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CHALLENGES AND PROSPECTS OF COMMUNITY HEALTH INSURANCE IMPLEMENTATION IN MIHUR AKLIL WOREDA, GURAGE ZONE

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Challenges and Prospects of Community Health Insurance Implementation in Mihur Aklil Woreda, Gurage Zone

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We hereby certify that we have read and evaluated this Thesis titled "Challenges and Prospects of Community health Insurance Implementation" prepared under our guidance by Dessie Gebre Kerga. We recommend that the Thesis shall be submitted as fulfilling the requirements for the award of MA Degree and recommend that it be accepted as fulfilling the thesis requirement for the Degree of Master of Arts (MA) in Governance& Developmental Studies with Specialization in Development Planning & Management.

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DECLARATION

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

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ABBRIVATIONS AND ACRONYMS

BOFED: Bureau of Finance and Economic Development

CBHI: Community Based Health Insurance Scheme

CBOS: Community Based Organizations

DAS: Development Agents

DHIS: Demographic Health Information Survey

DRC: Democratic Republic of Congo

ETB: Ethiopian Birr

EHIA: Ethiopian Health Insurance Agency

FMOH: Federal Ministry of Health

FGD: Focused Group Discussion

GZHD: Gurage Zone Health Department

HC: Health Center

HDA: Health Development Agent

HEWS: Health Extension Workers

KA: KebeleAdministration

KII: Key Informant Interview

LMICs: Least and Middle Income Countries

NGO: Non-Governmental Organization

OOP: Out of Pocket Payment

SHI: Social Health Insurance

SNNP: Southern Nations Nationalities and peoples

SPSS: Statistical Package for Social Science

SSA: Sub-Sahara Africa

USD: United States Dollar

UHC: Universal Health Coverage

WCA: West of Central Africa

WorHO: Woreda Health Office

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ABSTRACT

The main objective of this study was to assess & analyze the challenges and prospects of Community Based Health Insurance (CBHI) implementation in the rural area of Ethiopia; particularly in Mihur Aklil district, Gurage Zone of Central Ethiopia Regional state. The scope of the study was limited to CBHI members who had been enrolled on CBHI schemes before 2021(at least two years experienced members). Mixed research approaches have been employed to gather data from respondents. The study used discriptive research design beacause it focused on describing & showing the what, why and when of the actual CBHI challnges and prospects in the study area.Simple random sampling technique was adopted after multistage clustering of the woreda kebeles by two agro ecological categories & performance criteria. The quantitative data has been analyzed and presented using descriptive statistics such as table, percent and graphs and multiple linear regeression models was used to show the relation ship between the independent and dependent variables using SPSS verstion 23 software in chapter four. Outcomes on inefficient utilization of the available resources demand side factors & supplyside implementation challenges were discussed as the major findings of the study. In addition prospects of implementing CBHI program in the district were explored. Finally conclusions and recommendations on implication of the research have been discussed by addressing the stake holders, policy makers and implementers.

Key words: *Community based health insurance, Indigenous members, financial risk sharing*

1. INTRODUCTION

I. Background of the Study

Community-based Health Insurance (CBHI) is a type of insurance meant for informal sectors through contributing some amount of money that is owned, designed and managed by the members. The scheme is a not-for-profit type of health insurance that has been used by poor people to protect them against the cost of seeking medical treatment for illness. It is mainly financed by the contributions or premium regularly collected from its members, Sparrow and others (2015).

IN sub-Saharan Africa (SSA), out-of-pocket expenditures constitute approximately 40% of total health expenditures, imposing huge financial burdens and limiting access to healthcare services in some of the poorest countries around the world, Kado,etal (2020)

A recent study in Chad has shown that access to community based insurance schemes can help to mitigate risks. This is especially relevant in areas where risk markets do not exist and public programs are not available or inefficient, Weinberger and Jutting (2000).

Because of CBHI service packages people in rural areas saves their time in search for credits or sell assets as a result there is no delay in health seeking and they rely mainly on their labor productivity and on assets like livestock for income generation, a serious decline of income can be prevented as productive assets are protected and people can return to work sooner. Income is stabilized or, taken the sum throughout the year, may be even increased. Consumption will be more stable and probably even higher, which consequently would have been beneficial, (Kado,etal, 2020). To mitigate the catastrophic health expenditures imposed by out-of-pocket expenditures, Ethiopia has taken the initiative of healthcare financing reform. In 2011, Ethiopia introduced the CBHI scheme in 13 pilot districts in the four major regions: Amhara, Oromia, Tigray and Southern Nations, Nationalities and Peoples (SNNPS). In 2015, Ethiopia also decided to expand the implementation of CBHI scheme to 80% of the districts and enroll at least 80% of households by 2020, according to Ethiopian Federal Ministry of Health, FMOH(2016). However, the enrollment rate to CBHI scheme in Ethiopia is still low and varies from region to region.

In 2018, the enrollment at national level was around 48%, which ranges from 36% in Oromia Region to 61% in SNNPs Region. Moreover, the government of Ethiopia aimed to achieve universal health coverage for its citizens by the end of 2035.To meets this, enrollment into community health insurance scheme in all rural parts of the country is considered as one strategy. To this end Community Based Health Insurances scheme brought a potential to achieve universal coverage of health services through risk pooling and protect rural household and informal sector population from costly health care expenditure, Jutting and others (2003). The scheme is new for many developing countries particularly for Ethiopia. So, an investigation about CBHI and its contribution in the health care system is imperative, as it changed households access for healthcare service, improve healthcare seeking behavior and quality of service provisions.

Consequently, this study will examine the challenges and prospects of Community Based Health Insurance schemes for rural household particularly in Mihur Aklil Woreda in Gurage Zone of South Nations Nationalities and Peoples Regional State and contribute to the improvement of implementation of the schemes in the District.

II. Statement of the Problem

Community-Based Health Insurance (CBHI) schemes are an emerging tool for offering financial protection against the cost of illness or medical bills and improving access to quality health services for low-income rural households who are excluded from formal insurance, Donfouet &Mahieu(2012).

Segahu (2018), Conducted a study on "The Contribution of Community Based Health Insurance (CBHI) in Improving Access and Utilization of Healthcare Services". The Case of Adea District, East Shoa Zone, Oromia Region, Ethiopia, the findings of the result shows having health insurance cover contributes to increased access in modem healthcare, CBHI is increasing health services utilization of the local community, but the study is weak in addressing the issue of leadership and management.

Namomsa (2019),conducted a research work on "Assessing the practices and challenges of community based health insurance in Ethiopia": the case of oromia national regional state district of Gimbichu the findings of the research work shows attitudes of health employee is very low towards CBHI members, ,absence of nearest hospital , lack of skilled man power assigned for CBHI office members ,lack of concern and commitment from the concerned body, absence of good service package (benefits) to the CBHI employees, absence of identifying the indigent members were significant predictors of satisfaction .

But there is no one fit program for CBHI program implementation because it needs bottom up approach as the cultural, environmental, economic, institutional, human capital and infrastructural context differs from place to place even the premium payment varies from place to place .Hence it vital to address the issue of local problems by local solutions.

The reason that inspires me to select the topic was that from my experience and observation working in Mihur Aklil Woreda health office (the study area) as members of the staffs in various positions as an officer, as a plan coordinator and as the head of the office to lead the program, to provide awareness, training, mobilize resource, I practically observed the strength and the actual area specific challenges and opportunities on CBHI program.

