COLLEGE OF SOCIAL SCIENCES AND HUMANITIES

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The Advantages and Challenges of Community-based Health Insurance (CBHI) as a Social Protection Scheme in Promoting Universal Health Coverage: The Case of Tocha District, Dawuro Zone

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Declaration

I, Anteneh Ashenafi Sapa, hereby declare that this thesis entitled **"***The Advantages and Challenges of Community-based Health Insurance (CBHI) as a Social Protection Scheme in Promoting Universal Health Coverage: The Case of Tocha District, Dawuro Zone* "is my original work. All references and literatures used to conduct this research have been duly acknowledged.

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Acronyms and Abbreviations

BoH	Bureau of Health
CBHI	Community- based Health Insurance
CMAJ	Canadian Medical Association Journal
CSA	Central Statistical Agency
EHIA	Ethiopian Health Insurance Agency
FDRE	Federal Democratic Republic of Ethiopia
FED	Finance and Economic Development
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
HoPR	House of People's Representatives
ILO	International Labour Organization
MoLSA	Ministry of Labour and Social Affairs
NGOs	Non-Governmental Organizations
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
SNNPR	South Nations Nationalities and Peoples Region
TB	Tuberculosis
TVET	Technical and Vocational Education and Training
UHC	Universal Health Coverage
UN	United Nations
USAID	United States Agency for International Development
VET	Vocational Education and Training
WB	World Bank
WHO	World Health Organization

Abstract

The general objective of this research was to examine the advantages and challenges of CBHI as a social protection scheme in promoting universal health coverage. Theories used to guide this research were Anderson's model of healthcare utilization and Woolcock's Social capital framework. This research relied on pragmatist paradigm. Cross-sectional research design was used to guide the whole research process. Mixed research approach was employed to generate valid and reliable findings. Household survey, key-informant interview, in-depth interview, focus group discussion, observation and document analysis were used to collect reliable data on research issue. Quantitative data was analyzed using descriptive and inferential statistical tools. SPSS version 23 was used to process numerical data and qualitative data was analyzed by employing thematic analysis. The findings of this research revealed that the advantages of CBHI from service providers' perspectives were increased access to health care, enhanced health seeking behavior, increased health care utilization, improved health status of insured households, promoted health equity, increased availability of financial resources in contracted health facilities and improvement of the quality of health services. Advantages of CBHI from community's perspectives were increased access to health services, enhanced health seeking behavior, increased health care utilization, improved health status of CBHI members, reduced costs of health services, relief from concern about unexpected future health costs and reduction of the exposure to catestrophic and impoverishing health expenditure. CBHI promoted the involvement of indigent households and thereby their utilization of health services. However, there are challenges that hinder the impact of CBHI in ensuring UHC. These include lower proportion of insured population, deficiency in quality of health services, small-scale design (lack of large risk pools), financial insecurity, and inadequate enrollment of indigent households in the scheme. To conclude, CBHI is pragmatic and highly essential initiative to progressively achieve universal health coverage because it increased access to health care, promoted health equity and improved the quality of health services in the study area. To improve the performance of CBHI, concerned bodies should design mechanisms that increase the community enrollment, participation and solve problems associated with health service provision.

Key Words: CBHI Scheme, Social Protection, Household, UHC, Tocha District, Dawuro Zone

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

Substantial share of human beings across the globe face serious problems of lack of access to quality essential health care services. Half of the world's populations do not have full access to quality essential health services. About 800 million people across the world spend more than 10% of their household income on health care and each year about 100 million people are pushed into poverty due to impoverishing health service expenditure (Health Affairs 2018; World Health Organization and World Bank 2017). Health care expense is catastrophic when a household spends more than 10% of their income for medication (Getachew et al 2019; World Health Organization 2019). Coverage of quality essential health services vary significantly from continent to continent and from country to country. In this regard, East Asia, Europe and North America reached 77%, South Asia achieved 53% and sub-Saharan Africa 42% - the lowest coverage of essential health services (World Health Organization and World Bank 2017).

Ethiopia is one of the African countries with substantial burden of communicable and non-communicable diseases. The coverage of both basic health care services and health service utilization is low and there is higher geographical (Rural-Urban), sub-national and intra-regional inequality in service coverage among different segments of the population. In 2015, the overall universal health coverage was 34.3% (Getachew et al 2019). Direct-out-of pocket health care spending in Ethiopia is catestrophic (rose from 33.7% in 2010/2011 to 37% in 2016) leaving large proportion of population without health care service induced financial risk protection (World Health Organization 2019).

Despite the existing huge gap in health service coverage, the World Health Organization states that access to quality essential health service is one of the fundamental rights of all human beings without distinction on the basis of race, religion, political belief or economic or social condition (Sambo and Kirigia 2014). Based on this notion, in 2005, the World Health Assembly of WHO advised member states to gear their efforts to progressively achieve Universal Health Coverage and expand promotive, preventive, curative, palliative and rehabilitative health interventions on the foundation of equity (Sanogo, Arone and Yaya 2019).

Universal Health Coverage is conceptualized as a situation whereby all people have access to quality essential health care services that do not jeopardize the principles of financial risk protection and equity (Halima 2018; O'connel, Rasanathan and Chopra 2014; World Health Assembly 2005). Currently UHC is incorporated as one of the key components of sustainable development goals to be achieved by 2030 as global development agenda (WHO and WB 2017; Sanogo et al 2019).

Health financing problem is one of the most determining factors that hinder health care utilization and achievement of UHC in many resource constrained countries including Ethiopia (Nellie 2014; Sanogo et al 2019). To tackle this problem, basically to ensure the sustainability of health care financing, health service equity, financial risk protection, and to broaden access to quality essential health services, various health financing reforms have been implemented (Halima 2018; Molla 2018; Molla 2019; Pandey 2018).

Beginning from 2000s, many African countries initiated and implemented several health reforms to achieve UHC. However, only Rwanda and Ghana have made significant progress in achieving UHC through developing and implementing health insurance schemes that cover large proportion of their population (CMAJ 2012). Government of the FDRE adopted proclamation number 690/2010 which states about need to establish health insurance in Ethiopia in order to achieve universal health coverage. This health insurance strategy encompasses two separate but closely related health financing schemes: Social health insurance and community-based health insurance. Social health insurance (SHI) provides health service packages to employees who work in the formal sector and pensioners (EHIA 2020; Solomon et al 2015).

Community-based health insurance (CBHI) also known as mutual health organization is grounded in principles of solidarity and risk sharing. It is very important financial strategy to provide quality essential health care services to all people in agricultural and informal sectors. Rural households and people employed in the informal sector voluntarily join CBHI scheme by agreeing to pay membership premiums. The federal government covers 10% of the health costs in the form of general subsidy while provincial and District governments are mandated to pay premiums on behalf of indigent population in the form of targeted subsidy. Indigent population are entitled to utilize health care services free of charge (while the regional government covers

40% of the health cost, zonal and District governments cover 30% each) once they are screened and approved by relevant government bodies (EHIA 2020; Solomon et al 2015).Hence, the program essentially serves the purpose of social protection for the poor as vulnerable groups.

Community-based health insurance is a pro-poor health financing strategy to progressively move toward realizing UHC. It is one of the social protection initiatives that aim to put in place social justice and equity in health sector (ILO 2002; Tabor 2005). It targets to ensure health equity by expanding access to health services for all rural households and urban informal sector. It also provides financial risk protection by reducing catastrophic and impoverishing expenditure on health care services (Kesetebirhan, Taye and Tewodros 2016; Lavers 2016; Pandey 2018).

Ethiopia launched CBHI as a pilot program in Tigray, Amhara, Oromia and SNNP regional states in 2011 and scaled it up in 2014. Nowadays, with the exception of Somali and Gambella regional states, and Dire Dawa City Administration, CBHI is being implemented all over the country though District coverage and enrollment rate varies from region to region. CBHI scheme membership has reached 7 million households in 770 districts. When compared to the size of Ethiopia's population in the informal sector, CBHI enrollment and financial risk protection is still very low (EHIA 2020). However, CBHI is still considered as the most pragmatic and viable financial mechanism that is capable of promoting UHC in Ethiopia (Halima 2018; Ewunetie et al 2020). Molla (2018) showed that most people had positive attitude toward CBHI in study area.

However, little is known about CBHI as social protection scheme; particularly about access to quality and essential health services due to the recent introduction and implementation of CBHI scheme from the service providers' and community's perspectives; and the participation and healthcare utilization of the poorest households in CBHI in Ethiopia. Challenges that threaten the successful implementation of community-based health insurance and challenges of CBHI in ensuring UHC also should be comprehensively unearthed. This research generated empirical evidence that enhance understanding about the scheme and inform policy decision making aimed at improving the scheme. It also brought scientific findings that can be used to broaden our understanding about the progress of universal health coverage due to the introduction and implementation of CBHI and the challenges encountered in implementing it. The purpose of this

research was to examine the advantages and challenges of CBHI as a social protection initiative in achieving UHC in Tocha District of Dawuro Zone.

1.2 Statement of the Problem

Sub-Saharan Africa has the lowest Universal Health Coverage in the world (42%), indicating that many people in this region do not have access to essential healthcare services and disproportionately suffer from illness induced problems (World Health Organization and World Bank 2017). Ethiopia when compared to other Sub-Saharan African countries is characterized by higher burden of communicable and non-communicable diseases. Coverage and utilization of basic health care services is low. Universal health coverage in Ethiopia is 34.3 %, lower than even the sub-Saharan Africa average. On top of this, there is higher inequality of access to and utilization of health care services among different segments of the society (Getachew et al 2019).

In 2005, the world health assembly of WHO stressed the need to work for the realization of UHC and expansion of access to promotive, preventive, curative, palliative and rehabilitative health care services to all people regardless of their ability to cover health care services that Ethiopia has ratified. Universal health coverage agenda is grounded on principles of equity and financial risk protection. Accordingly, all people are entitled to quality essential health care services whenever they need it (O'connel et al 2014; World Health Assembly 2005; Sanogo et al 2019).

In order to achieve UHC, apart from the expansion of health care services, installing health financing system that guarantees sustainability, equity and financial risk protection is mandatory. In line with this, Ethiopia's government launched community-based health insurance scheme: a pro-poor path to UHC characterized by pooling health care risks and financial resources across the community. It is health risk sharing mechanism that provides health service benefit packages to rural households and people in the informal sector (Halima 2018; Molla 2017; Molla 2018; Molla 2019; Pandey 2018).

Several researches have been conducted concerning CBHI scheme (Amarach and Atagaba 2020; Alem et al 2020; Asnakew 2018; Ewunetie et al 2020; Halima 2018; Molla 2017; Molla 2018 and Tsega et al 2019). Generally these researches focused on willingness to join CBHI scheme, attitudes of rural households towards the scheme, enrollment level, households' satisfaction,

factors that affect the implementation, the effects of CBHI scheme on the utilization of health care services and the effects of CBHI on catastrophic healthcare expenditure.

Asnakew (2018) stated that despite the implementation of CBHI scheme in Ethiopia, the level of catastrophic spending on healthcare services is still very high. Amarach and Atagaba (2020) asserted that even though significant number of population in Ethiopia is impoverished due to catastrophic direct-out-of pocket payment for health services, CBHI is an important strategy that has contributed significantly for financial protection of rural households, people who make their living from informal sector and indigent population.

According to Halima (2018) and Molla (2017), CBHI scheme of Ethiopia is pragmatic and right path to make accessible healthcare for all persons and to meet UHC goals in a country where 83.6% of its population is predominantly agricultural and earn their living from informal sector. Molla (2018) found in one of his researches conducted in Tehuldere District of Northeast Ethiopia that most CBHI scheme members had positive outlook on CBHI. Outpatient health care utilization has shown significant increment due to the implementation of CBHI scheme: indicating the disruptive role of financial barrier on the utilization of health care services in resource constrained countries like Ethiopia.

Alem et al (2020), Ewunetie et al (2020), Molla (2018), and Tsega et al (2019) assessed factors that affect the acceptance of CBHI scheme in Ethiopia. These factors include family size, education level, age, gender, income, health status of household members, distance to health facility, awareness about CBHI, service adequacy, level of community participation and sense of ownership.

As far as the researcher's knowledge is concerned, so far little or no research has comprehensively examined CBHI from the stance of UHC in Ethiopia. Specifically, the advantages of CBHI in addressing health care needs have not been researched separately from the service providers' and community's perspectives. The participation and healthcare utilization of the poorest households in CBHI has not also been investigated. In addition, the social foundations of challenges of implementing CBHI and the challenges of CBHI in ensuring UHC have not been examined.

In a nutshell, little is known about CBHI as social protection scheme in promoting UHC; particularly about access to quality and essential health services due to the recent introduction and implementation of CBHI scheme from the service providers' and community's perspectives, the participation and healthcare utilization of the poorest households, challenges that threaten the successful implementation of community-based health insurance and challenges of CBHI in ensuring UHC. Therefore, this research attempted to fill this gap by examining the advantages and challenges of CBHI as a social protection scheme in promoting UHC in Tocha District of Dawuro Zone.

1.3. Research Questions

The concern of this research was answering the following basic research questions.

- What are the advantages of CBHI in addressing health care needs from the service providers' perspectives?
- What are the advantages of CBHI in addressing health care needs from the community's perspectives?
- To what extent are the poorest households covered by CBHI scheme and utilize insured health care services?
- What are the challenges of implementing CBHI scheme?
- What are the challenges of implementing CBHI scheme in ensuring Universal Health Coverage?

1.4. Objectives of the Study

1.4.1 General Objective

To examine the advantages and challenges of CBHI as a social protection initiative in promoting access to quality essential health care services and providing financial risk protection.

1.4.2 Specific Objectives

- To assess the advantages of CBHI in addressing health care needs from service providers' perspectives
- To examine the advantages of CBHI in addressing health care needs from the community's perspectives.

- To examine the level of participation and health care utilization of the poorest households in CBHI scheme.
- To examine the challenges of implementing CBHI scheme in study area.
- To examine the challenges of implementing CBHI scheme in ensuring universal health coverage.

1.5 Significance of the Study

Examining the advantages of CBHI in addressing health care needs of agricultural community, people in informal sector and indigent population; challenges of CBHI implementation and challenges of CBHI in ensuring UHC generated empirical findings that can be used by different actors. It will add knowledge to the existing literatures on CBHI and UHC. It will also serve as reference for researchers who want to conduct further researches on different aspects of CBHI scheme. The last but not the least, this research forwarded recommendations that inform policy decision making to improve the design and implementation of CBHI; and to redesign local level plans in a manner that it boosts the performance of CBHI scheme by addressing challenges in the study area.

1.6 Scope

The scope of this particular research was delimited to examining CBHI as a social protection scheme. Specific issues which are within the reach of this study are the advantages of CBHI in meeting the health care needs of the community, the involvement of poorest households in CBHI, challenges of implementing CBHI and challenges of implementing CBHI to ensure UHC. Therefore, other thematic issues related with CBHI are beyond the scope of this research primarily due to time and financial constraints. Concerning geographical scope, this research was conducted in Tocha District of Dawuro Zone.

