COLLEGE OF MEDICINE AND HEALTH SCIENCE

DEPARTMENT OF PUBLIC HEALTH

ASSESSMENT OF KNOWLEDGE, ATTITUDE AND PRACTICE TOWARDS COMMUNITY-BASED HEALTH INSURANCE IN WOLKITE TOWN,GURAGE ZONE, SOUTH ETHIOPIA, 2022 G.C.

Research Thesis Submitted to Department of Public Health for partial fulfillment of the Requirements for the Degree of Bachelor in Public Health.

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Table of Contents

Acknowledgement i

List of Tables vii

Lists Acronyms vii

Summary viii

CHAPTER ONE 1

1. Introduction 1

1.1 Background of the study 1

1.2 Statements of the Problem 3

1.3 Significance of Study 3

CHAPTER TWO 5

2. Review of Related Literature 5

2.1 The Meaning of Community-Based Health Insurance 5

2.2 Functions of Community-Based Health Insurance 6

2.3 Poverty and Community Based Health Insurance 7

2.4 Culture and Community-Based Health Insurance 8

2.5 Community-Based Health Insurance in Ethiopia 10

2.6 The Conceptual Framework of the Study 12

3. CHAPTER THREE 14

Objectives of the Study 14

3.1 General objective 14

3.2 Specific objectives 14

CHAPTER FOUR 15

4. Research Methodology 15

4.1 Study Area and Study Period 15
4.2 Study Design 16
4.3 Target population 16
4.4 Study Participants 16
4.5 Sampling Techniques and Procedures 16
4.6 Inclusion and Exclusion Criteria 17
4.6.1 Inclusion Criteria 17
4.6.2 Exclusion Criteria 17
4.7 Sample Size Determination 17
4.8 Study Variables 17
4.8.1 Dependent Variables 17
4.8.2 Independent Variables 18
4.9 Operational Definition of Terms 18
4.10 Data Collection and Quality Control 19
4.10.1 The Survey Questionnaire 19
4.11 Data processing and analysis 19
4.12 Ethical Considerations 19
4.13 Dissemination of the finding 20
CHAPTER FIVE 21
5. RESULT 21
5.1 Socio-Demographic Characteristics of Respondents 21
5.2 Community's Knowledge 23
5.3 Community's Attitude towards Community Based Health Insurance Schemes 25
5.4 Community Based Health Insurance Practice 27
5.4.1 When You Started enrolling in CBHI? 27
5.4.2 Before Enrolling in CBHI How Did You Cover Your Medical Expense? 28

5.4.3 Do You Think Your Health Status is improved After Enrolling in CBHI? 28
5.4.4 Types of Membership 29
5.4.5 Do You Renew Your and your family Membership ID Timely? 29
5.4.6 I Decide to Resign My Membership from CBHI 30
5.4.7 I haven't got any advantage enrolling in community based health insurance 30
5.4.8 What is reason not being beneficiary 31
5.4.9 Benefits of the CBHI to the respondents 31
5.4.10 Challenges facing as member CBHI 32
5.4.11 Are you very happy current premium level? 32
5.4.12 What is nearest conventional health institution to your home? 32
CHAPTER SIX 35
6. DISCUSION 35
CHAPTER SEVEN 36
7. CONCLUSION AND RECOMMENDATION 36
7.1 CONCLUSION 36
7.2 RECOMMENDATION 36
7. References 37
7. APPENDICIES 43
Appendix A: Consent Form 43
Appendix B: English version Questionnaire 43
Part one: Social-demographic characteristics of the respondents 43
Part two: Items related with Community's knowledge and perceived importance of CBHI 44
Part three: Items related with community's attitude towards CBHI 47
Part Four: Items related to community's Practice towards CBHI 48
አባሪ ሀ: የተሳታፊዎች መረጃ መስጫ እና የስምምነት መግለጫ ቅጽ 50
አባሪ ለ፡ መጠይቅ 50

ክፍሌ አንዴ፡ መጠየቅ የሚዯረግሇት ማህበራዊና ስነ-ህዝባዊ ጥያቄዎች 50

ክፍል ሁለት፡ ማህበረሰቡ ስለ ጤና መድህንን ፕሮግራም ምንነት እና ጠቀሜታ በተመለከተ የሚዳስሱ ጥያቄዎች 51

ክፍል ሶስት፡ ስለ ማህበረሰብ አቀፍ የጤና መድህን ፕሮግራምን በተማለከተ የማህበረሰቡን አመለካከት የሚለኩ ጥያቄዎች 52

ክፍል አራት የማህበረሰብ አቀፍ የጤና ምድን ልምድ የተመለከቱ ጥያቄዎች 53

List of Tables

Table 1: A time frame to conduct research on assessment of knowledge, attitude and practice of the community towards community-based health insurance schemes in Wolkite town, Gurage Zone, South Ethiopia, 2022 G.C, page 26

Table 2: Total budget required for conducting research on assessment of knowledge, attitude and practice of the community towards community-based health insurance schemes in Wolkite town, Gurage Zone, South Ethiopia, 2022 G.C, page 27

Lists Acronyms

AIDS: Acquired Immune Deficiency Syndrome

BOFED: Bureau of Finance and Economic Developed

CBHI: Community Based Health Insurance

CRIP: Community Rated Insurance Program

CSA: Central Statistical Agency

EHIA: Ethiopian Health Insurance Agency

FMOH: Federal Ministry of Health

GOs: Government Organization

HIV: Human Immune Virus

NGOs: Non-governmental Organizations

OOP: Out of Pocket

SRM: Social Risk Management

UHC: Universal Health Coverage

USAID: United States Agency for International Development

WHO: World Health Organization

Summary

Background :Community-based health insurance (CBHI) is a not-for-profit mechanism based upon solidarity among a relatively small group of people up to large community.It is also considered as any program managed and operated by a community-based organization, other than government or a private for-profit company, that provides risk-pooling to cover the costs (or some part thereof) of health care services. To ensure the community to get access the health care service, many developing countries have designed Community-Based Health Insurance Schemes. However, lack of knowledge, attitudinal and practical barriers made the process of the implementation of these schemes far behind attaining the intended goals and objectives.

Objective: The objective of this study was to assess knowledge, attitude and practice of the community towards CBHI in Wolkite town, Gurage Zone, South Ethiopia . The study was done from May, 2022 GC- June, 2022 GC.

Study Design- We used community based cross sectional study design to assess knowledge, attitude and practice of the community towards community based health insurance in the Wolkite town. Simple random sampling technique employed to select individuals from randomly selected kebeles in wolkite town. Data analyzed by using SSPS Software and presented by word and tables ; and could be used by any institutional and non institutional body who want to tackle the problems of study area.

Result: The community's knowledge, attitude and practices towards CBHI was found as 87%, 65% and 49% respectively in the study area.

Conclusion: There was good awareness about CBHI schemes in study area, but it is not adequate. There was also positive attitude towards CBHI and there was also relative good enrollment of CBHI in study area.

Key terms: CBHI, Knowledge, Attitude and Practice

CHAPTER ONE

1. Introduction

1.1 Background of the study

Since the late 1990s, Community-Based Health Insurance Schemes (CBHIs) have been implemented in several developing countries. The aim of such schemes is to reach out to undeserved low-income group of people, especially those who are engaged in the informal sector, and increase access to health services and provide financial protection from ill health. Health insurance is a means of pooling risks across different population groups so that the financial burden is significantly reduced [19]. The benefits of health insurance are many-fold. Health insurance schemes have been reported to help improve the efficiency and quality of health care services by creating greater competition among providers [11].

In addition, Community-Rated Insurance Programs (CRIP) create greater access to health care, and improve equity, as benefits are provided on the basis of need rather than income level [16, 53, 14]. Community-Based Health Insurance schemes have been initiated in several African countries, including Guinea-Bissau [7, 12, 15]. Some of these schemes are organized through existing agriculture cooperatives and timed to coincide with harvest seasons have met with some degree of success in Zaire, Guinea Bissau and other countries [37, 56]. In Guatemala and Philippines, cooperatives created through livelihood projects have served as important bases for health insurance schemes. In the Dominican Republic, lending association based risk pools were created for involvement in health care financing [37].

Over the past decade, Ethiopia has recorded notable progress in a number of population health outcomes. For instance child mortality per 1000 live births has fallen from 166 in 2000 to 88 in 2011 and maternal mortality rates have declined from 871 to 676 per 100,000 live births. These changes have been accompanied by a rapid expansion of health-care infrastructure at all levels [6]. In line with this, the Ethiopia's Federal Ministry of Health (2011) stated that there has been an 18-fold increase in the number of health posts from 833 in 2000 to 15,095 in 2011 and a 7-fold increase (356 to 2,660) in the number of health centers over the same period. Consequently it is

estimated that primary health care coverage, defined as village-level access to a health post, has increased from 51 percent in 2000 to 92 percent in 2011[25].

Despite these increases in the supply of health care services and increases in the utilization of some specific services, overall utilization rates remain low. The low utilization rates are accompanied by a high reliance on out-of-Pocket (OOP) spending to finance health care among other factors. Federal Ministry of Health (2010) estimates that out-of-Pocket spending by health care users contributes some 37% to the total health care financing in Ethiopia. However, this has brought burden to economically poor section of the community. Thus, as viable option and with the aim of enhancing access to health care and reducing the burden of out-of-pocket (OOP)expenditure, the government of Ethiopia launched a pilot Community Based Health Insurance (CBHI) scheme in 13 districts located in four regions such as Tigray, Amhara, Oromiya, and Southern Nations, Nationalities and Peoples.

Currently, the government of Ethiopia has also launched nationwide Community-Based Health Insurance schemes. However, the rate of implementing the schemes has been slow down due to several factors. For instance, the study conducted by Angaw(2015) identified factors affecting the enrollment decision of households to the Community Based Health Insurance schemes in Ethiopia. Among others, socioeconomic status, demographic traits such as sex, age, household size, health status, attitudes, educational level, quality of service, knowledge &understanding of health insurance are the major factors that affect the rate of enrollment.

Moreover, attitudinal variables as the perception concerning the importance and necessity of implementing CBHI schemes on the part of the community really have greater impact on enrollment rates. In supporting this, in its report on the evaluation of community based health insurance pilot schemes, the Ethiopian Health Insurance Agency (20) made it clear that community's awareness and knowledge on the aims and importance of CBHI played significant role to the acceptance and enrollment to the program on the part of community. This indicates that community's awareness raising activities are still unexhausted assignments of the government and other stakeholders to bring the full realization of the scheme. In relation to this, Our study assessed community's knowledge, attitude and practice towards CBHI schemes in wolkite town.

