Process Evaluation of Community Based Health Insurance Program in Damboya Woreda, KembataTembaro Zone, Southern Nations, Nationalities peoples' Region.

Evaluation Thesis to be submitted to Jimma University, Institute of Health, Public Health Faculty, Department of Health Policy and Management, Health Monitoring and Evaluation Unit for Partial Fulfillment of the Requirements for the Degree of Master of Science in Health Monitoring and Evaluation.

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Abstract

Background: In the developing countries, ensuring health service equity is difficult.The limited government capacity to cover health care costs and high out-of-pocket expenditure made it challenging. Eventhough cost of avoiding health service inequity is high, it is compulsory to assure health care equity for all; for health is fundamental human right. As a result, Ethiopian government endorsed Community Based Health Insurance Strategy in 2008. Nation wide, its implementation was piloted in 13 Woredas' in 2011; the study area was one of piloted Woredas'; i.e. it is capable to generate adequate evidence for the evaluation. Even if it has been implemented yet, to my best knowledge its implementation process is unknown.

Objective: To assess the process of community based health insurance program implementation in Damboya Woreda, Kembata Tembaro Zone, South Nations Nationalities peoples' Region.

Methods: A single case study design with mixed data collection methods was employed from March 16 to May 16/2020 with availability, compliance and satisfaction as an evaluation dimensions. A total of 610 households survey via multi-stage sampling and 16 key informant interviews were conducted by using structured questionnaire and Key informat interview guide respectively. Also a resource inventory and relevant documents of the program were reviewed by using standard checklists. Finally, quantitative data were entered into Epidata 3.1 and analyzed by SPSS 25. Logistics regression was used to identify factors associated with member satisfaction. Qualitative data were transcribed, translated, coded, and categorized into families by using ATLAsi.ti.7.1.4.; finally analyzed under five themes.

Results: The resources availability for program implementation, program activities compliance with regional standards and house holds satisfaction towards the scheme scores were 85 %, 62 % and 56% respectively; where educational level, getting laboratory service, explaining the service being provided, assessing the health problem, distance from the contacted health facility and need for service provision improvement were major barriers for program implementation.

Conclusion: The overall implementation level of the program was 67%; which is partial as per judgement parameter.The due concern by scheme for improving activities like: clinical audit, reimbursing, supportive supervision and feedbacks provision as well availing service registers.

Keywords: Process Evaluation, Community Based Health Insurance in Damboya woreda

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Abbreviations

UHC	Universal Health Coverage
OOPE	Out Of Pocket Expenditure
SHI	Social Health Insurance
OOP	Out of Pocket
EHIA	Ethiopian Health Insurance Agency
HI	Health Insurance
SNNPR	Southern Nations, Nationalities and People Region
KT	KembataTembaro
HAD	Health Development Army
SSA	Sub-Saharan Africa
HC	Health Center
HH	House Hold
HMIS	Health Management Information System
WorHO	Woreda Health Office
AOR	Ajusted Odds Ratio
CI	Confidence Interval
KII	Key Informant Interview
HP	Health Post
HEWs	Health Extension Workers
M and E	Monitoring and Evaluation
SARA	Service Availability and Readiness Assessment
PCA	Principal Component Analysis
SS	Supportive Supervision

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Operational Definitions

Active Members: Those households who can use the health services as members of CBHI scheme during the study period; i.e that members with updated ID cards to use health care whenever they need it.

Compliance: Means that when the activities mentioned under compliance dimension done according to the regional guidelines of the Community Based Health Insurance. Its levelling is as mentioned in the judgement parameter.

Financial hardship: To say health care cost is possing financial hardship, when direct health care related cost exceeds more than 10% to 25% of their daily food consumption. Also can be said as catastrophic effect.The daily food consumption estimate can be obtained by aggregating food expenditure for a given period of time.

HH's satisfaction: When the HH's satisfaction score is above or equal to the mean of the satisfaction measure.

Resource Availability: mean that the availability of resources required for the CBHI program implementation as per the regional program implementation guideline. Its levelling is as mentioned in the judgement parameter.

Standard judgment: Is quantitative as well as qualitative measure pre-determined by key program stakeholders with cut-off points that specifies what is good or less, failure or success, good implementation or poor implementation concerning the program worthiness.

Functionality of governing body: In this study governing bodies is general assembly and CBHI board; functionality means that the regular meeting (once a year for general assembly and four times a year for CBHI board), reviewing plans and performances and timely feedback provision.

Premium Collection: It includes: collection of registration fee and permium from HHs, targeted and general subsidy from government).

Benefit packages: All the services that the CBHI members are entitled to get in the scheme contracted health facilities without any additional cost except excluded services. These are

outpatient and inpatient (drugs,diagnostic services or laboratory tests, physical examinations and history taking, surgery and councelling)including referral service.

Indirect Family member: The family members living in the house hold but not had birth there and need additional payment whenever that HH become CBHI member**.**

Knowledge of CBHI: Those who respond four and more from seven points taken as having good knowledge of CBHI while those were reponding less than four from the seven points of knowledge measurement taken as poor knowledge on CBHI.

CBHI job aids: The CBHI program implementation guidelines, recording and reporting materials all together. When atleast one guideline and standard reporting available at the time of data collection in each of health centers.

Scheme staff: Scheme staff mean that those working in CBHI scheme office; it is three in number(one coordinator, one HIT and one accountant) as regional program guideline recommendation.

Trained provider: One who had training on CBHI program implementation; where all scheme staffs expected to be trained and atleast one trained provider in each of the health facilities.

Recommended number of health professionals: the number of health professionals with different professional mix recommended to urban and rural health centers by Ethiopian Standard Agency which is 19.

Recommended number of supportive staffs: the number of supportive staffs with different professional mix recommended to urban and rural health centers by Ethiopian Standard Agency which is 13.

Community Mobilization: when community mobilization is done in the form of community forum in the health facilities quarterly; where issues related to the CBHI program implementation raised and written on the minutes logbook. It is led by the woreda administrative head mainly.

Suportive supervision: It is one of CBHI program monitoring activities and when done quarterly by scheme using checklist and followed by feedbacks.

Clinical audit: It is one of health service quality monitoring activities and when done quarterly by scheme using checklist after reimbursing 75% of health care cost and before reimbursing the remaining 25% and followed by feedbacks.

Scheme waiting time: for members being enrolled in the scheme newly, expected to wait one month before using health care covered by the scheme where pre-requisites like: ID card is prepared.

Availability of tracer's drugs: When drug items recommended by HMIS are available in HCs during study period; tracer drugs include 25 drugs which are reported in the HMIS of hospitals and health centers. Weight for each tracer drug item was given by stakeholders and its availability was judged as per judgment parameter.

Availability of essential laboratory tests: Here a list of 10 laboratory tests which is included in inventory checklist as recommended by the Ethiopian Standard Agency available in HCs during the study period. Weight for each test was given by stakeholders and its availability was judged as per judgment parameter.

Availability of essential diagnostic equipment: When the list of 15 equipments which are included in resource inventory checklist are available in HCs during resource inventory. Weight for each equipment was given by stakeholders and its availability was judged as per judgment parameter.

Chapter-1: Introduction

1.1. Background

World Health Organization (WHO) defined: Universal Health Coverage(UHC) referred to ensuring access to needed health promotive, preventive, curative and rehabilitative services to all people with a sufficient quality and in a way that protects users from financial hardships(1). This is why because health is fundamental human right stated under Article 25 of the Universal Declaration of Human Rights (1948) and the Health for All agenda set by the 1978 Alma-Ata Declaration. The UHC is WHO's calling on the developing countries in order to avoid health service access inequities (2).

Risk Pooling is the health system function, whereby collected health revenues are transferred to purchasing organizations. Its main purpose is to share the financial risk associated with health interventions for which there is uncertain need(3). This entitles members to receive health services so as increases the service utilization and make it accessible(4).Now a days, there are different health care financial risk pooling mechanisms; these includes: Government revenues, National Insurance Systems, Social Health Insurance Systems, Community Based Insurance systems and Private Health Insurance(3).

In developed countries, risk pooling mechanism relies on top-down approach, i.e. that tax and Social Health Insurance(SHI) based(5). Unlikely, due to the limited ability of public health systems in developing countries to provide adequate access to health care and the shortcoming of informal coping strategies to provide financial protection against health shocks, different bottom-up approaches,i.e.that a large number of community based health financing schemes have been established in several low and middle income countries (6). Community Based Health Insurance (CBHI) is a non-profit emerging noticeable and encouraging concept of health care financing by pooling prepaid collective funds as per a pledge agreement that the health insurer to cover basic health service costs so as increases access to quality modern primary health care services to poor rural community and informal sector in the developing countries (7–11). It is an initiative built upon the ideologies of social unity and designed to provide financial protection against the health related poverty due to direct out of pocket health spending for households who are not included in formal sector (12,13).CBHI is among solutions designed in least developed countries since 1990s

to improve health care service utilization through sharing the financial burden of cost of illness. The community based health insurance becomes new findings and concepts, which address health care challenges faced in particular by the poor(14).

As a health care financing system, since putting CBHI into practice in Asia and Central Africa was recognized with giving profits like as keeping the needy against health related poverty, ensures financial safety for the poor, narrowing the equity gap, lowers the private spending's, established the confidence upon community control mechanisms with its scheme and put into practice problems(11). It is also ensures sustainable health care financing; since it is rooted in communities' deepest believe and strong involvement(5).

In response to the low health care access, the Ethiopia government endorsed both supply and demand side reforms under health care financing strategy respectively. As a demand-side financing reforms, the Federal Ministry of Health (FMOH) developed a community-based health insurance schemes(5). It has the following characteristics: voluntary membership, a non-profit objective, they are linked to a healthcare provider, they pool risk, and there is an underlying ethics of mutual aid trust, enrollment, and solidarity(15). Following its introduction there was remarkable increase in health care utilization, access to medicines, and quality of services as a result of the reforms(16). Hence, improves the health status of enrollees and increases productivity and labor supply(17).

A national implementation piloted CBHI scheme was started in Ethiopia in mid-2011. As a starting point, 13 districts were selected in four major regional states in Ethiopia for implementation of the pilot scheme. The pilot program scheme covered both outpatient and inpatient health care services in public facilities(18).

The program pilot studies shown that CBHI increased health care service uptake and health seeking behavior; immediate joining to health facilities whenever they feel sick. This is so because it provides financial protection to its members. The CBHI members per capital health service utilization were 0.7 outpatient visits in 2012/13. It is more than double folds of national per capital utilization rate of 0.3 visits(5).

1.2. Statement of the problem

Worldwide, nearly 44 million and 25 million house holds (HHs) face financial difficulties and fail into poverty, respectively due to health care OOP (11). Of this, more than 90% share goes to Sub-

Saharan African(SSA) countries; where resources are limited(19). It is due to increased expenditure caused by the need to cope with injury and illness has been identified as one of the main factors responsible for driving vulnerable households further in to poverty(6).

The financial hardship of direct payments worsens among people in the lower income groups, who struggle to cover daily consumption of food and shelter expenses(20). The OOP payments in of some of African countries like; 42% in Kenya(21), 27% in Ghana(22), 37% in Ethiopia(5), and 67% in Bangladesh(23); this is because of limited health insurance coverage, healthcare demands out-of-pocket payments by borrowing and selling properties(20).

Also, Ethiopian health care system still enduring from constrained accessibility of health assets, overreliance on OOP installments, and wasteful and unjustutilize of assets, which constrain all inclusive coverage of healthcare(26). The health sector is for the most part under-financed by both worldwide and territorial benchmarks and direct payments by families, contributing approximately 40% and 37 % of the national healthuse, consequently(25). As fundamental components of health care, drug financing is special case, with households' out of pocket consumption accounting for 47% of the entire drug expenditure(26).

Worldwide, nearly 1 billion and one third of population lack access and use to health care due to different socio-economic factors respectively (24–27). In Africa and SSA, the health service utilization rate ranges from 0.2-2 per person per year visits; which is very low (28). In Ethiopia, 0.25 per person per year visits; that is lowest in SSA as compared to recommended 3 visits of WHO and MDGs(29).

In response to this problem, the government of Ethiopia sets transformation agenda under Health Sector Transformation Plan (HSTP). Community Based Health Insurance is one of the woreda transformation agendas which with the aim of protecting citizens from health related financial risk and mobilizing additional resources to the health sector(29). Currently its scale up is on the way(29).

The evaluation of CBHI pilot study in 2015 in pilot woredas' including this study area shown around 90 percent of these respondents reported to have either been satisfied or verysatisfied with cleanliness of the facility, courteousness of health experts, and holding up time. There are major

challenges within the quality of services given. To begin with, contracted providers vary in their preparation in terms such as pharmacy services, laboratory facilities, reception, and outpatient services. Second, health facilities, particularly hospitals, are regularly shortage of drugs and patients must purchase drugs from private retailers. Third, there are frequent breakdowns of medical instruments, due basically to need of preventive support but moreover to health professions carelessness and misusing(5).

There were HH's satisfaction and associated factors studies done in Damoy Woyde and Sheko districts in Ethiopia(18,30) and study in Bagledish(23). But, in these studies factors like adequecy of benefit packages, distance from contracted facility, assessing the health problem and need for service provision improvement their association were not assessed.

The association of the schedule for premiun collection, insurance cards collection process, knowledge of CBHI,length of enrollment, amount of premium and explaining the service being provided were not assessed in the previous pilot evaluation done by the EHIA in 2015(5).

Also health service clinical audit specific to members service quality is important factor having relation with program implemetation recommended by the CBHI implementation guideline was not considered in the pilot study(31).

On top of that in the area, even though the program has been implemented yet, to my best knowledge it's level of implementation is unknown. In addition , the program stakeholders want to know that; so by taking into account these facts, this study is aimed at evaluating its level of implementation process incorporating three dimensions; availability, compliance and satisfaction.

1.3. Significance of the study

This study provided information on resource available for program implementation, compliance of program activities againist regional standards and members satisfaction towards the scheme as well as barriers responsible for the observed level of program implementation and gaps. This empower the program stakeholders improve program implementation. Also it will be utilized as significant inputs for scientific decision making and resources allocaton. It has pivotal role for planning, arranging and defining approach. Moreover, this evaluation will be used as baseline for conducting different researchs and impact evaluation.

Chapter-2: Program Description

2.1. Stages of program development

In 2008 Ethiopia has developed Health insurance (HI) strategy to guide the rollout of two types of HI schemes; Community-Based Health Insurance and Social Health Insurance. Community-Based Health Insurance targets informal sector which covers approximately 80-85% of the total population in the country. CBHI scheme includes volunteer enrolled members by paying their share and indigent (poor of the poor) whose share is covered by the government. Social Health Insurance targets formal sector employees and pensioners which covers approximately 15-20% of the total population in the country. Unlike CBHI scheme, the SHI is compulsory. In both cases via social bondage ensuring equity in health service access, community participation and ownership.This HI strategy targeted at achieving of 80% enrollment in 80% of woredas by 2020(32).

There was a pilot implementation of CBHI initiative starting from its launching in mid 2011 in the four main regions of the country. During the pilot implementation 13 Woredas were covered aided by collaborative effort Ethiopian Health Insurance Agency (EHIA) and Amhara, Oromia, SNNP, and Tigray regional governments.

The Government of Ethiopia is growing the Community Based Health Insurance with awesome accentuation with point of maintaining a strategic distance from out of pocket health consumption to informal sector as well move forward health service utilization(37). The coordination, control, driving execution part of both SHI and CBHI within the nation has a place to EHIA since its 2011 foundation by the Ethiopian government. Indeed inspite of the fact that it is still new organization, now a day the central station in Addis Ababa with 20 branches opened all through the nation, and empowered to hire a staff individuals more 500(5). As uncovered from the 2019 EHIA yearly report, as of now it is being implemented in 509 Woredas'(36).

CBHI program was started in Damboya Woreda as a pilot in 2011; since the woreda was one of 13 selected woredas' for CBHI pilot implementation; and so far it was being implemented. Now it can generate adequate information for evaluation.

2.2. The Goal of CBHI program

- To contribute to a reduction in morbidity and mortality of diseases by ensuring Universal Health Coverage in informal sectors of Damboya Woreda, Kembata Tembaro Zone, SNNPR.

2.3. General Objective of CBHI program

- To improve access, utilization and quality health services and reduce OOP payment for the community and informal sectors in Damboya Woreda, Kembata Tembaro Zone.

2.4. Specific Objectives of CBHI program:

- Increasing member enrollment 65% to 85% in the Woreda by 2020.
- Increasing members per-capital health service utilization to 1 in the Woreda by 2020.
- Improving perceived quality of health care services above 90% by 2020.
- Increase resource mobilization in the health sector by 15% from last year baseline by 2020.
- Enhance community participation in the management of health care services to 100% by 2020.

2.5. Stakeholder Analysis

Stakeholders of CBHI program were identified during the Evaluablity Assessment (EA). They had provided the general information about the program services, decided on the readiness of the program for evaluation, identified the areas of the program to be evaluated and participated in evaluation questions and indicators development. Also, they took part in providing the necessary information throughout the evaluation process. The list of program stakeholders, their role in the program and interest or perspective in the evaluation, including the communication strategies and their level of importance were presented below in detail in **(Table 1).**

Table 1: Shows that Stakeholder identification and analysis matrix of CBHI program at Damboya Woreda in 2020.

Stakeholders	Role in the program	Interest or perspective on evaluation	Role in the evaluation	Communication Strategy	Level of Importance (high and medium)
Woreda CBHI Scheme	implement the program technical support, facilitate enrollment, assure quality of the service via clinical audit reimburse the service cost to health facilities sign contract with service providing health facilities ID cards distribution	performance improvement, service quality improvement , service access to community and health insured community	source of data, facilitate evaluation, establish judgment criteria (developing evaluation question and indicators) and dissemination of findings	Report (timely updation) face to face telephone calls	high

Woreda Health Office	technical support , assure quality of the service via clinical audit, supervise and mentor the health service provision	service quality improvement service access to community	source of data, facilitate evaluation, dissemination of findings, establish judgment criteria (developing evaluation question and indicators)	face to face telephone calls	high
Woreda administration office	advocacy via administrative bodies, budget distribution and subsidy budget for indigent	performance improvement, service access to the community and health insured community	utilize evaluation findings for informed decision making and dissemination of findings	face to face telephone calls	high
Health Facilities (health professionals)	health service provision mobilize the community documentation of the service provided timely and complete reporting	service quality improvement service access to the community	source of data utilize the evaluation findings further service quality improvement	Report (timely updation) face to face telephone calls	medium

Kebles Administration	community mobilization facilitate enrollment	service access to the community	source of data, utilize the evaluation findings for further increase enrollment	face to face telephone calls	medium
Health Extension workers	community mobilization facilitate enrollment	service access to the community	source of data, utilize the evaluation findings for further increase enrollment	face to face telephone calls	Medium
Health Development Army(HAD)	community mobilization	service quality improvement, service access to the community	source of data	face to face telephone calls	medium

Primary Service beneficiaries (local community members)	pay the share (premium) on time, regularly update the membership, service utilization at the time of in case of need	service quality improvement service access to the community	source of data	face to face	medium

High Level of importance: Those stakeholders, i.e. that the front line utilizers of evaluation findings for informed decision making and entitled with endorsing program improvement as well who are included in designing evaluation questions and indicators. On top of that, even they have veto power to interrupt the evaluation if necessary.

Medium Level of importance: Those stakeholders,i.e.that may utilize evaluation findings for program improvement; also can be involved in designing of evaluation questions and indicators as well they might impose some challenges or positive effect even if they cannot interrupt the evaluation process.

2.6. Program components

As like any program CBHI program has five main program components to be logically arranged by assumptions to end up with the intended effects. These are: Inputs, process or activities, outputs, outcome and impact. In case of CBHI program,

2.6.1. Inputs

- Human resource
- Financial resource
- Drugs/ medical supplies or diagnostics
- Recording and Reporting materials
- Rooms with necessary equipments
- Guidelines/ mannuals

2.6.2. Activities

- CBHI scheme establishment
- Training staff about the CBHI scheme
- Community mobilization
- Conducting supportive supervisions
- CBHI governing board review meetings
- Clinical audit by CBHI scheme
- Enrolling members in CBHI scheme
- Reimbursement of facilities service expenditure
- Premium collection by CBHI scheme
- Recording and reporting

2.6.3. Outputs

- CBHI scheme staffs hired
- Staffs trained on CBHI scheme
- Mobilization sessions conducted
- Supportive supervisions conducted
- Review meetings by CBHI governing board

- Feedbacks provided
- Clinical audit conducted
- CBHI members enrolled
- Proportion of reimbursement
- Reports sent

2.6.4. Outcomes

- Increased awareness of CBHI scheme
- Increased access to primary health care services
- Increased health service utilization
- Improved quality of service
- Reduced Out Of Pocket expenditure
- Improved satisfaction with the Service

2.6.5. Impacts

- Reduce disease mortality and morbidity

2.7. Program Logic Model

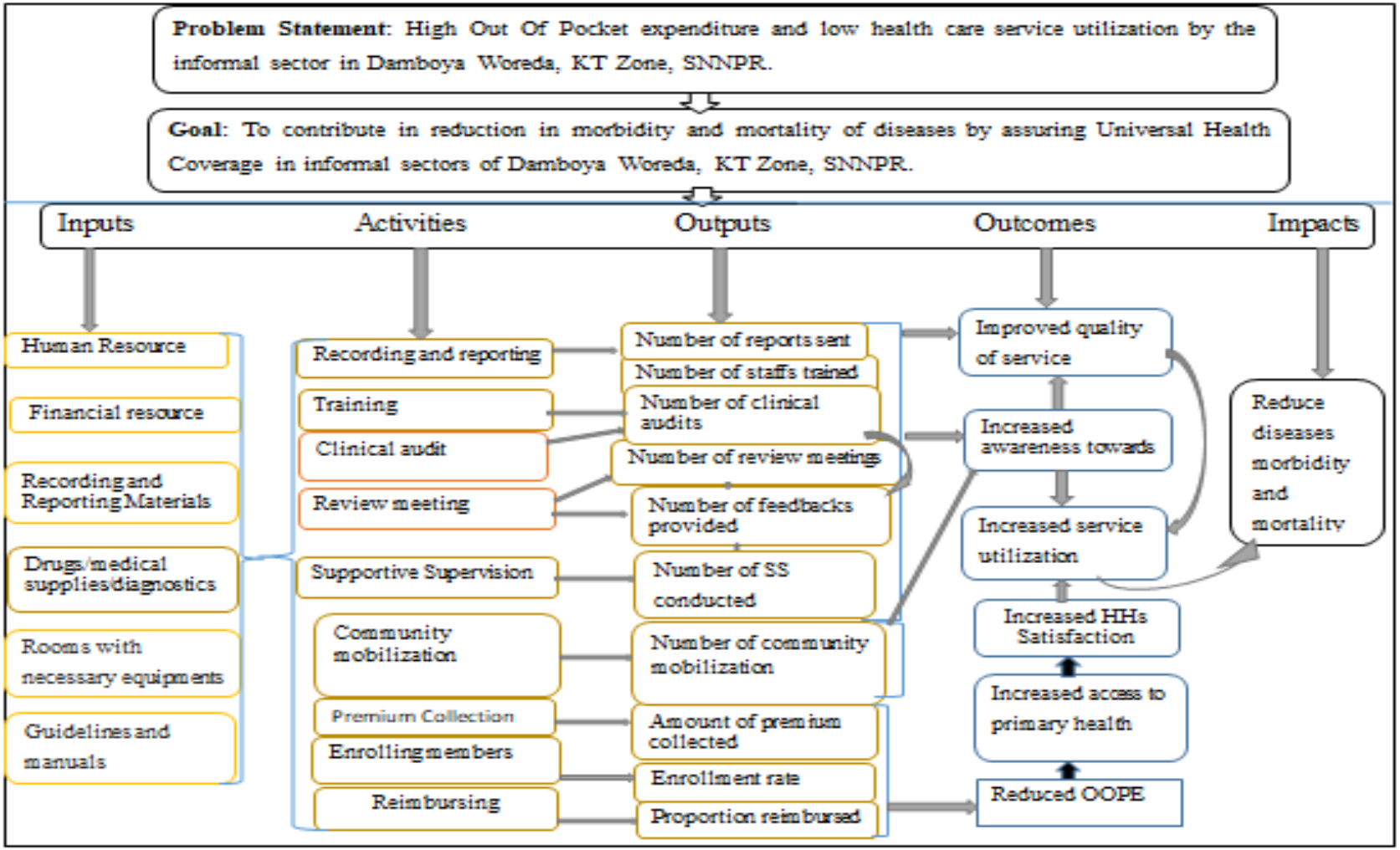


Figure 1: Logic model that shows CBHI program components and their linkage with one another in DamboyaWoreda in 2020.