1.7 Limitations of the Study

Due to time and resource constraint, given that this is a Masters' thesis planned to be completed within limited time, the researcher did not include other Districts and Zones in this study which would be even better to advance our understandings about the issue. In addition to factors already mentioned, with the intent of generating detailed information about the advantages and

challenges of CBHI from service providers' and community's perspectives', the researcher did not employ comparative cross-sectional research design. However, despite all these limitations, the researcher managed to generate reliable findings on the issue and achieved the objectives of the study.

1.8 Organization of the Thesis

This thesis is comprised of five chapters. The first chapter dealt with background, statement of the problem, research questions, objectives, significance, scope and limitations of the study. In the second chapter, literature review was included. Conceptual, theoretical and empirical reviews of literatures related to the research were also part of the second chapter. The third chapter included research methodology; specifically issues like description of the study area, research approach, research design, methods of data collection, sampling, methods of data analysis, data quality assurance and ethical considerations were discussed. The fourth chapter incorporated data analysis and discussion. Summary, conclusion and recommendations of this study are found in the last chapter.

CHAPTER TWO: LITERATURE REVIEW

2.1. Conceptual Definition of Key Terms

Community-based Health Insurance (CBHI): is a voluntary and not-for-profit mechanism of pooling healthcare risks and financial resources by rural households and people in the informal sector of urban settings to address their health care needs (Solomon et al 2015; Bekele and Keneni 2020).

Universal Health Coverage: is a level of health system development achieved when all people who want health care services have access to it, without being exposed to financial hardship (World Health Organization 2010).

Social Protection: Social Protection is a set of formal and informal interventions in the form of policies, programs and insurance schemes aimed to reduce social and economic risks, vulnerabilities and deprivation from all people; and to achieve the protection and prevention of vulnerable households and groups from shocks and risks; and to promote and transform their lives (MOLSA 2014).

The Poor: they are individuals or families who do not have financial resources to pay for health care services and to contribute premiums to health insurance schemes in exchange for health care services (Xu et al 2005).

Household: refers to individuals or group of people who are either related to each other by marriage, blood, and legal adoptions or not but live together in the same house and dine together (Jutting 2003).

Household Head: refers to a person who is primarily responsible to lead the household by providing actual support to other members of the household (CSA 2014).

Social Justice: is a situation characterized by fair and equitable distribution of resources and access to social services to all people in the society (UN 2006).

2.2. Conceptual and Theoretical Framework

2.2.1 Conceptual Framework

Community-based health insurance is voluntary and not-for profit health financing initiative established to pool health care risks and resources across the members and grounded in principles of solidarity and risk sharing to prevent catastrophic health spending and promote access to quality essential health care services. This financial strategy is designed to address financial barriers that hinder the realization of universal health coverage by reducing inequality of access to health care services. It is also a social protection initiative aimed at achieving health equity regardless of distinction on bases of race, ethnicity, age, gender, income, occupation and so on (Solomon et al 2015).

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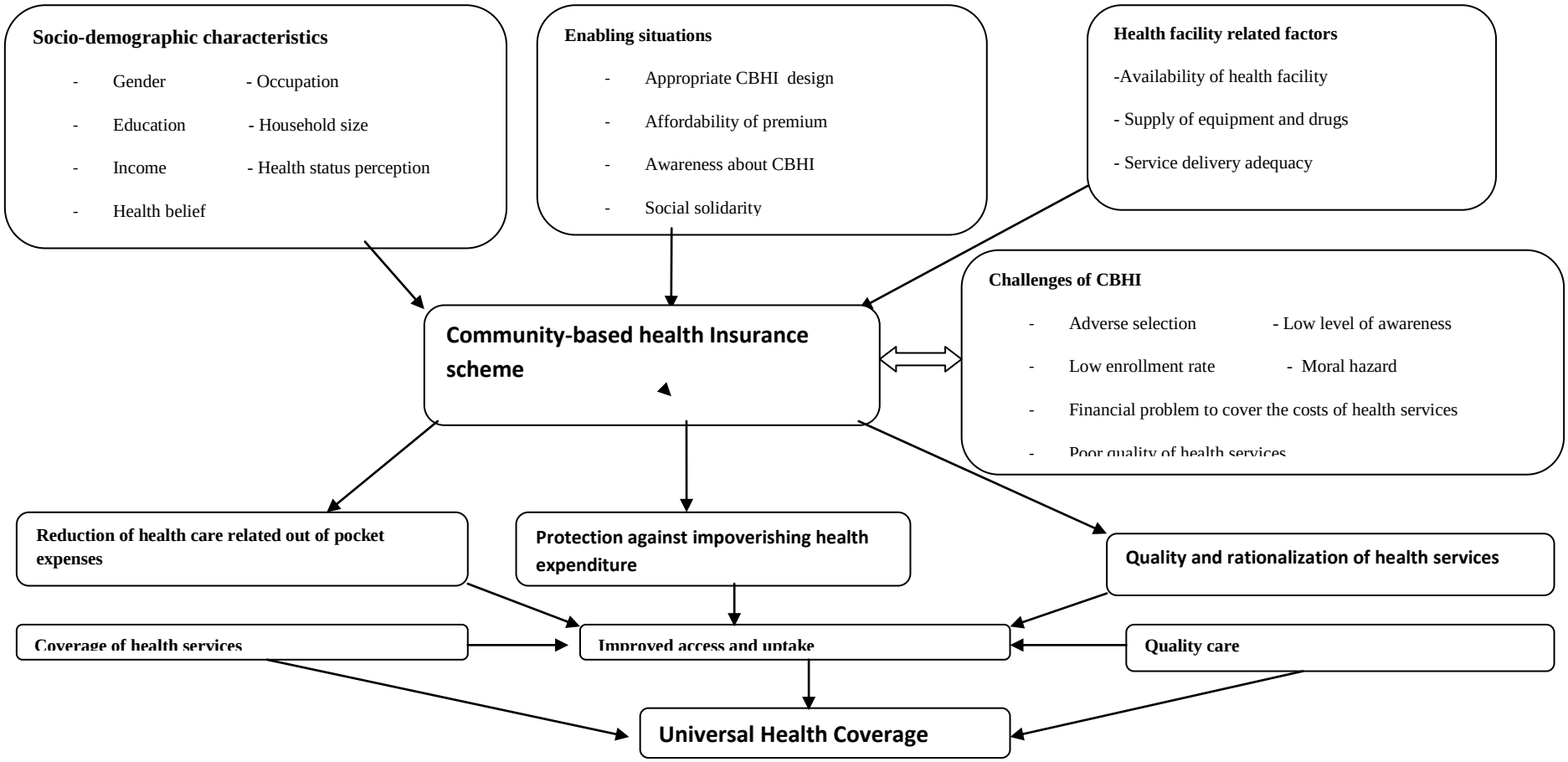

Figure 1. Adapted Conceptual Framework (Source: Bennet S (2004) cited in Hounton, Byass and Kouyate (2012))

2.2.2 Theoretical Framework

To examine the contributions of CBHI as social protection scheme in increasing access to modern healthcare services and challenges facing this health financing mechanisms, two theoretical frameworks, namely Anderson's Health Care Utilization Model and Woolcock's Social Capital Framework have been used. Theoretical triangulation of these two frameworks deepens our understandings of CBHI in boosting universal health coverage as well as the social factors that affect the performance of community-based health insurance. Anderson's model of healthcare utilization outlines factors that affect healthcare utilization and distributions of healthcare services. They are predisposing factors, enabling factors, health system characteristics, and external environmental factors and so on. This theoretical orientation is very important to examine factors that affect the acceptance of CBHI and advantages of CBHI in promoting Universal Health Coverage. It is also useful to examine the challenges of implementing CBHI and the challenges of CBHI in ensuring UHC.

Social capital framework primarily focuses on assessing the association between social capital such as trust, norms, values, culture of reciprocity, solidarity and cooperation existing in particular social groups; and the performance of CBHI scheme. The social context in which CBHI scheme is being implemented plays detrimental role in shaping the performance of CBHI scheme either positively or negatively. Social capital framework helps in advancing our understanding of social factors that affect the performance of community-based health insurance scheme.

2.2.2.1 Anderson's Model of Health Care Utilization

Ronald Max Anderson developed various models to explain factors that affect health care utilization and distribution of healthcare services. The first model was developed in 1960 to provide explanation concerning the reasons why families utilize health care services and the level of access to these services. The second model was developed in 1990 to examine the association between personal practices such as smoking, diet and exercises; and health outcomes. These models do have many shortcomings to provide relatively comprehensive explanation for the existence of inequality among different segments of the society because they were confined to assessing exclusively micro-level factors.

More advanced healthcare utilization framework was developed in 1995 that included macro-level factors affecting the distribution of health care services. According to Anderson and Newman (1973), access to health services and utilization is determined by several factors. These include:

Predisposing factors (the socio-cultural characteristics of individuals existing prior to illness) such as age, gender, education, income, occupation, health beliefs; enabling factors such as affordability of health services, possession of a health insurance, and adequate income; the need factors primarily the severity of illness; Health system characteristics such as availability and supply of services, availability of health facility and organization of health care system; External environmental factors such as political, geographic, environmental and economic that may determine the nature and organization of the health system; Personal health care practices/Lifestyle these include diet, smoking, exercise and self-care; and finally use of health services**.** In combination, these micro-level and structural factors were understood as the foundations that affect healthcare utilization, distributions of health services and subsequently health outcomes (Anderson and Newman 1973).

In order to examine the advantages and challenges of CBHI scheme in promoting universal health coverage, predisposing factors, health system characteristics, enabling factors, need factors and external environmental factors have been found out to be compatible with the purpose of this research. What have been the advantages of CBHI scheme as enabling factor in expanding access to healthcare services to all people without pushing them into impoverishment due to healthcare induced spending? What are those factors that affect the acceptance of CBHI? What are the challenges of CBHI in ensuring UHC? In this regard, Anderson's healthcare utilization framework was very valuable in guiding this research.

2.2.2.2 Social Capital Framework

Over the last many years, researches on the coverage and sustainability of CBHI have been underpinned by Economic and Health System Framework. While Economic Framework emphasizes the influence of information about the scheme, price of premium and quality of health care services, Health System Framework views interactions between insured, insurance

schemes, health service providers and the state as determining the performance of CBHI scheme. However, these frameworks do not take into account the social context in which CBHI is being implemented. Therefore, analyzing the social determinants of CBHI is valuable to identify social factors that constrain the implementation of CBHI. In this regard, Social Capital Framework developed by Woolcock is highly valuable (Miladovsky and Mossialos (2008)).

According to Woolcock (1998) and (2001), Social Capital Framework constitutes four types of social capital. These are bonding social capital existing in intra community ties; bridging social capita of extra-community networks; bridging social capital available in relations between communities and macro-level state institutions; and bonding social capital that are found at the level of social relations within public institutions.

Woolcock (1998) and (2001) underscored that solidarity, trust, extra-community linkages, vertical civil society networks, and state-society relations at the grass-root level appear to have significant impact on the performance of CBHI. Bonding social capital especially strong intra-community ties manifested by solidarity and trust may reduce adverse selection and moral hazard. However, it complicates this preposition by asserting that communities characterized by only strong intra-community ties may actually hamper the performance of CBHI due to higher prevalence rate of corruption and clientism, or increased dependence on informal financial networks.

Bridging social capital of extra-community relations tend to foster more professional relations, strategic alliances, and administrative capacity and enlarged risk pools in CBHI schemes. Bridging social capital found in relations between CBHI scheme and NGOs can generate benefits in terms of financial resources but may enhance dependency syndrome and it may also reinforce social structures that rely heavily on the works of technical experts. And the final component of social capital, relations between CBHI scheme and local government structure may expand the coverage of community-based health insurance scheme. This framework has depicted that certain types of social capital determine the success of CBHI (Woolcock (1998) and (2001)).

To sum up, the theoretical foundation of this research, Anderson's Health Care Utilization Model is highly relevant to examine the advantages of CBHI in addressing health care needs of the community. Both Anderson's Health Care Utilization Model and Social Capital Framework were used together to examine issues like the participation and health care utilization of poorest households, the challenges of implementing CBHI and the challenges of CBHI in ensuring UHC.

2.3. The Philosophy of Community-based Health Insurance (CBHI)

Community-based health insurance is health financing initiative grounded in principles of solidarity and risk sharing to remove financial barriers of access to health care services primarily for rural households, people in informal sector and the poor. It is characterized by pooling resources and health care risks from members of the scheme to realize health equity among different segments of the society. CBHI is guided by two basic missions.

The first one is promoting universal health coverage by pooling resources and health care risks across the community thereby reducing financial barriers of access to quality and essential packages of health care services to agricultural households, informal sector and the poor. It aims to ensure health equity by expanding access to quality essential health services. The second closely related mission is providing financial protection to these segments of society when seeking health care services. It provides financial protection against catastrophic health spending that pushes people in to impoverishment.

Though there are some differences in the implementation of CBHI from country to country, Community-based Health Insurance has five major characteristics that distinguish it from other health insurance schemes theoretically. According to Soors et al (2010), these fundamental defining features of CBHI are:

1. Community-based nature and risk pooling- people who share common characteristics (geographical, occupational, ethnic, religious, gender etc) organize the scheme and benefit from packages of insured health care services.
2. Solidarity: Sharing health care risks and pooling of resources is expected to cover all members of the community where CBHI is being implemented regardless of the presence of health risks without jeopardizing the principles of voluntary enrollment.

3. Participatory decision-making and management.

4. Non-profit character- the scheme is established to share health care related financial risks and promote access to health care services but not to earn profit.

5. Voluntary affiliation –enrollment and membership is dependent on free-will of individuals/households.

2.4. Universal Health Coverage in Africa

WHO and WB in collaboration with other stakeholders developed Universal Health Coverage Monitoring Framework that recommends the need to focus on targets of Service Coverage and Financial Protection (World Health Organization and World Bank Group 2016). Service coverage is measured by focusing on bundle of interventions provided to people: Promotive, preventive, curative and palliative health care services to address key health problems in countries. In Africa, since the major burden of disease include communicable diseases, maternal, neonatal and nutritional diseases, any evaluation of progress towards UHC must focus on reporting progress made to address these basic health problems. On the other hand efforts to measure financial protection are based on two types of standardized financial risk protection indicators. These indicators are incidence of catastrophic payments and the incidence of impoverishing expenditures.

UHC in Africa has been low though there are progresses compared to the past. Rapid improvement have been recorded in the coverage of insecticide treated bed nets for children that increased on average 15% per year between 2006 and 2014 in Africa. Maternal health indicators have shown significant improvement over years. Antenatal care visits and skilled birth attendance both increased from 40% in 1990 to 60% in 2014. Though this is the case, huge differences are still found within countries regarding access to more complex health care services such as skilled birth attendance and treatment of severe illness (World Health Organization and World Bank 2017).