1.2 Statements of the Problem

Universal Health care Coverage (UHC) has been difficult to achieve in many developing countries, with large populations remaining over-reliant on direct out-of-pocket (OOP) expenses [12]. The World Health Organization (WHO) views medical fees as a significant obstacle to health care coverage and utilization. WHO has also stated that the only way to reduce reliance on direct payments is for governments to encourage the risk-pooling prepayment approach [12]. However, effectively financing health care system is one of the most serious challenges for the poor countries like Ethiopia(1).

Community Based Health Insurance pilot schemes have been in practice in Ethiopia since 2011. The study conducted on enrolment in Ethiopia's community based health insurance scheme by using longitudinal survey of households supported by qualitative method in CBHI pilot regions, 2011/12, in Ethiopia overall the uptake of CBHI was 45.5% during December 2012. In piloted four regions the uptake was 44%, 35%, 49%, 34% in Oromia, SNNPR, Amhara and Tigray respectively since April 2020[41]

However, at national level, the practice and the level of uptake lag behind its expectation due to various reasons. For instance, two rounds of longitudinal household data gathered in 2012 and 2013 by Zelalem et.al, (2014) has shown that the decision to drop out of the CBHI scheme Ethiopia largely relies on its affordability, health status, knowledge and experience of insurance and the quality of care on the part of the community. Thus, community awareness concerning the objectives, meaning and importance of Community Based Health Insurance schemes needs further investigation in order to enhance its practice. However, in SNNPR, Gurage zone CBHI schemes have not been well researched yet. So, this study assessed knowledge, attitude and practices towards the community based health insurance in Wolkite town.

1.3 Significance of Study

This study done on community's Knowledge, attitudes and practices towards community based health insurance schemes had advantages to each individual in the community in particular and to the whole community in general. Thus, this study result have the following significance. As results of the study that showed the level of community's knowledge, attitude and practice about the Community Based Health Insurance schemes(CBHI) in the study area, government and non-

government stakeholders might take appropriate measures to enhance community's knowledge, attitude and practice through awareness raising and education programs. Results of the study might also been used as an input to policy makers and other stakeholders in their efforts to make Community Based Health Insurance schemes play its role in to achieving universal coverage with adequate financial protection for all against health care costs. Finally, study could also be used as a preliminary work on community based health insurance schemes future theoretical deliberation by other researchers.

CHAPTER TWO

2. Review of Related Literature

This chapter presents the review of literature on a range of issues related to Community Based Health Insurance. The literature chapter begins by providing clarifications of the meaning of Community Based Health Insurance, function of Community Based Health Insurance, poverty and Community Based Health Insurance, culture and Community Based Health Insurance, the Ethiopian Health Care System, Community Based Health Insurance in Ethiopia, key features of the Ethiopian Community Based Health Insurance..

2.1 The Meaning of Community-Based Health Insurance

Community Based Health Insurances are called by many different names, including: micro insurance, community health finance organizations, mutual health insurance schemes, prepayment insurance organizations, voluntary informal sector health insurance, mutual health organizations/ associations, community health finance organizations, and community selffinancing health organizations [55].

In fact, community-based health insurance (CBHI) is a not-for-profit mechanism based upon solidarity among a relatively small group of people. CBHI schemes vary a great deal in terms of who they cover, how, for what, and at what cost. The majority of CBHI schemes operate in rural areas, and their members are relatively poor. The best-known examples are the schemes in Africa known as mutuelles de santé [35]. They are deemed as "local initiative which is built on traditional coping mechanisms to provide small scale health insurance products specially designed to meet the needs of low-income households '' [12].

Community-Based Health Insurance is also considered as any program managed and operated by a community-based organization, other than government or a private for-profit company, that provides risk-pooling to cover the costs (or some part thereof) of health care services. Beneficiaries are associated with, or involved in the management of community-based schemes, at least in the choice of the health services it covers. It is voluntary in nature, formed on the basis of an ethnic of mutual aid, and covers a variety of benefit packages. CBHIs can be initiated by

health facilities, NGOs, trade unions, local communities, local governments or cooperatives and can be owned and run by any of these organizations [55] Schemes laid out by government within a roadmap towards universal coverage might maintain the principle of voluntary affiliation (in rural China) or make a deliberate choice for mandatory affiliation like in Ghana and Rwanda [54].

2.2 Functions of Community-Based Health Insurance

The Community Based Health Insurance has a wide range of functions such as it is considered as social protection mechanism. Social protection is broadly and traditionally defined as"public interventions to assist individuals, households and communities better manage risk and provide support to the critically poor" [34]. However, the application of social risk management extends social protection as traditionally defined since it goes beyond public provision of risk management instrument and draws attention to informal and market-based arrangements and their effectiveness [34]. In fact, Social protection has emerged to expand traditional social security measures protecting people within the formal structures of employment, to incorporate those people, in poverty, operating outside of formal employment structures.

According to the World Bank, the informal sector constitutes up to 80% of the workforce in Africa [14]. The majority of people from informal sector are not covered by any kind of social security though are more exposed to risk. It should be noted that Social Risk Management (SRM) framework is based on two important assessments: (i) The poor are typically most exposed to diverse risks ranging from natural (such as earthquake and flooding) to manmade (such as war and inflation), from health (such as illness) to political risks (such as discrimination), and (ii) the poor have the fewest instruments to deal with these risks (such as access to government provided income support and market-based instruments like insurance) [34].

As consequences, the poor are the most vulnerable in society as shocks are likely to have the strongest welfare consequences for them and the high vulnerability makes them risk averse and thus unable or unwilling to engage in higher risk/higher return activities. Access to SRM instruments would allow the poor more risk-taking and thus provide them with an opportunity to gradually move out of poverty [33]. The instruments of social protection are varied and broadly fall into the categories of social insurance and social assistance. Thus, CBHI is one of the instruments used to protect people, especially the poor from informal sector, against health risks.

There are a number of ways in which the Government can assist in the management of health risks of the poor. This includes, for example, improved provision and targeting of publicly provided health services to the poor; financing the inclusion of the poor in social or private insurance schemes; and by investing in programs that are complementary to improve health standards, such as clean drinking water, sanitation, and good nutrition, in poor regions. There are also ways in which low income communities can improve the management of health care risks, in partnership with Central Government and other sources of care.

Those ways range from informal/individual to formal ones. In the range of informal/individual ways, households have many ways of avoiding, mitigating and coping with the financial consequences of health risks. This includes private savings, reciprocal lending, asset accumulation/sales, and changes in labor allocation, reduced consumption, and participation in a variety of formal and informal savings or mutual benefit groups. Informal insurance mechanisms, which involve reciprocal exchange through local groups, work reasonably well for some risks.

Nevertheless, all of these coping mechanisms may prove insufficient to meet health costs, particularly if hospitalization is involved and illness is prolonged [47]. Concerning community based health insurance systems; it differs from those informal insurance or other traditional forms of reciprocal exchange. It offers ex-ante, well-defined protection with a more reliable premium, compared to traditional insurance, in which the transfers are made ex post and the transfer amount unknown. Informal arrangements generally cover a variety of life cycle, income and health risks, while CBHI is limited to defined health risks [55]. Thus, CBHI is deemed to be a better tool to deal with health risks for the poor than using coping mechanisms.

2.3 Poverty and Community Based Health Insurance

Community-Based Health Insurances often target people from informal sector and who are, in most of time, poorest categories of the rest of the community or nation. This section will explore the link between poverty and the success of CBHIs especially when it comes to the payment of premiums. Poverty can be defined in terms of material deprivation in terms of income as well as lack of access to resources, services and basic information [21].

Further dimensions can be added such as ‘’exclusion from social support networks’’ [44] ‘’state of relative powerlessness’’ [28]; and a lack of opportunities and choices . Poverty can be absolute where survival and subsistence is paramount, but relative poverty, as depicted by Townsend in 1979, is in relation to societal norms and whether people can do ‘’what is socially expected of them’’ [4]. In fact, widespread absolute poverty among potential members can be a serious obstacle to the implementation of insurance. If people are struggling for survival every day, they are less willing to pay insurance premiums in advance in order to use services at a later point in time. A positive impact of health insurance on equity and access must be doubted if a large proportion of the population cannot even afford CBHI membership [57]. In developing countries because of the big number of the poor, the governments are not able to assist all people in need that is why they use targeting methods to select most needy people.

In Rwanda those who cannot afford CBHI premiums are identified using community targeting. Targeting is a complex process which involves defining eligibility criteria. Mechanisms for targeting include geographic criteria, specifying categories, means tests, proxy means tests, community selection and self-selection, or a combination thereof [22]. The community targeting system, used in Rwanda, identifies and ranks households according to 6 different poverty levels using proxy indicators such as a lack of earners in the household; a disabled person in the household; the number of dependants; and land access [18]. The range is from destitute (no land, livestock, shelter, begging to survive), to food and money rich. Another example is from Ghana, where CBHIs are also implemented on nationwide level. The premiums for non government workers “were supposed to be based on income levels, but currently each district charges a flat premium because of the difficulty of grouping people in various income levels for the different premiums,” . They opted for flat premium system because identifying the poor is a challenge “some religious people don’t want to be labeled as poor. [56]

2.4 Culture and Community-Based Health Insurance

Although no single definition of culture is universally accepted by social scientists, there is general agreement that culture is learned, shared, and transmitted from one generation to the next, and it can be seen in a group’s values, norms, practices, systems of meaning, ways of life, and other social regularities [36]. Factors such as familial roles, communication patterns, beliefs relating to personal control, individualism, collectivism, and spirituality and other individual,

behavioral, and social characteristics are not inherently "cultural" but may help define culture for a given group if they have special meaning, value, identity, or symbolism to the group's members. In such a group, these and other factors may be directly or indirectly associated with health-related behaviors and/or with acceptance and adoption of health promotion programs [36]. For example in the case of health insurance, the demand of households depends not only on the quality of care offered by the health care provider, on the premium and benefit package, but also on socio-economic (as demonstrated in previous section) and cultural characteristics of households and communities.