There was no research work done on CBHI issues in the area as well as the zonal level at large. There were problems in selection of non-basic family members as basic family members without additional payment. In my personal observation negligence and lack of understanding the bigger aim of the program at the lower administrative level was observed ,there was problems in collection of community funds attributed to management and responsibility issues which puts a heavy burden in the health facility logistic supply and client satisfaction ,there was also a problem of referral linkage to the nearby hospital and adjacent woreda health centers due to pre payments fees requirement issues which was beyond the scope of the woreda, there was a problem of addressing /allocating/ timely and required amount of matching funds to cover the budget deficit which is the mandate of the government especially manifested at regional and zonal level.

The coverage of CBHI in the district is low 37% which among the three lowest performances in the zonal district according to Gurage Zone Health performance evaluation data,GZHD (2022) due to various factors which needs to be investigated. These questions are relevant and I understand that it is vital to conduct a research to understand the magnitude of the problem in the areas of challenges and prospects of CBHI implementation and the causes of low performance so as to contribute to my own in filling the gaps by formulating the following research objectives and questions.

III. Objectives of the Study

General Objectives

The main objective of this study is to assess the challenges and prospects of community based health insurance implementation in Mihur Aklil Woreda.

Specific Objectives

Specifically, this study intends:

- To identify the existing resources that would be necessary in order to successfully implement community based health insurance in Mihur Aklil Woreda.
- To identify and analyze the demand & supply side challenges in implementing community based health insurance in Mihur Aklil Woreda.
- To explore the prospects of implementing community based health insurance in Mihur Aklil Woreda.

IV. Research Questions

This study has attempted to answer the following research questions:

- How far resources are available for the successful implementation of community-based health insurance in Mihur Aklil Woreda?
- What are the demand and supply side challenges in implementing community-based health insurance in Mihur Aklil Woreda?
- What are the prospects of successfully implementing community-based health insurance in Mihur Aklil Woreda?

V. Significance of the Study

There is no research work done on CBHI issues in MihurAklilworeda, hence this research will be done to put foot prints in identifying the challenges and prospects of CBHI in the woreda so as to avail relevant actual in formations on the ground. The premium significance of the study is availing information on the actual challenges of CBHI in the study area, so as to inform the implementers, program managers and partners to be aware of the obstacles.

On the other hand researchers and experts may use this research work as firs-hand information to conduct other similar and related studies on the program to increase the scheme service quality, management capacity, efficiency and to sustain the program.

Additionally, the study will have a meaning full contribution on providing first-hand information to policy makers in addressing the policy gap areas in CBHI implementation. Besides these the findings of the research will have a potential role to Mihur Aklil Woreda health office ,the woreda government and to the zonal government at large to evaluate the strength and weakness of the program and take appropriate remedial action in addressing the challenges faced on practice.

VI. Scope of the Study

There are different types of health insurance, these are the private health insurance that focuses on individual contract scheme, the social health insurance (SHI) that focuses on citizens employed in formal sectors of the economy and that of community based health insurance (CBHI) which focuses on informal sectors of the economy. This study focused on Community based health insurance (CBHI) programs which concerns on peoples engaged on informal sectors of the economy and those who have more than one year's membership experience on the CBHI scheme. The study area (MihurAklil Woreda) is geographically located between longitude 37.83-38.27 and latitude 8.03-8.26. It is selected due to its low performance & some challenges during implementation. The District Performance last year is 37% which is the among the three least performer districts among the 21 zonal districts WorHO (2021).

VII. Limitation of the Study

The fact that this study was planned to be conducted in MihurAklil woreda, one of the Gurage zone districts in Central Regional State, raises the key question of representation for a bigger image. The first limitation of the study may be regard to sampling; the researcher determined sample size for the total number of households from the selected kebeles by using multi stage cluster sampling technique based on performance and agro ecologicalcriteria and simple random sampling method is adopted to select participants thatdidn't fully represent the studypopulation atDistrict due to resource constraints.

The study was focused on members who enrolled on CBHI programs and didn't include the idea of none members.

VIII. Operational definitions of key terms

Universal Coverage: access to adequate health care for all at an affordable price according to world health organization (WHO).

Moral hazards: refers to working in violation with the principles and rules of community health insurance both in beneficiaries and service provider sides and management sides

Basic family: refers to the households and their off springs <18 years old to be covered by CBHI.

None basic family members: refers to those people living within the house hold but needs additional payment per individual because they are either>18 years or parents, or wage workers.

2. REVIEW OF RELATED LITERATURE

2.1. Introduction

Community-based health insurance is a generic term used to explain variety of resource mobilization strategy designed for access to health care financing through a greater involvement of the community in its designing and management. The schemes are named differently in different countries/programmers; such as mutual health organizations, community-based health financing, and community-based health insurance which are dominantly used and in this study also. There is" no universally accepted definition of CBHI". Its definition varies from country to country and from the scheme to scheme. Thus, in this section we review different definitions of CBHI and conceptualize them, as cited by Endashaw(2019) and Adane (2014)).

Community-Based Health Insurance (CBHI): is defined as" a risk-pooling mechanism that tries to spread medical expenses across households with different health profiles to prevent catastrophic expenditures that come from unpredicted health events or chronic diseases, and enables cross-subsidies from rich to poor populations", EHIA (2015). From this definition, in Ethiopia, we can conclude that CBHI schemes are subsidized by the government that is by federal, regional and/or local government.

Community-based health insurance is also defined as "the scheme designed as a means for informal sectors to contribute some amount of money that is owned, designed, and managed by their members", and the schemes are a not-for profit type of health insurance that has been used by poor people to protect themselves against the high costs of seeking medical care and treatment for illness. It is mainly financed by the contributions/ premium regularly collected from its members Adane (2014).

Community prepayment health organizations are characterized by voluntary membership and payments are made in advance in order to cover potential medical expenses. Members of the schemes pay premiums on a regular basis, usually when their incomes are high. Such schemes are often initiated with the technical and financial support of NGOs and thereafter the community takes full responsibility for administering and managing the scheme. Local governments may also play a role in encouraging and supporting the efforts of such schemes

2.1.1. An overview of the importance of CBHI in achieving universal healthcare and improving access to healthcare services in low-resource settings

In most industrial and many middle-income countries," insurance has turned out to be a useful financial tool in the health sector", (Doriswe wiesmann/Johannes justting).

The debate about the potential of community-based health insurance to improve access to health care and social protection is still ongoing, while more and more schemes have been emerging during the nineties in rural and urban Sub-Saharan Africa.

Smith,etal (2006), explained that CBHI can help to improve financial access, utilization, resource mobilization, and quality of health care services through cooperative, community efforts. The most obvious effect of CBHI schemes is to reduce how much people pay for health care when they seek care. Fixed and prepayment of premium to CBHI scheme lead to more frequent utilization of health care services and less delay in seeking care. Furthermore, members of CBHI schemes are unlikely to need to borrow and go into debt in order to cover health care costs. CBHI schemes are characterized as hybrid arrangement from both traditional risk-sharing and formal health insurance policies. Similar to traditional risk sharing systems (like Edir in Ethiopia.)