Access to HIV, TB and malaria treatment has remained uneven and lower than other core indicators of Universal Health Coverage. In Eastern and Southern Africa, only 56% of people living with HIV/AIDS have been diagnosed and 54% have got treatment. On top of that poor

quality of care costs lives and led to waste of resources. There are severe problems of lack of essential drugs, availability of treatment equipment, and deficiency of knowledgeable and skilled health professionals (World Health Organization and World Bank 2017).

There are various factors that impede progress towards Universal Health Coverage in Africa. Challenges that constrain the realization of UHC in Africa include large proportion of population living in extreme poverty that cannot pay health insurance premiums, large informal sector with higher proportion of people earning from this sector not covered by health insurance schemes, higher number of members of health insurance scheme leaving the scheme (higher dropout rate), poorly funded primary health care system and fragmented health insurance fund pool (Umeh 2018).

2.5. Universal Health Coverage in Ethiopia

Universal Health Coverage in Ethiopia was 34.3% in 2015 – very low even when compared to most sub-Saharan and East African Countries. There are huge discrepancies of health service coverage across programmes. Universal Health coverage of infectious disease was 52.8%, Non-communicable disease was 35%, and service capacity and access to health facility was 34.3% in 2015 (Getachew et al 2019).

Extremely lower Universal Health Coverage in Ethiopia is explained by both demand side and supply side factors (O'Neill et al 2013). Demand side factors include higher level of multidimensional poverty (23.5% of the population lives in absolute poverty), low literacy rate and poor health seeking behavior (Anagaw et al 2014). Supply side factors that impede Universal Health Coverage in Ethiopia comprise lower public investment on health services. This is evident while looking at health service investment in Ethiopia, though the WB recommends national governments to commit $112 per person annually to achieve SDG, only $28 has been spent on health services per person (Stenberg et al 2017).

2.6. National Policy Foundations of Universal Health Coverage in Ethiopia

The Government of FDRE declared its political willingness to realize Universal Health Coverage in Ethiopia through designing various health policy instruments that advocates for the need to provide health care services to all segments of the population by utilizing resources from all

available sources of funding. The FDRE constitution which was ratified in 1995 included article 90(1) which states that depending on the capacity of country's resources, policies shall aim to provide all Ethiopians access to public health, education, clean water, housing, food and social security (HOPR 1995).

The Federal Ministry of Health of Ethiopia adopted Health Policy in 1993 that further affirmed the importance of achieving Universal Health Coverage. This policy emphasizes the development of an equitable and acceptable standard of health service system that provides services to all strata of population to the extent that country's resource permits. It also underscores the need to ensure accessibility of health care services for all people. Provision of health care services had to be based on scheme payment according to the income level of users and special attention was planned to be given for the poor segments of the society who cannot afford to pay (FMOH 1993).

In 1998 Ethiopia introduced Health Financing Strategy that aims to identify and obtain resources that can be spent on health care services in efficient manner. Health financing strategy is concerned with increasing resources to health sector to promote the sustainability of health financing that in turn is needed to improve the quality and coverage of health services. Health financing strategy incorporated fee waiver system, exempted services and health insurance schemes that support the progress towards Universal Health Coverage by promoting equitable access to Health care services (Abebe et al 2015).

Health sector programmes underscore the governments' priority investment area in health sector as strengthening primary health system that include Health Extension program, Health Centre expansion and Primary health care services. These investments are also highly needed to provide access to health care services to all segments of the population on equitable ways. Packages of essential services (2005) and Health insurance Strategy (2010) both have laid foundation in assisting progress towards the achievement of Universal Health Coverage in Ethiopia (Abebe et al 2015).

2.6.1 Health Care Financings Strategy of Ethiopia

Health Policy of Ethiopia that was adopted in 1993 generally mentioned sources of financial resources to provide health care services. These sources include raising taxes and revenues; contributions from health insurance of public employee, contributory health insurance schemes of private employees, individual or group health insurance and voluntary contributions (FMOH 1993).

However, despite progresses made over years regarding the provision of health care services to significant share of the population, health sector had been suffering from serious financial problems in the absence of financing strategy. In 1998 the councils of ministers developed Health Financing Strategy that served as the milestone for many health care reforms in subsequent years. This policy document underscores that the government alone cannot finance health care and the importance of cost-sharing in the provision of health care services.

Health financing strategy intends to achieve certain clearly articulated goals. These include identifying and obtaining resources that can be allocated to preventive, promotive, curative and rehabilitative health services, increasing abundant resources to health sector, increasing efficiency of using resources, ensuring the sustainability of health care financing and improving the quality and coverage of health services (Hailu 2012).

Major components of Health Financing strategy are revenue retention and utilization; systematizing fee waiver system, standardizing exemption services, outsourcing of non-clinical services in public hospitals, user fee setting and revision; Initiation of Health Insurance, establishment of private wing in public hospitals; and achieving health facility autonomy through the establishment of governing bodies(Abebe et al 2015).

Overall these health care financing reforms underpinned by health care financing strategy brought significant progress in the provision of quality health care services and expanded coverage to the poor segments of population through fee waiver systems and exempted services.

Health insurance strategy which was developed in 2010 based on health care financing strategy incorporated two separate schemes. These are Social Health Insurance for formal sector and Community-based Health Insurance for agricultural and informal sector.

2.7. Design of Community-based Health Insurance in Ethiopia

To reduce barriers of access to modern health care services and to realize Universal Health Coverage, Ethiopia designed two separate health insurance schemes in 2010. These are Social health insurance and Community-based Health insurance schemes

Community-based health insurance was designed to provide health insurance to rural households, the poor and informal sector in urban settings. It aims to realize equitable access of quality essential health care services to all people regardless of pre-existing disparity across different parameters. The specific objectives of CBHI include facilitating access to health services, upgrading quality of healthcare services, boosting resource mobilization to health sector, enhancing popular participation in the management of healthcare services and increasing health insurance coverage in the rural and urban informal sectors (Solomon et al 2015).

CBHI scheme of Ethiopia was designed in a way that government plays key leading role and community play an active role in the design, implementation and management of the scheme. It is implemented in strong collaboration with stakeholders such as administrators/Mayors, Health office, other governmental institutions, kebele officials, community leaders, religious leaders, beneficiaries and health facilities.

Though this is the reality about CBHI in Ethiopia, there are some variations in the design of community-based Health insurance from regions to regions. Southern Nations, Nationalities and Peoples Regional Government Health Bureau developed CBHI directive in 2020. This policy instrument is known as Directive number 005/2020.

According to this directive, to introduce CBHI in a given District/city administration, at least 50% of households who are capable of paying premiums must be registered voluntarily and pay annual premium contribution. District health insurance institutions have the responsibility to

enter in to contractual agreement with public health centers; and primary, District and tertiary hospitals to provide health care services to the members of the scheme (BOH 2020).

There are two types of members of the scheme. Paying members are those people who are capable of paying premiums from their household income and non-paying members are indigent population whose premium is paid by third party –government. Paying members of rural District are required to pay 10 birr registration fee and 240 birr annual contribution. If the household head has more than one wife, 50% of the premium is added on one more wife. There are also premium differences between basic household members (Husband, Wife, children under the age of 18, physically disabled and mentally ill household members) and additional household members (household worker, children above the age of 18 and so on). In rural Districts, to every additional household member, a household is required to pay additional 50 birr (BOH 2020).

The premium payment also varies from rural district (240 birr) to Towns which are also centres of Zones (300 birr) and Hawassa City administration (350 birr). If the household head has more than one wife, 50 % of premium is added based on the number of wives(Let's say if the person has three wives, household head in Zonal Towns is expected to pay 600 and household head in Hawassa City is expected to pay 700 birr). Accordingly, premium also differs when the number of additional household members increases.

Benefit packages of health services insured by CBHI include outpatient services, inpatient services, surgical services, physician ordered diagnostic services, generic drugs and infection induced root canal medications. Services which are not insured by CBHI include eye glasses, tooth or artificial tooth maintenance, accidents insured by other laws, transportation costs, dialysis medication for chronic kidney problem, and any medication outside the national boundary.

Members of the schemes are required to pass through the referral system to get health care services. They are expected to get health services from the nearby public health centres and progress towards the primary, district and tertiary hospitals through the referral system unless

there are emergency cases/there is physical distance barriers to public health centres. Members who do not observe the referral system are obliged to cover total expenses from their pocket.

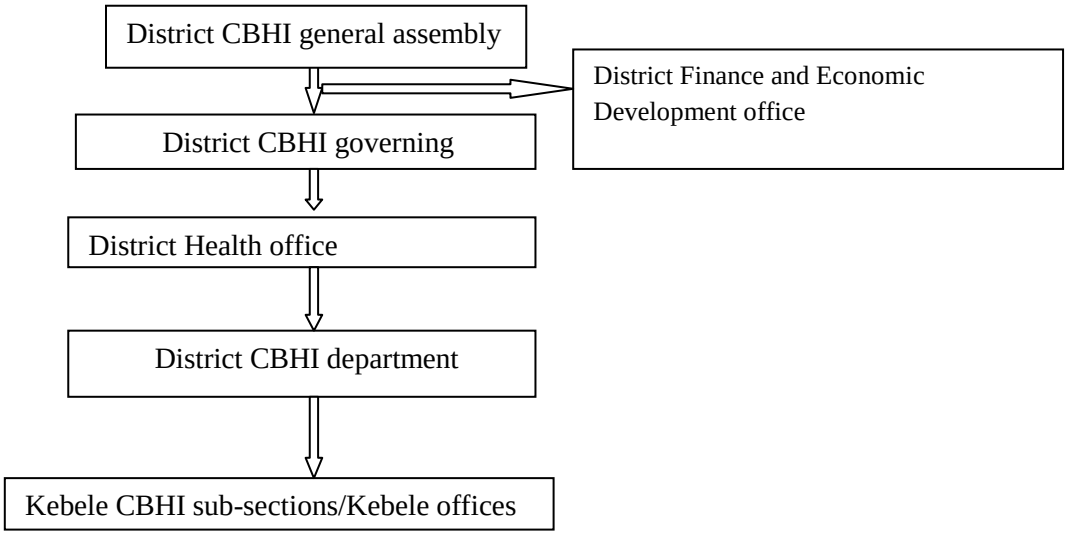

Figure 2. District CBHI Scheme Organizational Structure (Source: SNNP BOH CBHI Directive No. 005/2020)

The third party (government) is responsible to pay premiums on behalf of indigent population (approximately 10%) of the total population). While regional government is responsible to provide 40% targeted subsidy to indigents, zonal government covers 30% of the premium and the rest 30% of premium payments of indigent population is covered by district governments. In addition, the Federal government is responsible to provide 10% the total amount of premium collected from the members of CBHI as general subsidy.

The sources of income for CBHI scheme include registration fee, membership contributions, Fines, Targeted subsidy, General subsidy, Bank interests and other sources. Contracted Public health facilities do have legal obligations to provide quality essential services to beneficiaries and when there is an instance of lack of essential drugs in these institutions; District CBHI department in collaboration with Zonal Health department shall reach contractual agreement with Red Cross pharmacies, Community owned pharmacies and other publicly owned pharmaceutical venders (BOH 2020).

2.8. Implementation of Community-based Health Insurance in Ethiopia

In Ethiopia CBHI was initiated as pilot programme in 13 districts of four major regions (Tigray, Amhara, Oromia and SNNP) in 2011. Provision of actual health services in these districts to members started the following year in 2012. CBHI scheme had continued to be implemented as pilot in these regions for three years and after the performance evaluation of the success of CBHI, recommendations were provided to scale up the schemes to other districts and regions in 2014. Until 2017, only four major regions where CBHI had been implemented as pilot programme run this scheme by expanding district coverage. In 2018, Addis Ababa City administration and Benishangul Gumuz regional state started implementing CBHI. In 2020, Afar and Harrari regional states initiated the implementation of CBHI. In Somali, Diredawa and Gambella regional states CBHI schemes have not been launched yet (EHIA 2020).

CBHI implementation in Ethiopia has shown significant progress nowadays. As of 2020, about 6,944,784 million households have been enrolled in 770 districts of the country. Among these total member households, 1,459,123 households are indigent members while 5485661 households are paying members. National coverage of indigent population is 10% from eligible payee members and 21% from the total members of CBHI scheme including non-paying members.

CBHI district coverage has reached 75%. Taking the average family size as 5, the total number of population in informal sector who have been covered by CBHI scheme reaches only 32.2 million people. In a country where informal sector and rural dwellers constitute 85% of the total population (100 million), CBHI insured population accounts only 37% of the informal sector.

When CBHI implementation is evaluated in terms of indigent population coverage from eligible household members, Addis Ababa City administration (17%), Oromia (11%) and Tigray regional states (13%) have recorded relatively better performance. SNNP have registered very low performance in indigent coverage (6%). The performance of CBHI in providing insurance coverage to indigent population as a country is very weak because Ethiopia has 23.5% of the population who live under the poverty line (EHIA 2020).

2.8.1 Constraints of CBHI Implementation in Ethiopia

Though CBHI coverage has shown progress from year to year since 2011, coverage is still at 50% of eligible households. Dropout rate is the major challenge facing CBHI so that significant number of members have been withdrawing from CBHI scheme every year (EHIA 2020).

According to EHIA (2020), challenges facing CBHI include inadequate political commitment at all levels in promoting the scheme, inadequate supplies and equipment (drug, lab, diagnosis etc) in most health facilities, lack of appropriate CBHI organizational structure and miscommunication about the scheme. Tsega et al (2019) asserted that family size, health status of the family members, chronic disease in the household, scheme service adequacy, community solidarity, health institution service quality, CBHI awareness and wealth were identified as significant factors determining CBHI enrollment. Ewunetie et al (2020) also listed income, education, community participation, marriage, occupation, family size, illness experience, benefit package, awareness, previous OOP health expense, service quality and trust as factors that are positively related with CBHI enrollment. Contribution amount, self-perception about health status, and bureaucratic complexity were considered as negatively related to CBHI enrollment.

Health facilities service delivery and institutional capacity, awareness about CBHI, health status of eligible households, income level, and family size are factors commonly mentioned in all these three research findings as determining CBHI enrollment.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1. Description of the Study Area and Population

Dawuro Zone is one of the Zones that are found in today's SNNPR. It is located at about 500 km southwest of Addis Ababa, the capital of Ethiopia and 275 km from Hawassa, the political center of SNNPR. It shares boundary with Gamo and Gofa Zones to the south, Konta Special District to the West; Oromia regional State, Jimma Zone to the North; Hadiya and Kembata Tembaro Zones to the Northeast and Wolaita Zone to the east direction (FED 2019).

Dawuro Zone is estimated to lie between 60 º35' to 70 º 34' north latitudes and 360º 04 ' to 37 º 53 ' east latitudes. The altitude of Dawuro ranges from 500 m above sea level around the confluence of Zigina and Omo rivers to 3000 m above sea level at mount Tuta in Tocha District. Dawuro Zone has total area of 5,225.61 km². Based on 2007 census report, the total population of Dawuro Zone was estimated to be 936, 468 in 2018/2019.