Cultural habits in dealing with the risk of illness can influence the demand for insurance: for example, in rural Benin, people were used to put money aside for unpredictable events like marriages and funerals, but they believed that saving money for eventual health care costs meant "wishing oneself the disease" [57]. Fortunately, this attitude changedafter a CBHI had come into existence. Another example to illustrate how socio-cultural factors pose a barrier to demand for insurance refers to some societies where people believe that to think about the consequences of one's ill-health or death is to wish oneself the same. Similarly, in some societies people interpret ill-health as the wish of gods or links it to one's fate and hence refuse any medical treatment and turn to religious head [57].

However, despite the negative impact of culture on the demand of health insurance, there is also a positive side when the culture of a given society encourages people to help each other when it comes to management of health risks. A society with a strong solidarity, people will not worry so much if the benefits of the premiums they paid will accrue to themselves or other community members. For example, members of the Bwamanda scheme in Ex-Zaire expressed the opinion that if they would not need health care themselves, at least they had done something good for the community by contributing to the insurance fund [13]. The level of solidarity and mutual trust is probably higher in homogeneous, close-knit communities than in scattered and diverse populations comprising people of different ethnic origin, religion and culture [10] Existing, "traditional" institutions of risk-sharing and mutual help can on the one hand facilitate CBHI implementation, because health insurance may be built upon these groups, as has been done with the Engozi societies in Uganda by the Kisiizi Hospital Health Society [43].

On the other hand, the different logic of traditional networks sometimes induces misperceptions of insurance and disappointment, because people have expectations based on their experience with traditional institutions that are not fulfilled by CBHI, e.g. that the money paid into the common fund accumulates over time and that the benefits will correspond to the contributions made [10]. A lot of community sensitization and mobilization may be necessary in this respect. In any case, initiators and managers of health insurance schemes should pay more attention to consumer satisfaction and to people's preferences and perceptions, because these are crucial factors for successful implementation of CBHI.

2.5 Community-Based Health Insurance in Ethiopia

Over the past decade, Ethiopia has recorded notable progress in a number of population health outcomes. For instance child mortality per 1000 live births has fallen from 166 in 2000 to 88 in 2011 and maternal mortality rates have declined from 871 to 676 per 100,000 live births. These changes have been accompanied by a rapid expansion of health-care infrastructure at all levels. According to Ethiopia's Federal Ministry of Health (2011), there has been an 18-fold increase in the number of health posts from 833 in 2000 to 15,095 in 2011 and a 7-fold increase (356 to 2,660) in the number of health centers over the same period. Consequently it is estimated that primary health care coverage, defined as village-level access to a health post, has increased from 51 percent in 2000 to 92 percent in 2011.

Despite these increases in the supply of health care and increases in the utilization of some specific services, overall utilization rates remain low. For example, according to the Ethiopian Demographic and Health Surveys(2011), outpatient health care utilization per capita per year has increased only marginally from 0.27 visits in 2000 to 0.3 visits in 2011. The low utilization rates are accompanied by a high reliance on out-of-pocket (OOP) spending to finance health care. The FMoH estimates that the three main sources of health-care financing in Ethiopia are local and international donors (40 percent), out-of-pocket (OOP) spending by health-care users (37 percent), and central and local governments (21 percent) [27]. The remainder (about 2 percent) is covered by employer and other private insurance schemes. In July 2011, with the aim of enhancing access to health care and reducing the burden of OOP expenditure, the Government of Ethiopia launched a pilot Community Based Health Insurance (CBHI) scheme. The scheme

which caters to rural households and urban informal sector workers was rolled out in 13 districts located in four main regions (Tigray, Amhara, Oromiya, and SNNPR) of the country.

In June 2011, the Ethiopian CBHI scheme was rolled out in 13 pilot districts in four main regions (Tigray, Amhara, Oromiya, and Southern Nations, Nationalities and Peoples) of the country [28]. The pilot districts were selected by regional administrative bodies based on directives provided by the Federal Ministry of Health. While the chosen districts were expected to fulfill five selection criteria, in practice, selection was based on two conditions. Namely, the district should have undertaken health care financing reforms designed to increase cost recovery and retention of locally raised revenues and that health centers in these districts should be geographically accessible (located close to a main road).

The scheme is part of the government's broader health care financing reform strategy which aims to improve quality and coverage of health services by identifying alternative health care resources [51]. Feasibility studies, scheme design and scheme promotion were outsourced to Abt Associates and CARE Ethiopia. The basic design of the scheme in terms of benefit packages, registration fees and premium payments, co-payments were determined on the basis of feasibility studies and in collaboration with regional governments and are the same within each of the pilot regions but differ slightly across regions. Scheme implementation and monitoring is conducted by Abt Associates in collaboration with relevant government authorities at the central, regional, district, and village levels.

While the scheme has been introduced by the government, it is 'community based' in the sense that the community determines whether or not to join the scheme and is subsequently involved in scheme management and supervision. In particular, after being exposed to a range of awareness creation activities a general assembly at the village (kebele) level decided whether or not to join the scheme (a simple majority had to support the decision) and then households decide individually whether to enroll in the scheme. In order to reduce the possibility of adverse selection the unit of membership is the household rather than the individual and new members can use their CBHI card to get healthcare services after waiting for at least for one month [26].

Based on feasibility studies conducted by Abt associates, regional health administration officials determined the premiums to be charged. Household level monthly premiums for core household members range between ETB 10.50 in SNNPR to ETB 15 in Oromiya. For each noncore household member the monthly premium lies between ETB 2.10 and ETB 3.00. Premiums in Amhara region are set at ETB 3.00 per individual per month. The premiums amount to about 1-3 percent of household monthly income. To enhance affordability the central government subsidizes a quarter of the premium and district and regional governments are expected to cover the costs of providing a fee waiver to the poorest 10 percent of the population or so called "indigent groups".

2.6 The Conceptual Framework of the Study

As the understanding of the researcher, the concepts of the above theoretical frameworks best fits to explain the conceptual frame work of the study. In order to make CBHI schemes successful members of the community at every level (from micro-macro) should be considered to create strong social ties. Every individual, family, village, community should be part and parcel of the CBHI schemes. Thus, they should be given opportunities to participate during planning and execution of the CBHI schemes. Moreover, through community mobilization program, every member of the community should be communicated, convinced and be given the chance to share and discuss his/her ideas on CBHI schemes. Thus, communication, education, knowledge and awareness raising activities are deemed to be critical for the success of CBHI in the study area. The following figure illustrates how strong community ties and community mobilization works to gather to bring intended knowledge, attitude and practice on the part community members.

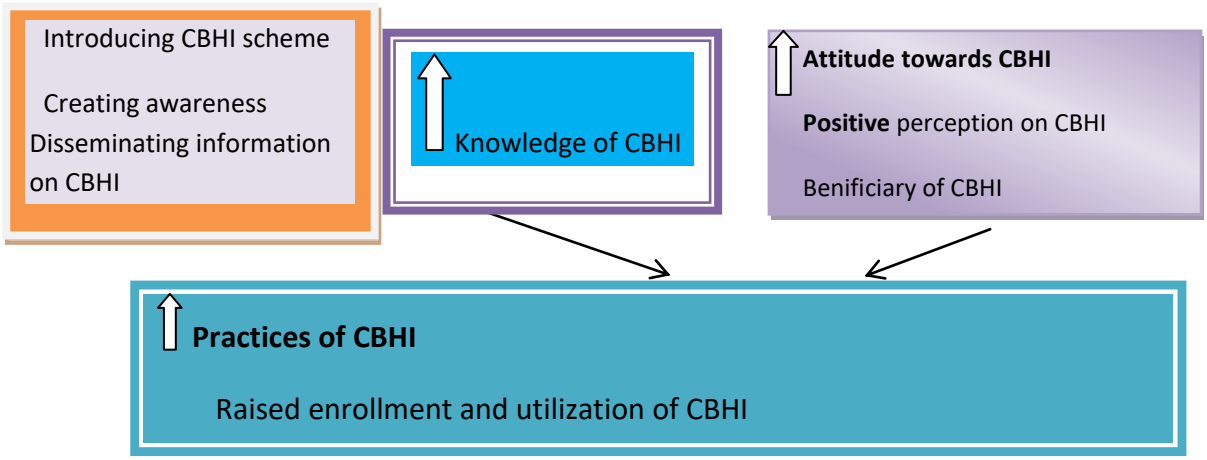


Fig.1.The Conceptual Framework of the Study

The study believes that the least implementation of the CBHI schemes in the study area is partly due to lack of adequate knowledge and positive attitude among community members towards CBHI schemes. As far as the community is the major actor both in the process of implementation and benefiting out of it, it should be made part of the scheme and this urges for the need to aggressively work out on effectively utilizing the community's social capitals. Because, social capitals are an informal guiding principle to bring about community wellbeing. Thus, the community should be encouraged to discuss and share opinions through informal social norms and networks. Moreover, the media should also support the implementation of CBHI schemes through promotional activities in the form of education. Thus, all these could bring about behavioral change on the part of community which leads to the development good knowledge and positive attitude. Finally, this results in effective and efficient practice of CBHI schemes in the study area.

3. CHAPTER THREE

Objectives of the Study

3.1 General objective

The general objective of this study is to assess knowledge, attitude and practice of the community towards community-based health insurance schemes in Wolkite town, Gurage Zone, South Ethiopia, 2022 G.C.

3.2 Specific objectives

In order to meet the general objective of the study, the following specific research objectives had addressed.

1. To evaluate community's knowledge about Community-Based Health insurance schemes in the study area

2. To examine the attitude of the community towards the intervention of CBHI schemes in the study area

3. To investigate the community's practice on CBHI schemes in the study area

CHAPTER FOUR

4. Research Methodology

This study assessed knowledge, attitude and practice of the community towards Community Based Health Insurance schemes in the study context. This chapter, therefore, presents the description of the methods that we used for our study. The chapter provides the brief description of the study area followed by the description of research design, sampling procedures as well as data collection and analysis techniques. Lastly, the chapter presents the ethical issues which was been followed in the study.

4.1 Study Area and Study Period

Our study conducted in Wolkite town which is the capital city of gurage zone, found in SNNPR and 158KM far from Addis Ababa in southern direction and 429km away from Hawassa which is, the capital city of the SNNP Region. Wolkite town is found in south western Ethiopia which is the administrative center of the Gurage zone with a total population of 92,517 from the town's administrative office.

The study conducted from April 2022, G.C up to June2022, G.C.