Though health insurance is an exogenous concept largely inspired by European history and occidental values, this does in no way preclude its appropriation by local populations. Given the unique ethnic, lingual and cultural diversity within African nations, the CBHI approach may be particularly promising for this continent because it allows adaptation to local conditions.

On the other hand, the running of a CBHI scheme requires a – not yet clearly defined - minimum of management capacity at the local level as well as rational organization of health care provisions. These prerequisites seem to be lacking in many instances in Sub-Saharan Africa (Doriswe wiesmann/Johannes justting). The actual implementation of CBHI schemes has had mixed results so far, with success and viability largely depending on design and management of the scheme, community participation, regulations at the level of the health care provider, quality of services and on the socioeconomic and cultural context.

As experience gained with CBHI has become the focus of several research initiatives and the lessons learned are offered to people running the schemes or intending to start new ones, the performance of CBHI will hopefully improve over time. The future will show if there are ways

to overcome common failings of CBHI which have been recognized in many schemes: limited participation, low cost recovery rates and the problems of including the poorest members of society.

2.1.2. Community Health Insurance (CBHI) implementation in Mihur Aklil Woreda

As part of its health care financing strategy in general and its health insurance strategy in Particular, the Government of Mihur Aklil woreda endorsed and launched community-based Health insurance (CBHI) schemes in seven catchment areas at health center level for 26 kebeles within the woreda administration boundary and for 4 kebeles out of the district boundary to adjacent Ezha woreda health facilities namely “Darcha” and “Yedege” health centers and in 2010/11 to provide risk Protection mechanisms for those employed in the rural and the informal sectors.

Successful CBHI models show that there are important conditions for CBHI to grow and develop, including: existence of a minimal level of (perceived) quality of care and gradual improvement of quality at the supply side; instituting minimal organizational practice and design including responsiveness to people's felt needs by the scheme management; government commitment and political will with clear action plans, national scope of implementation, existence of regulatory frameworks, commitment to subsidize and finance the premium for the poorest in society; and the need for CBHI schemes to join forces to expand risk pooling and ensure financial sustainability (Office, 2022).

However, document review information on performance of CBHI on the study area shows that the performance of the district below 50% for five consecutive years i.e., 2018-2022. The 2022 health office evaluation data in the district shows that the coverage of CBHI in the district was 37% which was among the three lowest performances in the zonal district according to 2022 zonal performance evaluation data (GZHD, 2022)due to various demand and supply side factors which needs to be investigated.

In addition, according to Mihur Aklil Woreda 2022 health office evaluation data, there were problems raised by communities in ”accessing health facility and hospital services”, “management and administrative issues”, challenges on selection of CBHI member without additional payment. Negligence and lack of understanding the bigger aim of the program at the lower administrative level was observed ,there was problems in collection of community funds attributed to stake holders role at lower administration level which “puts a heavy burden in the

health facility logistic supply and client satisfaction" ,there was also a problem of referral linkage to the nearby hospital and adjacent woreda health centers due to pre payments fees requirement issues which was beyond the scope of the woreda, there was a problem of addressing /allocating/ timely and required amount of matching funds to cover the budget deficit which was the mandate of the government especially manifested at regional and zonal level. Hence identification ofchallenges related to CBHI implementation in the study area were crucial for successful implementation of CBHI program

2.1.3. Purpose of the literature review

To critically examine existing literature on CHI implementation, identify challenges, and explore prospects.

2.2. Theoretical Framework

2.2.1. The theoretical framework(s) underpinning community health insurance and its implementation

In this section we review the two major theories (most cited) used to explain the theoretical framework of CBHI. These are Social Capital theory and Social Mobilization theory.

Social capital is the term used to explain a positive product of human interaction. Social capital is a set of shared values that permits individuals to work together in a group to effectively achieve a common goal. Thus, social capital can be defined as the existence of a certain set of formal or informal networks, values or norms shared among the members of a group that permit cooperation and coordination among them,Fukumia (1995).

Social capital theory states that social capital consists of characteristics of social organization such as formal and informal networks, norms, and social trust that assist coordination and cooperation for mutual benefit, Putnam (1993). According to Woolcock and Narayan (2000), social capital helps the poor to share the risk and vulnerability.

Thus, CBHI which aims at risk sharing and vulnerability may be well accepted by a community that possesses a high stock of social capital. Due to the nature of CBHI schemes, their success highly depends on the existence and survival of social capital in the community. CBHI can therefore attain sustainability, effectiveness and be long-lasting with the help of social capital in

a community; because social capital has a positive influence on the community demand for insurance Donfouet &Mahieu (2012).

Social capital is a prerequisite to implement CBHI. Due to the fact that social capital varies among countries, regions and even among localities, the design and action programmers are very specific to the local level. This makes condition makes it difficult to replicate the schemes in other areas, WHO (2020).

The concept of social mobilization is defined as the process of bringing together all stakeholders and individual influences to increase awareness of and demand for health care, assist in the delivery of resources and services, and promote sustainable individual and community involvement ,WHO (2020).

In other word, social mobilization can also be defined as the use of planned actions and processes to reach, influence, and involve all stakeholders across all relevant/concerned bodies, including the national and community level to raise awareness, change behavior, change policy, demand a specific development programmer, or reallocate resources or services'.

Social mobilization theory is a theory recognized as effective instrument for health care promotion especially when people are reluctant to respond positively to health programmers. Social mobilization is a multi-level, dynamic approach that can be initiated either top-down or bottom-up.

Community is perceived in its broadest sense to include all those who have a role and responsibility in effecting change. As information is made available and understandable to both experts and lay people, broad ownership and popular support are created, Russell and Levitt-Dayal (2003). Hence, due to the inability of governments to reach rural people and the informal sector, communities have highly been mobilizing themselves to secure financial protection against the cost of illness, Parker,(2012).

A community based health insurance like any other health program, to be effective, needs a multipronged approach and broadens public support through social mobilization. In case of CBHI, given the fact that most of people are unaware about benefits of health insurance, communities need to be mobilized in order to understand and to adhere to the program me.

It should also be noted that the CBHI to be sustainable needs mobilization for human and financial resources. According to, Mckee(1992), there are five approaches to mobilizing human and financial resources: political mobilization, government mobilization, community mobilization and corporate mobilization and beneficiary mobilization.

Social mobilization uses community events to attract the attention of policy makers, community members, and media representatives and motivate them to take action on a specific issue such as immunization, literacy, or family planning. Social mobilization amplifies advocacy activities, strengthens communication, and allows many more societal partners to participate in the program. To be successful a CBHI program needs to use all those approaches to mobilize human and financial resources.

2.2.2. The global and regional context of community health insurance adoption

In most industrial and many middle-income countries, insurance has turned out to be a useful financial tool in the health sector, Grrifin (1992).

Though health insurance is an exogenous concept largely inspired by European history and occidental values, this does in no way preclude its appropriation by local populations. Given the unique ethnic, lingual and cultural diversity within African nations, the CBHI approach may be particularly promising for this continent because it allows adaptation to local conditions.

On the other hand, the running of a CBHI scheme requires a – not yet clearly defined - minimum of management capacity at the local level as well as rational organization of health care provisions. These prerequisites seem to be lacking in many instances in Sub-Saharan Africa, Criel (1998). The actual implementation of CBHI schemes has had mixed results so far, with success and viability largely depending on design and management of the scheme, community participation, regulations at the level of the health care provider, quality of services and on the socioeconomic and cultural context.