The administrative center of Dawuro Zone is Tarcha Town administration. Dawuro Zone has 10 Districts and one Town administration, namely Marek'a, Gena, Zaba-gazo, Loma, Tocha, Tarcha Zuriya, Esara, Mari-Mantsa, Zisa, kachi and Tarcha Town administration (FED 2019).

Tocha District, which is the actual study area of this research, is one of 10 Districts found in Dawuro Zone. It has the total population of 62, 422. The total number of households in Tocha District is 12,739. Tocha District is subdivided into 15 kebeles (FED 2019).

Figure 3. Administrative map of Dawuro Zone (Source: Admasu (2014))

3.2. Research Approach

Both quantitative and qualitative approaches (mixed approach) were employed to collect and analyze data concerning the advantages and challenges of CBHI scheme. Triangulation of both approaches is preferable because it generates relatively better saturated data that help to reach at comprehensive and complete understanding of the issue which would be impossible if only one research approach is chosen (Creswell 2014).

To achieve objectives of this research, both approaches were used together throughout data collection, analysis and interpretation process. Data concerning the advantages of CBHI, the participation and healthcare utilization of the poorest households, the challenges of implementing CBHI; and challenges of CBHI in ensuring UHC was collected and analyzed by triangulating quantitative and qualitative research approaches, though the degree of their significance varies from objectives to objectives.

3.3. Research Design

Cross-sectional research design was applied. Collecting and analyzing data over long period of time was beyond the scope of this research partially due to the nature of research problem and the other rationale is resource constraint given it is a Masters' Thesis undertaken with limited financial support and completed within a year.

The purpose of the research was largely descriptive. Advantages and challenges of CBHI scheme in promoting UHC was described and examined; and the data was collected and analyzed by using concurrent mixed design.

3.4. Methods of Data Collection

3.4.1 Household Survey

A. Types and Sources of Data

Since membership of CBHI scheme is on household level, household survey was employed to collect quantitative data through structured interview. Data concerning the demographic and socio-economic profile of respondents, community participation, enrollment, affordability and expectations, health facility service delivery, indigent population participation, and challenges of

CBHI was collected from selected household heads by employing household survey. Selected household heads were interviewed because the majority of rural residents are illiterate in Ethiopia.

B. Sampling and Sampling Size Determination

Tocha District was purposively selected because it is better than other districts in terms of CBHI enrollment rate. Another factor that was considered in selection of Tocha District is the length of implementation period. In this regard, Tocha District along with Mareka, Loma, and Disa Districts launched CBHI in 2017/18. The remaining other six districts have implemented it only for two years. To evaluate the implementation of CBHI, the researcher thought it is more rewarding to collect relevant data from the first generation CBHI implementing districts.

From the total number of 15 kebeles in Tocha district, three kebeles, namely Medihanealem, Gibra and Botori were selected through simple random sampling technique (lottery method). Medihanealem, Gibra and Botori kebeles have 484, 1074 and 704 households respectively.

To determine sample size, Yamane's sample size determination formula was employed (Yamane 1967).

$n = N/1+N (e)^2$ where n is sample size, N is the total number of households in kebele, and e is the margin of error. This formula Considers 95% confidence level and 5% margin of error.

By employing this formula, a total number of 340 household heads were selected from three kebeles. Having determined the total sample size, sample size was allotted to each kebele according to the proportion of households in each kebele from the total population of 2262. Accordingly, from Medihanealem kebele = 73 household heads,

Gibra Kebele = 161 household heads and

Botori kebele = 106 household heads were selected by employing systematic sampling technique.

3.4.2 In-depth Interview

In-depth interview is one of the qualitative research methods that allow the researcher to collect detailed information about research problem. Meanings people attach towards particular social phenomena and their experiences can be best understood through this method because it gives them freedom to express their understandings the way they feel convenient (Neuman 2014).

Data regarding the provision of health care services, awareness about CBHI, challenges of CBHI, and the participation of indigent population was gathered through employing in-depth interview method. A total number of four interviewees: one subsidized indigent member, one CBHI paying member, one eligible household head not enrolled in CBHI and one indigent household head not enrolled in CBHI were purposively selected from each kebele and interviewed. In short, a total number of 12 informants were interviewed from three kebeles, namely Medihanealem, Gibra and Botori.

3.4.3. Key Informant Interview

Key informant interview is a version of in-depth interview that is administered to individuals based on their characteristics, experience, positions and knowledge. Interview guide was prepared and five key-informants (Kebele manager or CBHI representative, health extension worker, religious leaders, and elders) from each kebele were interviewed concerning the delivery of health services; the acceptance of CBHI and members feedback, challenges of CBHI and the advantages of CBHI in expanding access to health care services. In addition, a manager of a primary hospital, manager of a general hospital, CBHI officer, head of district health office and chief administrator were also interviewed.

In general, a total number of 17 key informants were interviewed to collect information about the advantages, implementation process, outcomes and challenges of CBHI.

3.4.4. Focus Group Discussion (FGD)

Focus group discussion has the advantage of synergistic group effect in generating valuable and relevant information on different research issues. It is more important particularly in examining community's attitudes towards initiatives like CBHI. Data concerning the acceptance of CBHI, community participation, health care service provision adequacy, and challenges of CBHI was

also collected through conducting FGD. Participants of FGD were purposively selected depending on their characteristics, position and knowledge. In each selected kebele, four FGDs were organized separately for CBHI paying members, CBHI subsidized member, indigent persons not enrolled in CBHI and eligible household heads who are not enrolled in CBHI.

Focus group discussions were organized for the above mentioned segments of the community separately because these groups may have more differences than similarities concerning their views and experiences about CBHI. Each FGD was comprised of eight purposively selected participants. Each kebele selected for household survey hosted four FGDs and the total numbers of twelve FGDs were conducted in Medihanealem, Gibra and Botori kebeles.

3.4.5. Observation

Observation is a very important research method most often practiced in field research to gather valuable information about social phenomena (events, interactions, and the like) from the natural settings. The researcher found it more rewarding in generating data about the health care service delivery. Beneficiaries' feedback about health care services was observed from comment recording file. Service delivery process was also observed and field notes were taken.

3.4.6. Document Analysis

Document analysis was also used to collect and analyze relevant secondary data from different published and unpublished literatures like articles, official plans, reports and health facility records.

3.5. Instruments of Data Collection

Designing instruments of data collection is highly essential and integral elements of any research process. Quantitative data from household survey was collected through structured questionnaire. A questionnaire is a research instrument consisting of a set of questions (items) intended to capture responses from respondents in a standardized manner. Structured questionnaire was designed in a way that it stands on its own in providing relevant data.

Qualitative data from in-depth interview, key informant interview, FGD, and observation was collected through interview guide, FGD guide and observation checklists. These instruments were designed in open-ended question format.

3.6. Methods of Data Analysis

Quantitative data collected from household heads was analyzed largely through descriptive statistical tools such as tables. Inferential statistics (binary logistic regression) was used to analyze how CBHI enrollment is associated with respondents' socio-demographic characteristics, health status and social capital**.** SPSS version 23 was used to process quantitative data.

Qualitative data collected by employing in-depth interview, key informant interview, FGD, and observation was analyzed through thematic analysis method. Data was coded into categories and analyzed based on their themes.

3.7. Data Quality Assurance

Data quality assurance is all about procedures followed and tools used to maintain the reliability and validity of data collected. It requires close examination and evaluation of each step throughout the entire research process. To assure the quality of data collected for this particular research, different mechanisms were translated in to action.

Triangulation of methods and instruments of data collection generates relatively complete data about the research problem. The design of questionnaire is carefully conducted to avoid ambiguous questions, and its validity (face and content) was assessed through pre-testing method. The questionnaire was administered to the total number of 15 household heads from the study area (Three kebeles randomly selected to conduct this research) to pretest the validity.

Appropriate sampling design was also employed to select samples. Structured questionnaire, interview schedules and FGD guide were translated to Dawurotsuwa. Data collected from purposively selected informants, participants and observation was transcribed accurately. Audio-tape was used to record interviews and photographs were taken.

3.8. Ethical Considerations

Strict observance of ethics approved by scientific community in research is crucial in any research project. To generate scientifically acceptable research findings that can be relied up on to advance understanding about the issue being investigated, to design appropriate policy instrument, to address the problems of health service access inequity and to improve the performance of CBHI, all ethical codes in research were strictly followed.

Letter of request for cooperation was obtained from the Sociology department. Two separate letters, one for the Zonal Health Department and the other for Tocha District Health Office that clearly articulate the purpose of the research were given to respective officials. Structured questionnaires included general information that aim to create awareness to respondents regarding the type of information sought, the purpose of research, respondents' right to withdraw from investigation at any stage if they feel inconvenient, anonymity of respondents and confidentiality of information provided not to use for reasons other than research. Informants and participants of qualitative research methods were also told the same general information included in questionnaire to obtain informed consent.

There was no intentionally entertained bias in data collection, analysis and interpretation; and appropriate research methodology (sampling design, instrument design and so on) was selected to seriously consider all ethical issues in research.

CHAPTER FOUR: DATA ANALYSIS AND DISCUSSION

4.1. Data Analysis

4.1.1. Socio-demographic Characteristics of Respondents

Information about the socio-demographic characteristics of respondents is exclusively based on data obtained through administering household survey to randomly selected household heads. Important background characteristics such as sex, age, religion, educational level, marital status, household size and household income level of respondents are discussed in this section.

4.1.1.1 Sex, Age, Religion and Marital Status of Respondents

As depicted in Table-1, the majority of sample household heads were males. From the total number of 340 samples, 87.9% of the respondents were males and the remaining 12.1 % were females. Concerning age composition, large proportion (77.9%) of persons included in household survey was found within the age category of 30-65. The remaining respondents were found within the age category of 15-29 (16.8%) and above 65 years (5.3 %). In the study area there are various religions. In this regard, 69.4% of the respondents were Orthodox Christians. Respondents who follow protestant and catholic religions accounted for 28.8% and 1.8% respectively.

Since respondents of household survey in this particular research were sample household heads, the majority of respondents 313 (92.1%) were married. From the remaining respondents, 12 (3.5%) were widowed, 8 (2.4 %) were divorced and 7 (2.1%) were separated.

4.1.1.2 Educational Level of Respondents

As it is the case in the most parts of rural Ethiopia, more than half of respondents 174 (51.2 %) cannot read and write. Table-1 shows that respondents who attended non-formal, primary level, and secondary level accounted for 6(1.8%), 85(25%) and 67(19.7%) respectively. The remaining 8 (2.4 %) of respondents have certificates from VET/TVET.

4.1.1.3 Households' Size

Since membership of CBHI is at the household level, the researcher collected data about the household size of respondents. Table-1 indicated that the majority of households, 208 (61.2%) comprised of 5 to 8 members. Households which host 9-12 members, accounted for 31(9.1 %) of

the total respondents. The remaining respondents' households have less than 4 and more than 12 members, each comprising 87(25.6%) and 14(4.1%) respectively.

4.1.1.4 Households' Income Level

Information concerning households' income level was obtained from respondents' self-report about their living conditions. They were asked to rate their income level from the given response items that included very poor, poor, medium, rich and very rich. In this regard, the majority of respondents 234(68.8%), do have medium income. Respondents who rated their living standard as very poor, poor, rich and very rich accounted for 13.8%, 7.4%, 6.2% and 3.8% respectively.

Table 1. Socio-demographic Characteristics of Respondents

No	Variables	Categories	Frequency	Percent
1	Sex	Male	299	87.9
		Female	41	12.1
		Total	340	100
2	Age	15-29	57	16.8
		30-65	265	77.9
		> 65	18	5.3
		Total	340	100
3	Religion	Orthodox Christian	236	69.4
		Protestant	98	28.8
		Catholic	6	1.8
		Total	340	100
4	Education level	Can't read and write	174	51.2
		Non-formal education	6	1.8
		Primary level	85	25
		Secondary level	67	19.7
		Certificate from VET and TVET	8	2.4
		Total	340	100
5	Marital status	Married	313	92.1
		Divorced	8	2.4
		Widowed	12	3.5
		Separated	7	2.1
		Total	340	100
6	Household size	< =4	87	25.6
		5-8	208	61.2
		9-12	31	9.1
		> 12	14	4.1
		Total	340	100
7	Household income level	Very poor	47	13.8
		Poor	25	7.4
		Medium	234	68.8
		Rich	21	6.2
		Very rich	13	3.8
		Total	340	100

4.1.2 The Relationship among CBHI Enrollment; and Respondents' Socio-demographic Characteristics, Health Status and Social Capital

To describe how CBHI enrollment is associated with respondents' socio-demographic characteristics, health status and social capital, the researcher employed binary logistic regression. The results showed that with the exception of age, religion, marital status and conformity to social norms, there is significant association between CBHI enrollment (dependent variable) and independent variables such as sex, education, household size, income level of households, perception about households' average health status, the existence of chronic disease in household, households heads' social participation, perception about community solidarity and community trust.

Female headed households were 132.89 times more likely to join CBHI when compared to male headed households. Educational level of household heads also affects CBHI enrollment. In this regard, the binary logistic regression results depicted that household heads with primary level education were 32.460 times more likely to join CBHI scheme when compared to those who cannot read and write. On the other hand, household heads with secondary level education were 82.914 times more likely to enroll in CBHI than those who have never attended education. When the effect of income considered, households within rich category were 47.904 times more likely to join the scheme than households within the poorest income category.

Regarding the health status, households with good perceived health status were 0.011 times less likely to join CBHI than households with poor perceived health status. Households which did not have chronic disease were 0.031 times less likely to join when compared to households with chronic disease.

In addition to the socio-demographic characteristics and health status, social capital has been considered as determining factors of CBHI enrollment. Households with good level of social participation were 17.604 times more likely enroll in CBHI scheme than households led by persons with poor level of social participation. Households with heads who perceived that there was good solidarity in the community were 253.665 times more likely to join the scheme when compared to those who perceived the existence of poor social solidarity in their environment.

Households led by heads who rated that the level of trust existing in the community was good were 327.453 times more likely to enroll than those run by persons who perceived the existence of poor trust in the community.

Table 2. Binary Logistic Regression Results of the Relationship among CBHI Enrollment; and Issues like Respondents' Socio-demographic Characteristics, Health Status, and Social Capital.