Assumptions

- Sufficient incentive,
- Capacity building,
- Up to date information,
- Conducive environment

External Factors

- Political instability,
- Geographical factor,
- Climate
- Lack of transportation

Chapter 3: Literature Review

3.1. Availability

The national CBHI implementation guideline sets human resource requirements of the scheme with the profession types as one health professional, one health information technologist and one accountant are the list of minimum personnel's in the CBHI scheme(5,31).

The Ethiopian standard Agency recommends that either the rural or urban health centers are expected to have 19 health professionals and 13 supportive staffs(33). Also the 2015 pilot CBHI scheme evaluation results revealed that Sulula rural health center in Tehuledere district of Amhara regional state had 17 health professionals and 8 supportive staffs; while Woreta Urban health center had 33 health professionals and 24 support staff(5). There is a difference between in availability of health professionals and supportive staffs throughout health facilities under CBHI scheme contract; as well in their preparedness to provide contracted health services such as pharmacy services, laboratory facilities, reception, and other outpatient services, and it has effect on the service quality in turn. Again the complaints are extended beyond the physical existence further to quality of existing staffs(5). All scheme staffs and atleast one provider have training on the program implementation(5,31).

All the contracted health facilities expected to provide the minimium list of benefit packages that CBHI members are entitled. These packages are outpatient, inpatient, diagnostics, drugs, sugery and etc(31,34,35). The Ethiopian revised 2017 Health Management Information System (HMIS) recommends 25 tracer drugs for the health centers; that being monitored via HMIS in monthly base(36). Also routine laboratory tests set for health centers by the Ethiopia Standard Agency(33). The general health service readiness score is a composite summary measure designed through combining information from the five general service readiness domains, namely basic amenities, standard precautions for infection prevention, basic equipment, diagnostics and essential medicines. For each domain, the average availability of tracer items was revealed as the domain score(37). Nation wide mean availability of 24 essential medicine tracer items was 28%; with highest score being 53% in Dire Dawa while lowest score being 15% in Gambela and SNNPR was 23%. The mean availability of eight basic diagnostic tests was 40% ; with highest score in Harari(78%) while lowest score in Oromia(29%).But, SNNPR(44%). The mean availability of WHO recommended seven basic equipment for minimal readiness of facilities service provision

was 60% with the highest score in Addis Ababa being 90%; while the lowest score in SNNPR being 57%(37). General service status record at health facilities excluding health posts from urban setting was 58 percent whereas it was 51 percent in rural setting(43).

The CBHI schemes got to be upheld with computers, furniture, and consumable items(service and membership registers, membership application formats), guidelines and trained providers as minimium requirement for the CBHI program(5,34).

3.2. Compliance

At woreda level the CBHI scheme office must be housed inside the Woreda administration holding responsibility to Woreda administration; the scheme thus gets free office space, along side utilities, transport, and communication administrations, and stationary supplies. Woreda directing committees anticipated to be built up and as of now the Woreda cabinet is included in CBHI execution(5,31).

At the kebele level, temporary Health Insurance Initiative Committee should be shaped by taking two volunteer community members for premium collection reason, along with the kebele chair individual and kebele director inside kebele administration structures; which are responsible for part enrollment, premium collection, follow-up, and store of premiums in to Woreda CBHI scheme account month to month on deliberate premise. The Woreda administration pays salaries of the CBHI official staffs. Moreover, CBHI schemes get operational budget from Woreda administration in spite of the fact that it is ordinarily tight. CBHI mandates assignment Woreda administrators and their workplaces with giving administration to the scheme counting setting up the General Assembly and the Board of Executives, and guaranteeing that these administration bodies meet routinely and regularly, and give the specified administration to the scheme. The General Assembly needs to meet once a year and enroll CBH board members, outline plan execution counting budgetary issues and set headings for concerned issues. CBHI board members needs to meet each quarter, is capable for checking on and favoring the facility's yearly operational and money related work arrange, looking into and favoring its utilization arrange for the inside income, favoring client fee revision proposals, and other assignments; in conjunction with the Common Gathering mobilize asset for CBHI execution(5,31). But the general assembly and CBHI board gatherings were distinctive in recurrence and consistency among four primary local (Amhara, Oromia, SNNPR and Tigray)(5). One imperative way in which the government is

appearing its commitment to CBHI is the arrangement of common and focused on endowments. As has been portrayed, districts and Woreda administrations give the focused on subsidy to cover the participation of poor family units. The FMOH and of late EHIA through the common subsidy subsidize 25 percent of premiums based on enrollment(5,31).

As of late, the approach to expect that 10 percent is poor as it were in nourishment uncertain Woredas, and 5 percent in food-secure Woredas. The plans need to be given with major specialized, monetary, and in-kind bolster. The extend helped CBHI from the starting, conducting the possibility consider, drafting the directive/operational manual, planning the show for the plans, and taking part within the training and sensitization of territorial and Woreda overseeing bodies, community elders/leaders, and the community. Within the early days, the extend doled out a full-time CBHI facilitator to each pilot plot and within the bigger Woredas an extra technical/field officer(5).

It is still taking after the operation of the schemes, empowering normal gatherings of the board and General Assemblies. Community bunches are other key partners in CBHI. Community individuals have changeless seats on the high-level decision-making bodies of CBHI. Within the CBHI General Assembly, in expansion to the two community agents per kebele, the kebele chairman and got pioneer are community agents as they are community individuals chosen by the community. Community agents from chosen Kebeles, too speak to the community on the Board of Executives(34).

Concerning community mobilization and inclusion, a unused quarterly health office community gathering was made in SNNP in 2005 EFY (2012/13). The Woreda Health Office(WorHO) and woreda administrative office organize the gathering, which is held in health centers. The WorHO /Woreda chairman chairs the gathering; community individuals, senior citizens, devout pioneers, special groups and other community pioneers and health office staffs take an interest. The community raises issues/complaints they have with the health benefit in common and with the CBHI conspire in specific. Issues are talked about and, where conceivable, settled. Those issues that cannot be settled aimed the gathering are enrolled by the WorHO for afterward activity. The community is educated approximately the advance within the another gathering. This gathering has genuinely engaged the community and has gone a long way in moving forward the quality of health benefite(5).

The assignments that got to be embraced by CBHI conspire along with its sub-committee at kebele are convenient re-establishment of participation and expanding enrollment. All the health facilities that can provide the minimium list of health services in the benefit packages expected to have service contract agreement with the CBHI scheme before service initiation and has to revise annually; since the list and cost of each benefit packages changes from time to time(31).

The plot should make agreement with the benefit suppliers earlier to benefit start and convenient repay health benefit use to contracted health offices taking after the ask via timely and complete quarterly request reports. The 75% of the ask has got to be repaid instantly without any pre-requirement; at that point the remaining 25% will be paid after conducting the clinical review or audits to benefit guidelines(31). The CBHI scheme office has to conduct clinical audit in all contracted facilities quartely following health expenditure request by using standard checklist(31). Then provide feedbacks for further service improvement and some punishment for understandard service provision(31,34).

As has been depicted, CBHI plan in Ethiopia permits for three sorts of government endowments to the plans: focused on and common appropriations and financing the conspire administration costs (compensations, office space, and operational costs). The territorial and Woreda governments fund premiums for indigents, utilizing distinctive courses of action. The government government pays the 25 percent common endowment, which is connected to premiums of all CBHI individuals, paying and non-paying(5).

General Federal and regional Guidelines set taking after CBHI pilot assessment in 2015 by the Ethiopian health protections organization were: the choice to select in plot to be taken by kebele collectively;may be adjusted based on the territorial circumstance; it has a few variety from local to region.The enlistment expense of Birr 5 per HH and Premium installment of 10.50 per month per HH= Birr 126 per year territorially set. The enrollment charge and premiums of the exceptionally poors are financed by locales and Woredas. Installment of this commitment secured 30% by the Woreda and 70% by local but in SNNPR Installment of commitment secured 100% by Woreda. The Supplier installment instrument is fee-for-service. All administrations accessible

in health centers and clinics, barring tooth implantation and eyeglasses were within the Advantage bundle. Government funds 25% of by and large enrollment commitments per year. Lodging of CBHI plot (Woreda organization) Woreda(5,38).

Nearby with review gatherings the supportive supervisions has got to arranged and conducted appropriately and taken after with constructive feedbacks to concerned bodies(34). The has got to be one month holding up period earlier to health benefit start; since it is availability period for health facilities beneath agreement(31).

Before propelling the pilot, broad training and sensitization was given to policy makers, planners, regional and Woreda authorities, kebele authorities, CBHI official staffs, community laborers, community members, and other CBHI partners. Underneath are recorded a few of the partners who were trained/sensitized some time recently or instantly after the foundation of the plans: Woreda cabinet and Woreda health protections directing committee individuals within the pilot Woredas, Kebele cabinet and kebele/ health insurance initiative committee individuals (two each from each pilot kebele/ administrators of health expansion laborers, WorHO agents, health facility staff, and beginner craftsmen. Woreda cabinet and Woreda health protections directing committee individuals were portion of the group of coaches, Kebele and got-level official staff, who gotten preparing on the CBHI financial administration and management system.

Community sensitization and awareness creation exercises were conducted in collaboration with executing accomplices both at Woreda and kebele levels, utilizing neighbourhood beginner specialists. Extra-mindfulness creation exercises were moreover conducted, counting kebele/ level meeting with community individuals; generation and dissemination of blurbs and pamphlets in nearby dialects; and organization of a one-day introduction workshop for zonal cabinet individuals in a few pilot regions(5). In expansion, health suppliers within the four regions were trained on chosen points counting essentials of health insurance; the method of reasoning for the CBHI program; legitimate system reports; the parts and obligations of health offices; and substance of contract assentions to be marked between health offices and schemes. Promotion occasions were organized for health laborers, recently enlisted health expansion specialists, improvement operators, teachers, CBHI official staff, Woreda segment workplaces, recently doled out Woreda cabinet individuals, kebele leaders/managers, and compelling community individuals(5).

3.3. Satisfaction

Members satisfaction is an critical pointer of health care quality and frequently related with more noteworthy adherence to therapeutic innovation, health service utilization, and health outcomes(18,33).

The study in Sheko area; Southwest Ethiopia appeared more than half (54.7%) of the households were satisfied with the CBHI scheme. Satisfaction to CBHI was positively associated with adequate knowledge of CBHI benefit packages (AOR = 2.29, 95% CI = 1.55–3.38), type of health facility visit (AOR = 1.93, 95% CI = 1.09–3.39), laboratory service provision (AOR = 2.07, 95% CI = 1.15–373) and length of enrollment (AOR = 1.53, 95% CI = 1.01–2.32)(30). Household's satisfaction to CBHI scheme was moderate. Modifiable factors, including ade- quate knowledge of CBHI benefit packages, type of health facility visit, laboratory service provision, and length of enrollment were independent determinants of satisfaction(30).

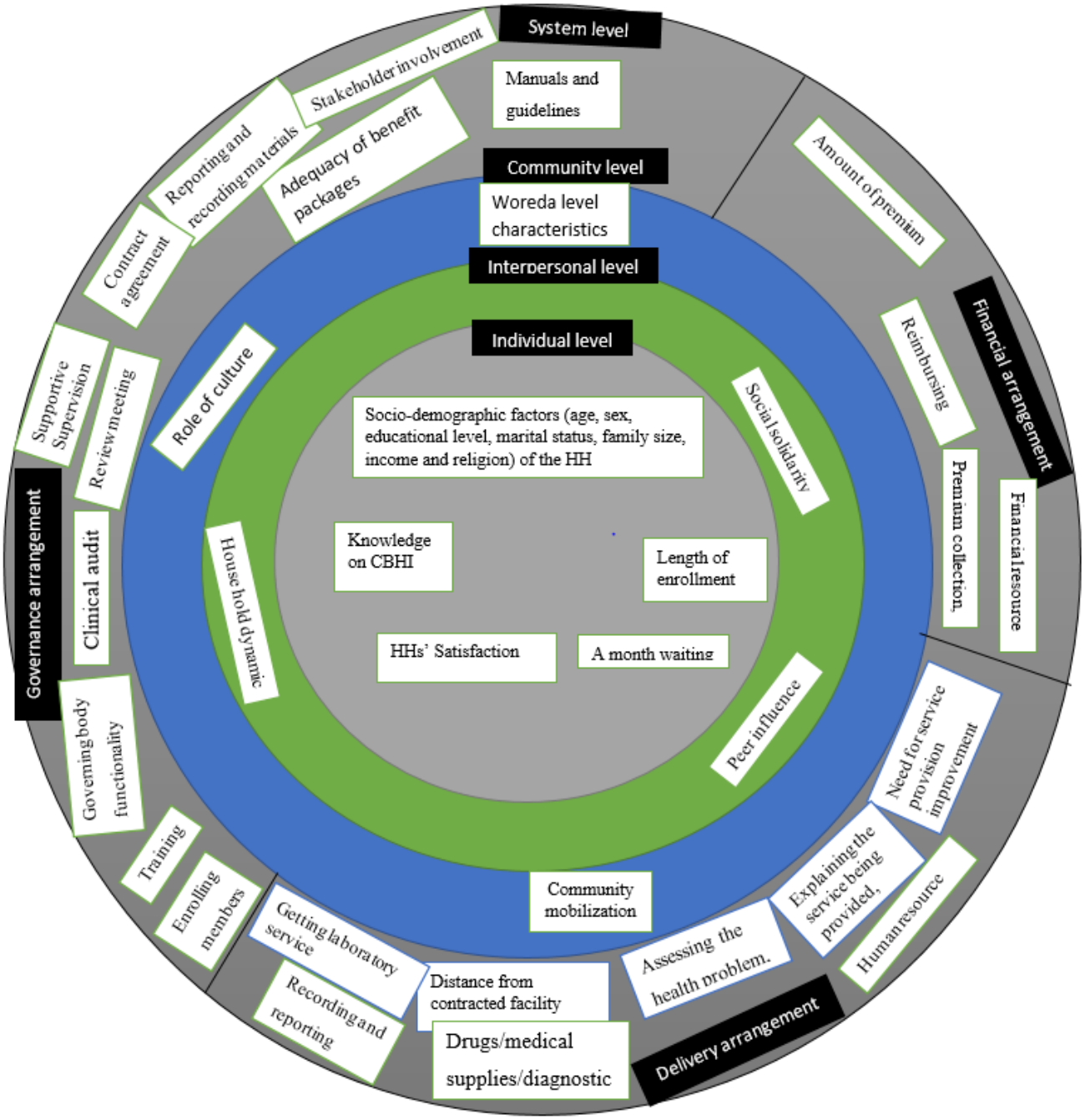
The household survey moreover evaluated patients' perceptions around changes in service quality. In respect to outpatient visits, more than 80 percent of the CBHI individuals were satisfied or very fulfilled by the conclusion, the cleanliness of the facility, and the kindness of the staff. Non-CBHI individuals detailed comparable satisfaction level(5). Huy and colleagues watched that satisfaction includes a significant affect on patient maintenance, persistent devotion and influences the proficient conveyance of quality in health care(18).

The study conducted in Bangladish had appeared that overall satisfaction mean score was 4.17 ± 0.04 (95% CI: 4.08–4.26) out of 5.00. The most satisfied domains were related to the diagnostic services (4.46 ± 0.98), explanation about the prescribed medicine (4.23 ± 0.81), the surrounding environment of healthcare facility (4.21 ± 0.70) and the behavior of health personnel toward clients (4.18 ± 0.73). Our study observed that the overall satisfaction level towards health services is quite favorable, but satisfaction scores can still be improved(23).

The study conducted in Damot Woyde district uncovered that generally family satisfaction with CBHI was 91.38 %. In addition, there was a noteworthy association between health service arrangement and CBHI members' satisfaction scores. For occurrence, household heads that

unequivocally oppose this idea with research facility services arrangement had an normal 0.878 diminish in CBHI satisfaction score compared to household heads that emphatically concurred. CBHI handle- and management-related variables were moreover essentially related with satisfaction(18). Satisfaction with CBHI was high. Age, family size, laboratory services provision, health services provider friendliness, CBHI offices opening times, membership card collection process, and time interval to use of services were significant predictors of satisfaction with CBHI (18).

3.4. Conceptual Frame Work



Conceptual framework for evaluation of process of CBHI program implementation and HH's Satisfaction towards the scheme as well its associated factors in Damboya Woreda, adapted from (DOI 10.1186/s12939-018-0721-4).

Figure 2: Conceptual framework for Evaluation of process of CBHI program implementation and HH's satisfaction towards the scheme in Damboya Woreda 2020.

Chapter 4: Evaluation Questions and Objectives

4.1. Evaluation Questions

- Are the required resources available for the implementation of the CBHI program? If yes, how? If no, why?
- Is the implementation of the CBHI program as per the national standard? If yes, how? If no, why?
- Are the CBHI enrolled members satisfied with the service being delivered? If yes, how? If no, why?

4.2. General Evaluation Objective

- To evaluate the process of CBHI program implementation in Damboya Woreda by 2020.

4.3. Evaluation Objectives

- To explore the required resource availability for CBHI program implementation by 2020 in Damboya Woreda.
- To measure the implementation of the CBHI program as per the national standard or not by 2020 in DamboyaWoreda.
- To measure members satisfaction towards the CBHI scheme by 2020 in Damboya Woreda.

Chapter 5: Evaluation Materials and Methods

5.1. Study Area

The study was conducted at DamboyaWoreda, which is found in KembataTembaro zone in SNNPR;It is located 350 km's from Addis Ababa and 110 km's from Hawassa the capital city of Ethiopia and SNNPR, respectively. It is bounded by East Halaba special Woreda, South KedidaGamela Woreda, North Shashogo Woreda and West Angacha Woreda. The Woreda Health Office report has shown that, there are 17 rural kebales and 3 urbankebeles;in total of 20 kebeles(39).

As revealed from the data obtained from Woreda Health Office a recent data in 2019, Damboya Woreda has a total population 105841, of whom 51862(48.9%) are males and the remaining 53979 (51.1%) are females. Total households in the woreda are 23157. Among this 15,337 HHs (66.2%) of HHs were enrolled in CBHI scheme(39).

In Damboya Woreda functional public facility providing health service are 4 health centers and 19 health posts. One primary hospital under construction. The private facilities are six clinics and five drug store/drug vendors providing preventive, curative, promotive and rehabilitative health service. The Worada Health Office annual report of 2019 indicated that the health service physical coverage of the Woreda is 100%(39).

5.2. Evaluation Period

Evaluability Assessment was conducted from October 1-30/2019. Data collection were collected from March 16 to May 16/2020.

5.3. Evaluation Approach.

Since, the major purpose of this evaluation isfor program improvement. So, the approach of this evaluation was a formative evaluation approach.

5.4. Focus of Evaluation

The evaluation focused on the process theory of the program which includes: inputs, activities, outputs and proximal outcomes of the program.

5.5. Evaluation Design

The design used in this study was case study design;so as to responded to how? And why? Questions which are written under evaluation question part. For a detailed understanding of the

CBHI program in DamboyaWoreda in its real context. To do so, this design allowed the generation of detailed description by using multiple data collection methods(40). Here in the study, mixed data collection methods (Community based survey,review of documents and resouce inventory for quantitative data and Key Informant Interviews(KIIs) for qualitative data collection methods; so as to generate strong evaluation evidence. Again the design enables to address the contemporary situation by using a number of variables. It has place for observation of the real program implementation environment. It was about CBHI case in the Damboya Woreda.

5.6. Dimensions of Evaluation

Three dimensions; availability, compliance and HH's satisfaction towards CBHI program was used.

5.6.1. Availability: Here the presence of all the resources required for CBHI program implementation were evaluated as per the standards. The list of resources were human, financial, rooms, guidelines or manuals, reporting and recording materials, vehicles, advocacy materials and drugs/medical supplies or diagnostics. This dimension was measured by using 12 indicators.