2.2.3. Models used in the literature to analyze C BHI implementation challenges

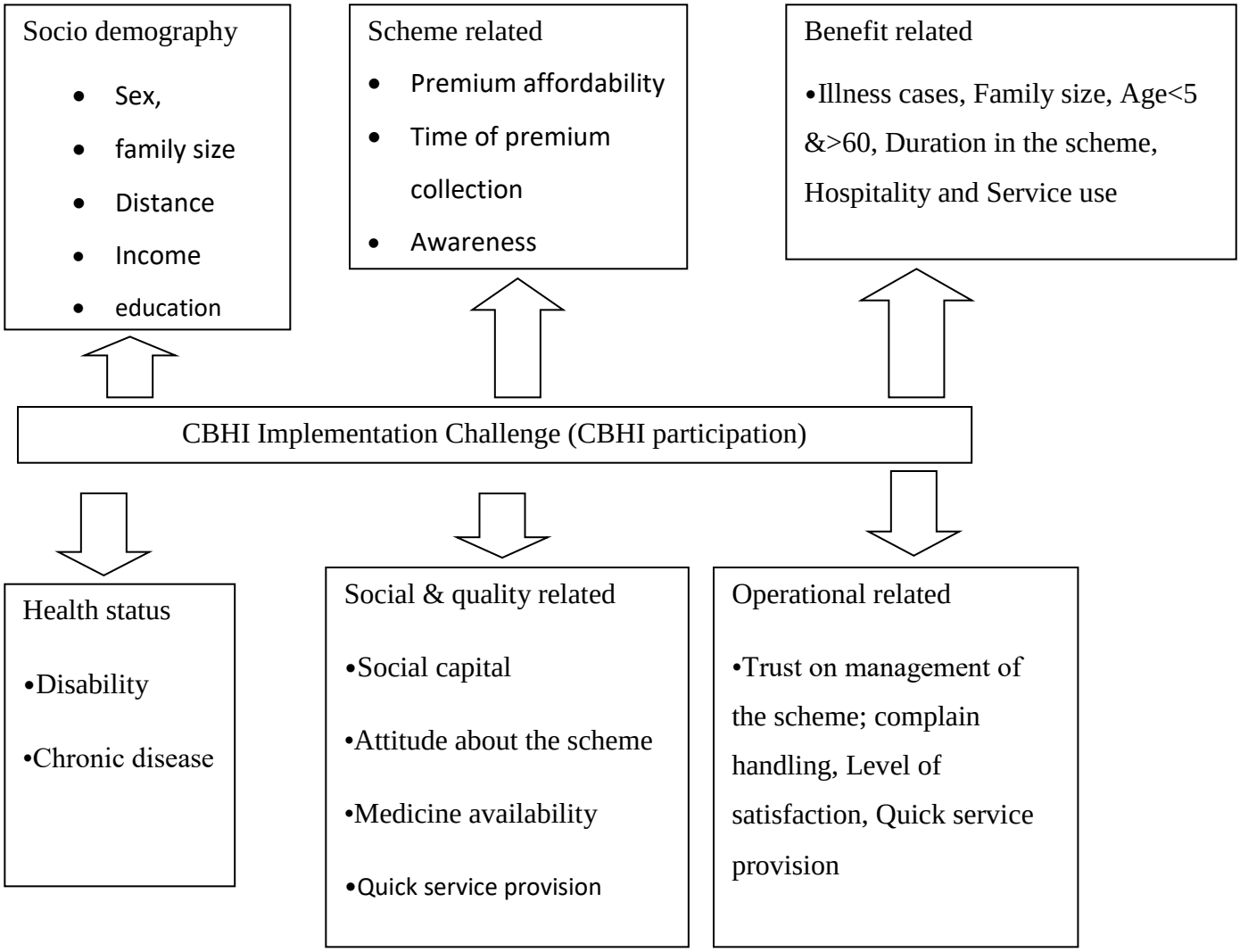

*Figure 1***.**conceptual frame work adopted from (Hussien & Azage, 2021).

2.2.4. Conceptual frame work of the study

To construct the conceptual framework with the research objectives, CBHI implementation challenge(CBHI participation) is the dependent variable for multiple regression model analysis whereas socio economic and, demography characteristic (Age, Sex, Income level, House-hold size, health service use related factors (Distance of health center), household related factors (Attitude towards CBHI, Awareness/information/, Chronic disease, disability status) and CBHI related factor(premium collection time) are independent variables .

2.3. Historical Development of Community Health Insurance

2.3.1. The global and regional context of community health insurance adoption

In most industrial and many middle-income countries, insurance has turned out to be a useful financial tool in the health sector, Grrifin (1992).

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In Africa, the wage-based social insurance and private health insurance have had very limited impact because they failed to cover informal sector workers and the rural self-employed, who constitute the majority of African populations.

The debate about the potential of community-based health insurance to improve access to health care and social protection is still ongoing, while more and more schemes have been emerging during the nineties in rural and urban Sub-Saharan Africa. In Sub-Saharan Africa (SSA) schemes are limited to formally employed people, like teachers' funds, were not included).

The majority of the schemes has come into existence in the nineties, therefore it is justified to call CBHI an „emerging movement"- especially as numerous new schemes. As experience gained with CBHI has become the focus of several research initiatives and the lessons learned are offered to people running the schemes or intending to start new ones, the performance of CBHI will hopefully improve over time. The future will show if there are ways to overcome common failings of CBHI which have been recognized in many schemes: limited participation,

low cost recovery rates and the problems of including the poorest members of society, creese and Bennett (1997).

2.3.2. The factors that influenced the adoption and implementation of CBHI in low resource settings.

Health insurance schemes in countries with long-standing social health protection mechanisms originated as home-grown initiatives involving social actors in designing and implementing the schemes, but, in many fragile African states, CBHI schemes are simply community-based and weakly supported by the state. They have been initiated by health facilities, NGOs, local communities or cooperatives and can be owned and run by any of these organizations, Wiesmann &Jutting (2005). Yet without functioning state endorsement and political engagement, it is difficult to envision CBHI's viability, enhancement or scaling-up. This problem has been faced by programs in China, Ghana, Rwanda, and Thailand, Wang and pielemeier (2012). Nonetheless, in many African countries such as the DRC, where the state's role is minimal, CBHI is presented as a rational step towards health system financing for achieving UHC.

2.4. Key Components of Community Health Insurance

2.4.1. The fundamental components of CBHI, including premium collection, risk pooling, benefit packages, and governance structures.

Premium prepayments for CBHI membership are characterized by voluntary membership and payments are made in advance in order to cover potential medical expenses. Members of the schemes pay premiums on a regular basis, usually when their incomes are high. Such schemes are often initiated with the technical and financial support of NGOs and thereafter the community takes full responsibility for administering and managing the scheme. Local governments may also play a role in encouraging and supporting the efforts of such schemes. CBHI schemes are characterized as hybrid arrangement from both traditional risk-sharing and formal health insurance policies. Similar to traditional risk sharing systems (like "Edir" in Ethiopia.) Risk-pooling mechanism tries to spread medical expenses across households with different health profiles to prevent catastrophic expenditures that come from unpredicted health events or chronic diseases, and enables cross-subsidies from rich to poor populations (EHIA).