Variables	**Categories**	**CBHI enrollment**		**COR(95%CI)**	**AOR(95%CI)**
		Yes n (%)	No n (%)		
Sex	Male	164(55%)	135(45%)	1.0	1.0
	Female	37(90%)	4(10%)	7.614 (2.647, 21.900)	132.892(6.854, 2576.744)
Age	15-29	16(28%)	41(72%)		
	30-65	167(63%)	98(37%)		
	>65	18(100%)	0(0%)		
Religion	Orthodox	137(58%)	99(42%)		
	Protestant	60(61%)	38(39%)		
	Catholic	4(67%)	2 (33%)		
Educational	Can't read and write	55(32%)	119(68%)	1.0	1.0
	Non-formal education	4(67%)	2(33%)		
	Primary level	73(86%)	12(14%)	13.162(6.608, 26.218)	32.460(8.215, 128.263)
	Secondary level	62(93%)	5(7%)	26.829(10.215, 70.463)	82.914(9.982, 688.675)
	Certificate from VET/TVET	7(88%)	1(12%)		
Marital status	Married	185(59%)	128(41%)		
	Divorced	5(63%)	3(37%)		
	Widowed	7(58%)	5(42%)		
	Separated	4(57%)	3(43%)		
Household size	<=4	34(39%)	53(61%)	1.0	1.0
	5-8	125(60%)	83(40%)		
	9-12	29(94%)	2(6%)	22.603(5.063, 100.917)	968.347(11.545, 81222.185)
	>12	13(93%)	1 (7%)		
Household income	Very poor	31(66%)	16(34%)	1.0	1.0
	Poor	9(36%)	16(64%)		
	Medium	134(57%)	100(43%)		
	Rich	17(81%)	4(19%)	2.194(.632, 7.619)	47.904(1.938, 1184.355)
	Very rich	10(77%)	3(23%)		
Household health status	Poor	69(88%)	9(12%)	1.0	1.0
	Medium	96(59%)	67(41%)	.187(.087, .400)	.026(.004, .179)
	Good	36(36%)	63(64%)	.075(.033, .167)	.011(.001, .085)
Chronic disease	Exist	126(85%)	22(15%)	1.0	1.0
	Do not exist	75(39%)	117(61%)		.031(.008, .127)

HH social participation	Poor	8(28%)	21(72%)	1.0	1.0
	Medium	17(26%)	49(74%)		
	Good	176(72%)	69 (28%)	6.696(2.832, 15.832)	17.604(2.542, 121.901)
Social norms	Poor	0(0%)	8(100%)		
	Medium	15(31%)	34(69%)		
	Good	186(66%)	97(34%)		
Community solidarity	Poor	2(10%)	18(90%)	1.0	1.0
	Medium	27(43%)	36(57%)	6.750(1.442, 31.604)	90.961(2.185, 3787.420)
	Good	172(67%)	85(33%)	18.212(4.130, 80.308)	253.665(7.519, 8557.775)
Community trust	Poor	3(10%)	27(90%)	1.0	1.0
	Medium	49(47%)	56(53%)	7.875(2.250, 27.566)	58.015(2.567, 1311.158)
	Good	149(73%)	56(27%)	23.946(6.987, 82.068)	327.453(13.502, 7941.528)

4.1.3 Enrollment Coverage and Rationale for CBHI Membership

From the total number of 340 respondents who provided responses for household survey, all of them have information about CBHI. After all, information about CBHI does not indicate the depth of knowledge about the scheme. Out of 340 household heads, 286 (84.11%) responded that for the first time they heard information about CBHI from awareness creation campaigns in public meetings. While the remaining 28(8.23%) said that they got information from mass media, 16(4.7%) reported that they got the first information about CBHI from neighbors/friends. Others, 6(1.76%) and 4(1.17%) got the first information about CBHI from health facilities and house- to- house awareness creation campaigns respectively.

When CBHI membership is considered, 201(59.11%) of sample household heads are CBHI members. The rest 139(40.88%) are non-members. Out of 201 CBHI members, 169(84.07%) are paying members while the remaining 32(15.92%) are indigent members.

To exhaustively collect information about the reasons for joining the CBHI scheme, a single sample CBHI member was allowed to provide more than one response. Hence, the total percent of respondents is greater than 100%.

Table 3.**Reasons for Joining CBHI Scheme (Multiple responses)**

No	Reasons	Frequency of responses	Percent of responses	Percent of respondents
1	Illness and/or injury occurs frequently in our household	48	7.63	23.9
2	Our household members need health care	176	27.98	87.6
3	To finance health care expenses	183	29.09	91.04
4	CBHI registration fee and premium is paid by government	31	4.92	15.4
5	Premium is low compared to user fee price to obtain medical treatment	191	30.36	95
	Total	629	100	312.94

As it's indicated in Table-3, respondents who joined the scheme provided multiple reasons for joining the scheme. From the total number of 201 sample CBHI members, 95% of respondents replied that their households joined the scheme because they thought that registration fee and premium is low compared to user fee payment for health services. The second highest percent of respondents, 91.04%, indicated that their households joined the scheme to finance health care expenses. Respondents who said that they joined CBHI scheme because their household members need health care accounted for 87.6%. The remaining respondents replied that they joined the scheme because illness and injury occur frequently in their households 23.9 % and premium is paid by government 15.4%.

Ethiopian CBHI allows enrollment at household level to control adverse selection. Once the households register in CBHI and renew their membership, by default all basic household members are guaranteed of free health care services from contracted health facilities whenever they seek it. In Tocha District, 87% of CBHI member respondents asserted that all of their household members are enrolled. The remaining 10.20% said that some of their household members are not enrolled.

4.1.4 Advantages of CBHI in Addressing Health Care Needs from Service Providers' Perspectives

To comprehend the perspectives of service providers about the importance of CBHI in addressing health care needs, data was collected exclusively from key informants such as CBHI representatives, health extension workers, manager of Tocha primary hospital, manager of Tarcha general hospital, District CBHI officer, head of District health office and Tocha District chief administrator.

4.1.4.1 Health Care Utilization of CBHI Members

One of the most important contributions of CBHI in addressing health care needs of the community is that it has increased the health care utilization of CBHI members. Prior to the implementation of CBHI scheme, significant number of people did not want to visit health facilities primarily due to financial barriers. Once households are registered in CBHI and renewed their membership, all their basic household members are entitled to free health services. Therefore, they do not worry about the costs of health services. This indicates the importance of CBHI in increasing access to health services.

Regarding the advantages of CBHI in increasing health care utilization of CBHI members, all health providers provided similar information. One key-informant, male aged 40 articulated it typically as follows:

> *The introduction and implementation of CBHI has resulted in increment of patients' visit to health facilities. CBHI has improved health seeking behaviors of our community. In the past, most people were negligent and unwilling to visit health facilities even though they have money. However with the introduction of CBHI, especially CBHI members started extensively utilizing health services even for previously neglected and undermined health problems.*

Health service providers also held the views that increased health care utilization has improved health status of CBHI members. After all, health status of people is the result of various inextricably linked factors, not just health care utilization/membership of health insurance.

In this regard, one key-informant, male aged 40 said:

> *…The contribution of CBHI in improving the health status of the community is paramount. This in turn has its' own implication on improving the living standard of people.*

Most key informants also stated that by reducing financial barriers of access to health services, CBHI has promoted health equity in the study area.

4.1.4.2 Effects on Financial Resource Availability and Improvement of Quality of Health Services

Health service providers asserted that the introduction and implementation of CBHI in the study area has increased the availability of financial resources in health facilities. Money obtained from different sources (subsidies and membership contribution) has been reimbursed to contracted public health facilities every three months to cover the costs of health services. This money has been used to increase the availability of essential drugs and medical equipments. Health providers underscored that CBHI has positively contributed to the improvement of health services.

Concerning this, one key informant male aged 43 summarized it as follows:

..thanks to CBHI, health institutions are now in relatively better financial position than before. This money has been spent on drugs and medical equipments. In short, CBHI has improved the quality of health services.

4.1.5 Advantages of CBHI in Addressing Health Care Needs from Community's Perspectives

4.1.5.1 Benefits of CBHI in Addressing Health Care Needs

Out of 201 CBHI member respondents of household survey, 163(82%) reported that their household got free health services from CBHI. The remaining 38(18%) responded that their household members have not got free health services from CBHI because none of their household members have visited health facilities.

Respondents who claimed to have enjoyed benefits from the CBHI scheme were also asked to specify and clarify those benefits they got. Multiple response items were prepared to collect information about the issue at hand and responses are summarized as follows.

Table 4. Benefits Entertained by CBHI Members (Multiple responses)

No	Benefits	Frequency of responses	Percent of responses	Percent of respondents
1	Increased access to health care services	154	37.01	94.5
2	Reduced costs of health care services	120	28.84	73.6
3	Reduced concerns about unexpected health care costs	142	34.13	87
	Total	416	100	255.1

Out of 163 respondents who claimed that they have enjoyed some sort of benefits, 94.5% indicated that CBHI increased their access to health care services. 87% of respondents emphasized that CBHI reduced concerns about unexpected costs of health care services. The remaining 73.6% depicted that CBHI reduced costs of health care services.

Table-4 is further supported by qualitative data obtained from CBHI member FGD participants and CBHI member informants of in-depth interview. Though the point raised is shared by the majority of participants, one participant of FGD constituted of CBHI members articulated it as follows:

> *Due to the introduction of CBHI in our vicinity, nowadays, we visit health facilities for previously neglected and undermined health problems such as headache, stomachache, injury and so on. This indicates that CBHI has increased access to health care. Thanks to this initiative, we do not worry about unexpected health costs that might occur sometime in the future because we are insured. CBHI has also largely reduced health costs because the premium we pay for the scheme(240 birr per year) may not even cover the costs of a single visit to health facilities.*

One informant, male aged 70, strengthened the points made above by adding other important issues:

> *The ultimate benefit I and my household members have got so far from CBHI is the improvement of our health status. We are healthy right now and health is the single most important capital. If you are healthy, then you can work and engage in productive activities.*

The overwhelming majority of 78(47.85%), out of 163 respondents claimed that 1-2 household members have benefitted from free health services provided to CBHI members since they become member. Others, 56(34.35%) responded that 3-4 household members have got free health services from CBHI. The remaining 29(17.79%) said from their households, 5-6 members benefitted from free health services.

Those respondents (163) who reported that they or any other members of their households have received benefits from CBHI contracted health facilities were presented with questions about the referral system. Out of 163 respondents, 37(22.69%) replied that they have received referral services. The remaining 126(77.30%) responded they were not referred to other health institutions. All respondents who received referral services said that the most common line of referral was from Tocha primary hospital to Tarcha general hospital. There were no contracted tertiary hospitals that provide free health services to CBHI members in the study area. However, the CBHI directive authorizes District CBHI office to enter contractual agreements with tertiary hospitals within the country and CBHI members do have the right to get free health services from these hospitals by strictly following established referral system.

Out of 37 respondent household heads that used referral services, 28(75.67%) said that all health costs were covered by CBHI contracted health facilities. The remaining 9(24.32%) responded that they bought some prescribed drugs from private pharmacies. Since transportation cost is not included in CBHI benefit package, it is wholly covered by CBHI members.

4.1.6 The Level of Participation and Health Care Utilization of the Poorest Households

In both the federal and SNNP CBHI directives, it is clearly stated that the third party (government at different administrative structure) is mandated to cover the registration fee and premium of the poorest households (indigents); which weighs not more than 10% of the CBHI

eligible households. Since the ultimate end of CBHI is to ensure UHC, the researcher is concerned with uncovering the level of participation and health care utilization of indigents in CBHI scheme.

Data collected from FGDs, in-depth interview, key informant interview, and documentary analysis showed that indigent households do have the opportunity to join CBHI scheme. In this regard, one participant of FGDs constituted of CBHI member indigent household heads said:

> *…certain proportions of indigent households have been enrolled in CBHI. Their registration fee and premium is covered by the government.*

An official report from District CBHI office summarizes the participation of indigents as follows.

Table 5. The Involvement of Indigents in CBHI

No	Year	Number of eligible households	Number of indigent households insured in CBHI	Percent(Proportion of indigent households from eligible households)
1	2018/19	4511	487	10.79
2	2019/20	12,451	416	3.34
3	2020/21	11,337	1116	9.84

Source: Official reports of Tocha District health office

Taken in to consideration the total number of Tocha population (62422) or the total number of eligible households (11338) as of 2020/21, the participation of indigents in CBHI is slightly below the standard set in CBHI directive.

Regarding the screening process of indigents and factors that constrain adequate involvement of the poorest households, one key-informant, male aged 42 said:

… kebele cabinets screen indigents based on prior information about the living conditions of dwellers. The level of inclusion of indigents depends on quota allotted for each kebele by District health office. However, there are still many indigent households who have been left behind due to lack of sufficient subsidy to cover their enrollment costs.

Key-informants were also asked to provide information concerning the sources of funding for indigent CBHI members. CBHI officer, male aged 37 put it as follows:

…regional, zonal and district governments pay 40%, 30% and 30% of targeted subsidy on behalf of indigent CBHI members respectively. If the district government fails to pay its share on time, then zonal and regional governments do not transfer their shares. Therefore, so far no problem has encountered regarding targeted subsidy.

Data collected by employing FGDs and in-depth interviews also depicted that the screening processes of indigent households have been carried out solely by kebele cabinets. Community at large and indigents themselves have not been allowed to participate in the process. However, this is against CBHI directive because the guideline states that screening of indigent households should be conducted by ensuring the active participation of the community. Concerning the reception in health facilities, once indigent households enrolled in CBHI, they have been treated equally with CBHI paying members.

4.1.7 Challenges of Implementing CBHI

CBHI scheme has been facing many challenges in the study area. Before conducting thorough discussion regarding challenges, it's better to take a look in to Table-6.

Table 6. Tocha District CBHI Scheme Enrollment and Financial Status

No	Variables		Year		
			2018/19	2019/20	2020/21
1	Number of eligible households		4511	12451	11337
2	Number of CBHI paying members		2546	1947	1752
3	Enrollment rate of eligible households (%)		56.4%	15.63%	15.45%
4	Number of indigent CBHI members		487	416	1116
5	Number of drop-outs		-	183	190
6	Amount of money collected from different sources	Premium (birr)	426,410	573,680	424,180
		Targeted subsidy (birr)	100,000	100,000	70,318
		General subsidy (birr)	52641	-	279,000
		Total amount of money collected (birr)	579,051	673,680	773,498
7	Amount of money reimbursed to health facilities (birr)		18,962	1,476,125	559,000
8	Net balance in CBHI bank account (birr)		560,081	-	214,498

Source: Official reports of Tocha District health office

In 2018/19 enrollment rate of eligible households was 56.4%, primarily due to the deliberate reduction of the number of eligible households to launch CBHI in Tocha District. CBHI directive states that to launch CBHI scheme, at least 50% of eligible households should be registered and pay annual premium. In subsequent years, since the number of eligible households is more than 11000, the proportion of eligible households enrolled in CBHI is lower than 16%. However, it must be underscored that CBHI enrollment rate is very low in the study area.

Primarily due to lower enrollment coverage, the scheme has encountered financial shortage. For example, in 2019/20 the cost of health services was higher than the total amount of money collected from members' contribution and other sources. When such problem occurs, the District

administration supports the scheme by covering the costs of health services. However, overall the scheme has encountered financial sustainability problem.