5.6.2. Compliance: Here determining weather the activities have been undertaken in line with national implementation guideline. Keeping a month waiting, signing contact agreements, supportive supervisions, review meetings, community mobilization, board and general assembly (governing body) meetings, recording and reporting activities, reimbursement for service delivery, clinical audits or mentoring, hiring staff in CBHI scheme, training for CBHI scheme and health professionals, members enrolling and premium collection. This dimension was measured by using 11 indicators.

5.6.3. Satisfaction: The HH's level of satisfaction towards the CBHI scheme was measured by using 6 satisfaction indicators.

5.7. Indicators or Variables

5.7.1. Indicators

A list of indicators for this evaluation were selected by the team of key CBHI program stakeholders discussed under stakeholder analysis part. By using the respective means of communications with stakeholders(mean that face to face communication for those available in

their office or working area, for those were not there, communicated via telephone) made clear the program to be evaluated, the purpose of evaluation and primary users of the evaluation findings. Report used for day to day updation of status progress with some of the key stakeholders. Then the number of indicators were selected from international and national sources. By considering the feasibility issue and good indicator criteria and information adequecy, from a potential list of total 79 indicators re-selection by multi-voting technique was done. Finaly 29 indicators, those indicators chosen by all stakeholders were taken; also the relative weight (see the indicators matrix of analysis part Annex-V) was given for each 23 indicators by comparative judgement and for 6 satisaction indicators the weight was given by PCA.

Table 2:Shows that list of indicators on availability, compliance and satisfaction dimensions of CBHI program evaluation in piloted Damboya Woreda in 2020.

S.no.	Dimensions	Indicators
1.	Availability	Number of staffs in the Woreda CBHI scheme in during data collection period.
		Number of HCs with trained provider on the schemes during data collection period.
		Number of HCs having recommended number of health professionals during data collection period.
		Number of HCs having recommended number supportive staffs during data collection period.
		Number of HCs with standard reporting formats to Woreda CBHI scheme during data collection period.
		Number of HCs with CBHI guidelines during data collection period.
		Number of kebeles' with the standard membership registration books during data collection period.

		Number of kebeles' with membership application forms during data collection period
		Number of HCs with standard members registration during data collection period.
		Proportion of tracer drugs available in the data collection period
		Proportion of essential laboratory tests available in the data collection period
		Proportion of essential medical equipments available in the data collection period
2.	Compliance	Number of HCs signed service agreement with CBHI scheme office in the last year as per the guideline
		Proportion of review meeting conducted with governing board in the last year as per the guideline.
		Proportion of supportive supervisions conducted by scheme office in the last year as per the guideline.
		Proportion of feedbacks to scheme office provided by governing board in the last year as per the guideline.
		Proportion of reports sent by HCs to the scheme office timelyin the last year as per the guideline.
		Proportion of complete report sent by HCs to scheme office in the last year as per the guideline
		Proportion of community mobilization sessions conducted by governing board in the last year as per the guideline
		Proportion of clinical audits conducted by scheme office in the last year as per the guideline

		The proportion of feedbacks given by scheme office to HCs following clinical audit in the last year as per the guideline.
		Number of HCs that had been reimbursed totally by the scheme office in the last year as per the guideline.
		Number of HCs that had started service after a month waiting time following members registration as per the guideline.
3.	Satisfaction	The proportion of members satisfied with the time to make use of the CBHI program after payment of registration fee
		The proportion of members satisfied with the schedule for paying of premium;
		The proportion of members satisfied with availability of health worker on time
		The proportion of members satisfied with the time spent in waiting before contact with health professionals
		The proportion of members satisfied with the referral service provided
		The proportion of members satisfied with availability of medicines whenever needed in the HCs

NB: In this study the 'last year' indicates 2019 G.C. i.e. that from January-December/2019.

5.7.2. Variables

5.7.2.1. Dependent variable

- Implementation status of CBHI
- Overall house holds satisfaction

The main outcome variable of this evaluation was implementation status of CBHI, which was computed as a weighted average of the pre-set judgment criterias for the three dimensions (availability, compliance and satisfaction). The analytic statistics (regression analysis) were done

by using households satisfaction with CBHI as an outcome variable and the following were explanatory variables considered in the analysis:

5.7.2.2. Independent variables

Socio-demographic variables

- Age of HH head,
- Marital Status,
- Religion,
- Sex of HH head,
- Educational status,
- Income level and
- Family size

CBHI members experiences

- Getting laboratory service ,
- Explaining the service being provided,
- Assessing the health problem,
- Need for service provision improvement,
- Knowledge on CBHI,
- Adequacy of benefit packages,
- Length of enrollment,
- Distance from contracted facility and
- Amount of premium

5.8. Populations and sampling

5.8.1. Source population

Source population for quantitative study: all CBHI enrolled households in the CBHI scheme of DamboyaWoreda.

Source population for qualitative study: Damboya woreda CBHI scheme staffs, health professionals working in the CBHI scheme contracted health institutions, Woreda Health Office,

all HEWs working in the CBHI scheme contracted catchment HPs, heads of contracted health facilities, woreda administrative head, leaders of HDAs, kebele level volunteers of sub-CBHI scheme and kebele administratives.

5.8.2. Study population

Study population for quantitative study:Those households under the scheme and were selected for study from the total enrolled members.

Study population for qualitative study: CBHI scheme coordinator ,head of woreda health office, heads of the 4HCs, 4 CBHI focals of the 4 HCs, 2 HEWs, 2 HDAs, 2 volunters from kebele level CBHI sub-scheme committes. It was determined by the data saturation.

5.8.3. Study Units and unit of analysis

Study Unit for quantitative study:

- **House hold heads:**Households heads in the HHs were selected by lottery method and who fulfilled the inclusion criteria.
- **Resource inventory**: tracer drugs register and annual resource inventory book in the facility main stores by crosschecking with service delivery pin point.

Study Unit of qualitative study: Purposively selected individual.

Unit of analysis

Primary unit of analysis : Health Center and HHs

Secondary unit of analysis: Woreda

5.8.4. Sample Size Determination and Sampling Techniques

- **For Community survey**

The Sample size was determined using single population proportion formula (for quantitative survey).

$$n = \frac{(Z\alpha/2)^2 p\ (1-p)}{d^2}$$

Where: n is the maximum possible sample size

Z α/2: is the standard score value for 95 % confidence level for two sides' normal distribution

P = is the proportion of the population taken from previous similar study.

d = is margin of error

The sample size was calculated using single population proportion formula $(Z\alpha/2)^2 p(1\text{-}p)/d^2$ assuming 54.7% of households satisfied with CBHI scheme taken from a study conducted in Ethiopia(30), a confidence level of 95% and a 0.05 margin of error. A multi-stage sampling procedures were undertaken. To account this, the sample size was multiplied by the design effect of 1.5. Finally by adding 10% non-response rates, the final sample size was 627.

A multi-stage random sampling technique was employed to select the study participants. Simple random sample selection was applied at each stage to eliminate selection bias. In the first stage, 30% of kebeles was selected using a lottery method. In the second stage, households enrolled in CBHI in the selected kebeles was identified using their individual enrollment identification numbers from the registration book through the help of health extension workers. Then, the sample size was proportionally allocated to each kebele. Finally, the study participants was selected using systematic sampling method. The members registration book of each kebele at scheme was used as the sampling frame. The first random start HH in each kebelewas selected.(table-3 below):
Table 3:Shows that the proportional allocation of survey sample size in the randomly selected kebeles' in CBHI piloted Damboya Woreda in 2020.

Kebele	**Enrolled CBHI members**	**Proportionally allocated sample size**	**K interval**	**Random start**
Wondo	462	78	6	2
Megere	397	68	6	6

Hamoancho	607	103	6	3
Bonga	853	145	6	2
Yebu	904	153	6	4
Geyota Gerba	473	80	6	3

- **Resource Inventory:**In CBHI piloted Damboya Woreda, resource inventory was done to check the availability of resource for CBHI program implementation by using resource inventory check list. Woreda CBHI scheme office, four health centers and six sampled kebeles' sub-scheme offices were included in the resource inventory. As a content the availability of human power, implementation guidelines or directives, recording and reporting materials, membership application formats and benefit packages were focused.In the four HCs,the laboratory, pharmacy or main store and human resource were included.
- **Documents and Records review:** the CBHI members' registration books (at CBHI scheme, kebeles and in the health facilities), all the quaterly reports, feedbacks and review meeting registers of the last year were reviewed in the 4 HCs, CBHI scheme and six selected kebeles'.

Qualitative data

For KII

- Purposively selected 16 individuals, i.e. that based on their experience, knowledge, position and relevance towards the scheme, the key informants were selected. The data saturation determined the number of key informants. The head of WoHO, CBHI scheme coordinator, heads of 4 HCs, 4 CBHI focals of 4 HCs, 2 committee members of kebele CBHI sub-scheme, 2 HEWs and 2 HDAs were involved. Both HEWs and HDAs were selected as aforementioned by the WorHO based of their experience, knowledge on CBHI and their tilent on the scheme activities.

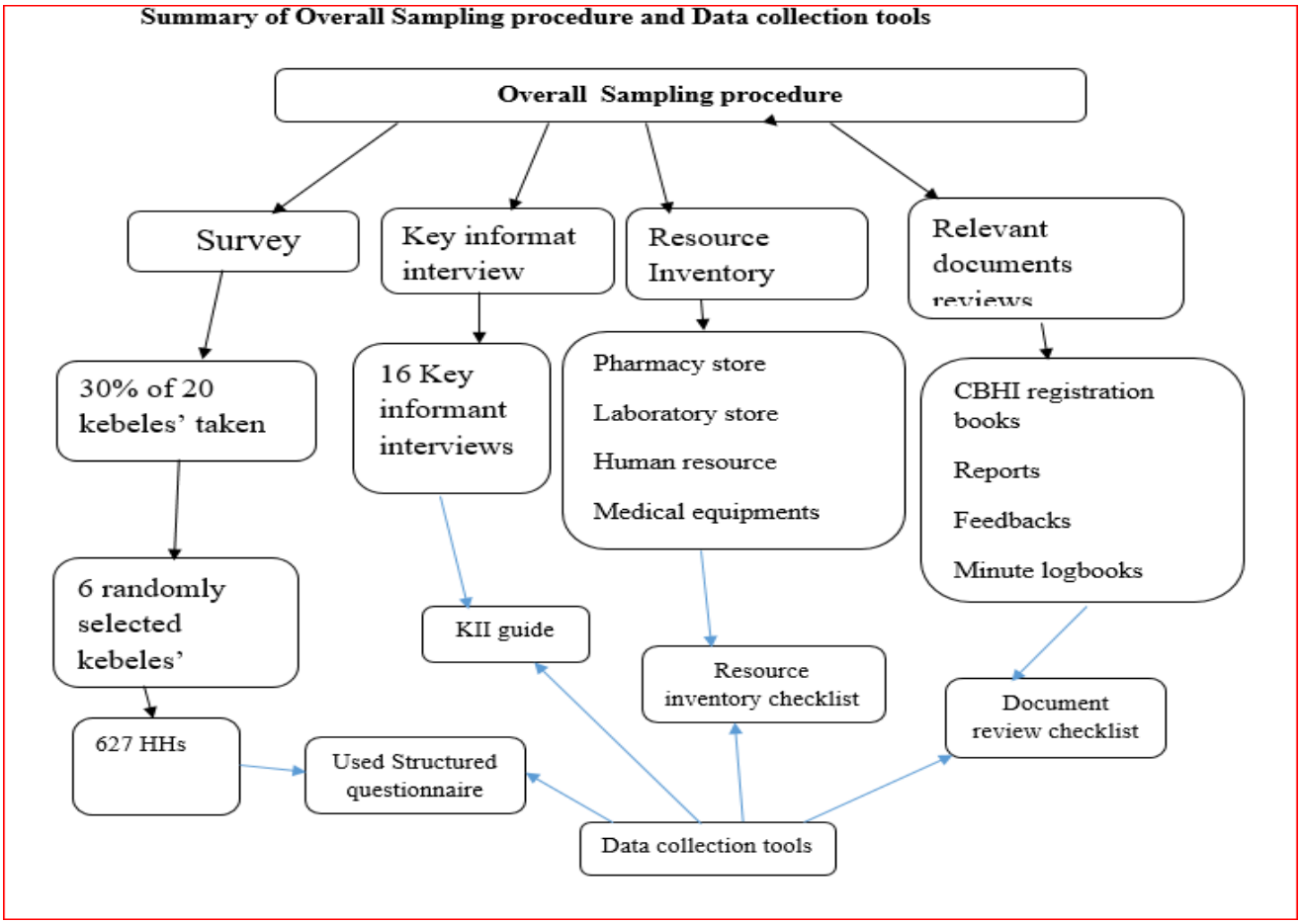


Figure 3: Shows that summary of sampling procedure for process evaluation of CBHI program in the piloted Damboya Woreda

5.9. Inclusion and Exclusion Criteria

Randomly selected CBHI member households heads were included; the household heads who were seriously sick and unable to give response,less than one month service year and never used service in the contracted health facilities were excluded.

For KII all mentioned before were interviewed; but those seriously sick and unable to give response, less than one month service year and never used service in the contracted health facilities were excluded also.

5.10. Development of Data Collection Tools

Data collection tools are:

1. **Structured questionnaire:** Used for quantitative data collection. Socio-demographic characteristics, experience, knowledge on CBHI and satisfaction of the HH towards the CBHI scheme were the major contents of the questionnaire. For the measure of reliability of the tools for the HH's satisfaction,Cronbach's alpha coefficient was calculated to be 0.815. Adapted from (5,18,23,30,30).
2. **Resource inventory checklists:**Laboratory test, list of tracer drugs, essential medical equipments and human resource were the major contents of the resource inventory ckecklist. Adapted and developed from (33,36,37,41).
3. **Document review checklist:** Suportive supervision feedbacks, review meeting registraton books, clinical audits, reimbursing, feedbacks, quarter reports ..etc were the of contents documents review checklist. Developed from (5,31).
4. **KII Guidelines**: used for qualitative data collection for explaining the quantitative findings. Developed from(5,31).

5.11. Data Collectors

Two health officers and 4 dipolma nurses who were fluent in and understand easily Amharic and Kambatisa local language were selected from the Kedida Gamela Woreda in Kembata Tembaro Zone. Two public health expertise(MSc and MPH)were assigned for supervision of data collection process.

5.12. Data Collection field work and Data Quality control

The structured questionnaire were prepared in English and translated from English to Amharic and Kambatisa language, then translated back into English to check its consistency. The interviews were conducted face-to-face. Before data collection, a pre-test was conducted using structured questionnaire in KedidaGamelaWoreda among 5%(32 in number) of the sample size. During the pre-test,sequential problem, understandability and clarity of questions were checked and modified accordingly; then based on the pre-test results, adjustments were made to the data collection tool. Two days training on the study objectives, method of data collection, and the tools for data collection. Spot checks on the quality of data collection was made in the field. Its completeness and missing values were checked on a daily basis and corrected. The additional visitswere made for households closed during the data collection period, then households closed during the third

visit was considered as non-respondents. The data collection process was closely supervised by the prinicipal evaluator.

KII with key informants and resource inventory and relevant documents reviewwere carried out by the principal evaluator using KII interview guide and checklist; and mobile phone recording, memo or note taking were done carefully during an in-depth interview.

5.13. Data Management and Analysis

5.13.1. Data entry

After cleaning and checking of data for accuracy and completeness, quantitative data were enteredEpiData version 3.1 and exported to SPSS version 25 by the principal investigator for analysis.

For qualitative data, the mobile records were transcribed in qualitative data analysis software called ATLAS.ti.7.1.4.

5.13.2. Data cleaning

Data cleaning and checking was startedinthefield and repeated after entry. The whole data were screened for lack of data,excess of data, outliers,inconsistencies,strange patterns andsuspect analysis result. Then missing data , errors, valid records or true extremes were diagnosed. After diagnosing, the data were treated by correcting. Finally , maintain a change log as well raw data and old values were archived; keep all documented.

5.13.3. Data Analysis

The analysis was continued by Principal Component Analysis(PCA); so as to reduce data, to give weight for each indicators and the iterative procedure to develop components. In addition to that descriptive statistics such as frequencies, mean and percentages were calculated by univariate analysis. Bivariate and multivariate logistic regressions were used to identify factors determining HH's satisfaction towards the scheme. Those factors with $p<0.025$ in bivariate analysis were taken into multivariate logistic regression. After measuring the satisfaction by using the Likert scale, the mean(21.3)was calculated to know the proportion of HHs' who were satisfied and not satisfied.

The KIIs were transcribed in Amharic and Kambatisa languages,then translated into English, openly coded, grouped into families and broadly categoried into 4 themes for analysis by using ATLAs.ti.7.1.4. qualitative data analysis software; thematic analysis was undertaken.

5.14. Analysis and judgment Matrix

Evaluation is systematic process of judging the worth,desirability,effectiveness or adequacy of something according to definite criteria and purposes. The judgment is based up on a careful comparison of observation data with criteria standards(42). Since there is no ready made criteria to judge the success or failure of a program by combining both empirical and rational approaches; i.e. that negotiating key program stakeholders and research findings/ experience. For indicators of availability and compliance dimensions the individual weight was given by comparative judgement by experts for public health experts; then weighted mean is taken. The formula, data source, collection methods,toolsand given weights including the two dimensions(availability and Compliance), but for satisfaction dimension variable weight was given by PCA;the detailed show in the Analysis and the judgement matrix table at the Annexed.

5.15. Ethical Consideration

The ethical approval and clearance letter was obtained from the Jimma University college of Public health and Medical science Institutional Review Board.Official permission letter was obtained fromJimma University, SNNPR Health Beauro and KT zone Health office and DamboyaWoreda Health Office to health institutions. Informed consent was obtained from the study participants after explaining the purpose of the study. During data collection all respondents were asked whenthey are volunteer to give information. Theywere told that the can stop whenever they become dis-interested. Nothing will be disclosed unless they are willing as well.

5.16. Evaluation dissemination Plan

The evaluation findings will be presented to Jimma UniversityInstitiute of health sciences for HSM department and health M and E unit and advisors. After getting accepted by the university, the finding will be disseminated to SNNPR Regional CBHI Agency, KT Zonal Health Department, Damboyaworeda CBHI scheme, Woreda Health Office, Health Institutions at the end of the evaluation as immediate as possible**.** All of them will be provided with clear, simple and

summarized soft copy of the report, while Jimma University and Woreda CBHI office will be provided with both softcopy and hard copy of the report.

Chapter-6: Result

6.1. Socio-demographic characteristics of the study participants

Six hundred ten HH heads participated in the study giving the response rate of 97%, of which 78% were male. Half of the respondents (51%) were greater than 40years and nearly four in ten (39%) were in the age group of 30 to 40 years. Most of respondents were Protestants (61%) followed by Muslisms (19%). From the participants 92% were married. The family size of 82% of HHs was greater or equal to five. Four in ten (41%) of them can read and write; while a third (32%)had no formal education. Farming was the main source of income which 96 % of the HHs relied on. However, 91% of HHs had one or less hectare cultivable land. Monthly income of 69% HHs was less or equal to 1000 Ethiopian birr (Table-4).

Table 4:Shows the socio-demographic characteristic of the CBHI members in piloted Damboya Woreda in 2020.

Variables		Frequency(n=610)	Percent
Sex	Male	479	78.5
	Female	131	21.5
Age	Less than 30 years	63	10.3
	30-40 years	238	39.0
	Greater than 40 years	309	50.7
Religion	Orthodox	45	7.4
	Muslim	115	18.9
	Catholic	79	13.0
	Protestant	371	60.8
Marital status	Never married	32	5.2
	Married	561	92.0
	Divorced	5	.8
	Widowed	12	2.0
House hold size	Less than five	110	18.0
	Five or more	500	82.0
Educational Level	With no formal education	193	31.6
	Reading and writing	253	41.5
	Primary education (Grade 1-8)	84	13.8
	Secondary education (Grade 9-12)	75	12.3
	Vocational training and above	5	.82

Farming	Yes	588	96.4
	No	22	3.6
Commercial activities	Yes	164	26.9
	No	446	73.1
Daily laborer	Yes	16	2.6
	No	594	97.4
Land Ownership	Do not have farmland	28	4.6
	One hectare and less	556	91.1
	Greater than one hectare	26	4.26
Household monthly income	Less than 1000 birr	424	69.5
	1000-1500 birr	71	11.6
	Greater than 1500 and less than 2500 birr	42	6.9
	2500-5000 birr	58	9.5
	Greater than 5000 birr	15	2.5

6.2. Availability Dimension

The resource available in Damboya Woreda for the CBHI program implementation was summarized under theme-1 below.

6.2.1. Theme-1: The resources available for the CBHI program Implementation

6.2.1.1. Human resource

Currently, the CBHI scheme office was hosted within woreda health office. In woreda scheme office, there were three workers for scheme implementation. One clinical nurse as scheme coordinator, one accountant and one HIT on data clerk. All of the workers were trained on the scheme implementation.

A 34 years old, male CBHI scheme coordinator said:

"…since the program was started as a pilot in our woreda, after organizing the office structure; mean that hiring required staffs, all scheme staffs were trained by regional CBHI agency incollaboration with FMOH on program implementation; since they were responsible to initiate the program implementation".

The workforce in the 4HCs categorized into two: Health professionals and the supportive staff. The numbers of workforce differs from health center to health center. It is shown in the table-5 below.

Table 5:Shows health workforce in the four Health Centers and CBHI scheme in piloted Damboya Woreda in 2020

S.no	Health workforce	Health centers				Woreda scheme office	Total Staff in the Woreda excluding WorHO
		HC-1	HC-2	HC-3	HC-4		
1.	Health professionals	38	17	19	24	1	99
2.	Supportive staff	24	18	14	15	2	73
3.	Staff trained on the scheme	2	1	2	1	3	9
	Total staff in each HCs	62	35	33	39	3	172

NB: HC-1= Damboya Health Center, HC-2= Funto Health Center, HC-3=Magare Health Center and HC-4=Wondo Health Center

From the table-4 above, in Damboya woreda in health facilities and CBHI scheme, in total there were 99 health professionals and 73 supportive staffs. Nine of the total were trained on the CBHI scheme implementation.

A 35 years old, male WorHO head said:

"In our woreda human resource manager regularly check human resource availability and fulfill the vacancies as immediate as possible and managing in a planned manner. As a result there was no a great shortage of human power. Even by considering the primary hospital under-construction that will be functioning soon, the number of both health professionals and supportive staffs in the HC-1 were above the recommendations and since it is an urban HC that fostered the staffs stay there and being kept for hospital soon functioning".