4.2 Study Design

This study adopted community based cross sectional methods to assess knowledge, attitude and practice the community towards community based health insurance schemes in the study area.

4.3 Target population

This study conducted in Wolkite town by considering all household heads in Edget ber kebele, Bekur sub city in wolkite town as target population.

4.4 Study Participants

This study involved household heads from Edget ber kebele. Their total population of kebele is 28,004 where, (male=14,282 & female=13,722) and 5,716 number of households. The selected participants had been interviewed by using questionnaire.

4.5 Sampling Techniques and Procedures

In this study simple random sampling method applied, the Wolkite town consists three sub city, from town, one the sub city randomly selected that consists of two kebeles. one kebele from two kebeles will be selected by simple random sampling method that is 16.67% of the total Kebeles in town. Then the required sample size will be proportionally allocated to selected kebele based on its number of households. Finally, lists of the households having house hold heads/spouses with informal work obtained from sub city administration office (village register) and after getting the lists households (heads/spouses with informal work) from selected kebele, sample selected by simple random sampling to get the required sample size.

<table>
<tr><td colspan="7">Wolkite town</td></tr>
<tr><td colspan="2">Bekur subcity</td><td colspan="3">Adis birhan subcity</td><td colspan="2">Gubrye subcity</td></tr>
<tr><td>Edget ber</td><td>Adis hiwoyt</td><td>Menaharia</td><td>Selam ber</td><td>Ediget chora</td><td colspan="2">01 kebele</td></tr>
<tr><td colspan="3" rowspan="2">Randomly selected kebele is Edgetber with population</td><td colspan="2">Totally</td><td colspan="2">28231</td></tr>
<tr><td colspan="2">Heads of HH</td><td colspan="2">5716</td></tr>
</table>

4.6 Inclusion and Exclusion Criteria

4.6.1 Inclusion Criteria

All household heads in selected kebele was included in study

4.6.2 Exclusion Criteria

Either household head or spouse which has mental illness, household heads who lived less than 6 months in wolkite town, household heads lived more 6 months in town but but his/her families are not with him/her and not household heads were excluded from the study.

4.7 Sample Size Determination

Using a single population proportion formula, $n= (Z\alpha/2)^2 *P (1-P)/D^{2,}$

Where;

Z: level of confidence =95% (Zα/2=1.96)

D: margin of error = 5% (d=0.05) in our case,

P: Proportion, taken from 2019 EMDHS in which The CBHI practices in SNNPR = 40.2%

So, $n= (1.96)^2(0.402) (0.598)/(0.05)^2= 368$

The total population is less than 10,000 we use correction formula

$$n = \frac{n_0}{1 + \frac{n_0}{N}},$$ n= 368/(1+(368/5716))= 346 After this, we will add the suspected percent of non-respondents, in our case it is 10% so, 346+(0.1*346) = 381.

Finally we are going to collect data from 381 household heads in Edget ber kebele.

4.8 Study Variables

4.8.1 Dependent Variables

Community based health insurance schemes

4.8.2 Independent Variables

Socio-demographic data: Age, household family size, education, occupation, marital Status, wealth index.

Health data : household members self-reported health status, accessibility of healthcare facility, perceived quality of health care, presence of chronic disease in house hold members.

4.9 Operational Definition of Terms

Community-Based Health Insurance Schemes: refers to the process of developing a financial risk pooling system that provides cross-subsidies in health systems where ability to pay determines financing contributions and the use of services is on the basis of need for care (WHO, 2010)

Knowledge: refers to the level of community's understanding about the operating Community-Based Health Insurances schemes in the study area.

Good knowledge; is when the respondents agree/ strongly agree above 7 question from the 15 knowledge assessing questions.
Poor knowledge; when the respondents agree/ strongly agree below 8 questions from the 15 knowledge assessing questions.

Attitude: refers to either positive or negative perceptions of the community towards Community-Based Health Insurance schemes in the study area.

Positive attitude; if the respondents give more than 7 positive answer correspondingly to each question.
Negative attitude; if the respondents give less than 8 positive answer correspondingly to each question.
Practice: the actual application or utilization or enrollment of community in community based health insurance scheme in study area.

Good practice; if respondent answer more than 7expected answers correspondingly to each question.

Poor practice; if respondent answer less than 8 expected answer correspondingly to each question.

4.10 Data Collection and Quality Control

Quantitative data collection method was used to collect data using structured, interviewer administered, questionnaires. The questionnaire was translated in to Amharic and then back to English language to ensure consistency. The data collector had been trained before the data collection in order to assure the quality of data. Data had been collected by group members.

4.10.1 The Survey Questionnaire

With the intention of assessing community's knowledge, attitude and practice towards community based health insurance schemes; slightly amended survey questionnaire from the mini EMHDS 2019 were used. The questionnaire had four parts. The first part focused on the demographic information of respondents. Part two consisted of items focusing on knowledge and perception of the community regarding community-based health insurance schemes in the study area. Part three consisted of items dealing with the attitude of the community towards community-based health insurance schemes. Lastly, part four consisted of items dealing with the practices of the community towards community-based health insurance schemes in study area.

4.11 Data processing and analysis

The collected data processed and analyzed by using SPSS software for windows after collecting the questionnaires. The completeness and consistency had been checked and the main findings of the study was interpreted in the form of appropriate figures, tables, percentage/proportions, frequency and then results will be compared and discussed with other already existing data such as literature reviews. Finally, the findings was concluded, recommended and disseminated.

4.12 Ethical Considerations

Permission had been obtained from heads of the selected departments through an official letter from department of Public health. However, the following ethical issues had been given particular emphasis to make the study ethical. Explanation about the purpose and significance of the study had been given to the respondents and to different relevant bodies. Informants had oriented about ways/procedure was been followed during interview sessions. Participants were be ensured to have the right to withdraw from filling the questionnaire and interview process at any particular point in time. Participants will be fully ensured their autonomy and the

confidentiality of their disclosure in the course of interview sessions. They were not be required to write their name and address in any part of the questionnaire.

4.13 Dissemination of the finding

The result of the study submitted to Wolkite University, College of Health Science and Medicine, department of public health. The finding would be presented in various seminars or workshops and may be also published in a scientific journal. Since the report of the study was expected to be useful in improving the community's KAP towards CBHI in study area the data would be disseminated through Wolkite University to different concerned bodies.

CHAPTER FIVE

5. RESULT

This chapter of the our thesis presents results of the study. The chapter is classified in to four major sections. The first section presents results on the socio-demographic characteristics of respondents; Sex, age, marital status, occupation, ethnicity, educational level, family size and monthly income and expenditure were considered as the socio-demographic characteristic of respondents. Section two provides results concerning community's knowledge towards CBHI. Section three deals with results related with community's attitude towards CBHI. Section four focuses on results related with the community's practices of CBHI schemes in the study area.

5.1 Socio-Demographic Characteristics of Respondents

In this study, Sex, age, marital status, occupation, ethnicity, educational level, family size and monthly income and expenditure were considered as the socio-demographic characteristics of respondents. This section describes each Characteristic using frequency and percentage.

No	Characteristics		Frequency	Percentage (%)
1	Sex	male	243	63.8
		female	138	36.2
2	Age	18-30	64	16.8
		31-50	200	52.5
		51-65	85	22.3
		>65	32	8.4
3	Relationship	Father	257	67.5
		Mother	109	28.6
		Child	5	1.3
		other	10	2.6
4	Occupation	Housewife	42	11.0
		Gov't employee	134	35.2
		Private employee	9	2.4
		Merchant	69	18.1
		Daily laborer	54	14.2
		other	73	19.2
5	Religion	Muslim	139	36.5
		Orthodox	213	55.9
		Protestant	13	3.4
		Catholic	7	1.8

		Other	9	2.4
6	Ethnicity	Gurage	264	69.3
		Hadya	20	5.2
		Kambata	7	1.8
		Oromo	23	6.0
		Amhara	62	16.3
		Other	5	1.3
7	Marital status	Single	12	3.1
		Married	324	85.0
		Divorced	17	4.5
		Widowed	28	7.3
8	Education	Illiterate	11	2.9
		Can read	81	21.3
		Elementary	51	13.4
		Secondary	11	2.9
		Preparatory	77	20.2
		Diploma	34	8.9
		Degree& above	116	30.4
9	Monthly income (in ETB)	1000-3000	79	20.7
		3001-5000	135	35.4
		5001-8000	99	26.0
		>8000	68	17.8
10	Monthly expenditure (in ETB)	1000-3000	71	18.6
		3001-5000	131	34.4
		5001-8000	141	37.0
		>8000	38	10.0
11	Family size	1-3	78	20.5
		4-6	175	45.9
		6-8	104	27.3
		>8	24	6.3

Table 5.1 provides the socio-demographic characteristics of participants of the study. According to the table, 243(63.8%) of the participants were male and 138(36.2%) were female. In terms of age, 64(16.8%) of the respondents were in the age range of 18 -30, 200(52.5%) of the participants were in the age range of 31-50, 85(22.5%) of the participants were in the age range of 51-65 and 32(8.4%) of the participants were above 65. Among the participants 257(67.5%) were fathers with the relationship and 109(28%), 5(1.3%) and 10(2.6%) were mother, child and other relatives respectively. Regarding the occupation of respondents 134(35.2%) were gov't employee, 69(18.1%) were merchantts, and the rest one were house wife, private employee, daily laborer and others. Most of respondents were Christians in religion and Gurage in ethinicty. By marital status 324(85%) were married and the rest were divorced,

widowed and single. With respect to educational level of the participants, 116(30.4%) were degree and above, 34(8.4%) were diploma and the rest were preparatory, secondary, and elementary school level educated and there were only 11(2.9) illiterates As far as the monthly income of the respondents 135(35.4%) got 3001-5000 monthly and they expent as the same amount, and there were about 79(20.7%) and 68(17.8%) who earn less than 3000 and greater than 8000 respectively. Among respondents most of them live in 4-6 and more members in their families.

5.2 Community's Knowledge

One of the objectives of this study is to assess participants' knowledge towards community based health insurance schemes in the study area. To this end, data were collected using self administered questionnaire containing 12 items having a Liket scale ranging from 1=strongly disagree to 5=strongly agree. High score indicates participants' high knowledge and the vice versa.