This position is supported by qualitative data collected from one key-informant; male aged 46:

> *…with the advent of CBHI, health care utilization has increased dramatically. This in turn has resulted in higher costs of health services. There is higher difference between the amount of money collected from different sources and the costs of health services. Therefore, the scheme is struggling to cover the costs of health services (provider payment).*

Another gigantic challenge confronting the scheme is lower level of community awareness about CBHI. Lower level of community awareness about the scheme could be attributed to various factors; however the focus here is not to discern its foundation. The problem associated with community awareness has been found out to be one of the major challenges of implementing CBHI. FGDs and interviews conducted backed up this reality. One of the participants of FGD constituted of CBHI paying members, male aged 68 articulated it as follows:

> *…some people are not aware of the benefits of CBHI. If they are healthy currently, they think that CBHI membership is not needed as if they will never fall in illness.*

The fourth major challenge threatening the sustainability of the scheme in the study area is lack of appropriate CBHI organizational structure that is capable of facilitating implementation. For one thing, they do not have organizational structure at kebele level where community mobilization, community participation and awareness creation activities are carried out. Kebele managers are delegated to conduct registration, collect registration fee and premiums. Health extension workers are expected to distribute CBHI identification cards. Kebele cabinets headed by kebele chairperson are mandated to raise awareness about the scheme. But in practice they do not consider CBHI as their major responsibility because they claim that they do have other major responsibilities.

On the other hand, at District level health office is responsible for supervising the provision of health services as well as coordinating CBHI scheme. That seems harder for this governmental office to correct problems associated with the provision of health services to CBHI members.

Five point scales Likert question about different aspects of CBHI kebele office was presented to respondents. To the statement that local CBHI agent tries hard to solve implementation problems, out of 201 respondents, 66(32.83%) replied that they strongly disagree. Others, 71(35.32%) responded that they disagree with the statement. On the other hand, 29(14.42%) replied that they agree with the statement, meaning it's true that local CBHI agent tries hard to solve the scheme's implementation problem. The remaining 35(17.41%) reacted that they strongly agree with the statement. To conclude the point, the majority, 68.15% of the respondents claimed that local CBHI agents do not work hard to solve implementation problems.

Regarding this problem, a kebele manager, male aged 45 gave the following interview.

> *…Many people do not have adequate awareness about the benefits of CBHI. We do not properly use available platforms to ensure the community participation. This is primarily attributed to lack of appropriate organizational structure at kebele level. Since we have many other activities, we are very busy. Therefore, enough attention is not given to the scheme.*

The most pressing challenge haunting CBHI scheme in the study area is that associated with the service delivery of contracted health facilities. In connection with this, respondents were asked to rate the quality of health services delivered in contracted health institutions. Out of 201 respondents, 77(38.30%) reacted that health services provided to CBHI members is poor. Others, 20(9.95%) replied that health services delivered by CBHI contracted health facilities to CBHI members is very poor. This shows that significant numbers of CBHI members are not happy with the quality of health services provided under CBHI scheme.

Furthermore, CBHI members who got health services from CBHI contracted health facilities were presented with questions about out-of pocket payment for health services. Table-7 below shows their responses to the statement that CBHI members became free from any out-of-pocket payment for health services.

Table 7.CBHI Members Became Free from Any Out-of-Pocket Payment for Health Services.

No	Response	Frequency	Percent
1	Strongly disagree	25	15.33
2	Disagree	77	47.23
3	Neither agree or disagree	31	19.01
4	Agree	30	18.4
	Total	163	100

As it was depicted in Table-7 above, only 30(18.4%) replied they agree with the statements that CBHI members became free from out-of-pocket payment for health services. Others, 31(19.01%) of the respondents said they neither agree nor disagree with the statement. While the remaining 77(47.23%) reacted that they disagree with the statement, 25(15.33%) responded they strongly disagree with the statement. Over all, this indicates that CBHI members are still suffering from out-of-pocket payment for health services.

Concerning the quality of health services provided under CBHI scheme, participants of FGDs and informants of in-depth interview provided similar information. One informant of an in-depth interview, female aged 52 expressed it as follows.

> *…when we go to health institutions, most often they write prescriptions and order us to buy drugs from private pharmacies. Those who have money may afford it but it's not fair to expose CBHI members to out-of-pocket payment for health services. In addition to inadequate supply of essential drugs, contracted health facilities do not have sufficient medical equipments to conduct diagnosis.*

CBHI directive allows District CBHI office to enter contractual agreements with Red Cross pharmacies, community pharmacies or government pharmacies when there is inadequate supply of essential drugs in contracted public health facilities. Unfortunately, there are no such

pharmacies in Tocha District. This further hardened the susceptibility of CBHI members to out of pocket payment for health services.

Data collected through multiple response questions presented to sample CBHI non-members depicted that the majority of respondents refused to join the scheme due to low quality of health services. Out of 139 sample CBHI non-members, 92.08% indicated that they refused to join the scheme due to poor quality of health services. The remaining 45.32% of respondents replied that non-members were unwilling to join the scheme because waiting time to receive health services is longer for CBHI members than non-members.

CBHI members who do not want to renew their membership have provided their responses to questions with multiple response items. Accordingly, out of 33 respondents, 97% replied that their lack of willingness to renew their CBHI membership is due to low quality of health services. The remaining 75.8% responded that waiting time is longer for CBHI members than non-members. In general, poor quality of health services has been negatively affecting CBHI enrollment and membership renewal.

When the findings regarding the advantages of CBHI in addressing health care needs are revisited, the existence of poor quality of health services at the same time seems contradictory; however, in reality there is no contradiction because the ratings of quality of health services may be based on the health service benefit packages of the scheme design and higher expectation.

4.1.8 The Challenges of CBHI Scheme in Ensuring Universal Health Coverage.

4.1.8.1 Challenges of Ensuring Equitable Access to Health Services

The primary objective of establishing and implementing CBHI is promoting equitable access to health services. However, CBHI scheme in Tocha District has been suffering from various challenges that hinder equitable access to health services.

Since CBHI scheme has lower enrollment rate; only 15.45% of eligible households were enrolled, the majority of population in the study area are not insured. In such condition, it is difficult to ensure equitable access of health services to all people because non-members may not use health services due to financial barriers.

Even CBHI members are not guaranteed of equitable access to health services due to poor quality of health services provided by CBHI contracted health facilities. As the researcher tried to depict in the challenges of implementing CBHI section, significant number of respondents complain that the quality of health services provided is poor. Poor quality of health services is manifested in lack of adequate medical equipments, inadequate supply of essential drugs and long waiting time for CBHI members.

Since the majority of CBHI members (respondents who utilized health services from CBHI) 62.56% replied that they were exposed to out-of-pocket payment for health services- ordered to buy essential drugs from private drug vendors(pharmacies), it implies that the scheme does not guarantee access to health services. If such problem is not curbed either by ensuring sufficient supply of drugs or by availing contracted community (Red Cross) pharmacies, CBHI members who do not have money to buy drugs from private drugs may not get treatment for their illness.

4.1.8.2 Challenges of Ensuring Financial Sustainability

Although there is a working relationship with zonal, regional and federal governments, CBHI scheme is established in District level. The ultimate responsibility of establishing and managing the scheme and thereby ensuring its sustainability, however, lies in the hands of District administration. This also includes meticulously evaluating and augmenting the financial capacity of the scheme.

The design of CBHI scheme is small-scale because CBHI schemes do not have associations which ensure their partnership and solidarity to support each other in times of financial insecurity. This implies that CBHI schemes do not have large risk pools which enable them to cover costs of health services when they do not have financial capacity due to, let us say, low enrollment coverage as in the case of Tocha District.

As described in the previous section, in Tocha District CBHI enrollment is low; only15.45% of eligible households has been enrolled. When there is lower enrollment rate, the total amount of premium collected and general subsidy received from federal government would be small. In contrary, the introduction and implementation of CBHI has increased health care utilization among members. This in turn, has led to higher costs of health services. There were instances

when the total amount of money collected from different sources (premium, targeted subsidy and general subsidy) could not cover the costs of health services.

As depicted in Table-6, in 2019/20 the scheme was unable to cover the costs of health services because it needs additional 242,364 birr to cover the costs of health services. District administration supported the scheme by providing 242,364 birr, however overall there is an overt financial insecurity. In 2018/19 and 2020/21, the financial status of the scheme seems to be slightly better but the scheme has remained highly dependent on subsidies and support from the government.

4.1.8.3 Challenges of Reducing Catastrophic and Impoverishing Expenditure

One of the key indicators of universal health coverage is ensuring financial risk protection. People should not be exposed to catestrophic and impoverishing expenditure when seeking health care services. Since CBHI shares risks of health care costs across the members and pools resources from the community, it is believed to be the most realistic initiative to achieve financial risk protection.

In this regard, CBHI members in Tocha District stressed that their exposure to catestrophic and impoverishing health care expenses has reduced. Many participants of FGDs and informants of in-depth interviews provided relatively similar information regarding the impacts of CBHI on financial risk protection but one CBHI member who is an informant of in-depth interview, male aged 62 expressed it in a coherent manner as follows:

> *Last year my son encountered serious illness. Therefore, I took him to Tocha primary hospital. Physicians examined his illness and wrote referral to Tarcha general hospital. When we went to Tarcha general hospital; there physicians told me that the boy needs surgery. They gave him bed and conducted successful surgery. My son stayed three weeks in hospital. The costs of all health services and bed were covered by CBHI. The only cost I paid from my pocket was for transportation. The total costs of health services could be 30,000 birr. If I am not a member of CBHI, I could have been impoverished by his medical costs alone.*

Despite its positive contribution in reducing catestrophic and impoverishing health expenses, participants of FGDs and informants of in-depth interviews did not hide their complaints about poor quality of health services. According to them, it's unfair that they are still not free from out-of-pocket payment for health services due to inadequate supply of essential drugs.

4.1.8.4 Challenges of Ensuring Enrollment of Indigents in CBHI Scheme

CBHI scheme design is considered as better when it aims to ensure the enrollment of indigents. When the design of the scheme allows enrollments of the poorest households, it could be said that the CBHI scheme design is realistic path to achieve universal health coverage. In this regard, CBHI scheme in Tocha District has been suffering from challenges.

Table-5 clearly depicts the enrollment level of indigent households. In 2018/19 the District administration deliberately reduced the number of eligible households to 4511 because they need to enroll at least 50% of this number to launch the scheme and that was achievable for them. This decision negatively affected the inclusion of indigents because only 487(10.79%) out of 4511 households were enrolled in that year. In 2019/20 out of 12,451 eligible households, only 416 (3.34) indigent households were enrolled in CBHI. In 2020/21, out of 11,337 eligible households, 1116(9.84%) indigent households were enrolled.

The CBHI directive entitles indigent households (not more than 10% of eligible households) to be enrolled in CBHI. In contrary, indigent households have not been enrolled as clearly stated in CBHI directive. On the other hand, in a country where more than 23.5% of the population lives below the poverty line, allowing indigent households (which accounts for only 10% of eligible households) does not ensure the enrollment of all indigents in CBHI.

4.2. Discussion of Results

The main objective of this research was to examine the advantages and challenges of CBHI as a social protection scheme in promoting UHC. Specific objectives were, to examine the advantages of CBHI in addressing health care needs from community's perspectives, to assess the advantages of CBHI in addressing health care needs from service providers' perspectives, to examine the level of participation and health care utilization of indigents in CBHI, to investigate

the challenges of implementing CBHI and to investigate the challenges of implementing CBHI in ensuring UHC.

The turning point of our discussion of the findings is the socio-demographic characteristics of respondents. The majority of sample household heads (87.9%) were males. Concerning the age distribution of respondents, the majority of household heads (77.9%) were within the age category of 30-65. When religious composition of respondents is considered, people follow various religious institutions. The majority of respondents (69.4%) were Orthodox Christians followed by Protestant Christians (28.8%). Even though respondents do have varied educational background, the majority of sample households (51.2%) cannot read and write (illiterate). Most sample household heads (92.1%) were married. Another important characteristic of respondents was the household size of their households. In connection with this, the majority of households (61.2%) do have 5-8 household members. The majority of sample household heads (68.8%) rated that their households were found within the medium income level.

Decisions to join the CBHI scheme in the study area was voluntarily made by households. This is consistent with the findings of other research conducted on the issue (EHIA 2015; Solomon et al 2015). Enrollment is being conducted at household level to avoid adverse selection. Regardless of the number of household members, every enrolled household is needed to pay the same amount of 240 birr premium contribution. To join or rejoin the scheme, each household is required to pay 10 birr registration fee and annual premium contribution already mentioned.

In the study area; community mobilization, registration fee and premium collection, and all other preconditions required to launch the CBHI were completed in 2017/18. It was in 2018/19 that the only CBHI contracted and available public health facility in the study area, Tocha primary hospital started providing health services to CBHI members. Ethiopian CBHI design is different from most scheme designs in that it is primarily led by governmental Ethiopian Health Insurance Agency and health offices at various administrative structures. The federal government has been transferring general subsidy which is equivalent to 10% of membership contribution per year. In addition to the general subsidy by federal government, the regional government and its lower administrative units have been discharging their responsibility of paying targeted subsidy

(regional government 40%, zonal government 30% and District government 30%) for indigents which make not more than 10% of eligible households.

The design of the scheme is made at regional level. Therefore, the community has limited role in the design of the scheme, basically concerning major parameters such as registration fee, premium amount, payment time, benefit package, contacted health facility, administration and management, organizational structure and the like. Professionals from District health office presented these issues to the community in open public meetings to raise awareness and ensure the acceptance of the scheme. From the total number of respondents of household survey, 297(87.35%) responded that they participated in the first CBHI community mobilization meeting. Regarding their consensus to basic parameters, the majority 240(70.58%) responded that they agreed with benefit package. On the other hand, concerning contracted health facility, registration fee and premium amount and premium payment time, all respondents, 297(100%) responded that they agreed to the proposal.

Even though it's claimed that CBHI schemes are owned and managed by the community, community involvement in the study area is very poor. The community at the grass root level is urged to pay premium and those who have not been enrolled are requested to join the scheme during the land tax collection time. This study revealed that, other than collecting premium and registering new members, there is no platforms which encourage the participation of community in administration and management of the scheme.

New members' registration has been conducted from October 01-December 30 every year. On the other hand, membership renewal has been conducted from October 01-January 31. Regarding the convenience of payment schedule, all CBHI member respondents (100%) said that the payment period is convenient for most rural residents because farmers harvest their crops in this period. Farmers sell their crops to earn money, therefore, the majority of farmers do not face financial problem.

As far as benefit package is considered, CBHI members are insured to get free health services from contracted health facilities. However, there are certain health services which are not insured by CBHI, these include tooth implantation, eye glass, plastic surgery, accidents insured by other laws, transportation costs, and referral to foreign countries. This study revealed that other than

Tarcha general hospital, there is no referral linkage to other higher health institutions which enable CBHI members to optimally utilize those health services included in CBHI benefit package.