CBHI schemes are subsidized by the government that is by federal, regional and/or local government. The scheme is designed as a means for informal sectors to contribute some amount of money that is owned, designed, and managed by their members, and the schemes are a not-for profit type of health insurance that has been used by poor people to protect themselves against the high costs of seeking medical care and treatment for illness. The benefit package primarily covers health service packages at health facility level. The benefits includes both inpatient and outpatient services. All types of essential health services that would be covered through out of pocket spending at time of sickness are covered by CBHI schemes.

2.4.2. The roles and responsibilities of various stakeholders in CBHI schemes.

The major stake holders in CBHI program schemes are patients, physicians, employers, insurance health facilities, pharmaceutical firms and government. Members of the schemes pay premiums on a regular basis. The health insurance facilities should avail skilled and committed man manpower otherwise, their low concerns affects the schemes effectiveness and sustainability, Namomsa, (2019). This is might be due to poor incentives for the management of the schemes and service providers, which should be considered. Such management related challenges are responsible for the creation of the problems as; low awareness creation, boring claims procedures, and longtime taking for claim settlement. Governments must develop clear policies, regulations, and guidelines that provide standard instructions and guidance for all those involved in a CBHI scheme.

The government role in reimbursing of the collected community fund and subsidy provision is vital for early logistic provision. The availability of health facility at accessible distance should also be the role of NGOS, government and private investors to solve accessibility challenges. Insurance health facility sell health coverage plans directly to patients or indirectly through employer or government intermediaries.

2.4.3. Analysis of the impact of these components on the successful implementation of CBHI programs.

According to ,Ermiayas (2016), community-based health insurance schemes have the potential to create awareness regarding the importance of insurance and minimizing the equity gap by; providing financial protection for informal segments of the population, reducing the problems

related to out-of-pocket payments, building self-belief among participants through community control mechanisms, and enhancing utilization of the health care scheme

2.5. Challenges in CBHI Implementation

The operations of CBHI schemes are not free from problems/challenges that limits scheme from achieve its primary objective. The major challenges are review as follows:

2.5.1. Adverse Selection

In CBHI adverse selection occurs when high-risk or sick individuals or households are more likely to become a member of the scheme than the low-risk or healthy individuals. Empirical studies show that individuals with better health were less likely to enroll in CBHI schemes, Ahmed (2018); and Purohit (2014).

Voluntary membership to the scheme is the risk factor of adverse selection that may challenge financial sustainability of the scheme. To enhance sustainability of CBHI schemes, it is important to balance strategies promoting enrollment and access, with strategies that would help minimize adverse selection problem in the CBHI schemes; as an example, mandatory enrollment of all individuals/ households in the catchment area/district of the scheme; since it decreases adverse selection by lowering probability of having only sick individuals enrolled in the scheme;(setting different premiums for individuals having different risk levels ; extending the waiting period for accessing healthcare after enrolled into the scheme; Enrolling low-risk people only ,Fadlallah (2018).

Limited Risk Pool CBHI schemes have failed to address the very low enrollment rates and lack of risk pooling for the people in unorganized sector. Because it is constrained by limited membership contributions' from the low-income and informal sector members, Bhat &Jain (2006).

According to the study conducted in China, there is a low demand despite great need for people to join such schemes. This is because CBHIs has a feature of voluntary contribution from its members. However, there are many poor people who cannot even afford minimum premium for the schemes and as a result their needs are not converted into demands, liu and Hsiao (2006).

Even though initial uptake is high, high dropout rates highly impend, the sustainability of CBHI schemes. As existing literatures shows there is high rate of non-renewal membership I.D card due to different reasons. The factors that are most likely to influence renewal rates of membership are health status of the households, quality of service offered, affordability of premium, lack of understanding about the scheme and insufficient information on how to use the insurance policy are the key challenges for success of the scheme.

To address this problem, greater awareness creation campaign to the community and understanding about the insurance concept is required. Existing literatures also indicates that informal sector of urban residents are ignored from equitable access for health service, however, it enables the government to attain UHC goal and enable the scheme for sharing the risk on large number of people. Limited Financial Risk Protection CBHI schemes are expected to provide financial risk protection by reduces out-of-pocket spending of their members, while increasing their utilization of health care services, Jakab & Krishnan (2001).

However, due to low risk pooling and revenue collection from their members in the form of premiums are very low and low subsidies from the government leads to limits financial risk protection for their members. CBHIs have really challenged in extending coverage to the needy and eligible people and limited to broaden health service coverage's, because there is low risk pool and the schemes are failed to increase peoples' interest to capture large number of people which leads to low enrollment rates. The effectiveness of financial risk protection offered by an individual CBHI scheme can be measured by extent to which the benefit package offered covers a comprehensive package of services, particularly higher cost services. If high cost services (commonly used) are excluded from the benefit package, then effective financial risk protection may be limited or under the question. However, WHO suggested that the CBHI schemes are not be expected to provide a greater source of financing or coverage, hence policy option for financial protection arrangements such as compulsory membership and the subsidies by government for those unable to pay have shown more potential to reach UHC goals than voluntary membership.

2.5.2. Lack of Quality Service and Availability

Quality and availability of health service is one of the main supply side factors identified to limit enrolment to the scheme. The quality of healthcare services can be measured in different dimensions; such as availability of drugs, diagnostic equipment, and referral system, waiting time, staff motivation & availability, and so on. Low quality of healthcare services at public facilities was one of the main factors discouraging people from joining the scheme and limits renewal of membership. When drugs are run out of the stock, members have to buy drugs at private pharmacies at high cost, Macha,etal (2014). Availability of health care (particularly hospital care) is also an issue; in some schemes are too remote from any hospital, or desired services are simply not offered at the local health post/centers. In such cases, the schemes may contract with regional-level hospitals and include transportation costs to those hospitals in their benefits packages, Bennett, etal (2004) Uncertainty related to the availability of drugs.

2.5.3. Lack of professional and committed management

On the other hand, lack of skilled manpower and their low concerns and commitments from the stakeholders (such as; community, management and service providers) are management related challenges that affects the schemes effectiveness and sustainability, Namomsa (2019). This is might be due to poor incentives for the management of the schemes and service providers, which should be considered. Such management related challenges are responsible for the creation of the problems as; low awareness creation, boring claims procedures, and longtime taking for claim settlement.

Thus, to increase the schemes sustainability, increasing number of members and retain the existing members the claims procedures of the schemes should be simplified and time lag between hospital discharge to reimbursements of medical expenses to the beneficiaries should be highly reduced, Purohit (2014). Poor communication and information flow between people who are managing the schemes and the beneficiaries limits the schemes' utilization and effectiveness. Better and clear communication has been done to finance healthcare which are all inclusive, sustainable, and suitable to the socio-economic situations of individuals in the formal sector, rural people and workers of informal sectors of the urban population become mandatory.

Hence, CBHI schemes are considered as one of the options mentioned to improve financial access, utilization, resource mobilization, and quality of health care services through cooperative, community efforts.