No	Variables		1	2	3	4	5	Total
1	There is ample information about Community-Based Health Insurance Schemes in my living area	frequency		21	32	183	145	381
		Percent		5.5	8.4	48	38.1	100
2	The prime principle of Community-Based Health Insurance Schemes is community's investment on community health care service	frequency	18	24	40	246	53	381
		Percent	4.7	6.3	10.5	64.6	13.9	100
3	Community-Based Health Insurance Schemes are an informal sectors for pooling of funds	frequency	100	91	26	115	39	381
		Percent	26.2	23.9	6.8	30.2	10.2	100
4	Only those who fall sick should consider enrollment in Community-Based Health Insurance Schemes.	frequency	95	195	33	58		381
		Percent	24.9	52.2	8.7	15.2		100
5	Only the very poor who cannot afford to pay for health care need to join the schemes.	frequency	67	203	60	42	9	381
		Percent	17.6	53.3	15.7	11	2.4	100
6	Community-Based Health Insurance Schemes are is savings schemes; you will receive interest and get your money back	frequency	60	129	63	118	11	381
		Percent	15.7	33.9	16.5	31	2.9	100

7	Under the Community-Based Health Insurance Schemes, you pay money (premiums) in order for the CBHIS to finance your future health care needs, if need arise	frequency	6	46	119	152	58	381
		Percent	1.6	12.1	31.2	39.9	15.2	100
8	Community-Based Health Insurance Schemes have good potential for financial protection against the cost of illness	frequency	21	116	196	43	5	381
		Percent	5.5	30.4	51.4	11.3	1.3	100
9	Under Community-Based Health Insurance Schemes, level of access by households to affordable health care is high	frequency	6	28	122	182	43	381
		Percent	1.6	7.3	32	47.8	11.3	100
10	Community-Based Health Insurance Schemes can improve households' health consumption patterns by ensuring that health care costs are reduced	frequency	9	47	99	197	29	381
		Percent	2.4	12.3	26	51.7	7.6	100
11	Community-Based Health Insurance Schemes can improve the quality of services provided by health care givers	frequency	15	35	65	215	42	381
		Percent	3.9	9.2	17.1	56.4	11	100
12	Community-Based Health Insurance Schemes can ensure constant availability of drugs at health facilities in your community	frequency	79	107	51	130	14	381
		Percent	20.7	28.1	13.4	34.1	3.7	100

Table 5.2; Illustrates the frequency and percentage scores of respondents to each of the items assessing respondents' knowledge towards community based health insurance schemes in the study area.

A close examination of respondents' agreement/disagreement to each of the items revealed that the majority of the respondents (eighty six percent) strongly agreed/ agreed that they have ample information about Community-Based Health Insurance Schemes in their living area. Similarly, the majority (seventy eight percent) of the respondents strongly agreed/ agreed that the prime principle of Community-Based Health Insurance Schemes is community's investment on community healthcare service. About 51 percent of the respondents strongly disagreed/disagreed that community-Based Health Insurance Schemes are an informal

sectors for pooling of funds. Seventy six percent of respondents of the study strongly disagreed/disagreed that only those who fall sick should
Consider enrollment in Community-Based Health Insurance Schemes. Seventy one percent of the respondents strongly disagreed/ that only poor shoul join CBHIs. Fifty five percent of the respondents strongly agreed/ agreed that under the Community-Based Health Insurance Schemes, people pay money (premiums) in order for the CBHIS to finance their future health care needs, if need arise.
Sixty two percent of the sample respondents strongly agreed/agreed
that community-Based Health Insurance Schemes have good potential for financial protection against the cost of illness. Fifty nine percent of the respondents strongly agreed/agreed that under Community-Based Health Insurance Schemes, level of access by households to affordable healthcare is high. Similarly fifty nine percent of the respondents strongly agreed/agreed that Community-Based Health Insurance Schemes can improve households' health consumption patterns by ensuring that healthcare costs are reduced. Sixty seven percent of the respondents strongly agreed/agreed that Community-Based Health Insurance Schemes can improve the quality of services provided by healthcare givers. Finally; unlike the above fourty eight percent of the respondents strongly disagreed/disagreed that Community-Based Health Insurance Schemes can ensure constant availability of drugs at health facilities in your community.
Generally evaluated, the majority of the respondents strongly agreed/agreed on each of the statements provided. This led respondents to an implication that the majority of respondents of the study have good level of understanding
towards the CBHI program.

5.3 Community's Attitude towards Community Based Health Insurance Schemes

This study assessed the attitude of the community towards community based health insurance schemes in the study area. To this end, data were collected using a survey a five point Likert scale survey instrument. The instrument helps to ask and rate respondents' agreement on each of the items measuring their attitude ranging from 1=strongly disagree to 5=strongly agree. The following table provides frequency, mean and standard deviation scores of respondents as follows.

No	Variables		1	2	3	4	5	Total
1	Community-Based Health Insurance Schemes are acceptable to you as a strategy for paying for health care services.	frequency	6	9	32	275	59	381
		Percent	1.6	2.4	8.4	72.2	15.5	100
2	I am enrolled in the CBHI scheme because it provide access for my household members to affordable health care	frequency	9	58	28	238	34	381
		Percent	2.4	15.2	7.3	62.5	8.9	100

3	Community-Based Health Insurance Schemes can cover health expenditure/financial protection against the cost of illness	frequency		40	38	232	71	381
		Percent		10.5	10	60.9	18.6	100
4	I am enrolled in Community-Based Health Insurance Schemes because government financed registration fee and premiums	frequency	26	170	93	83	9	381
		Percent	6.8	44.6	24.4	21.8	2.4	100
5	I am enrolled in Community-Based Health Insurance Schemes because the premium is less than OOP(Out of Pocket) payment	frequency	6	141	54	132	48	381
		Percent	1.6	37	14.2	34.6	12.6	100
6	I am enrolled in Community-Based Health Insurance Schemes because the benefit packages/ services offered by the scheme are broad/adequate	frequency	24	64	98	166	29	381
		Percent	6.3	16.8	25.7	43.6	7.6	100
7	I am pressured from the community members to be enrolled in CBHI	frequency	59	150	31	116	25	381
		Percent	15.5	39.4	8.1	30.4	6.6	100
8	I am pressured from the kebele administration to be enrolled in CBHI	frequency	70	170	79	44	18	381
		Percent	18.4	44.6	20.7	11.5	4.7	100
9	I do not have confidence on the CBHI management	frequency	61	201	54	46	19	381
		Percent	16	52.8	14.2	12.1	5	100
10	The benefit packages/ services provided by Community- Based Health Insurance scheme is adequate	frequency	24	67	87	182	21	381
		Percent	6.3	17.6	22.8	47.8	5.5	100
11	Community-Based Health Insurance Schemes provide quality health services	frequency	6	62	59	222	32	381
		Percent	1.6	16.	15.	58.3	8.4	100

				3	5			
12	Community-Based Health Insurance registration and premiums are unaffordable	frequency	99	106	54	106	16	381
		Percent	26	27.8	12	27.8	4.2	100

Table 5.4; shows the frequency and percentage scores of respondents in attitude towards community based health insurance schemes.

According to this study, respondents strongly agreed/agreed to the majority of the items. Detail examination of results indicates that the majority of (eighty seven percent) the respondents strongly agreed/ agreed that Community-Based Health Insurance Schemes are acceptable strategy for paying for health care services. Seventy one percent of the respondents strongly agreed/agreed that CBHI scheme provide access for affordable healthcare. Similarly, the majority of the respondents (seventy nine percent) strongly agreed/ agreed that Community-Based Health Insurance Schemes can cover health expenditure/ financial protection against the cost of illness.

But, fifty one percent of the respondents strongly disagreed/disagreed that government finances registration fee and premiums for Community-Based Health Insurance Schemes. Forty seven percent of the respondents strongly agreed/agreed that the premium of CBHIS is less than out of pocket payments.

Fifty one percent of the respondents strongly agreed/agreed that the benefit packages/ services offered by the CBHIS are broad/adequate. Fifty five percent of the respondents strongly disagreed/disagreed that that they were pressured from the community members to be enrolled in CBHIS.

Sixty three percent of the respondents strongly disagreed/disagreed that they are pressured from the kebele administration to be enrolled in CBHIS. Fifty three percent of the respondents strongly agreed/agreed that benefit packages/ services provided by Community- Based Health Insurance scheme is adequate.

Sixty two percent of the respondents strongly agreed/agreed that Community-Based Health Insurance Schemes provide quality health services. Fifty four percent of the respondents strongly disagreed/disagreed that Community Based Health Insurance registration and premiums are unaffordable

5.4 Community Based Health Insurance Practice

5.4.1 When You Started enrolling in CBHI?

When You Started Practicing in CBHI

	Frequency	Percent	Valid Percent	Cumulative Percent
1year	161	42.3	42.3	42.3
2-4 year	169	44.4	44.4	44.4
before 5 yrs ago	51	13.4	13.4	13.4
Total	381	100.0	100.0	100.0

Source: Own computation (2022)

The above table demonstrated that 44.4% of the respondents were enrolled in CBHI before 2-3 years since CBHI started in the woreda in 2014. The rest of the respondents (i.e. 42.3%) got enrolled before one years after the CBHI starting time of the Wereda. According to the information from health offices in Wolkite town CBHI has the age of fourr years. This indicated that the program is still in an infant stage. Even though the above survey data shows some achievements of the Wereda in the CBHI research attention has to be given in order to explore the success of the program and sustainability issues.

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

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

	Frequency	Percent	Valid Percent	Cumulative Percent
OOP	351	92.1	92.1	92.1
Borrowing	5	1.3	1.3	93.4
traditional way treatment	17	4.5	4.5	97.9
via Ikub and Edir	8	2.1	2.1	100.0
Total	381	100.0	100.0	

Source: Own computation (2022)

Regarding the health cost coverage of households before enrolled in CBHI, 92.1% of the respondents used the Out Of Pocket (OOP) payment modality to cover their health expenses whereas 1.3% of the respondents reported that they cover their medical costs by borrowing from others. Furthermore, 4.5%, and 2.1% of them cover their health expenses through the use of traditional medicine and support from iqub/ Idir respectively. This illustrated that the majority of the respondents (i.e. 92.1%) used Out Of Pocket in order to cover the costs of their health coverage. As a result, one can imply people from Wolkite town have saved money by enrolling in CBHI which requires members paying only once in a year to cover for the health care needs of all members of the family.