There are various factors that affect the acceptance of CBHI scheme. Previous research found that sex (Female headed households), age, educational level, income level, and household size were positively associated with CBHI enrollment (Adebayo et al 2015; EHIA 2015; Ewunetie et al 2020). Studies also uncovered that factors such as community participation, community solidarity, illness experience and the existence of chronic illness in household were positively related with CBHI acceptance (Adebayo et al 2015; EHIA 2015; Ewunetie et al 2020; Fadallah et al 2018).

To a large extent, these previous research findings are consistent with the present study. The present research revealed that female headed households were more likely to join the scheme. Households with relatively better educated heads, larger members, higher income, and chronic illness were also more likely to join the initiative. Household heads who perceived that their level of participation in social affairs was good were more likely to enroll in CBHI. Household heads who thought that there was strong solidarity and good trusts in the community had higher propensity of joining CBHI scheme than those who perceived that there was weak solidarity and poor trust. On the other hand, household heads who perceived that household members had good health status were found to be less likely to join the scheme**.**

Concerning the relationship among socio-demographic characteristics, health status and CBHI enrollment, the findings of the present research is in line with Anderson's model of health care utilization which asserts that predisposing factors (age, gender and education), enabling factors (affordability of the premium, possession of health insurance and income), need factors (severity of illness) and health system characteristics (availability of services) affect health care utilization (Anderson and Newman 1973). The relevance of this model to the present research is that, these factors have been found out to be affecting CBHI enrollment in Tocha District. Woolcock's assertion that social capital (community solidarity, cooperation and trust) enhances CBHI enrollment was also confirmed by the findings of the present study. Household heads who believed that their participation in societal affairs was good were more likely to join the scheme

when compared to those who thought their level of participation was poor. Household heads who also stated that there was good solidarity and trust in the community were more likely to join the scheme in the study area (Woolcock 1998 and 2001).

Studies conducted so far on the effects of CBHI in addressing health care needs have not addressed this issue separately from community's and service providers' perspectives. But these previous research revealed that CBHI increased health care utilization, increased health seeking behavior, promoted health status, improved quality of health services and increased resources in health facilities (Molla 2017; Solomon et al 2017). Bekele and Keneni (2020) stated that CBHI increased utilization of health services among insured households. Desta, Hiwot and Yihun (2018) asserted that the scheme had increased the utilization of outpatient health services.

The present study revealed that services providers view the benefits of CBHI in Tocha District as increased access to health services, enhanced health seeking behavior, increased health care utilization among CBHI members, improved health status of insured households, promoted health equity in the community, increased financial resources in health facilities and improved quality of health services. From the community's perspectives, CBHI increased access to health care, enhanced health seeking behavior, increased health care utilization among CBHI members, improved health status of insured households, reduced costs of health services, and relieved CBHI members from unexpected future health care costs. The community also asserted that CBHI reduced exposure to catestrophic and impoverishing health expenditure. Although the advantages CBHI in addressing health care needs are largely similar from both the service providers' and community's perspectives, while the former focused on the availability of financial resources in health facilities and improvement of the quality of health services, the latter stressed its contribution in removing financial barriers of access to health services and reducing catestrophic and impoverishing health care expenditure.

In Tocha District, even though the enrollment of indigents in 2018/19 and 2019/20 was far below 10% of eligible households, in 2020/21 their enrollment rose to 9.84% of eligible households. The regional government at different administrative structure covered registration fee and premium contribution for indigent CBHI members. The poorest households enrolled in this

scheme have been getting free health services from contracted health facilities without any discrimination when compared to paying members.

EHIA (2020) mentioned fragmented pooling system, failure to cover reimbursement expenses, inadequate political commitment, inadequate supplies of drugs and medical equipments and lack of conducive CBHI organizational structure as challenges confronting the implementation of CBHI in Ethiopia. On the other hand, Gutema (2019) found that health employees' inappropriate attitude towards CBHI members, shortage of medicines, absence of the nearest hospital, lack of skilled man power assigned for CBHI, lack of adequate attention from concerned body, viewing services delivered to CBHI members as extra activities by health institutions and absence of good benefit package were obstacles hindering the implementation and performance of CBHI schemes.

To a large extent the findings of research at hand are consistent with aforementioned studies regarding problems of CBHI implementation. The present study revealed that lower level of community awareness about CBHI, lower enrollment rate, financial shortage to cover the healthcare expenses, lack of appropriate organizational structure and poor quality of health services have been hindering the successful implementation of the scheme in Tocha District. Due to inadequate supply essential drugs, some CBHI members were forced to buy prescribed drugs from private pharmacies. CBHI members were also exposed to long waiting times to receive health services and that may be partly induced by higher health care utilization. While looking at findings regarding the advantages of CBHI in addressing health care needs, it might seem contradictory to see the existence of poor quality of health services at the same time; but in reality there is no contradiction because rating of the quality of health services may be based on the benefit packages of CBHI scheme design and higher expectation.

When theoretical underpinnings of this research is reconsidered, Anderson's model of health care utilization, specifically health systems characteristics and external environmental factors are relevant points that shed light on challenges of implementing CBHI in Tocha District (Anderson and Newman 1973). Problems associated with health service provision in public health facilities have been constraining the implementation of CBHI scheme. External environmental factors (political and economic aspects) manifested in lack of appropriate CBHI organizational structure

design and higher proportions of population (23.5% at country level) living in extreme poverty are challenges facing the scheme.

In addition to the challenges of implementing CBHI scheme in the study area, the researcher was also interested to reveal those issues that impede CBHI scheme from achieving universal health coverage. Umeh (2018) discussed that large proportion of population living in extreme poverty, large informal sector with large proportion of population who do not have health insurance, higher drop-out rate from insurance scheme, poorly funded primary health care system and fragmented health insurance fund were challenges of achieving universal health coverage in Africa.

Studies conducted on challenges of ensuring universal health coverage in Ethiopia found that higher level of multidimensional poverty, lower literacy rate and poor health seeking behavior have been impeding universal health coverage in the country (Anagaw et al 2014). Stenberg et al (2017) asserted that lower public investment on health services is one of the major issues that hinder progress towards universal health coverage in Ethiopia.

However, this research meticulously examined and exhaustively identified those challenges impeding the contribution of CBHI in achieving universal health coverage in the study area. The existence of large proportion of population not insured in CBHI, poor quality of health services manifested in inadequate supply of essential drugs and medical equipments hampered the progressive achievement of health equity. Small scale design (absence of large risk pools) or fragmented nature of CBHI schemes exposed the initiative to financial insecurity. In addition to low enrollment rate, there is no mechanism through which CBHI schemes share risks and support each other in times of financial insecurity.

Another important dimension of CBHI is its impact on reducing catestrophic and impoverishing health expenditure or providing financial risk protection. Small proportion of population covered by the scheme and poor quality of health services negatively affected progress towards universal health coverage. In other words, non-members of CBHI have been suffering from out of pocket payment for health services that could be in some instances catestrophic and impoverishing. Even CBHI members (63% of respondents) said that they were exposed to out-of-pocket payment for health services due to absence of drugs in contracted health facilities. Therefore, due

to lower coverage and poor quality of health services CBHI hindered from meaningfully reducing catestrophic and impoverishing health expenditure in the study area.

Ensuring enrollment of indigents in CBHI is often recommended to achieve universal health coverage. When the design and implementation of CBHI scheme in the study area is evaluated against these criteria, for one thing, the quota reserved for enrollment of indigents was not appropriately used. In 2018/19 and 2019/20, enrollment of indigent households was below 4% of eligible households. The second important point is that in the country where 23.5% of population lives in absolute poverty, reserving only 10% of eligible households for indigents would not ensure adequate enrollment of indigents.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary of the Findings

The acceptance of CBHI scheme in the community was dependent on individual characteristics, socio-demographic factors, health system characteristics and social capital. Female headed households, educational level of household heads, income level of households, the existence of chronic disease, household heads' level of participation in social affairs, household heads' perception about the level of community solidarity and perceived level of trust in the community were positively associated with CBHI enrollment.

Enrollment of eligible households in the study area was 15.45% in 2020/21. On the other hand, enrollment of indigent households was 9.8% of eligible households. People joined CBHI because registration fee and premium is low compared to out of pocket payment for health services, the scheme finances health care expenses and their households need health care.

Service providers emphasized that CBHI increased access to health care, enhanced health seeking behavior, increased health care utilization, improved health status, promoted health equity, increased the availability of financial resources in contracted health facilities and improved the quality of health services. On the other hand, CBHI members asserted that the introduction of this initiative increased their access to health services, reduced costs of health care services and freed them from concerns about unexpected costs of health services. CBHI beneficiaries also claimed that the introduction of the scheme increased health care utilization, enhanced health seeking behavior, improved health status and reduced their exposure to catestrophic and impoverishing health expenditure.

CBHI promoted health equity because it reduced financial barriers of access to health services. It also allowed the enrollment of indigent households (9.8% of eligible households) and their costs of enrollment have been covered by government. In this manner, especially by paving the way to ensure health services for all, it enhanced progress towards universal health coverage.

Even though CBHI played important role in addressing health care needs of the community as mentioned above, there are various challenges that threaten the implementation of the scheme in Tocha district. These include lower enrollment rate, financial insecurity, lower level of community awareness about CBHI scheme, lack of appropriate organizational structure and deficiency in quality of health services.

Associated with this, CBHI scheme has also faced with many challenges to ensure universal health coverage. The progress made to ensure health equity was fraught with obstacles because the majority of dwellers were not insured and even CBHI members were not guaranteed of good quality of health services. Due to inadequate supply of essential drugs, some people were forced to buy prescribed drugs from private drug vendors. The most common line of referral was to Tarcha general hospital. There was no referral linkage to tertiary hospitals under CBHI scheme.

The second challenge of CBHI in ensuring universal health coverage is small scale design. Fragmented nature of CBHI design and lack of large risk pooling mechanism among CBHI schemes would it make it difficult for them to sustain in times of financial insecurity. Due to lower enrollment coverage, small amount of money collected from different sources and with relatively higher costs of health services, the scheme in the study area has been susceptible to financial insecurity.

The third major challenge of CBHI in ensuring universal health coverage is that associated with the reduction of catastrophic and impoverishing expenditure. Lower enrollment rate and health service delivery problem has remained once again obstacle that negatively affected the role of CBHI in reducing catastrophic and impoverishing health care expenditure.

To ensure universal health coverage, financing the enrollment costs of indigent households (only 10% of eligible households) is not sufficient in the country where more than 23.5% of its population lives in extreme poverty.

5.2 Conclusions and Recommendations

Based on the findings and discussion of results, the researcher forwarded the following conclusions and recommendations.

- The acceptance of CBHI scheme largely depends on community's awareness about the design and benefits of the initiative. Therefore, community sensitization mechanisms which include face to face public meetings, door-to-door awareness creation campaigns, electronic Medias and the like should be devised and continuously implemented.

- The sustainability of CBHI can only be ensured when there are reliable platforms through which the community provides their feedbacks about the design and implementation of the initiative. Hence, platforms that ensure active participation of the community should be established and the role of community in management and administration of the scheme should also be encouraged as opposed to the conventional top-down decision making process.

- The current organizational structure of CBHI is not capable of facilitating the implementation of the scheme. At kebele level, delegated kebele cabinets have not been effectively implementing CBHI because they claim that they do have many other governmental responsibilities. At District level, it seems that health office which is mandated to manage and coordinate both CBHI scheme and health service provision is not capable of correcting deficiencies associated with health service delivery. Therefore, it's better if responsible entities revisit the current organizational structure and redesign it.

- Enrollment of the community into the program is far below the expectation and the implementation plan. To encourage the enrollment of community, increasing the supply of essential drugs and medical equipments is highly valuable. Therefore, it's better if the government works aggressively in collaboration with other key stallholders to ensure the availability of additional financial resources that can be invested on improving the quality health services.

- Social capital is vital to increase enrollment and enhance the implementation of CBHI scheme. Therefore, the scheme should design innovative mechanisms that encourage the participation of community, enhance solidarity and build trust.

- CBHI scheme has already made essential contribution to progressively achieve universal health coverage. However, the quality of health services provided by contracted public health facilities is characterized by many problems. For instance, it's unfair when CBHI members are exposed to out-of-pocket payments to buy prescribed drugs from private drug vendors. Therefore, it's recommended that the scheme seek alternatives of establishing contractual agreements with private health facilities.

- In Tocha District, there is no clearly defined and contracted referral linkage with tertiary hospitals. Therefore, CBHI scheme should enter contractual agreement with tertiary hospitals both at regional and federal levels.

- Small scale design increased the susceptibility of CBHI scheme to financial insecurity. It's highly rewarding if CBHI schemes establish associations at zonal, regional and national level which foster solidarity and cooperation. In this way, these schemes could establish large risk pools.

- CBHI scheme promoted the involvement and health care utilization of indigent households. However, the current level of involvement of indigent households in CBHI is not adequate. Poverty remains the mother of many social problems in the study area. To progressively achieve universal health coverage, financing the enrollment costs of the poorest households (indigents) is recommended. Actions taken to ensure the enrollment of indigent households should be expanded to cover all the poorest people. Social protection programmes aimed to improve the living standards of people who are vulnerable to social problems should be enhanced.

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Annexes

Annex-1 Questionnaire

Jimma University

College of Social Sciences and Humanities

Department of Sociology

Household Survey

Dear respondents, the objectives of this research are to examine the advantages of CBHI in addressing health care needs of the community, to examine the level of participation of the poorest households and their utilization of health care services from CBHI, to examine challenges facing the performance of CBHI; and to examine the challenges of CBHI in ensuring universal health coverage. This particular research is primarily designed for academic purpose to fulfill the requirements for Masters of art degree in Sociology and Social Policy. Your personal identity will not be disclosed to anyone. The information you provide here will be kept confidential. You have full right to withdraw completely from interview at any stage when you feel inconvenience. Your cooperation and information regarding CBHI is highly needed to accomplish this research successfully.

Therefore, I extend my heartfelt thanks to you for the willingness you have shown and sacrifices made to provide accurate information based on questionnaire.

Date of interview: _____ S. No of the questionnaire: _____

Name of the interviewer: _____

Name of the Kebele: _____

Part I: Background Information

1. Age of respondent _____ (in years)
2. Sex of respondent 1 = Male 2 = Female

3. Marital status of respondent

1) Married 2) Single 3) Divorced 4) Separated 5) Widowed

4. What is your highest educational status? _____ (specify for diplomas = 12+ diploma/TVET)

5. What is your religion? 1. Orthodox Christian 2.Protestant 3 Catholic 4.Other Christian 5.Muslim 6.None 7. Other (Specify) _____

6. How many people are there in your household (family size)? _____

7. Household's annual income in Birr _____

8. What is your perception about family's living standard? (1 = Very poor, 2 = Poor, 3 = Medium, 4 = Rich, 5 = Very rich).