Prior to CBHI program pilot implementation, one health professional and one supportive staff in four of the HCs had training on CBHI program implementation.

A 28 years old, female head of HC-2 said:

"Acoording to our woreda CBHI program implementation started as a pilot. For that the CBHI agency arranged the training sessions where one health professional and one from supportive staff were trained in each health facilities as well as scheme staffs."

6.2.1.2. CBHI job aids

In the CBHI scheme office, there was CBHI implementation guideline in both hard and soft copies. The system was computerized and membership registers were available. Again, four of the HCs had adequate reporting formats to the next level; so had CBHI implementation guidelines.

A 30 years old, male head of HC-1 said:

"The CBHI agency after training the staffs, provided the CBHI guideline including reporting formats to each health facilities and CBHI scheme office. At the beginning regional CBHI agency were providing quarterly reporting formats;but latteron HCs them selves begun to secure adequate report formats by making copies."

None of the HCs had standard members service registration book.

A 34 years old, male CBHI scheme coordinator said:

" It is due to intruption of its supply from FMOH; previously it was being supplied and the HCs were requesting it repeatedly but not supplied yet; it is beyod HCs capacity to publish it. But, they have developed local register by taking all the contents of the standard members service registration book in which members service utilization was being registered by assigned focals daily".

In the six of selected kebeles' the CBHI sub-scheme office were being organized by the pilot governmental platform available; where six of them had standardized members enrollment registers and application forms there.

A 29 years old, female HEW said:

"Sub-scheme committee members go to woreda scheme office so brought the membership application forms reguraly;so timely avail.But, the membership register was given by the scheme once, still it is with adequate space. It can serve for some extra time".

6.2.1.3.Benefit Packages

The list of packages included in the CBHI benefit packages were mentioned below in the table-6. In this study CBHI members had an opportunity to get the service either in their nearby contarcted HCs or if the service is not available there, via referral chain to nearby contracted Hospital, then they get the service there. The study shown that outpatient services, laboratory services, and pharmacy services were avialable in each health centers. However, inpatient services and surgery were not started yet in all HCs of the woreda.

A 35 years old, male WorHO head said:

"In all of the HCs there were no adequate rooms associated with building first design problem and now, budget shortage to built that made difficult even 24 hours stay at HCs. Again the HCs setup was not favourable for surgical procedures, except minor onces. Even though these services were not there, members get service via referral to nearby contracted Durame General Hospita".

Table 6:Shows the availability of CBHI program benefit packages in the Health Centers of Damboya Woreda in March 16 to May 16/2020.

S.no	List of Benefit Packages	HC-1	HC-2	HC-3	HC-4	By Referral linkage to Zonal General Hospital
1.	Out of Patient Services	Yes	yes	Yes	Yes	Yes
2.	Inpatient Services	No	no	No	No	Yes
3.	Laboratory Services	Yes	yes	Yes	Yes	Yes
4.	Pharmacy Services	Yes	yes	Yes	Yes	Yes
5.	Surgery	No	no	No	No	Yes

In the table-6 above 'yes' stands for 'availability' of the listed benefit packages and 'no' stands for 'not available' in the time interval of the study. For available services, how much is available shown annexes(I-III) at the end of the document.

NB: root canal treatment, artificial tooth implantation, eye glass provision, abroad treatment, dialysis,…etc were excluded from the above list of services. Because these were not part of benefit packages.

6.2.1.4. Availability of Tracer Drugs

Since it is part of benefit packages, tracer drugs availability was focus area in service aspect of the program. From 25 tracer drug items,56%,48%,68% and 60% of tracer drugs items were available in HC-1, HC-2, HC-3 and HC-4 respectively throughout the year. Among 25 tracer drug items Cloxacilin 250mg/5ml or 125mg/5ml syrup was not available throughout the year in all of the HCs.The tracer drug items availability was not this much varied from HC-1 to HC-4; but, the tracer drugs woreda average availability was 56%. The avialability of tracer drugs was relatively higher at HC-3 which was 68% (Annex-I).

A 29 years old, female head of HC-2 said:

" We couldn't get some of tracer drugs during procurement and some of the drug items were not properly forecasted since in our HC the storekeeper was not pharmacy professional; but deligated from other profession. Also, another issue was budget shortage to purchase drugs that the scheme was not reimbursing the health expenditure on time due to financial deficit".

A 28 years old, male head of HC-3 said:

"In our facility we gave priority for availing drugs as well as the storeman was concerned for early forecasting based on the previous dispensing trends. Purchase as per quarter plan on regular bases. But, still we did not get some drugs in PFSA then we were enforced to join private seller".

6.2.1.5. Availability of Essential Laboratory Tests

The laboratory investigation was also a focus area under CBHI benefit packages. From the 10 essentials laboratory tests, 100%,70%,70% and 80% were available at HC-1, HC-2, HC3 and HC-4 respectively. In the woreda in average 8 from 10 tests were available. HC-1 had all the recommended laboratory testes; but, in HC-2, HC-3 and HC-4 hematocrit and heamoglobintests

were not available as well in HC-2 and HC-3 HIV test kits were not available. Mean availability of the woreda 80% (Annex-II).

A 28 years old, male head of HC-3 said:

"In our HC, hematocrit and heamoglobin tests have not done because machines for the respective tests were not functional resulting from lack of regular maitainance. The absence of biomedical egineers in the woreda was cause for these.There was supply intruption for HIV test kits from woreda for sometime".

6.2.1.6. Availability of Medical Equipments

From 17 lists of medical equipments 80%,73%,80% and 73%were available in HC-1,HC-2,HC-3 and HC-4 respectively. It was between 73-80%; but, mean availability was 77% (12 out of 15 tracer items). Beds for emergency admission as well as admission rooms, adult weight scale and plan B under 5 OPD rooms were not available in four of the HCs as well child weight scale was not available in HC-2 and 3. (Annex-III).

A 29 years old, female head of HC-2 said:

"…. Some of the medical equipments were not functional; due to the lack of regular maintainance since there was no biomedical engineer at woreda level and few of them were not available at the time of purchasing. Also there were rooms shortage for emegency admission due to the lack of capital budget to build it; this is true in all of the HCs".

6.2.2.Judgement Matrix of the Availability Dimension

Based on the judgment parameter, the implementation status of CBHI program with respect to avialablity of program resource was scored 85% (Table-7).

Table 7: The judgement matrix of the availability dimension in the Process Evaluation of CBHI program in piloted Damboya Woreda from March 16-May 16/2020.

S.no	Availability Indicators	Given wt	Required	Observed	Score	Achieved (100%)	Judgement parameter

1.	Number of staffs in the Woreda CBHI scheme in the during data collection period.	15	3	3	15	100	V.good
2.	Number of HCs with atleast one trained provider on the schemes during the data collection period.	10	4	4	10	100	V.good
3.	Number of HCs having recommended number of health professionals during the data collection period.	7	4	3	5	75	Good
4.	Number of HCs having recommended number supportive staffs during the data collection period.	6	4	4	6	100	V.good
5.	Number of HCs with standard reporting formats to Woreda CBHI scheme during the data collection period.	7	4	4	7	100	V.good
6.	Number of HCs with CBHI guidelines during the data collection period.	12	4	4	12	100	V.good
7.	Number of HCs with standard members registration book during the data collection period.	7	4	0	0	0	Critical
8.	Number of kebeles' with the standard membership registration books during the data collection period.	8	6	6	8	100	V.good

9.	Number of kebeles' with membership application forms during the data collection period.	8	6	6	8	100	V.good
10.	Proportion of tracer drugs available in the data collection period	8	25	14	4	56	Poorly implemented
11.	Proportion of essential laboratory tests available in the data collection period	6	10	8	5	80	Good implementation
12.	Proportion of essential medical equipments available in the data collection period	6	15	12	5	77	Good implementation
	Availability Dimension	**100**			**85**	**85**	**V.good Implementation**

Judgement parameters: >=85% Very Good Implementation, 75-85 Good Implementation, 60-75% Partially Implemented , 50 - 60 Poorly Implemented and < 50 % Critical

6.3. Compliance Dimension

The alignment of CBHI program implementation activities with the regional guidelines was presented below under 4 themes.

6.3.1. Theme-2: Pre-requisites for health service utilization covered by CBHI scheme

6.3.1.1. Mobilization and awareness creation for the CBHI program implementation

Within Damboya woreda there were different community mobilization ways on CBHI program. Commonly it was being conducted in the form of community forum in the health centers quarterly; in which mainly HDAs were participated and also especial groups. On average per single community forum 200 and above individuals were participated; where issues related to health service delivery and CBHI program activities raised by the community members.Most of the community forums were led by the woreda administrative head and few of the forums were led by other delegated bodies. In each of the 4 HCs it was done every quarter; 16 times at woreda level.

Other than community forum, community mobilization related to CBHI program was done in the public gatherings such as meeting at woreda and kebele level by using different governmental administrative platforms(i.e. as Damboya woreda pilot govermental structure organized by five pilot leadership, gots, HDAs).

A 35 years old, male WorHO head said:

" *Already there is structural platform adjusted by government, other than the mobilization conduted by HEWs and woreda supervisors, there was a community forum at health faicility done quaterly. It was already planned in quarter bases. When time for forum is approaching meeting call letter were being sent to all concerned bodies before meeting day. The meeting was being led by woreda administrative head. Meeting held in the facilities compound and on issues like how health service was being delivered, based on the feedbacks of government administration offices(mekirbet) on that we are creating awareness. Other, where-ever good governance become an issue , the CBHI program become an agenda, relevant decisions were made and set directions. The detail of meeting was written on the minute logbook" (R10,M).*

A 36 years old female HAD said:

"…Then community mobilization mostly including the HAD leaders they were informed, believed and accepted that then the CBHI activities started".

Concerned bodies from kebele leadership, i.e. kebele sub-scheme committee members were trained by woreda CBHI scheme staffs on CBHI program implementation.

A 40 years old male, kebele sub-scheme committee member said:

"For kebele CBHI sub-scheme committee and other concerned bodies orientation training was delivered by woreda scheme office by using CBHI implementation guideline at woreda center; then they were told and given direction that to create awareness to the community, then mobilized in each assigned got and provide information".

Following that woreda front leadership became oriented on the program implementation and given responsibility; The awareness creation activities have been conducted repeatedly as necessary as

possible basically for HDAs; since it was not snapshot activity. Again, the role models, i.e. that those who were CBHI members and ever used health service including surgeries costing high were allowed to share their life experience in different meetings.

A 32 years old HEW said:

".....so we informed HHs together with leadership people to become CBHI member in absence or presence of luxure. At the time we use model HHs or those who were CBHI member and ever used health service covered by CBHI scheme; then we let them to tell their life experience. Different experiences were shared on different public gatherings till the community members understood the CBHI program well".

Parallely, the health professionals in the four HCs were oriented on CBHI program implementation by priorly trained personnels that made CBHI program implementation activities in the health facilities in line with the national guideline.

A 30 years old, male HC-1 CBHI focal said:

"In the health facilities, the whole staff members made have information on CBHI benefit packages, rights and reponsibilities of the CBHI members, how to record and report to scheme office. The training sessions were adjusted by health facilities and by priorly trained health personnels. The regional implementation guideline used as reference for all CBHI related activities".

6.3.1.3. Enrollment

In DamboyaWoreda the CBHI program was launched in 2011. Since the time, the permium that each HH contributing was 200 birr and 5 birr as a registration fee. The HH with indirect family member has been paying 40 birr per indirect family member; but additional payment per family members older than 18 years was not familiar so far. The husband with polgamous marriage has been paying regular permium with one of the wives and paying 120 birr per each extra wife additionally.

A 38 years old HAD said:

"If one indirect family member in the family, the HH will pay 290 birr to be CBHI member.."

A 29 years old, female HEW said:

"...for example, if the HHs expected to pay 240, if one indiret family member in that house hold pay additional 40 birr, totally 280 birr will be paid for the membership. Also if the husband had two wives pay additional 120 birr for the second wife, totally pay 360 birr".

In 2019, the permium and registration amount were revised to be 240 and 10 birr respectively; but still family members older than 18 years remain with HH without additional payment.

A 32 years old HEW said:

"…during the launching the permium was 205 for all the community members. But in 2012 EFY the permium raised to 240 for renewal and 250 for the members newly enrolled into the CBHI scheme; ….".

In 20 kebeles' of woreda there were legally hired cash collectors during members enrollment.They have been collecting permium and registration fee by legal cash collection voucher; they have been depositing collected cash into CBHI scheme account within the collected week. Then they came with bank slipe of cash deposition.

A 45 years old kebele sub-scheme committee member said:

"Before, there was a situation where collected cash stay at hand in some kebeles', even the leadership fail in corruption…".

"In our kebele there were assigned permium collectors at kebele level by using standard cash collection voucher…".

A 40 years old male, kebele sub-scheme committee member said:

"The collected permium stay at hand not more than one week, summarized within the week of cash collection and deposited into ommo-microfinance account; then brought the bank slipe from, we were check it on weekly bases wether the cash was collected to bank account or not at the

beginning of every week. Every Friday he/she goes with money and on next Monday come with bank slipe that was what we were checking".

Related to waivers, 10% (1500HHs) of the HHs of the woreda were enrolled in CBHI scheme their permium was covered by local government in the form of targeted subsidy.

A 35 years old, male WorHO head said:

"There was a situation where around 1500 waivers were selected and their health service costs were being covered by the government.

Based on the percentage; 10% of the total HHs in the woreda multiplied with the permium a mount of 240 birr, in this regard there was no problem".

In 2019, 66% (15,337) of HHs became members of the scheme; eventhough this figure shown decreament compared to previous achievement in the same woreda; since most of members had complain with health service provision, especially drugs shortage and lack of compassionate care.

A 32 years old HEW said:

"*... but, this year the enrollment has greatly decreased, because most of the people complained that no one was concerned to us……this year many problems were happened that can reduce the membership: ...there was shortage of drugs in the health center. The cash collected from the CBHI members was not collected into the account, the CBHI scheme were not reimbursed, where is the cash collected from us? So we never pay the permium again. Also, the CBHI membership reduced due to the problem of health service provision in the health center, then* in *the hospital. The health professionals service provision manner cannot attract the CBHI members… ".*

A 34 years old, male CBHI scheme coordinator said:

"... during the members creation season especially December and November they complained that last year we did not get adequate drugs in the health facility so that we do not want to pay this year. Additionally, referral service for the hospital was intrupted because of no reimbursement of service cost of last year. These two reasons became cause for decreasing the membership".

6.3.1.4. Contract agreement with the health facilities

Since the health care cost is covered by third body, four of the HCs had contract agreement with CBHI scheme office and revising it in annual bases. One of the heads of HCs reported that it is must to revise contract agreement annually, for changing the list of benefit packages and their respective prices. The contract agreement document contained list of benefit packages;like: list of drugs, laboratory tests, councelling…etc with individual item and service costs. It was prepared in three copies between three bodies; mean that the CBHI scheme, health facility heads and attorney of woreda as moderator signed agreement prior to entry of fiscal year. The three of them signed on the document and given one copy of the document to each. One of the 4 HCs explained the procedure,but did not know where the document was.

A 34 years old, male head of HC-3 said:

"… since the payment is covered by the third body i.e. that CBHI scheme; the number of members fluctuates year to year,medicine list and price fluctuates from time to time. After orienting the benefit packages to HPs, including those benefit packages and their respective prices, our HC, CBHI scheme and attorney of woreda as moderator sign the contract, then duplicated in three copies and was given to three of us. ***….*** *service will never be given in situation where contract agreement is not renewed".*

A 34 years old, male CBHI scheme coordinator said:

"The woreda CBHI scheme , health service providing health facilities in the presence of Attorney of woreda as moderator , the contract agreements was prepared in three copies and each copy was given".

6.3.1.5. Keeping waiting time before using health service

In the 4 clusters of woreda, all newly registered CBHI members stayed for a month before utilizing the health care covered by scheme. The kebele sub-scheme committee informed that within a month stay requirements of membership, like ID card preparation will be completed. Few of newly registered members were still visiting to health facility immidiately after registration; there health professionals awared and sent them back.

A 40 years old male, kebele sub-scheme committee member said:

"For new CBHI members there is one month gap after registration before starting health service utilization. By creating awareness and also by the direction given, while requirement will be fullfillied within a month. If we told that properly they say ok, then stay volunterly".

6.3.2. Theme-3: Monitoring CBHI program related activities

6.3.2.1. Review meetings

The structural organization of the CBHI governing board in Damboya Woreda included woreda administration head as the head of the board and as members of the board Woreda Education Office, Woreda Revenue Office, Woreda Cultural Office, Woreda 'mekirbet', Woreda CBHI scheme, WorHO, etc. The board met at woreda level but not at cluster level. In 2019, met 4 times and reviewed the the strength and weekness of the program; where some decisions were made like: service clustering and subsidy to health centers due to the excessive health care cost.The decisions made at board level cascaded to health facilities and kebele sub-scheme committee via circular letter. Also the meeting of general assembly was conducted in October where people's represetatives from each kebele, CBHI focals from HCs, woreda administrative heads, head of WorHO and others concerned bodies, all came together and reviewed the plan performance report and other facing issues.

At kebele level, the CBHI program activies have been led by command post on weekly bases. Where how many members were renewed their membership, how many were enrolled, whether collected permium was deposited into scheme account on weekly bases or not were monitored together with other activities. But, agreat focus was given in the season of membership renewal and newly enrolling which was from October to December; it was a golden time for CBHI activities also for frequent reviews. Other than this there was no plan for quaterly review of CBHI program alone at clusters level; but it was with other health activities.

A 35 years old, male WorHO head said:

"This year focus was given to CBHI since problems associated with CBHI were diversified; clustering was started and direction was set for subsidization to health facilities. It had its own role to subsidized the health facilities from regular woreda budget; for that in 2012 E.C. the woreda administration subsidized 239,ooo birr to our heath center. These so following the feedback of the board".

A 40 years old male, kebele sub-scheme committee member said:

"At kebele level, the leadership reviewed what we have done related to CBHI in each got for which we are responsible individually. We did not wait external body to conduct the review meeting; review every Thursday weekly".

6.3.2.2. Supportive supervision

The supportive supervion of the scheme office was not planned and conducted on quaterly bases; rather it was occasional. It mostly focused kebele level program activities than the health facilities.i.e.that program aspect focused than service aspect. As reported from key informants, Even it is possible to say there was no supportive activities at health facilities. Again at kebele level, it was not uniform throughout all kebeles'. There were some gaps to say poor supportive supervision that there were some opportunities of collected permium stay at hand for a long time. It's main focus was enrollment from October to December.

A 45 years old male, kebele sub-scheme committee member said:

"The supportive supervision done occasionally. Especially there was an occasion in which members get income , October upto November at the time they supervise with especial focus; ....but, there was no plan for it, it was seasonal supervision".

A 32 years old HEW said:

"....the CBHI enrollment is not this much frequent activity; since it is done once a year, supervised occasionaly".

A 34 years old, male CBHI scheme coordinator said:

".... The budget shortage made impossible the supervision of the CBHI activities in quarter base".

6.3.2.3. Clinical audits

In 2019, clinical audit was done once in the first quarter only by the scheme office. It was not done frequently since it is for reimbursing remaining 25% of health service expenditure and so as to check service quality. Due the shortage of budget not done repeatedly.i.e. that the scheme assumed that for not reimbursing the health care cost, conducting the clinical audit is meaningless. Even at

the time it was conducted, it was not comprehensive; mainly active members and price focused audit, detailed checklist was not used.

A 33 years old, male HC-4 CBHI focal said:

"...for example: in 2011 EFY, the situation where three quarters 25% were not paid. The CBHI scheme couldn't conduct clinical audit on time since there was no money to reimburse to health facilities after clinical audit. As well as there was single health professional in the scheme due to the workoverload".

6.3.2.4. Reports

The 4 HCs sent complete service expenditure reports to scheme office on the locally agreed time interval quaterly; that within ten days after quarter complition. It is so, because there are assigned CBHI focals who were trained on and daily collecting the report. Again there were available report formats that made the task easy.

A 26 years old, male CBHI focal of HC-2 said:

"Our HC sent complete and timely report every quarter".

A 30 years old, male head of HC-1 said:

"There were focals assigned for this purpose so register daily; we had soft copy of reporting format as a result we don't wait the CBHI office to provide the reporting format rather we use available computers and print-out the report formats, as a result no shortage of reporting formats".

At kebele level, there was trend of reporting newly enrolled HHs by using membership application forms as frequent as possible. Also the was a trend of reporting a family dynamics; mean that death and birth in the family. For death the photo to be detached from CBHI ID card and for newborn the photo to be attatched into ID card. Reporting family dynamics was not this much familiar throughout the kebeles'.

A 29 years old, female HEW said:

"…. when there is a new born in the HH, it may face health problem, so as early as possible the family have newborn they bring the photo of that newborn and it will be attached on the ID card. In case of death in the family since Mister X has died, then his/her photo is detached from the CBHI ID card".

6.3.2.5. Feedbacks

There was no written clinical audit feedbacks due to workload; but frequent oral communications and calls. The feedbacks of scheme board was cascaded via written circular once;but the detail review contents were written on the minute logbook in each quarter at scheme level. Following cluster level meetings, oral communications were usual but there were no written feedbacks.

A 31 years old HC-1 CBHI focal said:

"No written feedback following clinical audit.……., rather the scheme communicate orally".

A 35 years old, male head of WorHO said:

".....for example this year clustering was decided to start, for that the written circular to health facilities following the board decision".

A 34 years old male CBHI scheme coordinator said:

"The feedback was given not on time. Since, the health professional in the CBHI scheme was one and became bussy".

6.3.2.6. Re-imbursing

The year 2019's the health care cost of CBHI members in the 4 HCs of the Woreda and Durame General Hospitals were not reimbursed. The 25%s' of the first three quarters and the total expendiure of fourth quarters were not reimbursed yet. It was reported by many of the key informats possible causes for not reimbursing were mismatch of permium and health care cost; i.e. that the amount contributed by individual CBHI members was lower than the service cost. There were some examples like there was an opportunity where a single individual was admitted for one hundered days used the service costing upto 25 thousands birr. Also an other CBHI member had surgery costing 17 thousands birr. Eventhough there were some high costs, CBHI program is for cross-subsidization. Also the cost of health care is rising from time to time. Previously, there

was no clustering that has given a great opportunity for CBHI members to use health service in the health facilities in the woreda without referral paper that raised health care cost; but ended in 2020 by the decision made by governing board.Eventhough it is decreasing, the collected permium was staying at hands of some cash collectors resulting from lack of supportive supervision. This made the scheme unable to reimburse health care cost and bankrupsy of health facilities mean that the health centers lack capacity even to purchase drugs. In addition to clustering, modifying the permium and greatly increasing membership..etc.were theproposed solutions for the problem.

