors	P. Evaluator																								
Submission of proposal to the department	P. Evaluator																								
Ethical clearance and securing budget	P. Evaluator																								
Recruit and train data collectors & supervisors	P. Evaluator																								
Pretest and tool modification	P. Evaluator																								
Actual data collection	P. Evaluator																								
Data analysis and report writing	P. Evaluator																								
Submission of 1st draft thesis to advisors	P. Evaluator																								
Receiving comment/feedback from advisors	P. Evaluator																								
Submission of 2nd draft thesis to advisors	P. Evaluator																								
Receiving comment/feedback on 2nd draft from advisors	P. Evaluator																								
Mock defense	P. Evaluator																								
Incorporating comment from mock defense	P. Evaluator																								
Submission of thesis to the department	P. Evaluator																								
Final defense																									

Budget Break Down

Table 10: Budget breakdown of the evaluation of CBHI of Limu Kossa district, 2015

Personal cost						
S/N	**Categories**	**Unit**	**No. of participants**	**Per diem**	**No. of day**	**T.Cost**
1	Data collectors	No.	4	123	12	5904
2	Supervisors	No.	2	147	12	3528
	Total					**9432**

Stationery Cost					
S/N	**Item list**	**Unit**	**Quantities required**	**Unit price**	**Total prices**
1	Computer paper	pack	1	190	190
3	Eraser	piece	10	1	10
4	Pencil	piece	10	1	10
5	Pen	piece	10	4	40
6	Marker	pack	3	10	30
Total Cost					**280**

Transport cost		
1	Fuel for motor cycles	200
2	Public transport	88
	Total cost	**288**
	GRAND COST	**10,000 ETB**

DECLARATION

I, the undersigned, declare that this thesis is my original work, has not been presented for a degree in this or any other university and that all sources of materials used for the thesis have been fully acknowledged.

Name: _____

Signature: _____

Name of the institution: _____

Date of submission: _____

This thesis has been submitted for examination with my approval as university advisor

Name and Signature of the first advisor

_____

_____

Name and Signature of the second advisor

_____

_____

Name and signature of third advisor

_____

_____

Name and signature of Internal Examiner for approval

_____

_____

Date_____

Name of department head _____

Signature_____

Date_____