9. If you are very poor, are you getting free health service? (1 = Yes, 2 = No)

10. If your response to Qn 9 is "No", how do you cover your health cost in times of illness?

Part II: Awareness of CBHI, perception about household members' health status and social capital

11. Have you ever heard about community-based health insurance programme (CBHI)?

(1 = Yes, 2 = No)

12. If your response for Q no 11 is "Yes", when did you first hear about the CBHI programme? _____(Year in Ethiopian calendar), and

13. From whom did you hear about CBHI?

1 = From neighbors/friends

2 = From CBHI officials' awareness creation campaigns in public meeting

3 = From CBHI house-to-house awareness creation campaigns

4 = From health professionals in health facilities

5 = From mass media: ETV, Radio. Etc.

6 = Others, specify_____

14. Perception about CBHI

	Correct (1)	**Not correct(2)**	**Do not know(3)**
14. 1 Only those who fall sick should consider enrollment in CBHI			
14.2 Only the very poor who cannot afford to pay for health care need to join CBHI schemes			
14.3 Under the CBHI program, you pay money in order for the CBHI to finance your future health care needs			
14. 4 CBHI programs are like saving schemes, you will receive interest and get your money back			
14.5 If you do not make claims through CBHI, your premium will be returned			

15. How do rate the average health status of your household members?

(1.Poor 2.Medium 3.Good)

16. Are there people in your household suffering from chronic disease?

(1.Yes 2.No)

17. How do you rate the level of your participation in social affairs such as *Idir, Ekub, Debo, Jige,* and the like?

(1.Poor 2.Medium 3.Good)

18. How do you rate the level of your conformity to social norms?

(1.Poor 2.Medium 3.Good)

19. How do you evaluate the level of social solidarity in your vicinity?

(1.Poor 2.Medium 3.Good)

20. How do you rate the level of your trust in your community?

(1.Poor 2.Medium 3.Good)

Part III. Enrollment (Re-enrollment)

21. Is your household enrolled in the CBHI programme? (1 = Yes, 2 = No) ----------(If "No" skip to Qn. 39).

22. If your household is enrolled in CBHI, which member category is it? (1= Paying member, 2= Indigent member)

23. Why did your household decide to enroll in the CBHI program? (Multiple answers possible – list in order of importance).

1 = Illness and/or injury occurs frequently in our Household
2= Our Household members need health care
3= To finance health care expenses
4= CBHI registration and premium is paid by government
5= Premium is low compared to user fee price to obtain medical treatment
6=Pressure from other family members/Community
7= Pressure from kebele
8= Others please specify _____

24. Are all members of your household enrolled in the CBHI programme? (1 = Yes, 2 = No)

25. If some of your household members are not enrolled, what is the reason? (Multiple answers are possible – list in order of importance).

1= Members are healthy
2= Do not have enough money to pay for CBHI
3= Members are not nuclear family members
4= others, specify _____

26. Is the registration payment/premium made at household level or individually? _____

27. If the payment is at household level, how much does the household pay for:

- the registration fee and (for all members)? In Birr _____
- the regular payment/premium? in Birr _____

28. If the payment is individually, how much is the payment per person? _____

29. For how long does the registration fee or contribution/premium makes the household members insured/free from paying for health service? _____

30. Do you think CBHI program has benefited the household? (1 = Yes, 2 = No)

31. If your response to Qn. 30 is "Yes", what is your reason? (Multiple responses are possible – list in order of importance).

1= Increased access to health care

2 = Reduced costs of health care

3 = Reduced concerns about expected health care costs

4 = others, please specify _____

32. If your response to Qn. 30 is "Yes", how many household members have been benefitted from CBHI per year? _____

33. If your response to Qn. 30 is "Yes", what would be the estimated health care cost of your household per year, if it has not been insured by CBHI? _____

34. If your response to Qn. 30 is "No", what is your reason? (Multiple responses are possible – list in order of importance).

1 = We still have to pay high user fees for treatment

2 = The quality of service for CBHI members is worse than for non-CBHI patients

3 = Waiting time to access services is longer for CBHI members than the non-CBHI patients

4= Not all costs for medication are covered/they make us to buy some medicines ourselves.

4 = No one in my household has visited health facilities

5 = Others, specify _____

35. Have you or any household member been referred to a higher health institution?

(1 = Yes, 2 = No)

36. If your response to Qn. 35 is “Yes”:

- Is the transportation cost covered by CBHI? (1 =Yes, 2 = No)
- Is all the health service cost covered by CBHI? (1 = Yes, 2 = No).
- Please list the uncovered health service cost if any?

_____

37. Do you have plan to renew your CBHI membership in the future? (1 = Yes, 2 = No)

38. If your response to Qn. 37 is “No”, why are you not interested to renew your CBHI membership (multiple responses allowed-list in order of importance)?

1 = Illness and injury does not occur frequently in our household
2 = The registration fee and premiums are not affordable
3 = There is limited availability of health services
4 = The quality of health services is low
5 = CBHI management staff is not trustworthy
6 = The quality of service for CBHI members is worse than for non-CBHI members
7 = Waiting time to access services is longer for CBHI members than the non-CBHI members
8 = Other, specify _____

39. If your household is not enrolled in CBHI program, why does your household decide not to be enrolled? (Multiple responses are possible –list in order of importance).

1 = Illness and injury does not occur frequently in our household
2 = The registration fee and premiums are not affordable
3 = Want to wait in order to confirm the benefits of the scheme from others
4 = We do not know enough about the CBHI scheme
5 = There is limited availability of health services
6 = The quality of health care services is low
7 = The benefit package does not meet our needs
8 = CBHI management staff is not trustworthy

9 = Waiting time to access services is longer for CBHI members than others

10 = Other reasons, please specify

_____

40. Do you have a plan to enroll in the CBHI scheme in the future? (1 = Yes, 2 = No)

41. If your response to Qn. 40 is "Yes", what is your reason? (Multiple responses are possible – list in order of importance)

1 = Illness and/or injury occurs frequently in our Household

2= Our Household members need health care

3= To finance health care expenses

4= CBHI registration and premium is paid by government

5= Premium is low compared to user fee price to obtain medical treatment

6=Pressure from other family members/Community

7= Pressure from kebele

8= Others please specify _____

42. If your response to Qn. 40 is "No", what is your reason? (Multiple responses are possible – list in order of importance)

1 = Illness and injury does not occur frequently in our household

2 = The registration fee and premiums are not affordable

3 = Want to wait in order to confirm the benefits of the scheme from others

4 = We do not know enough about the CBHI scheme

5 = There is limited availability of health services

6 = The quality of health care services is low

7 = The benefit package does not meet our needs

8 = CBHI management staff is not trustworthy

9 = Waiting time to access services is longer for CBHI members than others

10 = Other reasons, please specify

<u>Part IV</u>: Affordability and expectations

Please respond to the following statements and indicate your level of agreement

43. The CBHI membership payment/premium is affordable for my household.

(1 = strongly disagree, 2 = disagree, 3 =neither agree nor disagree, 4 = agree, 5 = strongly agree)

44. The timing/time interval of premium payment is convenient for my household.

(1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree)

45. CBHI members became free from any out-of-pocket payment for health service cost.

(1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree)

<u>Part V</u>: CBHI experience

	1 = Strongly disagree 2 = Disagree, 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree	1 = Highly unsatisfied 2 = Unsatisfied 3 = Neither satisfied nor unsatisfied 4 = Satisfied 5 = Highly satisfied	1 = Excellent 2 = Very good 3 = Good 4 = Poor 5. = Very poor
46. The local CBHI agent tries hard to solve CBHI implementation problems			
47. The community (CBHI members) have the right to guide and supervise the activities of the CBHI administration			
48. Health professionals treat patients with CBHI membership and out-of-pocket payers without discrimination/fairly.			
49. The CBHI benefit package meets the requirements of my household.			

50. The local CBHI management is trustworthy.			
51. How satisfied were you with the experience at the local CBHI office when you went to register?			
52. How satisfied were/are you with the local CBHI office when you pay the regular contribution (premium)?			
53. How do you rate the quality of healthcare services provided under the CBHI scheme?			

Part VI: The Poorest households' Participation in CBHI and their access to health care services

54. Do the poorest households have the chance to be enrolled in CBHI? (1=Yes, 2=No)

55. If they do have the opportunity to be enrolled in CBHI, who pays registration fee and premium for them?

1= Government 2= NGO 3= Relatives 4= Community

5= others, specify _____

56. Are all the poorest households enrolled in CBHI? 1= Yes 2= No

57. If your response for Qn 56 is "No", what prevented them from being enrolled in CBHI?

1= Lack of Sufficient subsidy to cover premium for all indigents

2= Lack of willingness to join CBHI on the part of the poorest households due to cultural barriers

3= Others, Specify _____

58. Have indigent CBHI member households been equally treated to utilize health care services from contracted health facilities compared to paying members of CBHI scheme? 1= Yes, 2=No

59. If your response for Qn 58 is "No", specify reasons_____

<u>Part VII:</u> Community Participation in the design and implementation of CBHI scheme

60. Did you or any other household member participate in the meetings where the final community decision was made to launch CBHI in your kebele? 1= Yes, 2= No

61. If your response for Qn 60 is "Yes", did you agree on benefit package adequacy? 1= Yes, 2=No

62. If your response for Qn 60 is "Yes", did you reach agreement concerning contracted health institution? 1=Yes, 2= No

63. If your response for Qn 60 is "yes", then did you agree on registration fee and the amount of premium? 1= Yes, 2= No

64. If your response for Qn 60 is "yes", did you agree with the premium payment period? 1= Yes, 2= No

65. Are there platforms through which CBHI members participate in the evaluation of CBHI scheme generally and Provision of health care services from Contracted health institutions particularly?

1= Yes, 2= NO

66. If your response for Qn 65 is "Yes", then what are those platforms and how frequent do you participate? _____

67. Have you ever presented complaints regarding CBHI health care provisions to concerned government officials? 1= Yes, 2=No

68. If your response for Qn 67 is "Yes", have you seen any improvement in the performance of CBHI?

1= Yes 2= No

69. What are your recommendations to improve the performance of CBHI? _____

_____

Annex -2

Interview guide for Key informants

1. When was the implementation of CBHI started in your district/kebele? _____

2. How do you evaluate the awareness of community about CBHI? _____

3. What are those strategies that have been implemented to create awareness about CBHI? ____

4. Do you think that strategies implemented to create awareness have been successful? If you do not think so, what are their shortcomings? _____

5. What are the advantages of CBHI in addressing health care needs of community?

_____

5. How do you evaluate the acceptance level of CBHI among the community? _____

6. What are those factors that negatively affected the acceptance of CBHI? _____

7. How do you evaluate the CBHI enrollment coverage in your district? _____

8. What are those factors that prevent eligible households from being enrolled in CBHI?

_____

9. How much is the registration fee and premium payment? _____

10. When is the enrollment and renewal time in your district/kebele? _____

11. Do you think that premium amount is affordable to most eligible households?_____

12. What are the packages of health care services provided by CBHI? _____

13. What are health care services that have not been covered by CBHI? _____

14. Is there consultation with the community in choosing contracted health facility primarily considering physical distance? _____

15. How do you evaluate the provision of health care services from contracted health institutions? _____

16. What are those actions taken to address the problems of health care provisions (absence of drugs, lab, and so on) from contracted health facilities? _____

17. Which health center; district, general and tertiary hospitals have signed contractual agreement to provide health care services to CBHI members in your district/kebele?

_____

18. How do you see the role of CBHI on reducing direct out of pocket payment to health care services?_____

19. Do you think that the poorest households have been benefiting from CBHI? If you think so, how?_____

If you do not think so, what are your reasons? _____

20. How do you evaluate the inclusion of indigent population in CBHI? Are they adequately included? If you do not believe that they are adequately included, what are the reasons

_____

21. How are indigent households screened from the community to be members of CBHI?

_____

22. Which administrative structure is responsible to cover the health care expenses and registration fee for Indigent CBHI members? How much money do they pay to cover health care expenses?

At region level

_____

At zone level

_____

At district level

_____

23. Do these governmental institutions transfer the amount of money required to provide CBHI insured health care services to indigent CBHI member on time?_____

24. Does CBHI have proper Organizational structure capable of facilitating CBHI implementation? If you do not think so, what are its weaknesses? _____

25. What are the challenges of implementing CBHI? _____

26. What are your recommendations to improve the performance of CBHI? _____

Annex -3

Interview guide for informants of In-depth interview

1. Would you explain what Community-based Health Insurance is? _____

2. What are the awareness creation mechanisms that have been implemented in your kebele?

_____

3. Do you think that awareness creation mechanisms have been successful? If you think so, how do you evaluate it? _____

If you do not think they are successful, what are its shortcomings? _____

4. When was CBHI implementation started in your kebele? _____

5. Do you think that CBHI members/Community/ have been involved in the design and implementation of CBHI? _____

If your response is "Yes", how do they participate?____ _____

Are there any improvements in the performance of CBHI due to the participation of the community? If you remember any improvements, please mention_____

6. What are the advantages of CBHI in addressing health care needs of the community? _____

7. What are the packages of health care service benefits included in CBHI? _____

8. What are the services that are not covered by CBHI? _____

9. What are the advantages of CBHI in reducing direct out of pocket payment for health services?_____

10. What are the advantages of CBHI in reducing impoverishing health care expenditure?

_____

11. Do you think that the poorest households have been benefiting from CBHI? If you think so, how?_____

If you do not think so, what are your reasons? _____

12. How do you see the inclusion of indigent population in CBHI? Are they adequately included? If you do not believe that they are adequately included, what are the reasons

_____

13. How are indigent households screened from the community to be members of CBHI?

_____

14. How do you evaluate the provision of health care services from contracted health institutions? _____

15. What are those factors that prevent households from being enrolled in CBHI?

_____

16. Does CBHI have proper organizational structure capable of facilitating CBHI implementation? If you do not think so, what are its weaknesses? _____

17. What are the challenges of implementing CBHI? _____

18. What are your recommendations to improve the performance of CBHI? _____

Annex -4

Observation checklist

To substantiate data collected through employing other research methods regarding the delivery of health care services to CBHI members, contracted health facilities in the study area will be observed. Observation will be made to gather information concerning the following key points.

1. The distance of contracted health institution from the community (CBHI members)?

2. Delivery of health care services to paying CBHI members?

3. The treatment of indigent CBHI members in health facilities?

4. The reaction of CBHI members towards the health care services they have already received?

5. Service satisfaction feedback written on documents?

Annex -5

Focus Group Discussion guide

1. What is Community-based Health Insurance?

2. When was the implementation started in your kebele?

3. What are the advantages of CBHI in addressing health care needs of the community?

4. What are the advantages of CBHI in reducing direct out of pocket payment for health services?

5. What are the advantages of CBHI in reducing impoverishing health care expenditure?

6. How do you evaluate the provision of health care services from contracted health facilities?

7. How do you evaluate the enrollment level of CBHI?

8. What are those factors that prevent eligible households from being enrolled in CBHI?

9. How do you evaluate the participation of the poorest households in CBHI and their utilization of insured health care services?

10. How do you evaluate the participation of community in the design and implementation of CBHI?

11. What are the challenges of implementing CBHI?

12. What are your recommendations to improve the performance of CBHI?