A 45 years old male, kebele sub-scheme committee member said:

"…. an individual HHs pay 240 birr to be CBHI member but can get service from simple drugs priscription to a great surgery; i.e. with little permium they can get service with larger cost; that made service expenditure cost very high".

A 30 years old, male head of HC-1 said:

"…but some thing is left from leadership that cash collected from members stay at hand long time without being accounted in CBHI scheme account. Other, related to service utilization CBHI members were using the service without clustering in 2011 E.C. ……. It leads to drugs shortage and health service cost to became high. In 2012 EFY till this third quarter service cost is not reimbursed. The CBHI scheme is reimbursing last years service cost in 2012 EFY".

A 35 years old male, head of WorHO said:

"It limits the capacity of the health facilities, since it is the fee for service. ……".

6.3.3. Theme-4: Service aspect of CBHI program implementation

6.3.3.1.Benefit packages provision

In four of HCs, most of the benefit packages were being provided to CBHI members. For benefit packages that were not available in the HCs, members were being referred to Durame General Hospital for the services. Eventhough the referral linkage is currently functional, it was intrupted for months because the health expenditure of the Durame General Hospital was not reimbursed timely. Due to the rooms shortage, in the 4 of the HCs there was no admision service; even there was no 24 hours emergency stay.

A 30 years old male head of HC-4 said:

"The HC provides those services included in CBHI benefit packages……, but there was a great problem associated with drugs shortage,those complaining on the drugs shortage during the community mobilization for renewal and in a season where new members created around 90% of the CBHI members complain on drugs shortage. As a result, they were being referred to private health facility frequently.".

"…. once an individual become a member he/she has to get referral service properly including the hospital via referral linkage; so far referal linkage faced problem but recently the problem was solved".

A 29 years old female head of HC-2 said:

"The absence of admision was due to room shortage. If there was adequate class, it would have been simple; so we keep for some time and if referral is necessary we can refer it".

Most of the CBHI members want injection where ever they visit health facilities and assumed that they are undermined by health profesionals since they are CBHI members. Concerning health professionals service provision, some of key informants repeatedly reported that the way some health professionals providing the health service was not compassionate; it needs improvement.

A 32 years old HAD said:

"Whenever the community members go to the health facilities their interest is to have injection….".

A 29 years old, female HEW said:

"*….the health professionals service provision manner cannot attract the CBHI members….*" .

"*…. Also the health professionals were giving first opportunity for non-CBHI members since they were paying directly out of pocket".*

6.3.4. Theme-5: Benefits of CBHI program implementation

In this study area, since CBHI program implementation the service equity was insured; in especiallythose in low socio-econemic status had opportunity of getting the health service without selling livestocks and other properties. The CBHI program had contribution in the reduction of mortality and morbidity as well as enhance saving culture.

A 32 years old, female HEW said:

"If there were no CBHI program since 2011, many HHs would have sold their houses and livestocks. Due to the CBHI program with few payment they had an opportunity to get agreat service".

Table 8:Shows that judgement matrix of compliance of CBHI program Process Evaluation in piloted Damboya Woreda from March 16 to May 16/2020.

S.no	Compliance Indicators	Given weight	Expected	Observed	score	Achieved (100%)	Judgement parameter
1.	Proportion of Community Mobilization sessions conducted governing body in the last year	8	16	16	8	100	v.good implementation
2.	Number of HCs signed service agreement with CBHI scheme in the last year	9	4	4	9	100	v.good implementation
3.	Proportion of review meeting conducted with governing board in the last year.	10	4	4	10	100	v.good implementation
4.	Proportion of supportive supervisions conducted by scheme in the last year.	7	16	0	0	0	Critical
5.	Proportion of feedbacks provided by governing board in the last year.	10	16	4	2.5	25	Critical
6.	Proportion of reports sent to scheme on time last year.	10	16	16	10	100	v.good implementation

7.	Proportion of complete report sent to scheme in last year	10	16	16	10	100	v.good implementation
8.	Proportion clinical audits conducted by the scheme in last year	9	16	4	2.5	25	Critical
9.	Proportion of feedbacks given by the scheme following clinical audit in the last year.	9	16	4	2.5	25	Critical
10.	Number of HCs had been reimbursed totally in the last year	11	4	0	0	0	Critical
11.	Number of HCs started service after appropriate waiting time following members registration	7	4	4	7	100	v.good implementation
	Compliance Dimension	**100**			**62**	**62**	**Partially implemented**

Judgement parameters: >85% Very Good Implementation, 75-85 Good Implementation, 60- 75% Partially Implemented , 50 - 60 Poorly Implemented and < 50 % Critical

6.4. HH's Satisfaction Dimension

6.4.1. CBHI members' experience

Majority of HHs (97%) stayed enrolled for 12 months and above. For 94% HHs, premium amount falls in between 200 and 250 birr. Seventy percent of the HHs perceived the premium amount as medium. The premium collection schedule was perceived convenient for 48%, but 37% of the HHs had no idea about the premium collection schedule. For 52% of the HHs, contracted health facilities were nearby (takes thirty minutes and less for arrival). Of the total interviewed, 53% the respondents complained that the included benefit packages were not adequate so as to meet HHs health service requirement.

Majority (79%) of the participants agreed with need of improvement of the health professionals' service provision.

Table 9:Shows that CBHI members' experience related to CBHI program in piloted Damboya Woreda in 2020.

Variables		Frequency(n=610)	Percent
Length of enrollment	less than 12 months	19	3.1
	above or equal to 12 months	591	96.9
Permium amount	less than 200 birr	35	5.7
	200-250 birr inclusive	574	94.1
	above 250	1	.2
Premium amount paid	High	84	13.8
	Medium	432	70.8
	Low	94	15.4
Distance from contracted health facility in hour	less or equal to 1 hour	448	73.4
	Greater than one hour	162	26.6
Benefit packages adequate	Yes	241	39.5
	No	369	60.5
Health professionals service provision need improvement(n=427)	Yes	350	81.96
	No	77	18.03
Assessing health problems(n=427)	Yes	301	70.5
	No	126	29.5
Explaining the health service being provided by health professionals(n=427)	Yes	295	69.2
	No	132	30.8
Respondent get laboratory services in the contracted health facility(n=427)	Yes	298	69.5
	No	129	30.5

6.4.2. Knowledge on CBHI among members

Among study participants, majority(74%) responded four and above from the seven points as "yes", had good knowledge onCBHI. On the other hand, 152(26%) said, "yes" less than four points categorized as having poor knowledge on CBHI(30).

Within the house hold for the family members older than 18 years, additional payment is expected based on their number whenever the HH become CBHI member and renew the membership every year; However, fifty two point six percent of the HHs not understood that. Sixty four point six percent of the respondants were informed about additional payment for indirect family members per individual. Also 70% understood the need of reporting the family dynamic i.e. that death and birth.

Of the total of the repondents, 97% understood the CBHI program as non-profit risk pooling mechanism built on soliderity and also 97% were informed that the service entry point for CBHI members is the health facility nearby them.

The 94% and 98% of the respondents were clear with that the insurance cards are obtained from the CBHI scheme and members are expected to renew their membership every year, respectively.

Table-9: Shows that knowledge on CBHI among members in piloted Damboya Woreda, SNNPR, in 2020(n=610).

Variables		Frequency	Percent
Additional payment for older than 18 yrs	Yes	289	47.4
	No	321	52.6
Additional payments for indirect family members	Yes	394	64.6
	No	216	35.4
Report family dynamics	Yes	425	69.7
	No	185	30.3
Nearby health facility as service entry point	Yes	593	97.2
	No	17	2.8
Non-profit risk pooling mechanism built on solidarity	Yes	592	97.0
	No	18	3.0
Insurance cards can be obtained from CBHI scheme	Yes	573	93.9
	No	37	6.1
Respondents are expected to renew their membership every year	Yes	597	97.9
	No	13	2.1
Poor knowledge on CBHI		158	25.9
Good knowledge on CBHI		452	74.1

6.4.3. CBHI members' satisfaction level measurement

The overall level of CBHI member satisfaction was analyzed using composite score of validated 6 items. Using the mean score (n=610, with larger sample size mean is preferable centeral tendency measure) as a cut of point (mean equal to 21.3), 306(50%) of participants were scored above the mean score and satisfied. Fifty nine percent of the participants were satisfied with the availability of health workers and 41% were not. Fourty eight percent of the of the members were satisfied with the waiting time before contact with health professionals and 52% were not.The detail is in the table-1 below.

Table-10: Shows that CBHI members' satisfaction towards CBHI scheme in Damboya Woreda, SNNPR, in 2020.

Table 10:Shows that CBHI members' satisfaction towards in CBHI scheme in Damboya Woreda in 2020(n1=610 and n2=427).

Variable	Strongly dissatisfied	Dissatisfied	Neutral	Satisfied	Strongly satisfied	Satisfaction	
PCA-1: Related to health service							
N	n(%)	n(%)	n(%)	n(%)	n(%)	Satisfied n(%)	Dissatisfied n(%)
Health workers availability(n=427)	3(0.7)	51(12.0)	122(28.5)	201(47.2)	50(11.6)	252(58.9)	175(41.1)
Wait time before contact with health professionals(n=427)	3(0.8)	76(17.7)	143(33.6)	150(35.2)	54(12.6)	205(47.9)	222(52.1)
Waiting time after regitration in the scheme(n=610)	5(0.8)	86(14.1)	185(30.3)	238(39.0)	96(15.7)	334(54.8)	276(45.2)
Getting drugs in the facility(n=427)	11(2.6)	140(32.8)	97(22.6)	167(32.0)	43(10.0)	179(42.0%)	248(58.0%)
PCA-2: Related to CBHI scheme							
Referral Service(n=427)	6(1.5)	57(13.4)	112(26.2)	118(27.7)	133(31.1)	252(58.9%)	175(41.1%)
Schedule for permium collection(n=610)	12(2.0)	50(8.2)	114(18.7)	251(41.1)	183(30.0)	434(71.1)	176(28.9)
Overall level of Satisfaction						306(50.2%)	304(49.8%)

6.4.4. Factors associated with CBHI member satisfaction.

In bivariate logistics regression analysis, from the socio-demographic variables HH heads sex (p=0.026), educational level(p=0.00), and HH income(p=0.002) were significantly associated with CBHI members' satisfaction to wards CBHI scheme but other socio-demographic variables were not significant. The health service provision related factors like: getting the laboratory service in the contracted health facility(p=0.000), explaining the health service being provided(p=0.000), assessing the health problem(p=0.00), need for health service provision improvement(p=0.000), benefit packages adequate(p=0.000) and distance from the contracted health facility(p=0.000) and also CBHI scheme related factors such as: understanding the concept of CBHI(p=0.002) and amount of permium paid(p=0.049) ; all were significantly associated(p< =0.05) with the members' satisfaction towards the scheme; but length of enrollement(p=0.257) was not significantly associated with members' satisfaction towards CBHI scheme.

Variables with the p<=0.025 in bivariate logistic regression analysis were taken into multivariate logistics regression analysis to identify independent factors associated with member satisfaction. In multivariable logistics regression analysis, HH head educational status, distance from the contracted health facility, Assessing health problem,benefit packages adequate, need for health service provision improvement, getting laboratory service in the contracted health facility and explaining the health service being provided were had statistically significant association with member satisfaction towards CBHI scheme.

Table 11:Multivariate Logistsic regression of factors associated with members' satisfaction of CBHI scheme in Damboya Woredain 2020.

Variables	**Categories**	**Satisfied (n,%)**	**Dissatisfied (n,%)**	**COR**	**B**	**AOR**
Sex	Male	252(52.6%)	227(47.4%)	1.560(1.055-2.305)*		1.429(0.905-2.258)
	Female	54(41.2%)	77(58.8%)	Ref		Ref
Educational Level	with had no education	**76(39.4%)**	**117(60.6%)**	Ref		Ref
	reading and writing only	**156(61.7%)**	**97(38.3)**	2.476(1.686-3.636)*	+ve	1.938(1.241-3.028)*
	primary education (Grade 1-8)	**44(52.4%)**	**40(47.6%)**	1.693(1.010-2.838)*	+ve	1.274(0.701-2.315)
	secondary education (Grade 9-12)	**29(38.7%)**	**46(61.3%)**	.971(0.562-1.677)	+Ve	1.039(0.552-1.957)
	vocational trainingand above	**4(0.65%)**	**1(0.16%)**	6.158(0.675-56.148)	+ve	2.936(0.277-31.176)
House hold income	<1000birr	**191(45.05%)**	**233(54.95%)**	Ref		Ref

	1000-1500birr inclusive	**46(64.8%)**	**25(5.2%)**	2.245 (1.330-3.780)*		1.345(0.746-2.456)
	1500-2500 birr	**26(61.9%)**	**16(38.1%)**	1.982(1.033-3.803)*		1.248(0.576-2.704)
	2500-5000 birr inclusive	**34(58.6%)**	**24(41.4%)**	1.728(0.991-3.015)		1.658(0.830-3.313)
	>5000, but <=10000 birr	**12(80%)**	**3(20%)**	4.880(1.357-17.542)*		4.065(0.993-16.638)
Distance	less or equal to 1 hour	**202(45.09%)**	**246(54.9%)**	0.420(0.290-0.614)*	+ve	0.357(0.219-0.583)*
	Greater than one hour	**107(66.05%)**	**55(33.95%)**	Ref		Ref
Permium amount paid	High	**36(57.1%)**	**48(42.9%)**	1.058(0.583-1.919)		1.202(0.571-2.528)
	Medium	**231(53.5%)**	**201(53.5%)**	1.621(1.032-2.546)*		1.199(0.677-2.124)
	Low	**39(41.5%)**	**55(58.5%)**	Ref		Ref
Explaining health service provided	Yes	**244(57.8%)**	**178(42.2%)**	2.594(1.815-3.708)*	+ve	1.753(1.071-2.869)*
	No	**65(34.6%)**	**123(65.4%)**	Ref		Ref

Need for improvement of health service provision	Yes	**208(43%)**	**276(57%)**	Ref	-ve	Ref
	No	**101(80.12%)**	**25(19.88%)**	5.361(3.339-8.606)*		5.752(3.359-9.849)*
Benefit packages adequate	Yes	**166(68.9%)**	**75(31.1%)**	3.498(2.480-4.933)*	+ve	2.091(1.390-3.145)*
	No	**144(38.9%)**	**226(61.1%)**	Ref		Ref
Assessing health problem	Yes	**260(60.5%)**	**170(39.5%)**	4.089(2.714-5.884)*	+ve	1.743(1.050-2.893)*
	No	**49(27.2%)**	**131(72.8%)**	Ref		Ref
Getting laboratory service	Yes	**256(60.4%)**	**168(39.6%)**	3.581(2.471-5.191)*	+ve	2.974(1.842-4.823)*
	No	**53(28.5%)**	**133(71.5%)**	Ref		Ref
Understanding CBHI concept	Poor concept	**246((54.4%)**	**206(45.6%)**	Ref		Ref
	Good concept	**63(39.9%)**	**95(60.1%)**	1.801(1.246-2.603)*		1.214(0.746-1.977)

R-reference category *For all $p<0.05$

Table 12:Judgement matrix for members' satisfaction dimension of Process Evaluation of CBHI Program in Damboya Woreda in 2020.

S.no	HH's Satisfaction Indicators	Given weight	Required	Observed	Achieved (100%)	Score	Judgement parameter
1.	The proportion of members satisfied with the time to make use of the CBHI program after payment of registration fee	16.22	610	334	55%	8.9	partially
2.	The proportion of members satisfied with the schedule for paying of premium;	17.13	610	434	71%	12.2	V.good
3.	The proportion of members satisfied with availability of health worker on time	15.75	427	251	59%	9.27	Partially
4.	The proportion of members satisfied with the time spent on waiting	17.64	427	205	48%	8.45	Critical
5.	The proportion of members satisfied with getting drugs from HCs	15.32	427	179	42%	6.43	Critical
6.	The proportion of members satisfied with the referral service provided	17.94	427	251	59%	10.56	Partially
	Overall HH's Satisfaction	100			55.81	55.81	Partial

Judgement parameter: >70% Very Good Implementation, 60-70 Good Implementation, 55-60% Partially Implemented, 50-55 Poorly Implemented and < 50 % Critical

Total Members' satisfaction score=55.81 judged as partial implementation.

NB: Individual weight for each indicator was given by PCA.

Table 13:Overall judgement matrix and analysis of dimensions for Process Evaluation of CBHI program in piloted Damboya Woreda from March 16 to May 16/2020.

S No.	Dimensions	No. of Indicators	Weight given(W)	Observed(O)	Achievement in%=W/O	Judgment Criteria
1	Availability	10	30	25.5	85	• >85% Very Good Implementation • 75-85 Good Implementation • 60- 75% Partially Implemented • 50 - 60 Poorly Implemented and < 50 % Critical
2	Compliance	11	40	24.6	61.5	
3	HH's satisfaction	6	30	16.743	55.81	
Overall CBHI program implementation level		27	100	67	67	

The overall CBHI program implemetation level in piloted Damboya Woreda is 68.64% which is partial.

Chapter-7: Discussion

UHC is WHO's calling upon the developing countries so as to avoid health care access inequities (2). Since the CBHI program is as step on the road to Universal Health Care(38), the Ethiopian government endorsed it as an strategy in 2008(43); then it was implemented as a pilot in 13 districts in 2010/11(5). Currently being on scale-up stage made it focus area for different implementation and scale-up studies(32). This study 'named implementation process of CBHI program in piloted Damboya Woreda in KT,SNNPR' had three major study dimensions i.e. that Availability, Compliance and House holds' satisfaction towards the scheme and associated factors so as to measure the implementation level of the program in this study area may add something in this concern.

7.1. Availability Dimension

The availability areas for CBHI program implemetation human power, implementation guidelines or directives, recording and reporting materials, membership application formats, and some of benefit packages were focused in four HCs and six sampled kebeles.

In the CBHI scheme there are three staffs. The number of staff in the scheme and profession mixing was inline with regional CBHI implemetation guideline(31); this made program implementation easier. But, at district level, the number of the staffs in the scheme differs in Rwanda, which was four in number(44). The difference is due that in Rwanda the scheme was organized at directorate level since the CBHI program implementation in Rwanda at national level in wider scope working for sustainability of the program; but in our case it is in scale-up level. In this regard the work load in Rwanda is higher than Ethiopia. The availability of trained providers in the scheme as well as in the HCs were atleast one and more which was consistent with regional guideline recommending atleast one trained provider(31); this prodided an opportunity for doing CBHI activities in a scientific way as well as made doing easier.

In HC-3 and HC-4 the four HCs the number of health professionals was consistent with the Ethiopian Standard Agency that recommends 19 health professionals for urban or rural HCs(33). Again, in HC-1 the HCs, the number of the health professionals is double fold than the Ethiopian Standard Agency; this was by considering the Primary Hospital under construction. But, in HC-2 the number was below the standard; because of the high attrition rate. The number of supportive

staffs in four of the HCs was comparable with Ethiopian Standard Agency recommending 13(33); the availability of health workforce in the health facility was necessary since they can play a great role in providing the benefit packages so as to strengthen the routine service provision that leads to increament in membership. The evaluation finding of pilot CBHI implementation by EHIA in 2015 revealed, Woreta HC in Tehuledere woreda of Amhara region had 33 health professionals and 24 supportive staffs(5). It was comparable with the Damboya HC with 38 health professionals and 24 supportive staffs in this study area. This is due to that both are urban HCs. In the similar study in Amhara region, Sulula HC in had 17 health professionals and 8 supportive staffs(5). It is comparable with Funto HC with 17 health professionals in this study area; but 18 supportive staffs in Funto HC. This variation in supportive staff was because the Funto HC is an urban HC that fosters staff preference to urban area than rural.

Regarding to the guidelines, recording and reporting materials, in Woreda CBHI scheme office and all HCs, there were implementation guidelines and reporting formats available; which is consistent the minimium recommendations of national implementation guideline(31). The availability of aforementioned CBHI job aids served as working framework and tracking root for program activities so as to strengthen it continuously respectively. But, in all of the HCs there was no standard members service registration books; it is not in line with the implemetation guideline. It is due to intruption of its supply from FMOH; previously it was being supplied and the HCs were requesting it repeatedly but not supplied yet; it was beyod HCs capacity to publish it. Eventhough it was not being supplied, the HCs availed local registers by adopting the all contents of standard register to make the service sustainable. Eventhough the service delivery was being registered it may not be sustainable; due to that the opportunity of missing data become high. In six sampled kebeles' in all there were standard registration books and membership application forms that fits the standard(31). It has a great role in generating relevant information that can be basic for informed decision making on the CBHI program activities.

Outpatient service, inpatient services, surgery, drugs or medicines, laboratory tests and medical equipments are major areas under the umbarella of benefit packages(35).The tracer drugs, laboratory tests or diagnostics and medical equipments availability in this study area were 56%, 80% and 77% respectively.These three listed items are still lower than Ethiopian Standard Agency

recommendation; that recommends 100% as well the implementation guideline(31,33,35). i.e. for 44% tracer drugs, 20% laboratory tests and 27% others, members were being referred to private facility where burdened by out of pocket expenditure. These inturn can affect HHs' satisfaction towards the scheme and leads to high drop-out rate. However, this finding is by far greater than national level health facility readiness assessment results 28%, 40% and 60% respectively(37).This great gap was due that in former study all the health facilities from health center to tertiary hospitals were included and large number of health facilities nation wide; but in this study only four HCs in single woreda. The CBHI members deserved to have all the listed included services in the benefit packages(35). Eventhough aforementioned availability gaps were there, the overall resource availability for CBHI program implementation was 85%; which is very good implementation as per the judgement parameter.