5.4.3 Do You Think Your Health Status is improved After Enrolling in CBHI?

To calculate the points for each critical factor, two considerations were taken in to account: the score for each significant element of the factor and the weight for each significant element. A score of “5” (strongly agree) would yield a full mark of 5 towards that element; a score of “4” (agree) would yield the mark of 4 towards that element; a score of “3” (neutral) would yield 3 mark; a score of “2” (disagree) marks 2 and 1(strongly disagree) yields 1 mark. The respondents answer to the question; whether their health status is improved after enrolling in CBHI or not is illustrated in the following table.

	Frequency	Percent	Valid Percent	Cumulative Percent
stongly agree	20	5.2	5.2	5.2
agree	321	84.3	84.3	89.5
neutral	16	4.2	4.2	93.7
disagree	24	6.3	6.3	100.0
Total	381	100.0	100.0	

Source; Own computation (2022)

Regarding the health status of the households after enrolling in CBHI, as the data in the above table shows, only 4.2% of them are neutral. Of the total respondents, 5.2% of them strongly agreedthat their family's health status is improving after enrolling in CBHI. The majority (84.3%) of the total respondents reported that their health status is improved after enrolling. This can show that 88.6% of them have benefited from CBHI with the improvement of health status of their family.

This can also imply that CBHI is the program not only reducing health expenses of the household but also improves the health status of the households.

5.4.4 Types of Membership

	Frequency	Percent	Valid Percent	Cumulative Percent
indegent member	64	16.8	16.8	16.8
non indigent member	300	83.2	83.2	100
Total	381	100.0	100.0	

Source: Own Computation (2022)

From the total respondents as indicated in table , 16.8% of them are very poor households /indigent types of beneficiaries getting health service without being charged any payment. The majority of the respondents (i.e. 83.2%) are economically better /non-indigent households who are getting health services by paying the premium once in a year. This shows that the program is giving the health service to the indigent members freely without paying any costs.As indicated in the above table, the number of non-indigent beneficiaries

exceeds many times than indigent to make the program financially strong and insures the sustainability of the program where the standard is 90% to be no indigent and 10% to be indigent.

5.4.5 Do You Renew Your and your family Membership ID Timely?

	Frequency	Percent	Valid Percent	Cumulative Percent
yes	366	96.1	96.1	96.1

	no	15	3.9	3.9	100.0
	Total	381	100.0	100.0	

SOURCE; Source: Own Computation (2022)

The above data table shows that from the total respondents only 15(3.9%) of them did not renew their membership ID of CBHI on time while 366(96.1%) of them have renewed their membership ID of CBHI on time. This indicated that the majority (more than 95%) of the respondents have good trends on renewing their membership ID on a timely basis.

5.4.6 I Decide to Resign My Membership from CBHI

	Frequency	Percent	Valid Percent	Cumulative Percent
agree	15	3.9	3.9	3.9
neutral	10	2.6	2.6	6.6
disagree	348	91.3	91.3	97.9
strongly disagree	8	2.1	2.1	100.0
Total	381	100.0	100.0	

Source; Source: Own Computation (2022)

Pertaining to the decision on resignation/ existing from CBHI, as data in the above table indicated, 3.9% of the respondents were neutral regarding the decision to resignation from CBHI; whereas 93.4% of them showed to stay within the membership.

5.4.7 I haven't got any advantage enrolling in community based health insurance

	Frequency	Percent	Valid Percent	Cumulative Percent
agree	38	10.0	10.0	10.0
neutral	23	6.0	6.0	16.0
disagree	301	79.0	79.0	95.0
strongly disagree	19	5.0	5.0	100.0
Total	381	100.0	100.0	

Source: Own Computation (2022)

Based on the above table among the total household respondents only 10% of them were not get the benefits of Community Based Health Insurance. On the other hand 6% of the respondents were neutral whether they are benefited or not. Whereas 84% of the majority of the respondents were benefited from the service given by the scheme. This means the majority of the respondents

highly benefited with reducing Out Of Pocket health expenditures and covers their health expenses
with minimum premium payment to all family members, reduce health risks, improve the health status of their family and increase labor productivity of the family by investing more time to
produce asset rather staying in the house with illness.

5.4.8 What is reason not being beneficiary

		Frequency	Percent	Valid Percent	Cumulative Percent
	poor quality of their services	9	2.4	23.7	23.7
	absence of medicine	21	5.5	55.3	78.9
	lack of medical equipments	8	2.1	21.1	100.0
	Total	38	10.0	100.0	
Missing	System	343	90.0		
Total		381	100.0		

SOURCE; Own computation (2022)

As the above table some number of households not benefiting from the scheme. This is because of lack of medicine (5.5%) and poor service delivery 2.4% by health facilities, boring of beneficiaries in waiting long time to get service from the scheme.

5.4.9 Benefits of the CBHI to the respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
reduce OOP	169	44.4	44.4	44.4
increase productivity	98	25.7	25.7	70.1
improve health	92	24.1	24.1	94.2
reduce risk	22	5.8	5.8	100.0
Total	381	100.0	100.0	

Source; Own computation (2022)

The above Table explains that, about169 (44.4%) of the respondents reported that they have benefited from the program by reducing Out Of Pocket (OOP) medical expenses. On the other hand, 25.7% and 24.1%, 5.8% of the respondents have got different benefits like increasing productivity, reduced health risks,
Insuring/securing all the family members etc.
Members of the program highly benefited through reducing Out Of Pocket (OOP) medical expenses, improve health status of the family by checking their health condition thoroughly, reducing health risks in securing with insurance and increasing the

productivity of people by increasing working time and reducing waiting at home by illness. Beneficiaries have chance to get
services from health post to referral and specialized hospitals through keeping the process of referral linkage.

5.4.10 Challenges facing as member CBHI

	Frequency	Percent	Valid Percent	Cumulative Percent
absence of availability of medicine	287	75.3	75.3	75.3
absence of laboratory equipments	57	15.0	15.0	90.3
lack of ambulance service	37	9.7	9.7	100.0
Total	381	100.0	100.0	

Source; Own computation (2022)

5.4.11 Are you very happy current premium level?

	Frequency	Percent	Valid Percent	Cumulative Percent
strongly agree	54	14.2	14.2	14.
Agree	178	46.7	46.7	60.
Neutral	76	19.9	19.9	80.
Disagree	67	17.6	17.6	98.
strongly disagree	6	1.6	1.6	100.
Total	381	100.0	100.0	

Source: Own Computation (2022)

According to the survey data in the above table, from the total respondents 19.9% of them were neutral in deciding whether it is affordable or not. The majority (60.9%) of the respondents have indicated that the current premium is affordable for the service they got from the contracted
Health facilities.

5.4.12 What is nearest conventional health institution to your home?

	Frequency	Percent	Valid Percent	Cumulative Percent

	health center	275	72.2	72.2	72.2
	health post	50	13.1	13.1	85.3
	hospital (gov't)	56	14.7	14.7	100.0
	Total	381	100.0	100.0	

Source: Own Computation (2022)

According to Table , 72.2% of the respondents are nearest to the Edget ber health center and 13.1% of the respondents have covenant to the health post.

CHAPTER SIX

6. DISCUSION

The ultimate objective of this study was to assess the community's knowledge, attitude and practice towards CBHI in Study area. To achieve this objective data were collected from 381 respondents (male 63.8% and female 36.%) and the was analyzed to get results. The result was compared with preliminary reports and other previous researches which had been done in the study area, around the study area and at the national level. Unfortunately there is no research that had been done on same topic in the study area; so this thesis compared the last results with results that had been done around the study area and at the national level.

As this research showed majority (87%) of respondents had knowledge on CBHI in area. But it is lower than when we compare this result with research conducted in pilot woreda yirglam; in SNNPR 2015 which was 100% respondents had knowledge on CBHI. [23]

Similarly majority (65%) of respondents in study area had positive attitude towards CBHI. However the result is much lower than the national expected level (95%) positive attitude towards CBHI. This result is lower than the research conducted in pilot woreda Gimbichu, Oromo which is 83% of respondents had positive attitude towards CBHI.

Finally the practice of CBHI is low when it is compared with pilot woreda like, yirgalem which had universally enrollment; this is because majority (51%) of respondent covers their medical expenses with OOP and by option like Ekub and Idir in study area. So, only 49% of respondents enrolled in to CBHI in study area. But, this result is greater SNNPR regional enrollment (practice) level (40.2%). [23]

CHAPTER SEVEN

7. CONCLUSION AND RECOMMENDATION

7.1 CONCLUSION

Ethiopia launched CBHI schemes in 13 pilot woredas in three regions SNNPR, Oromia and Tigray since 2011. The report showed that the knowledge, attitude and practice towards CBHI in pilot woredas were good and increasing with progressively with time.
Similarly, the majority of study participants had knowledge on CBHI and positive attitude towards CBHI in wolkite town . The practice CBHI study area was good relative with SNNPR regional CBHI practice level and national CBHI practice level.
In generally there was awareness about CBHI community and there was also positive attitude towards the benefits of CBHI in study. The practice CBHI in community is increasing progressively with time.

7.2 RECOMMENDATION

Based on the result our research we would like to recommend the following issues to Wolkite town community, Wolkite town stake holders, any responsible NGOs and Wolkite Universtiy.

- ✓ To wolkite town community to discuss about the benefits of CBHI with concerning bodies and with town stake holders.
- ✓ To Wolkite town administration to create opportunity to discuss community on benefits of CBHI and to create awareness in order to achieve universally knowledge, positive attitude and practice in town.
- ✓ To Wolkite University to create opportunity to senior researchers to carry out research on CBHI, because there was no adequate research on CBHI in study area to evaluate the progress of CBHI with time.

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7. APPENDICIES

Appendix A: Consent Form

My Name is----------. I am working as a data collector for the study being conducted in this community for my bachelor degree at Wolkite University, the college of Medicine and health science,the department of Public health. I kindly request you to give me your attention to explain you about the study and being selected as a study participant.

Appendix B: English version Questionnaire

This questionnaire is prepared for collecting information on assessment of knowledge, attitude and practice towards Community based health insurance Wolkite town,Gurage Zone, SNNPR, Ethiopia, 2022 G.C.