Most literature conclude that the community-based health insurance schemes have the potential to reaching a large number of low-income populations by creating awareness regarding the importance of insurance and minimizing the equity gap by; providing financial protection for informal segments of the population, reducing the problems related to out-of pocket payments, building self-belief among participants through community control mechanisms, and enhancing utilization of the health care scheme. This is due to the fact that fixed and prepayment of premium to CBHI scheme lead to more frequent utilization of health care services and less delay in seeking care and members of the schemes are unlikely to need to borrow and go into debt in order to cover health care costs.

2.6. Prospects and Innovations in CBHI Implementation

2.6.1. Innovative approaches and strategies being used to address the challenges of CBHI implementation.

Large risk pool, increasing revenue generation and subsides to promote financial sustainability to enhance resource availability, more strategic purchasing are best strategies to address the challenges of CBHI implementation. CBHI implementation needs a multipronged approach and broadens public support through social mobilization. In case of CBHI, given the fact that most of people are unaware about benefits of health insurance, communities need to be mobilized in order to understand and to adhere to the program me. Raising the roles of stakeholders in policy, management and implementation are innovative strategies for the successful implementation of the program.

2.6.2. The potential benefits and opportunities for CBHI in improving healthcare delivery.

According to Mulat,etal (2022),community-based health insurance schemes have the potential to create awareness regarding the importance of insurance and minimizing the equity gap by; providing financial protection for informal segments of the population, reducing the problems of

out-of-pocket payments, building self- belief among participants through community control mechanisms, and enhancing utilization/ of the health care scheme.

According to Mulat,etal(2022),"regardless of the challenges CBHI schemes currently face the program implementation have significant roles in protecting the poor from financial catastrophe and increasing health service utilization". CBHI can help to improve financial access, utilization, resource mobilization, and quality of health care services through cooperative, community efforts. The most obvious effect of CBHI schemes is to reduce how much people pay for health care when they seek care. Fixed and prepayment of premium to CBHI scheme lead to more frequent utilization of health care services and less delay in seeking care. Furthermore, members of CBHI schemes are unlikely to need to borrow and go into debt in order to cover health care costs.

2.6.3. Examples of successful CBHI programs and their impact on healthcare outcomes.

Rwanda has developed a successful national CBHI scheme known as "mutuelles de santé", Collins,etal(2016) that has overcome many obstacles. Coverage is high, communities are involved, risks are pooled, and adverse selection is minimized. Despite many challenges, such as limited management capacity and dependence on government (and donors) for subsidies, the CBHI scheme has greatly increased access to care and has contributed to much-improved health results. The Rwandan CBHI scheme is best described as a national community-based health insurance program. More than a decade of implementation and refinement of CBHI in Rwanda has provided an ideal learning environment to draw lessons that may also benefit other countries.

There are many reasons for the successful development of CBHI during this time, including: A broad level of awareness of poverty, health needs, and problems of access to health care; Community solidarity and mutual aid values that are embedded in Rwandan culture; Influence and support of civil society, with key roles played by religious leaders; Leadership of national and local government, which encouraged, facilitated, and monitored the process and developed and issued policies and laws; Key role of the Federal Ministry of Health (FMOH) as policy initiator and champion, which often participated in official launches of the schemes and stressed the importance of CBHI in the fight against poverty; Ministry of Finance funding to cover premiums for the poor

" Evaluation of Community-Based Health Insurance Pilot Schemes in Ethiopia", EHIA(2015) shows that Successful CBHI models show that there are important conditions for CBHI to grow and develop, including: existence of a minimal level of (perceived) quality of care ,gradual improvement of quality at the supply side; instituting adequate organizational practice and design including responsiveness to people's felt needs by the scheme management; government commitment and political will with clear action plans, national scope of implementation, existence of regulatory frameworks, the unequivocal commitment to subsidize and finance the premium for the poorest in society; and the need for CBHI schemes to join forces to expand risk pooling and ensure financial sustainability are among the positive outcomes gained from the successful CBHI scheme model implementation.

2.7. Research Gaps and Justification

Kahssay (2014) conducted a study on" Socio economic Determinants of Community Based Health Insurance": the Case of KilteAwelaelo District, Tigray Regional State. Almost their awareness, access to primary health care service, local meetings have a large contribution in creating awareness.48% of male headed households have a share in the enrolled group which have also participation in PSNP (Productive Safety Net Program) as compared to 34% in the non-participants .But This study mainly introduces the startup of Community Based Health Insurance in Ethiopia and focus on PSNP which not recommended as it creates dependency and raises sustainability issues

Hussien,etal (2022) conducted a research on "A mixed methods study of community-based health insurance enrollment trends and underlying challenges": at two districts of northeast Ethiopia, (Tehulederie and Kallu), the findings of the study shows that 43% CBHI members experienced negative growth ratios in both districts with inconsistent trends, 44 % showing that the scheme is not functionally viable. The most prominent challenge is poor quality of health care, the lack of awareness of the risk-sharing principle and the benefits of insurance plans availability and perceived quality of medicines according to the result of the study outcome. But the risk sharing challenges are not analyzed well, accessibility issues are not assessed in detail.

Nana(2020) conducted a research on "Assessment Of Factors Influencing Enrollment Of Community Based health Insurance Scheme": in Amaro district of SNNPR, Ethiopia, the finding

of the study shows lack of awareness about the scheme (35%), Illness/injury does not occur frequently 23%, registration and premiums are not affordable 21% and the quality of health service is low 17% were among the factors that influence the enrollment of community health insurance. But quality issues were not addressed well. In addition the study limitation was social desirability bias because the respondents were asked about events that occurred in the past.

Segahu(2018) conducted a study on "The Contribution of Community Based Health Insurance (CBHI) in Improving Access and Utilization of Healthcare Services": The Case of Adea District, East Shoa Zone, Oromia Region, Ethiopia, the findings of the result shows having health insurance cover contributes to increased access in modem healthcare ,CBHI is increasing health services utilization of the local community, but the study is weak in addressing the issue of the causes of increasing health facility visits in addition implementation challenges are not assessed in detail by addressing stake holders role. Only the coordinator of the CBHI scheme was interviewed as a stake holder.

Namomsa (2019) conducted a research work on "Assessing the practices and challenges of community based health insurance in Ethiopia": the case of oromia national regional state district of Gimbichu the findings of the research work shows attitudes of health employee is very low towards CBHI members, ,absence of nearest hospital , lack of skilled man power assigned for CBHI office members ,lack of concern and commitment from the concerned body, absence of good service package (benefits) to the CBHI employees, absence of identifying the indigent members were significant predictors of satisfaction .

The reason of increasing halth facility visits, inappropriate registration of members in the house hold's CBHI ID or irrational utilization of health services,effect of low performance on government expenditures,suitability of mobilization and membership id renewal period,reasons of low performance related to the districts existing infrastructure and cultural conditions were not addressed well in the previous studies.

Hence, these studies would fill the practical CBHI implementation gaps in the context of the districts exixting conditions, because there is "no one fit program for CBHI program implementation", Wang and pielemeier (2012) because it needs "bottom up approach as the

cultural, environmental, economic, institutional, human capital and infrastructural context" differs from place to place even the premium payment varies from place to place

The reason that inspires me to select the topic was that from my experience and observation working in Mihur Aklil Woreda health office (the study area) as members of the staffs in various positions as an officer, as a plan coordinator and as the head of the office as atop leader to lead the program, to provide awareness, training, mobilize resource, I practically observed the strength and the actual area specific challenges and opportunities on CBHI program. There was no research work done on CBHI issues in the area as well as the zonal level at large. There were problems in selection of household family members on individual CBHI Id list.