7.2.Compliance Dimension

In the this study, Compliance of implementation was included so as to measure level and compare implementation quality of the CBHI program as per the regional standards. Forthat the community mobilization, contract agreement with health facilities and keeping a month waiting time as pre-requisites for health service utilization and review meetings, suportive supervision,clinical audits, feedbacks provision, follow-up reports and reimbursing the service expenditure as monitoring CBHI program related activities were included.

In the four of the HCs there was a community mobilization in the form of facility forums every quarter led by the head of woreda and board as per the facility forum plan; mean that with 100% achievement; which is better than the pilot evaluation findings of 2015 by EHIA(5). It is because it is believed that community participation was backbone for the implementation by increasing enrollment and fosters the sustainability of the CBHI program.

The four of the HCs had contract agreement with the CBHI scheme being revised on annual bases; which is inline with the regional standard(31). Since both CBHI scheme and heads of facilities are aware of pre-requisites of the CBHI program implementation. This lied legal ground for service provision and reimbursing health care cost compulsory.

Keeping a month wait for newly enrolled CBHI members prior to use the health service so as to avoid adverse selection is kept in the four HCs' clusters. It is consistent with the regional standard

of implementation(31); it avoids the side effects of adverse selection.i.e that reduce early comers or already predisposed groups(risk groups) over burdening the scheme by high cost. Also it is the same with CBHI program implementation of Rwanda(44). It is due to the use of similar implementation strategies in both countries.

The CBHI scheme govering board conducted meeting in quartely bases as per the regional standard;but provided feedbacks to four of the HCs once on the set directions which is below the standard(31). Related to board meeting, this funding is better than the piloted study evaluation finding of EHIA in 2015 national wide(5). It was due that the former study was with the wider scope than this. In case of feedbacks, it was due to the work-overload of govering board. Even though review meetings were conducted as per the guideline but feedbacks not. i.e the diecisions made by governing board not cascaded it affects level of program execution. In the this study area the supportive supersion was almost nill, It is opposed with the standard and the plan (31). It implies that program activities were well monitored negatively affects program execution.

The CBHI activities report to scheme completeness in the four of HCs was 100%; which is the same with the revised 2017 HMIS recommendations; as well its' timeliness was 100%, which is greater than the revised 2017 HMIS recommendation being 90%(36). It was due to the presence of trained CBHI focals with their due commitment in the four of the health centers. This fosters program execution by lying right ground for informed decision making.

In the four of the HCs the clinical audit was done once and also its feedbacks; mean that only 25%(4 times), that was below the national standard recommending every quarter or 100%(16 times)(31). This was due to the budget deficit in the CBHI scheme to reimburse;since one of the purposes of the clinical audit is to reimburse remaining 25% of the health service expenditure. Eventhough it is an standard; being single health professional in the scheme; due that high workload. This reduces quality of health service delivery and HH's satisfaction; inturn increases dropout rates.

None of the HCs health expenditure was reibursed totally and timely, as per the contracted agreement and the national standard recommending reimbursing in quaterly bases totally within the given time interval(31). It was associated with the low amount of the permium and high and

changing health care cost, deliance of collected permium in the hands of collectors to some extent, lack of local leadership commitment…etc. This leads to bankrupsy of health facilities where HCs cannot avail health service supplies. On other hand, members become dissatisfied with service delivery so as increase dropout rates that negatively affects the scheme sustainability.

7.3.HH's Satisfaction Dimension

To start with satisfaction, in this study area almost half of the HHs(50%) were satisfied with scheme. This finding was comparable with the study finding in Sheko district South-West Ethiopia with HHs satisfaction level 55%(30). This may be due to the employment of the same study design in both study area. But it was by far lower than Damot Woyde district with HHs satisfaction level 92%(18). The gap may be due to HHs over expectation on the scheme in this study area than the former.

From the socio-demographic variables only the educational level was significantly assoscited with the HHs' satisfaction towards the scheme. House holds heads' who can read and write were 1.938(95%CI=1.241-3.028) times more likely to be satisfied with the scheme than those with no education. It is true that education can enable HHs think differently and understand easily. But, others were not significantly associated. Similarly, study in Sheko district; Ethiopia: sex, marital status and house hold income were not significantly associating(30). Also study finding in Bagladesh: age, sex, marital status, family size were not associating significantly(23).

Distance from the contracted health facility was associating with the HH's satisfaction towards the scheme. House holds joining health facility an hour and less long were 0.357(CI=0.219-0.583) times more likely to be satisfied with the scheme than those joining more than an hour. This is the case that coming from near has less transportation cost and more efficient for time management than coming from far distance.

However, health service provision related factors like: getting laboratory service was significantly associated with the satisfaction towards the scheme; with the similar study finding in Ethiopia(30). In this study; HHs getting laboratory service in the contracted health center were 2.9(95%CI=1.828-4.602) times more likely to be satisfied with the scheme than those not getting the laboratory service; since the laboratory service is part of benefit packages and indicator of quality service.

Explaining the health service being provided was significantly associated with the CBHI scheme satisfaction in this study; in line with this finding supported here(23). Here, House holds had been explained about the health service being provided were 1.753(95%CI=1.071-2.869) times more likely to be satisfied with the scheme than had not been explained. It is because explaining about the health service being provided may increase confidence of HHs in the service and initiate the clients to participate in the service provision as well as enable them make decision. Since, it is part of health litracy enhances service quality.

The need for health service provision improvement became determinant factor for HH's satisfaction. House holds complaining in need of health service provision improvement were 5.752 times less likely to be satisfied with the scheme than those not had complain. It is due to that being not served well has its own role on the service quality, if it is not provided friendly.

The benefit packages adequacy and assessing the health problem both became determinants for the HH's satisfaction towards the scheme. House holds said benefit packages adequate were 2.091 time more likely to be satisfied with the scheme than those said not, and HH's whose health problem assessed were 1.743 times more likely to be satisfied with the scheme than those not.

7.4. Strengths and limitations of this study

The experience and the way the researcher understand,analyze and interperiate the data can affect results. Beyond this limitation, the study generated program performance level and its associated barriers mean that level of program resource availability, level of program activities compliance towards the predetermined standards and level HH's satisfaction as well as responsible factors for observed level of program perfomance by using multiple data collection methods.

Chapter-8: Conclusions and Recommendations

8.1.Conclusion

There were no standard service registers resulting from supply intruption and unability of HCs to publish registers and no inpatient services due to rooms shortage in all HCs. Laboratory investigations like: heamatocrit and haemoglobin test were not being done because haematocrit centerfuge was not functional except HC-1. Absence of some drugs because of budget shortage.The adult weight scale in all HCs and child weight scale in HC-2 and 3 were not functioning due to minor maitainace problem. However, most of the required resources for the CBHI program implementation were available as per the national standards; this resulted in very good implementation with regards of overall resource availability.

The program pre-requisites such as community mobilization, contract signing and a month waiting as well as program activities like: review meeing and reporting were consistent with national standards while supportive supervision,clinical audit, re-imbursing service expenditure, written feedbacks provision by scheme as well as by govering board were not inline with national standards that made overall CBHI program implementation compliance partial.

The household's satisfaction towards the CBHI scheme in Damboya woreda was parial. Where, educational level, getting laboratory service , explaining the service being provided, assessing the health problem, distance from the contacted health facility and need for service provision improvement were independent determinants of HHs satisfaction towards the scheme. In general, the overall CBHI program implemetation level in piloted Damboya woreda was partial.

8.2. Recommendations

CBHI governing board

- CBHI board ought to built additional rooms to enable HCs provided their level inpatient services atleast 48 hours stay.
- It is better that the scheme board provide feedbacks to the HCs following quarterly reviews so as to improve the program impementation.
- It is better that the scheme board mobilize fund and subsidize the scheme to enable reimburse the HCs health expenditure.

Woreda CBHI scheme office

- The woreda CBHI scheme better to mentor and supervise the contracted HCs by using standard checklists for the availability of the benefit packages inorder to sustain CBHI program implementation.
- The CBHI scheme ought to conduct clinical audit as per the standard inoder to improve service quality using standard checklist
- The CBHI scheme better to supervise the kebele level sub-scheme for the early deposition of collected permium.
- The CBHI scheme ought to reimburse timely the health service expenditure of health facilities to capable them avail benefit packages.

Health Facilities/ health workers/

- It is better that the HCs publish standard service register using standard template to standardized the service by efficient utilization of internal revenue.
- All contracted HCs ought to avail atleast tracer drugs by pre planning, propare forcasting and timely purchasing so as to avoid unnecessary referal to private providers where members are being burdened by direct out of pocket expenditure.
- The HC-2,3 and 4 better to do before and after daily cleaning and maintaince on medical equipments basically haematocrit centerfuge regularly by assigning resiposible body for remiding so as to provide haematocrit and Haemoglobin tests to members.
- All contracted HCs, and HC-2 and HC-4 ought to do before and after daily cleaning and assigning resiposible body for remiding maintaince of adult weight scale and child weight scale regularly to provide comprehensive services.
- It is better that the health professionals explain the service they are providing and assess comprehensivly the health problems by relying on standard protocols and guidelines.

Chapter-9: Meta-Evaluation

It is an evaluation of evaluation beining done alongside with this evaluation inorder to assure the credibility, quality and utilization of the finding. In this evaluation, the meta evaluation is going on alongside. By doing so uncertainties were identified and corrected throughout the evaluation,i.e that during the planning, implementation and analysis of information of the evaluation. It was done by considering the four basic evaluation standards(Utility=7, Feasibility=3,Propriety=8 and Accuracy=12, total 30 sub-standards) including sub-standards under each; so far these evaluation standards being measured and also was keptbeing measured till the end of the evaluation. The total score of the four evaluation standards and substandards is shown in the table(annex-IV) by using standard formative meta evaluation checklist(45). It was done by HM and E expert and other public health experts at the KT Zonal Health Department.The total score of 83% which is judged as very good score as per checklist.

9.1. Utility

The main purpose of program evaluation is its utilization;here to assure this from the very beginning the key program stakeholders were involved and their role and interest in the program as well as in the evaluation were explored during the EA. The evaluation questions set was reflective of the needs of the key stakeholders and preliminary beneficiaries of the program. The final evaluation findings was judged as per the judgement criteria set by the stakeholders. The thecontext,evaluation procedures were explained under concerned parts. At the end the evaluation findings will be disseminated as per the schedule.The total score is 84%.

9.2. Feasibility

This evaluation was done by economizing limited resource which is dipicted under resource plan. Already the list of activities and resources were linked clearly by doing so unplanned wastage of resources was avoided;there wasthe use of the right resource for right activity. Also, most of key program stakeholders are in line with the CBHI program so it was believed to politically accepted and supported. The available local resources enable the evaluation activity. Even though the study design in use is mixed, the available resource was used efficiently.The total score is 83%.

9.3. Propriety

In this study all those involved key stakeholders were involved during EA based on their willingness via verbal informed consent; and also during data collection all study participants were participate voluntarily. A great respect was given to human rights and dignity. The data collectors were told about the objective, the method and procedures of the evaluation. The participants have the right even to cross-out from the study at any time. The purpose and the procedures of the study was clearly informed to the participants before the data collection. The confidentiality will be kept; will not be disclosed to the third bodies without the permission of the participant. The total score is 84%.

9.4. Accuracy

To maintain the accuracy standards; so far different appropriate documentswere reviewed, program documents and records discussed with stakeholders to understand the program. Training was 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. Using the mixed data collection methods(Community based survey,KII,document, records and report review and resource inventory), triangulation of different data collection techniques generated accurate findings. Different data quality assurance techniques also used. The total score is 79%.

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ANNEX-I: Availability of Tracer Drugs

Table-14: Shows the tracer drugs availability in the Health centers of Damboya Woreda in March 16 to May 16/2020.

S.no	List of tracer drugs	HC-1	HC-2	HC-3	HC-4	Remark(%)	Wt given	score
1.	Are there amoxicillin 500mg 0r 250 mg capsule in pharmacy/store?	Y	Y	Y	Y	100%	0.5	0.5
2.	Is there amoxicillin 250mg/5ml or125mg/5ml syrup in pharmacy/store?	Y	Y	Y	Y	100%	0.50	0.5
3.	Are there amphicilin500mg or 250 capsules in pharmacy/store?	X4month(67%)	X4months(67%)	X2(83%)	6month(50%)	67	0.35	0.23
4.	Is there amphicilin125mg/5ml or 250mg/5ml syrup in pharmacy/store?	X6month(50%)	X4months((67%)	X2(83%)	X3month(75%)	69	0.3	0.21
5.	Are there cotrimozathole480 or 960 mg tablet in pharmacy/store?	X3months(75%)	X3months(75%)	X3month(75%)	X2month(83%)	77%	0.5	0.4

6.	Is there cotrimozathole 240mg/5ml syrup in pharmacy/store?	Xmonths(75%)	X6months(50%)	Y(100%)	Y(100%)	81%	0.5	0.4
7.	Are there 500mg or 250mg ciproflaxin in pharmacy/store?	X2months(83%)	X 2amonth(83%)	X4month(67%)	X3months(75%)	77%	0.3	0.23
8.	Are there metrodazole 500mg or 250mg capsule in pharmacy/store?	X3months(75%)	X3months(75%)	Y(100%)	X2months(83%)	83%	0.2	0.17
9.	Are there metrodazole 250mg/5ml or 125mg/5ml syrup in pharmacy/store?	X6months(50%)	X2months(83%)	X3month(75%)	Y(100%)	77%	0.3	0.23
10.	Are there mebendazole or albendazole tablet in pharmacy/store?	Y(100%)	Y(100%)	Y(100%)	Xmonths(92%)	98%	0.3	0.29
11.	Is there third generation anti-biotic like ceftrizone in pharmacy/store?	Y(100%)	Y(100%)	Y(100%)	X one wk(92%)	98%	0.25	0.24
12.	Are the anti-pain drugs tablet (paracetamol or ibuprofen or indometacin or diclofenac) in pharmacy/store?	Y	Y	Y	Y	(100%)	0.5	0.5

13.	Are there anti-pain injection (diclofenac or dipron) in pharmacy/store?	Y	Y	Y	Y	(100%)	0.5	0.5
14.	Are there cloxacilin 500mg or 250mg capsule in pharmacy/store?	X6months(50%)	X6months(50%)	X5months(58%)	X month(92%)	62%	0.25	0.15
15.	Are there cloxacilin 250mg/5ml or 125mg/5ml syrup in pharmacy/store?	X3months(75%)	X2months(83%)	Xmonth(92%)	X 12months(0%)	62%	0.3	0.2
16.	Is there gentamacin injection in pharmacy/store?	X3months(75%)	X3months(75%)	Y(83%)	Y(83%)	79%	0.3	0.24
17.	Is there pencillin or benzatine injection in pharmacy/store?	X3months(75%)	X4months(67%)	X4months(67%)	X4months(67%)	69%	0.25	0.17
18.	Is there dermatology cream in pharmacy/store?	Y	Y	Y	Y	(100%)	0.5	0.5
19.	Are there iron sulphates tablet in pharmacy/store?	Y	Y	Y	Y	(100%)	0.5	0.5
20.	Are the anti-acid syrups or omeprazole tablet in pharmacy/store?	Y	Y	Y	Y	(100%)	0.2	0.2
21.	Are the ORS sachets in pharmacy/store?	Y	Y	Y	Y	(100%)	0.3	0.3

22.	Are there Normal saline for Iv fluid in pharmacy/store?	Y	Y	Y	Y	(100%)	0.5	0.5
23.	Are there a coartem in pharmacy/store?	Y(100%)	X3month(75%)	Y(100%)	Y(100%)	94%	0.5	0.47
	Total	56%	48%	68%	60%	56%	8	4.48

NB: The 'X' for drug item not available; in this case, write number of months that drug item was not available in the remark column. As well 'Y' for available drug item.

ANNEX-II: Availability of Laboratory Equipments

Table-15: Shows that the availability of the laboratory equipments and investigations in the Health Centers of Damboya Woreda from March 16- May 16/2020.

S.no	Essential laboratory services	HC-1	HC-2	HC-3	HC-4	Remark	Wt given	Score
1.	Is there Stool examination service in the laboratory?	1	1	1	1	4	0.6	0.6
2.	Are there urine analysis services in the laboratory?	1	1	1	1	4	0.6	0.6
3.	Are there AFB services in the laboratory?	1	1	1	1	4	0.7	0.7
4.	Is there H pyloric test services in the laboratory?	1	1	1	1	4	0.4	0.4
5.	Is there RH test in the laboratory?	1	1	1	1	4	0.7	0.7
6.	Is there HCG test in the laboratory?	1	1	1	1	4	0.4	0.4
7.	Is there hemoglobin test service in the laboratory?	1	0	0	0	1	0.7	0.2
8.	Is there hematocrite test in the laboratory?	1	0	0	0	1	0.7	0.2
9.	Is there VDRL test service in the laboratory?	1	1	1	1	4	0.6	0.6
10.	Is there HIV test in the laboratory?	1	0	0	1	2	0.6	0.3
	Total	10(100%)	7(70%)	7(70%)	8(80%)	8(80%)	6	5

NB: - '1' stands for availability of the listed laboratory item or investigation and '0' stands for the absence of that the time interval of the study.

ANNEX-III: Availability of Essential Medical Equipments

Table-16: Shows the availability of essencial medical equipmentsin the Health centers of Damboya Woreda in March 16 to May 16/2020.

S.no	List of Medical Equipments	HC-1	HC-2	HC-3	HC-4	Remark (total)	Wt given	score
1.	Are there functional microscopes in the laboratory?	1	1	1	1	4	0.5	0.5
2	Are there microscopic slides in the laboratory?	1	1	1	1	4	0.5	0.5
3.	Is here hemoglobin centrifugal machine in the laboratory?	1	0	0	0	1	0.3	0.075
4.	Are there enough beds in admission room?	0	0	0	0	0	0.2	0
5.	Are there IV standards in admission rooms?	1	1	1	1	4	0.2	0.2
6.	Are there forceps and scissors in OPD rooms?	1	1	1	1	4	0.2	0.2
7.	Is cotton in emergency in OPD rooms?	1	1	1	1	4	0.3	0.3
8.	Is there guaze in emergency OPD rooms?	1	1	1	1	4	0.3	0.3
9.	Are there disposal glove in emergency OPD rooms?	1	1	1	1	4	0.4	0.4
10.	Are there surgical glove in emergency OPD rooms?	1	1	1	1	4	0.5	0.5
11.	Are there safety boxes in OPD rooms?	1	1	1	1	4	0.3	0.3
12.	Are there MUACs in under 5 OPD rooms?	1	1	1	1	4	0.3	0.3
13.	Is there plan B under 5 OPD rooms	0	0	0	0	0	0.2	0

14.	Are there functional adult Weight scales in OPD?	0	0	0	0	0	0.3	0
15.	Are there functional BP apparatus in OPD rooms?	1	1	1	1	4	0.6	0.6
16.	Are there functional stethoscopes in OPD rooms?	1	1	1	1	4	0.4	0.4
17.	Are there functional child Weight scales in OPD rooms?	1	0	1	0	2	0.3	0.15
18.	Are there Examination Coaches in OPD rooms?	1	1	1	1	4	0.3	0.3
	Total	15(80%)	13(73%)	14(80%)	13(73%)	46(77%)	6	5

NB: - '1' stands for availability of the listed medical equipment and '0' stands for the absence of that the time interval of the study.

ANNEX-IV: Data Collection Tools

- **Questionnaire for Household Survey**

Consent form for member of the CBHI

Name of the kebele _____

Dear Madam/Sir Good morning/afternoon! My name is _____ and I am a member of an evaluation team that evaluate the implementation process 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 tell 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 she/he does not agree, respect his/her decision to decline and go to the next Participant.

Section I: General Information

Respondent's Kebele Name: _____

Given house number: ----------

Questionnaire ID Number: _____

Part-II: Socio-demographic Characteristics of respondents

S.No.	Socio-demographic Characteristics of respondents	Response
201.	Sex (Male=1,Female=2) –fill as observed	---------code
202.	Age of the respondent in complete year----------(years)	---------code
203.	Religious status(Orthodox = 1 , Muslim = 2, Catholic = 3, Protestant = 4, Other specify=88_____)	---------code
204.	Marital Status (Never Married = 1, Married = 2, Divorced =3, Widowed = 4)	---------code
205.	Household Size 1= 1<X<=5 ,2=>5	---------code
206.	Highest Educational Level of Head of the Household attained (with no education =1, reading and writing =2, primary education (Grade 1-6)=3 , secondary education (Grade 7-12) =4, vocational training=5, tertiary education=6)	---------code
207.	What is your main source of income (Farming = 1, Commercial Activity = 2, Heady craft =3, other, specify= 88	---------code
208.	Ownership of Cultivable Farmland (Do not have Farmland= 1, One Hectare and less =2, 1.1-2 Hectare=3, 2.1-3 Hectare=4, Above 3 Hectare =5) (Note that: one hectare is equivalent to Four tsimad)	---------code
209.	Household Income ----------ETB	---------ETB

Part-III:CBHI members experience related questions.