Kebele: _____

House code_____

Name of Data Collector: ___

Name of Supervisor: _____

Signature_____ Date: _____

Part one: Social-demographic characteristics of the respondents

1.1 sex 1.M 2.F

1.2 Age 1) 18-30 2) 31-50 3) 51-65 4) >65

1.3 What is the relation of the respondents to the house hold?

A. Father B. Mother C. Child
D. other (Parent sibling, child in law) ----------

1.4 occupation

A) housewife

B) Government employee

C) Private employed

D) Merchant

E) Daily labor

F) Other(specify)

1.5 Religion

A) Muslim

B) Orthodox

C) Protestant

D) Catholic E) other specify

1.6 Ethnicity

A) Gurage

B) Hadiya

C) Kambata

D) Oromo

E) Amhara

F. Other specify_____

1.7 Marital statuses

a) Single b) Married c) Divorced) d.Widowed

1.8 Educational status A) uneducated C) Elementary (1-8)

B) Can write and read D) Secondary(9-10) E) Preparatory (11-12) F) College (10+3) G) BSC/BA h) Other specify

1.9 monthly incomes in birr

A) < 1000 C) 2001-3000

B) 1001-2000 D) 3001-4000 E) >4000

1.10 family size_____

Part two: Items related with Community's knowledge and perceived importance of CBHI

The rating scale is as

follows:

1= Strongly disagree

2 = Disagree.

3 =Undecided

4= Agree

5= Strongly agree

No	Statements	1	2	3	4	5
1	There is ample information about Community-Based Health Insurance Schemes in my living are					
2	The prime principle of Community-Based Health Insurance Schemes is community's investment on community health care service					
3	Community-Based Health Insurance Schemes are an informal sectors for pooling of funds					
4	Only those who fall sick should consider enrollment in Community-Based Health Insurance Schemes.					
5	Only the very poor who cannot afford to pay for health care need to join the schemes					
6	Community-Based Health Insurance Schemes are is savings schemes; you will receive interest and get your money back					
7	Under the Community-Based Health Insurance Schemes, you pay money (premiums) in order for the CBHIS to finance your future health care needs, if need arise					
8	Community-Based Health Insurance Schemes have good potential for financial protection against the cost of illness					
9	Under Community-Based Health Insurance Schemes, level of access by households to affordable health care is high					
10	Community-Based Health Insurance Schemes can improve households' health consumption patterns by ensuring that health care costs are reduced					

11	Community-Based Health Insurance Schemes can improve the quality of services provided by health care givers					
12	Community-Based Health Insurance Schemes can ensure constant availability of drugs at health facilities in your community					

Part three: Items related with community's attitude towards CBHI

The rating scale is as follows:

1= Strongly disagree

2 = Disagree.

3 =Undecided

4 = Agree

5 = Strongly agree

No	Statements	1	2	3	4	5
1	Community-Based Health Insurance Schemes are acceptable to you as a strategy for paying for health care services.					
2	I am enrolled in the CBHI scheme because it provide access for my household members to affordable health care					
3	Community-Based Health Insurance Schemes can cover health expenditure/financial protection against the cost of illness					
4	I am enrolled in Community-Based Health Insurance Schemes because government financed registration fee and premiums					
5	I am enrolled in Community-Based Health Insurance Schemes because the premium is less than OOP(Out of Pocket) payment					
6	I am enrolled in Community-Based Health Insurance Schemes because the benefit packages/ services offered by the scheme are broad/adequate					
7	I am pressured from the community members to be enrolled in CBHI					
8	I am pressured from the kebele administration to be enrolled in CBHI					
9	I do not have confidence on the CBHI management					
10	The benefit packages/ services provided by Community- Based Health Insurance scheme is adequate					

11	Community-Based Health Insurance Schemes provide quality health services					
12	Community-Based Health Insurance registration and premiums are unaffordable					

Part Four: Items related to community's Practice towards CBHI

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

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

B. Before5yearsago-------

2. Before you joined the community based health insurance how did you cover your medical expense?

A. OOP C. We were using traditional way of treatment

B. Borrowing D. Via Ikub & Idir----------

E. Government/free----------

3. Our health statusis improved after we enrolled of the scheme.

A. Strongly Agree C. Neutral

B. Agree D. Disagree

E. Strongly disagree

4. Which type of member you are?

A. Indigent Member

B. Non-indigent Member

5. Do you renew your & family's membership ID timely?

A. Yes B. No

6. I decided to resign my membership from CBHI

A. Strongly agree C. Natural

B. Agree D. Disagree

E. Strongly disagree

7. I haven't got any advantage enrolling in community based health insurance?

A. Strongly Agree C. Neutral

B. Agree D. Disagree

E. Strongly disagree

8. If your response for the above question number „"7" is strongly agree/ Agree what is your reason?

A. Poor Quality of their service

B. Absence of Medicine

C. Lack of medical equipment (Lab digenesis)

D. Cost of premium is not affordable

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

A. Reduce OOP C. Improve health

B. Increase productivity D. Reduce risks

10. Which challenges you are currently identifying as beneficiary?

A. Absence of availability of medicine

B. Absence of laboratory equipment(agents)

C. Lack of ambulance service

D. Poor service delivery

11. Are you very happy with current premium level?

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

E. Strongly Agree

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

A. Health center C. Health Post

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

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

አባሪ ሀ: የተሳታፊዎች መረጃ መስጫ እና የስምምነት መግለጫ ቅጽ

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አባሪ ለ፡ ማጠቃለያ

ይህ ማጠቃለያ የተዘጋጀውብህብረተሰብጤ ትምህርት መቀከ ለአንደኛ ድግሪ ማሟያ ለሜረግ ጥናት/ምርምር መጀለመቀበሰብነው፡ የጥናቱ አላማየ ወልቂጤከተማመህበረሰብስለ ማህበረሰብአቀፍየጤ መድህን ፕሮግራምያለመን ግ ን ዘ ቤ ፣ አ መ ለ ካ ከ ት እ ና ል ም ድ ማ ጥ ና ት ነ ው፡ ፡ ስ ለ ዚ ህ የ እ ር ሶ ዎ ግ ል ጽ ና ታ ማ ኛ መ ል ሶ ች ይ ህ ን ጥ ና ት ከ ፍ ጻ ሜ ለ ማ ደ ረ ስ ከ ፍ ተ ኛ ሚ ና የ ሚ ጫ ወ ቱ መ ሆ ኑ ን ተ ገ ን ዝ በ ው ለ እ ያ ን ዳ ን ዱ ጥ ያ ቄ መ ል ስ እ ን ዲ ሰ ጡ እ የ ጠ የ ቅ ን ለ ሚ ያ ደ ር ጉ ል ን ቀ ና ት ብ ብ ር ም ስ ጋ ና ች ን ን በ ቅ ድ ሚ ያ እ ና ቀ ር ባ ለ ን ፡ ፡

ቀ በ ላ ---------- የ ቤ ት ቁ ጥ ር ----------
-
የ ተ ቆ ጣ ጣ ሪ ስ ም ---------- ፊ ር ማ ---------- ቀ ን ----------

ክፍሌ አንዴ፡ መጠየቅ የሚድረግሆት ማህበራዊና ስነ-ህዝባዊ ጥያቄዋች

1. ዖ ታ ፡ ወ ን ድ -------- ሴ ት --------
2. ዕ ድ ሜ ፡ ከ 18-48 --------- ከ 49 – 69 ---------- ከ 70 በ ላ ይ ----------

3. በ ቤ ተ ሰ ቡ ዉ ስ ት ያ ለ ዉ ዝ ም ድ ና ም ን ድ ን ነ ዉ? አ ባ ት ---------- እ ና ት ---------- ል ጅ ---------- ሌ ላ ----------

4.የ ስ ራ ሁ ኔ ታ የ ቤ ት እ መ ቤ ት --------- የ መ ን ግ ስ ት -------የ ግ ል ስ ራ ---------- ን ግ ድ ---------- የ ጉ ል በ ት ስ ራ ---------- ሌ ላ ----------

5. ሀ ይ ማ ኖ ት ሙ ሲ ሊ ም ኦ ር ቶ ዶ ክ ስ ፕ ሮ ቴ ስ ታ ን ት ካ ቶ ሊ ክ ሌ ላ

6. ብ ሔ ር ? ጉ ራ ጌ ሀ ዲ ያ ካ ም ባ ታ አ ሮ ሞ አ ማ ራ ሌ ላ

7. የ ጋ ብ ቻ ሁ ኔ ታ ያ ገ ባ /ች / ---------- ያ ላ ገ ባ /ች / ---------- የ ፈ ታ /ች ---------- ባ ሏ የ ሞ ተ ባ ት ----
8. የ ት ም ህ ር ት ሁ ኔ ታ ያ ል ተ ማ ረ ---------- ማ ን በ ብ ና መ ፃ ፍ ---------- 1ኛ ደ ረ ጃ --------- ሁ ለ ተ ኛ ደ ረ ጃ ---------- ዲ ፕ ሎ ማ / ዲ ግ ሪ ----------

9. ገ ቢ እ ና ወ ጪ የ ወ ር ገ ቢ ---------- የ ወ ር ወ ጪ----------

10. የ ቤ ተ ሰ ብ ብ ዛ ት ወ ን ድ -------- ሴ ት ---------- አ ጠ ቃ ላ ይ ------

ክፍል ሁለት፡ ማህበረሰቡ ስለ ጤና መድህንን ፕሮግራም ምንነት እና ጠቀሜታ በተመለከተ የሚዳስሱ ጥያቄዎች

ቁ ጥ ሮ ቹ የ ሚወ ክ ሉ ት ሃ ሳ ብ እ ን ደ ሚከ ተ ለ ው ነ ው፡

1=በ ጣ ም አ ል ስ ማ ማ ም

2=አ ል ስ ማ ማ ም

3=መ ወ ሰ ን አ ል ች ል ም

4=እ ስ ማ ማ ለ ሁ

5=በ ጣ ም እ ስ ማ ማ ለ ሁ

ተ.ቁ	ዓረፍተ-ነገሮች	1	2	3	4	5
1	እርስዎ በሚኖሩበት አካባቢ የማህበረሰብአቀፍ የጤና መድህን ፕሮግራምን በተመለከተ በቂ መረጃ ማግኘት ችላሉ					
2	የማህበረሰብአቀፍ የጤና መድህን ፕሮግራምተቀዳሚመሆህ በማህበራዊ የጤና ክብካቤዘርፍ ላይመዋለ ነዋይ ማፍሰስ ነ ወ					
3	ማህበረሰብአቀፍ የጤና መድህን ፕሮግራምማሻት ኢ-መደበኛ በሆነ መንገድ ከማህበረሰቡፈንዶችንመቀበሰብነ ው					
4	በማህበረሰብአቀፍ የጤና መድህን ፕሮግራምመሻተፍ የሚባቸወየጤና ችግር ያለባቸወየማህበረሰበክፍሎች ብቻናቸው					
5	ለህክምና ገንዘብመቅፈል የሚቸሉየማህበረሰቡክፍሎች በማህበረሰብአቀፍ የጤና መድህንፕሮግራምመሻተፍ ይገባቸዋል					
6	የማህበረሰብአቀፍ የጤና መድህን ፕሮግራምማሻት ልክ እንደ ቁጠበ እና ብድር ተቋማት አባላትብከፊሉት ገንዘብልክ ወላድእንዲያገኙይደረጋል					
7	እርስዎ ለማህበረሰብአቀፍ የጤና መድህን ፕሮግራምየሚዋጡት ገንዘብየወደፊት ጤና ክብካቤወጪዎችን ለመሸፈን ያግዛል የሚል እምነት ነ ወ					
8	የማህበረሰብአቀፍ የጤና መድህን ፕሮግራምየ ጤና ክብካቤ ወጪዎችን የመሸፈን አቅምአለው					