In my personal observation I observed negligence and lack of understanding the bigger aim of the program at the lower administrative as well as at the district level. ,there was problems in collection of community funds attributed to Keble administration which puts a heavy burden in the health facility logistic supply and client satisfaction ,there was also a problem of referral linkage to the nearby hospital and adjacent woreda health centers due to pre payments fees requirement issues which was beyond the scope of the woreda, there was a problem of addressing /allocating/ timely and required amount of matching funds to cover the budget deficit which is the mandate of the government especially manifested at regional and zonal level. The coverage of CBHI in the district is low 37% which among the three lowest performances in the zonal district according to 2022 zonal performance evaluation data due to various factors which needs to be investigated.

These questions are relevant and I understand that it is vital to conduct research using mixed research approaches from beneficiaries and stakeholders on challenges and prospects of CBHI implementation in the study area so as to avail factual information on CBHI implementation challenges, the prospects CBHI implementation in the district and to forward feasible strategy for the successful implementation of the program to the concerned stakeholders, partners and government bodies by formulating research objectives and questions on challenges and prospects of CBHI implementation in the district.

3. METHODOLOGY OF THE STUDY

3.1. Description of the Study Area

The study area MihurAklilworeda is found in Central Regional State, Gurage zone Administration 207kms south of Addis Ababa and 176kms from Hossana capital of the Central Regional State and 52kms from Gurage zone capital, Wolkite town. Its boundary is connected to Kokir Gedebano Woreda in the North, Ezha Woreda in the south, Kebena Special Woreda in the North West, and Meskan Woreda in the East.

Geographically it is located between longitude 37.83-38.27, and latitude 8.03-8.26. The altitude varies from 1501m-3500m above sea level, woyinadega 44.4%, and dega 55.6% agro ecology zone. The total area coverage is 472.9 km^2 which constitutes 8.02% the total zonal area which is about 5893.3 $km^{2(}$including the two newely separated Special woredas namely Kebena & Mareko Special woredas $^{)}$ with different land use and land cover such as cultivated land with seasonal crop 8857.5 hectares, land covered by permanent and annual crop 22064 hectares, land covered by water 411 hectares, potential investment area 625 hectare, pasture 375hectare, forests 10,920 hectare (Mihur Aklil Woreda Plan commistion office strategic Plan document,2022).

The total number of population of Mihur Aklil Woreda in 2022 is 133,159, which is based on the projection of 2007 population census. From these 62406 are males and 70753 are females. Agriculture is the most dominant means of livelihood in the district. There are also a considerable number of people engaged in selling livestock, petty trading, livestock products and firewood selling.

The district has 29 rural Kebele and 1 urban Kebele, the livelihood of Mihur Aklil woreda is dominated by subsistence agriculture and engaged on small trade. Average size of cultivated land Owned by households are categorized as below (according to woreda plan commistion2022 data)

0.1-0.5 hectares owners, male6113 female 865 total 6978,0.5-1 hectares owners male 4465 female 1023 ,total 5488,1.01-2 hectares owners male 3725 female 593 ,total 5488,2.1-5 hectares owners male 2298 female 523, total 2821, and 5.1-10 hectares owners male 998 female 105, total 1103.

Teff, barely, wheat, bean, corn and pea are the major crops and Enset is a popular annual crop grown in the area. Chat production is the main revenue source of income in the woreda, raring livestock product, engaged in many other activities like pottery production and small business are among the activities significant number of people is engaged.

The researcher has been selected the study area because of his prior knowledge and familiarity in the area. There are higher incidence of diseases and lower economic condition of the people; on the other hand the woreda CBHI coverage is low compared to other few best achiever woredas in the zone, which might be associated with various socio economic factors unique to the woreda context

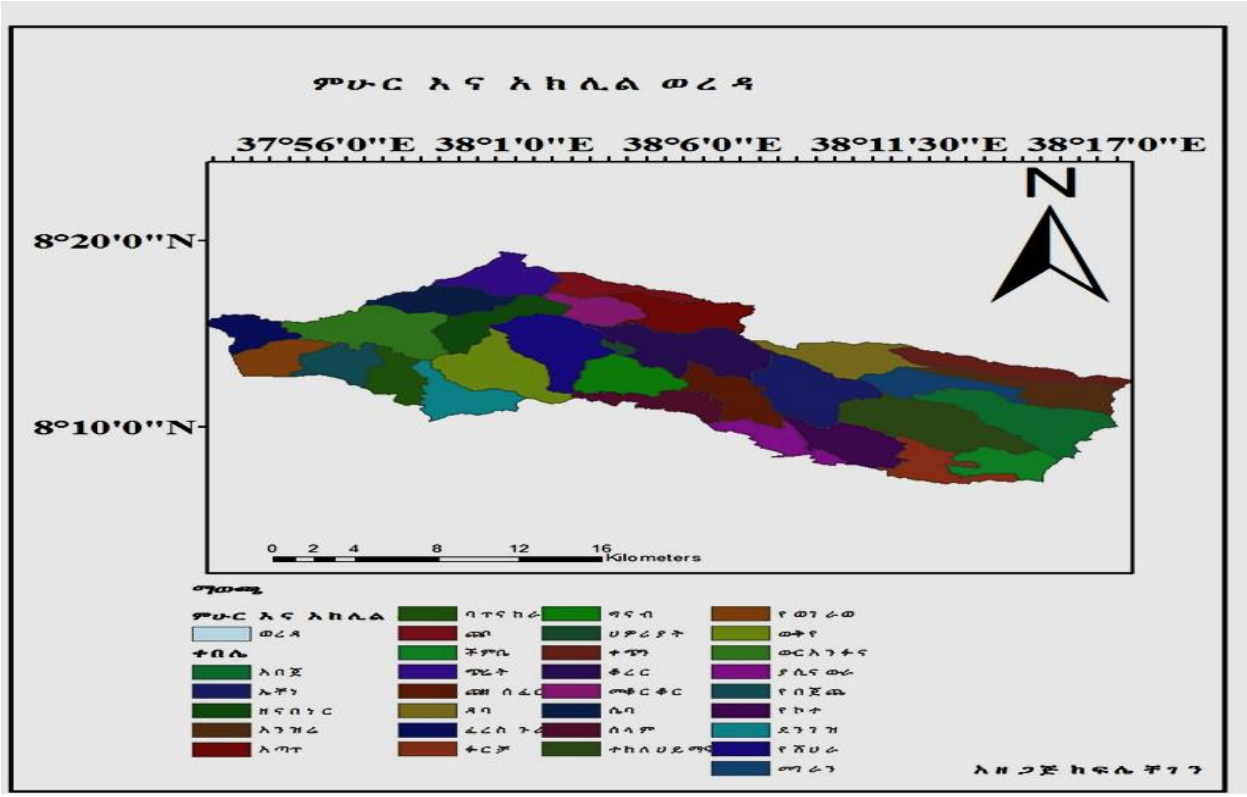


Figure 2.Location map of the study area.