S.no.	CBHI members experience related to CBHI program	Put code for your response
210.	For how long did you stay enrolled in CBHI Scheme?----------years(in complete years) 1=<12 months, 2=>=12months	----------code
211.	How much did you pay at a time you become scheme member? ----------ETB	----------ETB
212.	How do you think about premium you pay?1= high, 2= medium, 3= low	----------code
213.	How long does it take, after payment of registration fee and premium, to start utilizing health services? 1=< 30 days , 2=30 days, 3=>= 30days	--------code
214.	The timing schedule/time interval of premium payment is convenient for my household. 1=disagree, 2=indifferent, 3=agree	----------code
215.	How far is you CBHI contracted health facility? ----------minutes	----------minutes
216.	Which one from the list below is not included in the promised benefit packages; More than on response is possible. 1= outpatient service 2=inpatient service 3= laboratory sevice 4=drugs/medication 5=referral to next higher health facilities 6=root canal treatment 7=cosmothicsurgey	

	8=out of country treatment 9=dialysis 88= others specify.	
217.	Did you have promised services in your contracted health facility? 1=yes, 2=no,	----------code
218.	If yes for above question, what are those benefit packages you have got?(can choose more than one) 1=laboratory service, 2=Drugs, 3=referral to next level, 4=Counseling, 5= admision , 6=all ,88=other specify?----------	----------code
219.	The CBHI benefit package meets the requirements of my household. 1= Disagree 2= indifferent 3=Agree	----------code
220.	The promised benefit packages are adequate. 1=yes , 2=no, 3= in between	---------code
221.	Does the CBHI scheme have complaint addressing mechanism? 1=yes, 2=no	---------code
222.	If yes for ques-221, which one? (more than one is possible). 1= suggestion box, 2= suggestion book , 3=meetings, 4= media, 5= through HAD, 6=through HEWs,7=patient satisfaction survey, 88= others specify	---------code
223.	Are the local CBHI management are responsible? 1=yes, 2=no	---------code
224.	If yes for ques-223, in which aspect?(more than one choices is possible). 1= provided as insurance cards on time, 2= respond to our complaints properly & on time, 3=regulary remind us to renew our ID cards, 4= follow whether we are getting or not the benefit packages 5= are communicative when we visit to their office, 88= others specify	---------code
225	Does the CBHI scheme provide you information? 1=yes, 2=no	---------code
226.	If yes for the ques 225, which one?(more than one choices are possible)	

	1= about the purpose of CBHI, 2=about schedule for renewal, 3=about benefit packages, 4= time to start service utilization, 5= how to follow referral linkages ,88=others specify	---------code
227.	Are health providers available at work place time? 1. Yes 2. No	----------code
228.	The health professionals care at the contracted health facility is needs some improvemet. 1= agree, 2= disagree, 3= nuetral	---------code
229.	Did the health provider assess your problems (including physical examination)? 1=Yes, 2 =No	----------code
230.	Did the health providers explain about health services that you had provided for ? 1=Yes, 2=No	---------code
231.	Did you get laboratory services? 1=Yes , 2=No	---------code
232.	If No for question 231, 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’tknow it's the reason	---------code
233.	Did you get all prescribed drugs in that health center? 1=Yes 2= No	---------code
234.	If no for 233, why you did not get all prescribed drugs in this institution?	---------code

	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,88=other specify----------	

Part-IV: Questions for measuring understanding(knowledge) of the concept CBHI amoung members. Put the code for each question listed below.

S.no	The concept of CBHI among members	Code
235.	The CBHI is non-profit risk pooling mechanisms built on soliderity. 1=yes, 2=no	---------code
236.	For CBHI members their service entry point is nearby contracted health facility 1=yes, no=2	---------code
237.	Those members whose bypass the referral chain are expected to cover half of the their health care cost. 1=yes, 2=no.	---------code
238.	At the time of service utilization co-payment is expected from members. 1=yes, 2=no.	---------code
239.	The insurance card can be collected from CBHI scheme offfice. 1=yes, 2=no.	---------code
240.	During enrollment members are expected to pay registration free & premium. 1=yes, 2=no.	---------code
241.	After registration CBHI members are expected to wait for a month prior to service reception. 1=yes, 2=no.	---------code

242.	The CBHI members are expected to renew their membership every year. 1=yes, 2=no	---------code
243.	For the children greater than 18yrs additional payment is expected based on their number acoordingly. 1=yes, 2=no	---------code
244.	For additional family members i.e that those not had birth in that household but living together needs additional permium according to their number 1=yes, 2=no	---------code
245.	For CBHI members, any family numbers dynamics(birth or death) has to reported and registered. 1=yes, 2=no	---------code
246.	Being members is volunteerly done at any time regardless of heath problem. 1=yes, 2= no	---------code

Part-V: CBHI members satisfaction measuring questions to be leveled on, five points ratings (Strongly satisfied=5, satisfied=4, neutral=3, dissatisfied=2, Strongly dissatisfied=1).

Ask the questions below in the table & put the code indicating their level of satisfaction with the service provided

s.no.	CBHI members satisfaction measuring questions	Put code here
247.	How you satisfied Opening hours of CBHI scheme office?	
248.	How you satisfied Schedule for premium collection?	
249.	How you satisfied Collection process of insurance cardsfrome CBHI scheme office?	
250.	How you satisfied Waiting time prior to service initiation after payment?	
251.	How you satisfied medical record service?	
252.	How you satisfied availability of health worker on time?	

253.	How you satisfied time spend on waiting before contact with health professionals?	
254.	How you satisfied with the health professionals care?	
255.	How you satisfied with the OPD services	
256.	How you satisfied with the IPD services	
257.	How you satisfied with the referral services	
258.	How you satisfied laboratory services?	
259.	How you satisfied getting drugs from Health Center?	
260.	How you satisfied with overall CBHI packages	
261.	How you satisfied overall health services provided(overall satisfaction)?	

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

_____

Data collector name: _____Signature_____ Date__/__/__

Supervisor name: _____Signature_____ Date----/---/---

o ቤት ለቤት ጥናት መጠይቅ/ቅጽ

የማዐጤመአባል ፈቃደኝነት ቅጽ

አቶ/ወ/ሪት/ወ/ሮ ደህና አደርክ/ሽ?/ደህና ዋልክ/ሽ? ስሜ _____ነው። እናም እኔ የማዐጤመመርሃ-ግብር ትግበራ ሂደት ከጅማዩኒቨርሲቲ ጋር በመተባበር የሚገመግም የግምገማ ቡድን አባልነኝ። ዓላማዉምየተሻለ ልምምድ ካለ ለመማማር እና ክፍተት ካለም ዉሳኔ ለምሰጥ አካል በእዉነተ ላይ የተወሠረተ መረጃ ለመስጠት ነዉ። የእርስዎ ስምና የግል መረጃ አይጸፍም ደግሞም ምስጥራዊነቱም የተጠበቀ ነዉ። በመሆኑም እርስዎ አስፈላጊዉን መረጃ ለመስጠት ይስማማሉ?

1. **አዎን**

2. **አልስማማም**

የመረጃ ሰብሳቢው ስም _____ፊርማ_____ ቀን __ / __ / __

የሱፐርቫይዘር ስም: - _____ፊርማ_____ ቀን __ / __ / __

ማስታወሻ፡- ተሳታፊው ለመጠየቅከተስማማ ለፈቃደኝነቱ አመስግነዉ ቃለ-መጠይቁን ይቀጥሉ። እሱ ካልተስማማ ላለመቀበል የወሰነውን ውሳኔ ያክብሩ እና ወደ ቀጣዩ ተሳታፊ ይሂዱ።

ክፍል I አጠቃላይ መረጃ

የተሳታፊዉ የቀበሌ ስም _____ የቤት ቁጥር----------

የመጠይቁ ቁጥር _____

II-የስነ-ሕዝብአወቃቀርባህሪዎች(ሶሾ-ዴሞግራፊክ ካራክቴሪስትክ)

ተ.ቁ.	**የስነ-ሕዝብአወቃቀርባህሪዎች**	**የመልሱ ኮድ**
201.	የተሳታፊዉ ፆታ (ወንድ = 1 ፣ሴት = 2) - እስከተመለከተውድረስ	---------ኮድ
202.	የተሳታፊዉ ዕድሜሙሉዓመት ----------	--------አመት

203.	የሃይማኖትአቋም (ኦርቶዶክስ = 1 ፣ሙስሊም = 2 ፣ካቶሊክ = 3 ፣ፕሮቴስታንት = 4 ፣ሌላ ይጠቀስ = 88 _____)	--------ኮድ
204.	የጋብቻሁኔታ (ያላገባ/በች = 1 ፣ያገባ = 2 ፣የተፋታ = 3 ፣የትዳርጓደኛ የሞተችበት/ባት = 4)	--------ኮድ
205.	የቤተሰብ ብዛት 1 <= 5, 2 => 5	--------ኮድ
206.	የቤተሰቡከፍተኛየትምህርትደረጃ (ምንም ያልተማረ = 1 ፣ንባብእናጽሑፍየምችል/ትችል= 2 ፣የመጀመሪያደረጃትምህርት (ከ1-6ተኛክፍል) = 3 ፣ሁለተኛደረጃትምህርት (ከ7-12ተኛክፍል) = 4 ፣የሙያስልጠና = 5 ፣ከፍተኛትምህርት= 6)	--------ኮድ
207.	ዋናየገቢምንጭዎ (እርሻ = 1 ፣የንግድእንቅስቃሴ = 2 ፣የጉልበት ሥራ = 3 ፣ሌላ፣ይጥቀሱ = 88)	---------ኮድ
208.	ለእርሻየሚሆንመሬትባለቤትነት (እርሻመሬትከሌለዎት = 1 ፣አንድሄክታርእናከዛበታች = 2 ፣ 1.1-2 ሄክታር = 3 ፣ 2.1-3 ሄክታር = 4 ፣ከ 3 ሄክታርበላይ = 5) (ልብይበሉ-አንድሄክታርከአራትጥማድ ጋርእኩልነው)	---------ኮድ
209.	ገቢዎ በብር ----------(የኢትዮ ብር)	---------- (የኢትዮ ብር)

ክፍል-III - የማዐጤመአባላትተዛማጅጥያቄዎች ከተሞክሮአቸው::.

ተ.ቁ.	የማዐጤመአባላትተዛማጅጥያቄዎች ከተሞክሮአቸው::.	የመልሱ ኮድ
210.	የማዐጤመ አባል ሆነዉለምንያህልጊዜቆይተዋል? ---------- (በዓመታት) 1 = ከ12 ወር በታች፣ 2 = 12 እና ከዚያ በላይ ወራት	----------ኮድ

211.	የማዐጤመ አባል በሆኑበት ጊዜ ምን ያህል መዋጮ ከፈሉ? ---------- (የኢትዮጵያ ብር)	---------- (የኢትያ ብር)
212.	ስለከፈሉበት የአባልነት መወጮ እንዴትያስባሉ? 1 = ከፍተኛ፣ 2 = መካከለኛ፣ 3 = ዝቅተኛ	----------ኮድ
213.	የምዝገባእና የአባልነት መወጮ ክፊያከከፈሉ በኋላየጤና አገልግሎት መጠቀምለመጀመርምንያህልጊዜ ወሰደቦት? 1 = ከ30 ቀናት በታች፣ 2 = 30 ቀናት ከ፣ 3 => = 30 ቀናት	--------ኮድ
214.	የምዝገባም ሆነ የአባልነት መዋጮ ክፊያ ወቅት ለቤተሰብዎ ተስማሚ ነዉ።። 1 = አልስማማም፣ 2 = ምንም አይደለም፣ 3 = እስማማለሁ	----------ኮድ
215.	የጤና አገልግሎት የሚያገኙበት የማዐጤመ ስምምነት ዉል ጤና ተቋም ምንያህል ይርቃል?----------(በደቂቃ)	---------- (በደቂቃ)
216.	ከዚህበታችከተዘረዘሩትውስጥ በጥቅም ማዕቀፉ ውስጥ የማይካተት የትኛውነው? (ምላሹ ከአንድ በላይሊሆንይችላል)።። 1 = የተመላላሽ ህክምና አገልግሎት 2 = የተኝቶ ህክምና አገልግሎት 3 = የላቦራቶሪ አገልግሎት 4 = መድሃኒት 5 = ለሚቀጥሉትከፍተኛየጤናተቋማትማስተላለፍ(ሪፌራል) 6 = ለጥርስ ወርቅ ማስገባት 7 = የኮስሞቲክ ቀዶጥገና (የዉበት ቀዶ ህክምና) 8 = ከሀገር ዉጭ ሕክምና	

	9 = ዲያሊሲስ 88 = ሌሎችይጥቀሱ፡፡	
217.	የማዐጤመ ዉል ስምምነት በተደረገበት የጤና ተቋም በጥቅም ማዕቀፉ የተካተቱ አገልግሎቶች አግኝተዋል? 1 = አዎ፣ 2 = የለም፣	----------ኮድ
218.	ለጥያቄ 217 አዎ መልሶ ከሆነ፣እነዚያ የጥቅም ማዕቀፍ ዉስጥ የትኞቹን ነዉ ያገኙት? (ከአንድበላይመምረጥይችላሉ) 1 = የላብራቶሪአገልግሎት፣ 2 = መድኃኒቶች፣ 3 = ወደሚቀጥለውደረጃ መላክ (ሪፈራል)፣ 4 = የምክክርአገልግሎት፣ 5 = ተኝቶ ህክምና፣ 6 = ሁሉም፣ 88 = ሌላይጥቀሱ? ----------	----------ኮድ
219.	የማዐጤመ የጤና አገልገሎት የጥቅማጥቅም ማዕቀፉ የእርሶንና የቤተሰብዎን ፈላጎት ያሟላል፡፡ 1 = አልግባባም 2 = ምንም አይደለም 3 = እግባባለሁ	----------ኮድ
220.	የማዐጤመ የጤና አገልገሎት የጥቅማጥቅም ማዕቀፉበቂ ነዉ፡፡ 1 = አዎ፣ 2=አይደለም	---------ኮድ
221.	የማዐጤመ አመራሩ የደምበኞችን ቅሬታ የሚከታተልበት ስርዓት አለዉ ወይ? 1=አዎ፣ 2=የለዉም	--------ኮድ
222.	ለጥያቄ 221አዎከሆነ፣የትኛውነው? (ከአንድበላይ መልስ ይቻላል)፡፡ 1 = የአስተያየት መስጨ ሳጥን፣2 = የአስተያየት መስጨ መዝገብ፣3=በስብሰባ, 4=በሚዲያ, 5= በልማት ቡድኖች በኩል, 6=በጤና ኤክስቴንሽን አማካኝነት,7= በተጋልጋይ እርካታ ደሰሳ ጥናት, 88= ሌላ ካለ ይጠቀስ	---------ኮድ
223.	የማዐጤመ አመራር(ወረዳና ቀበሌ) ኃላፊነት ይሰመዋል? 1 = አዎ፣ 2 =አይሰማዉም	---------ኮድ
224.	ለጥያቄ-223 አዎከሆነ፣በየትኛውገጽታ? (ከአንድበላይ ምርጫ ይቻላል) ፡፡	

	1 = የአባልነት ካርዶችን በሰዓቱ ያቀርባል፣ 2 = ቅሬታዎቻችንንበተገቢውና በጊዜ ምላሽይሰጣል፣ 3=በቀጠይነት አባልነታችንን እንድናድስ ያሳስባል, 4= ተገቢውን የጤና አገልግሎት ማግኘት አለማግኘታችንን ይከታተላል፣ 5= የማዐጤመ ቢሮ በሄድን ሰዓት ተገቢውን አግልግሎት ይሰጣል፣ 88= ሌላ ካለ ይጠቀስ	---------ኮድ
225	የማዐጤመ አመራር ማዐጤመን አስመልክቶመረጃይሰጥዎታልን? 1 = አዎ፣ 2 = አይሰጥም	--------ኮድ
226.	ለጥያቄ 225አዎከሆነ፣የትኛውነው (ከአንድበላይ ምርጫ ይቻላል)። 1 = ስለእድሳትመርሃ-ግብር፣ 2 = ስለጥቅማጥቅም ማዕቀፉ(አባላት ማግኘት ስለምችሉአቸዉ የጤና አገልግሎቶች)፣ 3 =የአገልግሎትአጠቃቀምን መች መጀመር እንደለብን፣4 = ሪፈራል ቅብብሎሽ ስርዓቱን እንዴት መከተል እንዳለብን፣ 88 = ሌሎችይጥቀሱ	--------ኮድ
227.	የጤና ባለሙያዎች በስራቦታቸውይገኛሉ? 1. አዎ 2. አይገኙም	---------ኮድ
228.	የጤናተቋም የሚሠሩ የጤናባለሙያዎች የጤና አገልግሎት አሰጣጣቸዉ የተወሰነመሻሻል ያስፈልገዋል? 1 = እስማማለሁ፣ 2 = አልስማማም፣ 3 = ገለልተኛ	--------ኮድ
229.	የጤናባለሙያው የጤና እክልዎን (የአካልምርመራንጨምሮ) መርምሯል? 1 = አዎ፣ 2 = አልመረመረም	--------ኮድ
230.	የጤና ባለሙያዎች ስለምሰጡት የጤናአገልግሎት ማብራሪያ ይሰጣሉ? 1 = አዎ፣ 2 = አይሰጡም	--------ኮድ
231.	የላቦራቶሪ ምርመራዎችን በጤና ተቋሙ አግኝተዋል? 1 = አዎ፣ 2 = አላገኙም	-------ኮድ

232.	አላገኙም ለጥያቄ 231 ከሆነ፣ለምን አላገኙም ነበር? 1 = የላቦራቶሪአገልግሎቶችለኔህመምአስፈላጊአልነበሩም 2 = የላብራቶሪ ባለሙያዎች የሉም 3 = በተቋሙውስጥየላብራቶሪአገልግሎትየለም 4 = ምክንያቱምንእንደሆነአላውቅም 88= ሌላ ካለ ይጠቀስ	--------ኮድ
233.	በዚያየጤና ተቋም ውስጥየታዘዘመድኃኒቶችንሁሉአግኝተዋል? 1 = አዎ 2 = አላገኘሁም	--------ኮድ
234.	ለ233 አላገኘሁም ከሆነ፣በዚህተቋምውስጥየታዘዘመድኃኒቶችንሁሉለምን አላገኙም? 1 = በቂመድኃኒቶችየሉም 2 = ብዙ መድሓኒቶች የሉም 3 = የግልፋርማሲከዚህተቋምየበለጠመድኃኒቶችአሏቸው 4 = መድኃኒት ክፍሉ ተዘግቷል 5 = አይታወቅም ፣88= ሌላ ካለ ይጠቀስ	--------ኮድ

ክፍል-IV በአባላትመካከልየማዐጤመ ፅንሰ-ሀሳብን (ዕውቀትን) መለኪያ ጥያቄዎች።ከዚህበታች ለተዘረዘሩ ለእያንዳንዱጥያቄ ኮድ ያስገቡ።

ተ.ቁ.	በአባላትመካከልየማዐጤመ ጽንሰ-ሀሳብ	ኮድ

235.	ማዐጤመበአንድነትላይየተመሠረተ ለትርፍ ያልተቋቋመ ወጭ የመጋራት ዘዴ ነው። 1 = አዎ፣ 2 = የአይደለም	-------ኮድ
236.	ለማዐጤመአባላት የጤና አገልግሎት መጀመር ያለባቸዉ በአቅራቢያቸው በሚገኝ የስምምነት ጤናተቋምነው ። 1 = አዎ፣ 2=አይደልም	-------ኮድ
237.	የሪፈራልሰንሰለትአቋርጠውየሚያልፉአባላትከጤና አገልግሎት ወጪያቸውግማሹንይሸፍናሉተብሎይጠበቃል። 1 = አዎ፣ 2 = አይደለም።	-------ኮድ
238.	አባላት የጤና አገልግሎት በሚያገኙበት ጊዜ ተጨማሪ ክፊያ ይጠየቃሉ። 1 = አዎ፣ 2 = አይጠየቁም።	-------ኮድ
239.	የአባልነት መታወቂ ካርድ የምገኘዉ ከማዐጤመ ቢሮ ነዉ። 1 = አዎ፣ 2 = አይደለም።	-------ኮድ
240.	የማዐጤመ አባል ለመሆን የምዝገባና የአባልነት መዋጮ መክፈል ይጠበቃል። 1= አዎ፣ 2= አይደለም	-------ኮድ
241.	አንድ የማዐጤመ አባል ከተመዘገባ በኋላ የጤና አገልግሎት ከመጀመሩ በፊት የአንድ ወር የእፎይታ ጊዜ መጠበቅ ይኖርበታል። 1 = አዎ፣ 2 = የለም።	-------ኮድ
242.	የማዐጤመ አባላትአባልነታቸውንበየዓመቱማደስይጠበቅባቸዋል። 1 = አዎ፣ 2 = የለም	-------ኮድ
243.	ዕድሜያቸውከ 18 ዓመትበላይለሆኑሕፃናትተጨማሪክፍያየሚጠየቀው በሰዎቹ ቁጥርነው። 1 = አዎ፣ 2 = አይደለም	-------ኮድ
244.	ለተጨማሪ የበተሰብ አባላት ተጨማሪ ክፊያ ይከፈላል። 1=አዎ ፣ 2= አይደለም	------ኮድ
245.	የማዐጤመ አባላትማንኛውምየቤተሰብቁጥሮችተለዋዋጭ (ልደትወይምሞት) ሪፖርትመደረግእናመመዝገብአለባቸው። 1 = አዎ፣ 2 = የለም	-------ኮድ

246.	አባልመሆንየጤናችግርምንምይሁንምንበማንኛውምጊዜበፍቃደኝነትይከናወናል። 1 = አዎ፣ 2 = የለም	-------ኮድ

ክፍል-V: - የማዐጤመ አባላት እርካታ መለኪያጥያቄዎች፣ከአምስትነጥብየተሰጡደረጃዎች (በጣም ረክቻለሁ= 5 ፣ረክቻለሁ= 4 ፣ምንም አይልም = 3 ፣አልረካሁም= 2 ፣በጣም አልረካሁም = 1)።ከዚህበታችበሰንጠረዥ ውስጥያሉትንጥያቄዎችይጠይቁየተቀመጠውንአገልግሎት እርካታቸዉን ደረጃየሚያመለክተውንኮድያኑሩ ።

ተ.ቁ.	የማዐጤመአባላት እርካታ መለኪያ ጥያቄዎች	ኮዱንያስገቡ
247.	የማዐጤመ ቢሮበምከፈትበት የሥራ ሰዓት እንዴትረክተዋል?	
248.	የአባልነት መዋጮን መስብስቢያ የጊዜሰሌዳእንዴት ረክተዋል?	
249.	የማዐጤመ የአባልነት ካርድ አወሳሰድ ሂደቱ ላይ እንዴት ረክተዋል?	
250.	የጤና አገልግሎት ከመጀመሪዎ በፊት ባለዉ የአንድ ወር እፎታ ጊዜ እንዴት ረክተዋል?	
251.	የህክምና መረጃ አያያዝ ስርዓቱ ላይ እንዴት ረክተዋል?	
252.	በሰዓቱየጤና ሰራተኞች በሥራ ቦታ በመገኘታቸዉ እንዴት ረክተዋል?	
253.	ከጤናባለሙያዎችጋር ከማግኘትዎበፊት በወሰደቦት ጊዜ ላይ እንዴት ረክተዋል?	
254.	በጤናባለሙያዎችእንክብካቤ እንዴት ረክተዋል?	
255.	በተመላላሽ ህክምናአገልግሎት እንዴት ረክተዋል?	
256.	በድንገተኛ ተኝቶ ህክምና አገልግሎት እንዴት ረክተዋል?	