9	የማህበረሰብአቀፍ የጤና መድህን ፕሮግራምየ ታቀፉ ሰዎች ተማጥኝ በሆነ ገንዘብ የጤና ዉጪዎችን መሸፈን ይችላሉ					
10	በማህበረሰብአቀፍ የጤና መድህን ፕሮግራምየ ታቀፉ ሰዎች የጤና አግልግለት አጠቃቀማቸዉን በማሻሻል ተማጥኝ በሆነ ገንዘብየ ጤና ዉጪዎችን መሸፈን ይችላሉ					
11	የማህበረሰብአቀፍ የጤና መድህን ፕሮግራምየ ጤና አግልግለት ሰጪዎቹ የሚጠቅን አገልግለት ጥራት እንዲጠበቁ ያስችላቸዋል					
12	የማህበረሰብአቀፍ የጤና መድህን ፕሮግራምበጤና አግልግለት ሰጪዎቹ አስተማማኝ የሆነ የመድሃኒት አቅርቦት እንዲኖራቸ ያስችላል					

ክፍል ሶስት፡ ስለ ማህበረሰብ አቀፍ የጤና መድህን ፕሮግራምን በተማለከተ የማህበረሰቡን አመለካከት የሚለኩ ጥያቄዎች

ቁጥሮቹ የሚከለት ሃሳብእንደማይተለወጎ ው

1=በጣምአልስማማም

2=አልስማማም

3=መወሰን አልችልም

4=እስማማለሁ

5=በጣምእስማ

ተ.ቁ	ዓረፍተ-ነገሮች	1	2	3	4	5
1	ለርስዎ እምነት መሰረት የማህበረሰብአቀፍ የጤና መድህን ፕሮግራምለጤና ክብካቤ አስፈላጊ የሆነ ወጭ ዉጪለመሸፈን ተቀባይነት ያለዉስልት ነው					
2	እርስዎ በማህበረሰብአቀፍ የጤና መድህን ፕሮግራምየ ታቀፉበት ምክንያት ለቤተሰብዎ አባላት የጤና አግልግለት ተማጥኝ በሆነ ገንዘብየ ጤና ዉጪዎችን ለመሸፈን ስለሚያስችል ስለሆነ ነው					
3	የማህበረሰብአቀፍ የጤና መድህን ፕሮግራምየ ጤና አግልግለት ዉጪዎችን ለመሸፈን ያስችላል					
4	እርስዎ በማህበረሰብአቀፍ የጤና መድህን ፕሮግራምየ ታቀፉነት ምክንያት መንግስት የአባልነት ምዝገባመዋጮ እና አመታዊ ክፍያን ስለማሻፍን ነው					
5	እርስዎ በማህበረሰብአቀፍ የጤና መድህን ፕሮግራምየ ታቀፉበት ምክንያት የማህበረሰብአቀፍ የጤና መድህን ፕሮግራምከግለሰቦች ከስ ከሚጣመየ ጤና ዉጪ አንፃር በጣምስለማሰንስ ነው					

6	እርስዎ በማህበረሰብአቀፍ የጤፍ ሞደህን ፕሮግራምየ ታቀፉብት ምክንያት ፕሮግራሙ የሚቀርባቸዉየ ጤፍ አገልግለቶች ሰፉ እና በቂ በመሆናቸዉነ ው					
7	እርስዎ በማህበረሰብአቀፍ የጤፍ ሞደህን ፕሮግራምየ ታቀፉብት ምክንያት በፕሮግራሙ እንዲሰተፉ በለለ አካል ግፊት ስለተደረገ ብዎ ነ ው					
8	እርስዎ በማህበረሰብአቀፍ የጤፍ ሞደህን ፕሮግራምየ ታቀፉብት ምክንያት በፕሮግራሙ እንዲሰተፉ የሚሩብት ቀበሌአመሪሮች ግፊት ስለተደረገ ብዎ ነ ው					
9	እርስዎ በማህበረሰብአቀፍ የጤፍ ሞደህን ፕሮግራምአሰራር ላይ እምነ ት የለዎትም					
10	በማህበረሰብአቀፍ የጤፍ ሞደህን ፕሮግራምየ ሚቀርባቸዉየ ጤፍ አገልግለቶች ሰፉ እና በቂ ናቸው					
11	በማህበረሰብአቀፍ የጤፍ ሞደህን ፕሮግራምጥራት ያላቸዉየ ጤፍ አገልግለቶች ያቀርባል					
12	በማህበረሰብአቀፍ የጤፍ ሞደህን ፕሮግራምለመላተፍ ግለሰቦች መብፊል ያለባቸው የመጣዉ ቢያ እና አመቻዊ ክፍያ አቅምነ ያላገ ናዘቡናቸው					

ክፍል አራት የማህበረሰብ አቀፍ የጤና ምድን ልምድ የተመለከቱ ጥያቄዎች

1. በማህበረሰብአቀፍ የጤፍ ሞደህን አገልግለት የ ታቀፍከዉ/ሽወመቾ ነ ዉ?

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

ሐ ከ 5 አመት በፊት ---------

2. በማህበረሰብአቀፍ የጤፍ ሞደህን አባል ከመሆንህ በፊት የ ህክምና ውጩን/ሽን እንደታ ነ በር የ ምዛሽፍነ ዉ/ኝዉ?

ሀ. ካለዉ ቢውጩበሞጂረግ ----------ለ. በመፃደር -------- ሐ ባህላዊ ህክምና በመጠቀም--------

መ በእቁበ/ እድር ---------- ሠ. በመግስት/ በነ ፃ ----------

3. በማህበረሰብአቀፍ የጤፍ ሞደህን ከታቀፉ በኃላ የ ጤናዎ ሁኔታተሻሽሏል ብለዉያስባለ?

ሀ. በጣተሻሽሏል---------- ለ. ተሻሽሏል ---------- ሐ መቀከለኛ----------

መ ለወጥ የለም---------- ሠ. ፍፀምለወጥ የለም----------

4. የ ትኛዉአይነ ት የ ጤፍ ሞደን አባል ነ ዎት?

ሀ. ምስኪን ---------- ለ. የ ክፍያ ----------

5. የ እርስዎንና የ ቤተሰብዎን የ ሚጠቅመአባለነ ት በጊዘመአደሰዋል?

ሀ. አወ---------- ለ. የለም----------

6. ከሚጠቅባፍላጎ ትዎ ከአባለነ ት ለመዉጣ መዉጠን ይችላለን?

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

ሠ. ፍፀምአልፈልግም----------

7. ከማህበረሰብአቀፍ የጤፍ ሞደህን ምንምጥቅምአላገ ኘሁም ብለዉያስባለ?

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

ሠ. ብዙ ጥቅም አግኝቻለሁ----------

8. ለጥያቄ ለተራ ቁጥር 7 የሰጡት ምላሽ እጅግ በጣም/በጣምከሆነ ምክንያቱ ምንድን ነ ው?

ሀ. ደካማየ አገልግሎት አሰጣጥ ---------- ለ. በቂ የ መድሃኒት አቅርቦት አለመኖር ----------

ሐ በቂ የ ህክምና ቁሳቁስ አለመኖር/ የላብራቶሪ ምርመራ--------- መ ተመጣጣኝ የ ሆነ ክፍያ አለመሆን-

ሠ ለለ ካለ ይገለፅ ----------

9. በማእከሙከታቀፉ በኋላ ምን ጥቅም አግኝቻለሁ ብለወያስባለ?

ሀ. የ ህክምና ውጤመቀነ ስ---------- ለ. የ ጠፍ ሀኔታመሻሻል----------

ሐ አያሻች ዜጋ መሆን----------መ የ ጠፍ ስጋትን መቀነ ስ----------

10. እንደ ማእከሙአገልግሎት ተጠቃሚ ትዎ በአሀኑ ጊዜ ምንምን ችግሮች አሉ ብለወሊያተዋል?

ሀ. በቂ የ መድሃኒት አቅርቦት አለመኖር ---------- ለ. በቂ የ ህክምና ቁሳቁስ አለመኖር/ የላብራቶሪ ምርመራ-------- ሐ የ አምቡላንስ አገልግሎት አለመኖር ----------

መደካማየ አገልግሎት አሰጣጥ----------

11. አሀን ባለወያ ክፍያ ሀኔታደስተኛ ነ ኝ ብለወያስባለ?

ሀ. እጅግ በጣም--------- ለ. በጣም--------- ሐ መካከለኛ ---------መ.ደስተኛ አይደለሁም---------

ሠ.እጅግ በጣምደስተኛ አይደለሁም----------

12. የ ጠፍ አገልግሎት አሰጣጡ ምን ይመስላል?

ሀ. በጣምጥሩ---------- ለ. ጥሩ---------- ሐ አጥጋቢ---------- መ ደካማ----------

13. በእርስዎ መኖሪያ አቅራቢያ የ ሚ ኘወደ ጠፍ ተቋምየ ትኖዉነ ዉ?

ሀ. ጠፍ ጣቢያ ---------- ለ . ጠፍ ክሊ ---------- ሐ የ ግል ክሊኒክ ----------

መ የ መንግስት ሆስፒታል ----------

ስለ ትብብርዎ እና ስለ ተሳትፎዎ ከልብ አመሰግናለሁ!!!