257.	በሪፈራል ስርዓቱ ላይ እንዴት ረክተዋል?	
258.	በላቦራቶሪ አገልግሎቶች እንዴት ረክተዋል?	
259.	ከጤና ተቋም መድኃኒት በማግኘትዎ እንዴት ረክተዋል?	
260.	በአጠቃላይየማዐጤመ የጥቅማትቅምፓኬጆች ላይ እንዴት ረክተዋል?	
261.	በአጠቃላይ በሚያገኙት አገልገሎቶች ላይ እንዴት ረክተዋል?	

የመረጃ ሰብሳቢዉ ስም _____**ፊርማ** _____ **ቀን** __ / __ / __

የሱፐርቫይዘር ስም _____**ፊርማ** _____ **ቀን** ---- / --- / ----

Key Informant interview

- **Consent form For key informant of CBHI**

Name of Health Institute----------

Code for Interviewee_____

Dear Sir/Madam, Good morning! My name is _____and I am a member of the evaluation team that evaluates implementation process of CBHI program at DamboyaWoreda and the evaluation conduct with the collaboration of Jimma University. We are tending to conduct an evaluation on the way CBHI implemented in order to find the best practice and the weakness that needs for 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 the program was implemented. To assure your confidentiality I am not recording 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; If s/he does not agree, respect his/her decision to decline and go to the next Participant.

Key Informant Interview for health professional(case team leaders) and health facilities' heads

Name of Health institution_____

Code for Interviewee_____

For how long you stayed here ----------

1. When was the CBHI program launched as a pilot in your Woreda?
2. Did your HC sign service agreement with the scheme before service initiation? If yes, how? ,if no, why?
3. Did your HC started service provision to scheme members a month later contract agreement? If yes, how? If no, why?
4. Did your HC have standard members' registration book when the come to health service? If yes, how? If no, why?
5. Are the numbers of members of CBHI coming for services increasing ? If yes, how? If not, why?
6. Are there adequate reporting formats to Woreda CBHI scheme? If yes, how? If not, why?
7. Have you sent reports (reimbursement request report) to Woreda CBHI scheme on time in the last yr?If yes, how? If not, why?
8. Did the scheme totally reimbursed your HC's service expenditure of last yr? If yes,how?,If not, why?
9. Did the scheme conduct clinical audit in your HC in the last yr? If yes, how?, If not why?
10. Is there written feedback given to your health center by scheme in the last six months following the clinical audit? If yes, how? If not, why?
11. Is there a review meeting concerning CBHI scheme with govering bodies in the yr with the scheme? If yes,how? If not why?

12. Is there a supportive suppervision concerning CBHI scheme in the last yr by scheme? If yes how?,If not why?
13. Is there written feedback given to your health center by scheme in the last yr following the SS? If yes how?,If not why?
14. Are members of the scheme get benefit packages(outpatient & inpatient services including emergency admission) when they come into your health center? If yes how?, If not why?
15. Have you ever conducted community mobilization sessions in your catchment on CBHI in the last yr? If yes how, If not why?
16. Do you have any other comments/issues/gaps related with the CBHI program implementation process that you would like to share?

- **Interview guide for CBHI scheme staff**

Number of workers that work in the CBHI office _____

Code for Interviewee_____

1. How long did you stay in the scheme?----------years.
2. When was the CBHI program luanchedas a pilot in your Woreda? ----------year.
3. Do you have the CBHI implementation guideline now? If yes how? If not why?
4. Do the scheme have recommended number(1health professional,1accountant &1 HIT)of staffs?If yes how? If not why?
5. Did you get training on the CBHI program operation? If yes how? If not, why?
6. Did the scheme sign service agreement with HCs before service initiation? If yes how? If not, why?
7. Did HCs start service provision to scheme members a month later contract agreement? If yes how? If not why?
8. Did the scheme have standard members registration book for members enrolment? If yes how? If not why?
9. Is the numbers of members of CBHI being enrolled increasing in the last yr? if yes how? If not, why?
10. Are there adequate reporting formats in the CBHI scheme ? If yes how? If not why?

11. Did the scheme totally reimbursed your HC's service expenditure of last yr?if yes how?, if not why?
12. Did the scheme conduct clinical audit in HCs in the last yr? If yes how?, if not why?
13. Is the written feedback given to HCs by scheme in the last yr following the clinical audit? If ye how?,If not why?
14. Is there a review meeting concerning CBHI scheme in the last yrwith the scheme? If not why?
15. Is there a supportive suppervision concerning CBHI scheme to HCs in the last yrby scheme? If ye how?,If not why?
16. Is the written feedback given to HCs by scheme in the last yr following the SS? If yes how?,If not why?
17. Do members of the scheme get benefit packages(outpatient & inpatient services including emergency admission) when they go to HCs? If yes how?, If not why?
18. Have you conducted community mobilization sessions in the Woreda on CBHI scheme in the last yr? If yes how, If not why?
19. Have you used the advocacy materials(banners, leaflets,broushures,) while conducting community mobilization? If yes how? If not why?
20. Do you have any other comments/issues/gaps related with the CBHI program implementation process that you would like to share?

Interview guide for HDAs, HEWs& Kebele Administration office.

Code for Interviewee_____

1. When did the CBHI program started in your kebele?
2. Was there community mobilization in your kebele on CBHI in the last yr? If yes, how? If no, why?
3. Was there review meeting on CBHI in your kebele in the last yr? If yes, how? If no, why?
4. Was the number of CBHI members is increasing in your kebele in the last yr? If yes, how? If no, why?
5. Was there extra payments for additional familiy members in your kebele? If yes, how? If not why?

6. Was there additional payment related to the family members older than 18yrs? If yes, how? If not why?
7. Did any dynamics (death and birth) in member households being reported? If yes, how? If not why?
8. Do the contracted health center provides the all the promised benefit packages? If yes, how? If no, why?
9. Did the laboratory service available in the contracted health facilities in the last yr? If yes, how? If no, why?
10. Did the drugs available in the contracted health facilities in the last yr? If yes, how? If no, why?
11. Have you started health service utilization a month after you became registered?If yes, how? If no, why?
12. Did your kebele CBHI office have members' registration book? If yes, how? If no, why?
13. Did your kebele CBHI office have members' members enrollment (application) form? If yes, how? If no, why?
14. Have you been supervised by Woreda CBHI scheme office? If yes, how? If no, why?
15. Have had adequate advocacy materials for community mobilization ? If yes, how? If no, why?
16. If you have anything more to add?

Part 3: document and record review

3.1. Checklist for documents and records review on CBHI service

Name of health institution _____

Table 1: Documents and records review checklist on review on CBHI service given from March 2019 to March 2020.

S.no.	Activities and services	yes	No		Remark
	Benefit packages(OPD & IPD services)				
1.	Did members get counseling(hx taking and physical examination) services in HC?				
2.	Did members get emergency admision services in HC?				
3.	Did members get laboratory services in HC?				
4.	Did members get drugs in HC?				
5.	Did members get referral to hospital if necessary in HC ?				
7.	Did the HC provide services not included in the benefit packages?				
	Governing bodies functions	Plan	achievement		remark
			no	%	
1.	Did the HC send report on time to the next level in the last yr?				
2.	Did the HC send complete report to the next level in the last yr?				
3.	Did the HC get payment on time from the scheme?				
4.	Review meeting conducted with HC on CBHI?(cross check with scheme)				
5.	Review meeting conducted with community on CBHI?				

6.	Community mobilization conducted with community on CBHI?				
7.	Supportive supervision conducted byWoreda CBHIscheme?(cross check with scheme)				
	Inventory part	**Yes/#**	**no**	**Remark**	
1.	CBHI implementation guideline now				
2.	Trained health worker on CBHI scheme in health center				
3.	Health professionals				
4.	Supportive staffs				
5.	Essential medical/diagnostic equipments for CBHI implementation				
6.	Tracer drugs in your health center				
7.	Essential laboratory tests in your health center				

3.2.Data collection tools used at Woreda CBHI scheme offices

Table 2: Documents and records review checklist for evaluation of the implementation of CBHI in DamboyaWoreda from March 2019 to March 2020.

S.no.	Activities and services	No	%	Remark
1.	# Active members in CBHI schemes in the district			
2.	# birr of premium collected in district CBHI scheme			
3.	# members got benefit packages in the district totally			
4.	# birr paid for HCs by scheme			
5.	# average cost by HC to members			

6.	Proportion of birr HCs get from CBHI scheme payment(requested versus reimbursed)				
	Governing bodies functions	plan	achievement		Remark
			no	%	
1.	# HCs send report on time				
2.	# HCs send complete report to scheme				
3.	# HCs get payment on time by scheme				
4.	# review meeting conducted with HFs on CBHI				
5.	# of supportive supervision conducted				
6.	# of general assembly meetings conducted				
7.	# of board meetings conducted				
8.	#of clinicat audits conducted				

Observation Part

4.1.checklists for observation

Table 4: Observation checklist for Documents and records review checklist generally for OPD department for evaluation of implementation of CBHI in DamboyaWoreda ,2020.

S.no.	List of items	yes	no	Remark
1.	Are there IV standards in admission rooms?			
2.	Are there antiseptic agents in OPD and emergency OPD rooms?			
3.	Are there forceps and scissors in OPD rooms?			
4.	Is cotton in emergency in OPD rooms?			
5.	Is there guaze in emergency OPD rooms?			

6.	Are there disposal glove in emergency OPD rooms?			
7.	Are there surgical glove in emergency OPD rooms?			
8.	Is there lidocane in emergency OPD rooms?			
9.	Are there safety boxes in OPD rooms?			
10.	Are there MUACs in under 5 OPD rooms?			
11.	Is there plumplet in under 5 OPD rooms?			
12.	Is there plan B under 5 OPD rooms			
13.	Are there functional adult Weight scales in OPD?			
14.	Are there functional BP apparatus in OPD rooms?			
15.	Are there functional stethoscopes in OPD rooms?			
16.	Are there functional child Weight scales in OPD rooms?			
17.	Are there Examination Coaches in OPD rooms?			

4.2. Checklist for Invertory of pharmacy department

Table 5: observation Checklist Documents and records review checklist for pharmacy department for evaluation of implementation of CBHI in Damboya Woreda,2020.

S.no.	Essential Drugs	yes	no	Remark
1.	Are there amoxicillin 500mg 0r 250 mg capsule in pharmacy/store?			
2.	Is there amoxicillin 250mg/5ml or125mg/5ml syrup in pharmacy/store?			
3.	Are there amphicilin500mg or 250 capsules in pharmacy/store?			
4.	Is there amphicilin125mg/5ml or 250mg/5ml syrup in pharmacy/store?			
5.	Are there cotrimozathole480 or 960 mg tablet in pharmacy/store?			
6.	Is there cotrimozathole 240mg/5ml syrup in pharmacy/store?			
7.	Are there 500mg or 250mg ciproflaxin in pharmacy/store?			
8.	Are there metrodazole500mg or 250mg capsule in pharmacy/store?			
9.	Are there metrodazole 250mg/5ml or 125mg/5ml syrup in pharmacy/store?			
10.	Are there mebendazole or albendazole tablet in pharmacy/store?			
11.	Is there third generation anti biotic like ceftrizone in pharmacy/store?			
12.	Are the ant pain drugs tablet (parasitamol or ibuprofen or indometacin or diclfena) in pharmacy/store?			
13.	Are there anti pain injection (diclofena or dipron) in pharmacy/store?			
14.	Are there cloxacilin 500mg or 250mg capsule in pharmacy/store?			
15.	Are there cloxacilin 250mg/5ml or 125mg/5ml syrup in pharmacy/store?			
16.	Is there gentamacin injection in pharmacy/store?			
17.	Is there pensilin or benzatine injection in pharmacy/store?			
18.	Is there dermatology cream in pharmacy/store?			
19.	Are there iron sulphates tablet in pharmacy/store?			
20.	Are the anti acid syrups or omeprazole tablet in pharmacy/store?			
21.	Are the ORS sachets in pharmacy/store?			

22.	Are there Normal saline for Iv fluid in pharmacy/store?			
23.	Are there a coartem in pharmacy/store?			

4.3. Checklist for observation of Laboratory department

Table 6: observation Checklist for Documents and records review checklist for Laboratory department for evaluation of implementation of CBHI in Damboya Woreda,2020.

S.no.	Essential laboratory services and equipment	yes	no	If yes, quantify it
1.	Are there functional microscopes in the laboratory?			
2.	Are there microscopic slides in the laboratory?			
3.	Is here hemoglobin centrifugal machine in the laboratory?			
4.	Is there Stool examination service in the laboratory?			
5.	Are there urine analysis services in the laboratory?			
6.	Are there AFB services in the laboratory?			
7.	Is there H pyloric test services in the laboratory?			
8.	Is there RH test in the laboratory?			
9.	Is there HCG test in the laboratory?			
10.	Is there hemoglobin test service in the laboratory?			
11.	Is there VDRL test service in the laboratory?			
12.	Is there HIV test in the laboratory?			

Data collector name: _____Signature_____ Date__/__/__

Supervisor name: _____Signature_____ Date__/__/__

ANNEX-V:Indicator Information and JudgmentMatrix

Table-23: Indicators information matrix of process evaluation of CBHI program in Damboya Woreda by 2020.

Evaluation Questions	Dimensions	Indicators	Formula	Sources of Data	Data Collection Method	Data collection tools
Are there available resources for the implementation of the CBHI program? If yes how? If no why?	Availability	Number of staffs in the Woreda CBHI scheme	#	scheme	Human resource Inventory	Inventory chechlist
		Number of HCs that had at least one trained provider on the schemes on the day of data collection	#	HCs	Training inveentory & KII	Inventory chechlist & KII
		Number of HCs having recommended number of health professionals	#	HCs	Human resource Inventory & KII	Inventory chechlist
		Number of HCs having recommended number supportive staffs	#	HCs	Human resource Inventory & KII	Inventory chechlist& KII
		Number of HCs with CBHI guidelines on the day of data collection	#	HCs	Resource inventory	Inventory checklist
		Number of HCs with standard members registration book	#	HCs	Resource inventory	Inventory checklist

		Number of Hcs with standard reporting formats	#	HCs	Resource inventory	Inventory checklist
		Number of HCs with emergency admission rooms (IPD) service for severe ill insured patients	#	HCs	Observation	Inventory chechlist
		Number of HCs with essential diagnostic equipment	#	HCs	Resource inventory & KII & Observation	Inventory chechlist
		Number of HCs with essential laboratory tests	#	HCs	Resource inventory Observation & KII	Inventory chechlist
		Number of HCs essential (tracer drugs) in HCs	#	HCs	Resource inventory Observation & KII	Inventory chechlist
Are the implemen	Complian	Number of HCs got supportive supervision from Woreda CBHI scheme office in previous six months	#	HCs	Report review or minute logbooks	Checklist

		Number of HCs with feedbacks provided by governing bodies in the last six months	#	HCs	Report review or minute logbooks	Checklist
		Number review meeting conducted with governing bodies in the previous six months	#	HCs	Review the report or minute logbooks	Checklist
		Number of HCs signed service agreement with CBHI scheme annually	#	HCs	obervation	Checklist
		Number of times advocacy materials prepared by governing bodies	#	Scheme & HCs	obervation	Checklist
		Number community mobilization session conducted by governing bodies in the last year	#	HCs	Review the report or minute logbooks	Checklist
		Number of HCs started service after appropriate waiting time following members registration	#	HCs & scheme	Review register & agreement sign	Checklist
		Number HCs sent report on time to scheme last quarter	#	HCs & scheme	Review the report or minute logbooks	Checklist
		Proportion of permium collected by the scheme in the last year	%	scheme	Observe the leager or banck statement	Checklist

		Number of CBHI members enrolment rate by the scheme in last year	#Erol/plan	Scheme	Observe register	Checklist
		Number of HCs providing all the benefit packages at the day of data collection	#	HCs & Scheme	Review the report	Checklist
		Number HCs with clinical audit in last six months	#	HCs	Review the report	Checklist
		Number of times CBHI scheme financial audit by Woreda finance office in the last year	#	scheme	Review feedback and minute logbooks	Checklist
		Number of HCs had been reimursed totally in the last six months	#	HCs and Scheme	Observe the leager or banck statement	Checklist
Are the CBHI enrolled members satisfied with service being delivered? If	Satisfaction	Proportion of members satisfied with local CBHI management trustworthiness	#satisfied/ #Intervied*100	Community(HHs)	Community Based Survey	Structured questionnaire
		Proportion of members satisfied with the opening hours of the CBHI				
		Proportion of members satisfied on the way assessing health problems				
		Proportion of members satisfied with the collection process of insurance cards				

		Proportion of members satisfied with the time to make use of the CBHI program after payment of registration fee				
		Proportion of members satisfied with the information provided				
		Proportion of members satisfied with the schedule for paying of premium;				
		Proportion of members satisfied with CBHI packages;				
		Proportion of members satisfied on the Cleanliness/ facility environment /				
		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 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				

Table-24: Judgement matrix of process evaluation of CBHI program in Damboya Woreda in 2020.

Evaluation Questions	Dimensions	Indicators	Required(100%each dimension)	Average weight(100% total)	Observed weight	Judgment parameters
Are there available resources for the implementation of the CBHI	Availability	Number of staffs in the Woreda CBHI scheme	8	2.4		• >85% Very Good Implementation, • 75-85 Good Implementation
		Number of HCs that had trained provider on the schemes on the day of data collection	9	2.7		
		Number of HCs having recommended number of health professionals	9	2.7		
		Number of HCs having recommended number supportive staffs	8	2.4		

		Number of HCs with CBHI guidelines on the day of data collection	9	2.7		• 60- 75% Partially Implemented • 50 - 60 Poorly Implemented and • < 50 % Critical
		Number of HCs with standard members registration book	8	2.4		
		Number of Hcs with standard reporting formats	9	2.7		
		Number of HCs with emergency admission rooms (IPD) service for severe ill insured patients	10	3		
		Number of HCs with essential diagnostic equipment	10	3		
		Number of HCs with essential laboratory tests	10	3		
		Number of HCs essential (tracer drugs) in HCs	10	3		
Are the implementation activities of the CBHI program being done as per the	Compliance	Number HCs got supportive supervision from Woreda CBHI scheme office in previous six months	6	2.4		• >85% Very Good Implementation, • 75-85 Good Implementation • 60- 75% Partially Implemented
		Number of feedbacks provided by governing bodies in the last six months	7	2.8		
		Number review meeting conducted with governing bodies in the previous six months	7	2.8		
		Number of HCs signed service agreement with CBHI scheme annually	8	3.2		

		Number of HCs started service after appropriate waiting time following members registration	6	2.4		• 50 - 60 Poorly Implemented and • < 50 % Critical
		Number community mobilization session conducted by governing bodies in the last year	8	3.2		
		Number of advocacy materials prepared by governing bodies	6	2.4		
		Number HCs sent report on time to scheme last quarter	8	3.2		
		Proportion of permium collected by the scheme in the last year	7	2.8		
		Number of CBHI members enrolled by the scheme in last year	7	2.8		
		Number HCs with clinical audit in last six months	7	2.8		
		Number of times CBHI scheme financial audit by Woreda finance office in the last year	7	2.8		
		Number of HCs had been reimursed totally in the last six months	8	3.2		
		Number of HCs providing all the benefit packages at the day of data collection	8	3.2		
Are the CBHI	Satisfacti on	Proportion of members satisfied with local CBHI management trustworthiness				• >70% Very Good Implementation,

		Proportion of members satisfied with the opening hours of the CBHI				• 60-70 Good Implementation • 55-60% Partially Implemented • 50-55 Poorly Implemented and • < 50 % Critical
		Proportion of members satisfied on the way assessing health problems				
		Proportion of members satisfied with the collection process of insurance cards				
		Proportion of members satisfied with the time to make use of the CBHI program after payment of registration fee				
		Proportion of members satisfied with the information provided				
		Proportion of members satisfied with the schedule for paying of premium;				
		Proportion of members satisfied with CBHI packages;				
		Proportion of members satisfied on the Cleanliness/ facility environment /				
		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 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				
Overall implementation		Availability 30	100	100		• >85% Very Good Implementation • 75-85 Good Implementation • 60- 75% Partially Implemented • 50 - 60 Poorly Implemented and • < 50 % Critical
		Compliance 40				
		Satisfaction 30				

ANNEX-IV: Meta Evaluation of process evaluation of CBHI program in DamboyaWoreda by 2020.

S.no	Sub-standard	Yes or no	remark
1.	**Utility Standard**		
U1	Stakeholder Identification	Yes=10	21% out of 25%
U2	Evaluator Credibility	Yes=8	
U3	Information Scope and Selection	Yes=9	
U4	Values Identification	Yes=8	
U5	Report Clarity	Yes=9	
U6	Report Timeliness and Dissemination	Yes=8	
U7	Evaluation Impact	Yes=7	
total		59(84.3%)	
2.	**Feasibility**		
F1	Practical Procedures	Yes=8	20.8% out of 25%
F2	Political Viability	Yes=9	
F3	Cost Effectiveness	Yes=8	
total		25(83.3%)	
3.	**Propriety**		
P1	Service Orientation	Yes=8	21% out of 25%
P2	Formal Agreements	Yes=9	
P3	Rights of Human Subjects	Yes=10	
P4	Human Interactions	Yes=9	
P5	Complete and Fair Assessment	Yes=8	
P6	Disclosure of Findings	Yes=8	
P7	Conflict of Interest	Yes=7	
P8	Fiscal Responsibility	Yes=8	
total		67(84%)	

4.	**Accuracy**		
A1	Program Documentation	Yes=8	20% out of 25%
A2	Context Analysis	Yes=9	
A3	Described Purposes and Procedures	Yes=8	
A4	Defensible Information Sources	Yes=9	
A5	Valid Information	Yes=9	
A6	Reliable Information	Yes=8	
A7	Systematic Information	Yes=9	
A8	Analysis of Quantitative Information	Yes=7	
A9	Analysis of Qualitative Information	Yes=7	
A10	Justified Conclusions	Yes=6	
A11	Impartial Reporting	Yes=7	
A12	Metaevaluation	Yes=8	
total		95(79%)	
Overall total			82.8%

Thesis declaration form

I, the undersigned, hereby declare that this thesis is my original work. The work has not been presented for degree in any university and source of materials used for the project has been acknowledged.

Thesis title: Process Evaluation of Community Based Health Insurance Program in Damboya Woreda, Kembata Tembaro Zone, Southern Nations, Nationalities peoples' Region.

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