Source: Mihur Aklil Woreda Plan Commission Office strategic plan document (2022)

3.2. Research Design

This research used the descriptive study design. Because it presents facts & reality about the CBHI prospects & challenges at existing condition in the area of the study. To this end, the study

employed a cross-sectional research design. This design has been chosen in order to capture data from many respondents at one point in time in the study area, given the quantitative nature of require data and shortage of time. Besides, in order to analyse the challenges and prospects of community based health insurance in the study area in an in-depth and detailed manner, this study has deliberately been made to be a case-study.

3.3. Research approaches

The approach employed in this study was mixed research approach, which is a procedure for collecting, analyzing and "mixing" both quantitative and qualitative data at some stage of the research process within a single study.The qualitative data was used to triangulate the response of the participants gathered a through structured questionnaires which had been computed on SPSS in descriptive statistics to fully understand the research problem in depth.

3.4. Sources of data

The study employed both quantitative and qualitative types of data. The quantitative data were gathered information using questionnaire while the qualitative data were collected using semi structured questionnaire, FGD, KII and in-depth interview with structured checklists.

3.4.1. Primary Data Sources

To achieve the objectives of the study, primary data sources were collected from firsthand information. The sources of primary data addressed members of CBHI through a questionnaire and had been collected through closed ended and some open ended questions. Furthermore, key informant interviewee (8 stake holders)including Woreda CBHI coordinator, health center heads, health extension workers, Woreda and Keble CBHI board members and nurses. Focus Group Discussion (10 people) including Keble CBHI board members, beneficiaries and Health extension worker were participated in the discussion at each selected cluster.

3.4.2. Secondary Data Sources

In this study, information from the secondary sources of data was collected from different Published and unpublished materials which included government official documents such as health Plans, reports, and evaluation checklists, manuals, and performance evaluation reports of woreda On CBHI implementation it was used as inputs of main sources of secondary data.

3.5. Target population

The target population was CBHI beneficiaries' who have more than one years' experience (8383) taken from 2022 Mihur Aklil Woreda health sector performance report. This data has been taken because it would cover those households who had a better experience in utilizing CBHI services at health facilities.

3.6. Sampling technique and sample size

3.6.1. Sampling technique

Household units who had been members of CBHI was the unit of analysis in this study, in which, household heads would have been contacted to fill up the questionnaire. Multistage cluster sampling of probability sampling technique methods had been used to represent the sample population by clustering the woredakebele by two agro ecology (10 Dega and 20 Weyenadega) from the two agro ecological category three kebeles from each divisions one from high performers, one from medium performers and the other from low performers with a total of six kebeles. Hence, purposively households enrolled less than one year had been excluded in order to get very depth information from those who have good enrollment & stay with long time on schemes. Thus the researcher had randomly selected respondents for the data collection through the questioner, in depth interview and KPI from the household.

.Mihur Aklil Woreda has been selected because of its low performance among the zonal districts which has a CBHI coverage of 37% according to 2022 zonal evaluation performance (taken from woreda health office document) and other institutional, infrastructural, and topography barriers compared to the other districts in the zone.

3.6.2. Sample size determination.

The total target population from the selected six kebele was 1507(taken from woreda 2022 performance evaluation document).

Taro Yamane Sample size formula (Yamane, 1973), have been used for small population

$$n=\frac{N}{1+N(e2)},$$

Where, n= required sample size, N= population size, e=acceptance sampling error (level of precision), always sets the value of 0.05.

At reliability level 95% or significance level 0.05; z=1.96

Hence, $n=\frac{N}{1+N(e2)},$

$$n=\frac{N}{1+N(e2)}=\frac{1507}{1+1507(0.052)}=\frac{1507}{1+1507(0.0025)}=\frac{1507}{1+3.7675}$$

$\frac{1507}{4.77}$ =316 +10% contingency=348

Sample size determination from each kebele is determined using proportionate allocation rule as from kebeles target population size , $\frac{nR}{NR}=\frac{n}{N}$

Where n=sample size=total number of CBHI beneficiaries in the kebele. Hence using sampling frame formula the sample size from each kebele is determined as shown in table below.

Table 1.Population and sample selection of the study

Agro ecological category of kebeles	Performance category of kebele	Name of selected kebele	Total population who have more than 1 years' experience on CBHI (Ni)	Sampled population (ni)	%
dega clusters	High performed	Chinbe	301	63	20%
	Medium performer	Megeran	215	45	14.3%
	Low performer	Kechin	153	32	10.2%
Weynadega clusters	High performed kebeles	Mekorkor	436	91	28.9%
	Medium performer	Yebejeche	170	36	11.2%
	Low performer	Echene	232	49	15.4%
Total			1507(N)	316	100%

Source: Taken from health office 2014 data

3.7. Methods of data collections

In-depth interview were conducted from 316 sampled CBHI beneficiaries who had at least two years of experinces in utilizing CBHI services at health facilities. Structured questionnaires were used to to gather the required information from the respondents. kebeles were chosen based on agro-ecology and performance criteria.Villages and participants were randomly selected to contact the households for interviewees based simple random sampling techniques. Focus Group Discussion/FGD with 10 stake holders (CBHI board members,DAS, HEWS, elders, influential community leaders ,women representatives and youth representatives were conducted at two agro ecological clusters i.e. one from high land clusters and one from low land clusters. At woreda level KII was conducted with stake holders, CBHI managers and board members. Documents were reviewed from annual report of the woreda health.

3.8. Data collection instruments

3.8.1. Questionnaire: Administered for CBHI members who had more than two years experiences.To collect data, semi-structured questionnaires (both open ended and close ended questions) had been developed in English language and translated in to Amharic. Six (6) experienced data collectors were recruited based on their proficiency and they had been trained on the data collection techniques and on the content of questionnaire.

3.8.2. Key Informant Interview/KII/

At woreda level one KII discussion was conducted. Eight participants were participated in the discussions. People (expertise) who are responsible for implementing CBHI scheme at different levels such as design and implementation, management and governance, regulatory framework, sensitization, capacity building, and CBHI fund management were participated. As part of the qualitative survey, KII had been carried out using a guide developed for this purpose and attached as Annex.

3.8.3. Focus Group Discussion/FGD/

10 participants were participated at each FGD at two clusters. Focused Group Discussion was conducted with kebele CBHI board members, beneficiaries, Keble administrators, Health extension worker and Development agents (DAS), youth representatives, women representatives participated in the discussion. Focus group discussion was employed to better understand Communities' perspective and consensus regarding benefit package, quality of services provision and health services utilization.

3.9. Reliability and Validity of the Instruments

According to Drost(2011) ,reliability is “the extent to which measurements are repeatable when different people perform the same measurement on different occasion ,under different condition supposedly with alternative instruments which measure the construct or skill “.It can also be defined as the degree to which the measure of a construct is consistent or dependable. “The extent to which a measure adequately represents the underlying construct that is supposed to measure” is called validity. Checking the validity and reliability of data collecting instruments before providing to the actual study subject is the core to assure the quality of the data Drost(2011). From the final multiple linear regeression model analysisthe Rsquared value was 0.902 which shows astrong direct relation ship between the dependent and independent variables indicating that the model used is abetter interpreting model.In addition the T value was greater than one at 0.05 significance levele, this shows that the data collecting instruments were valid and reliable so that it can be replicable at any time and space. The linearity, heatroscadacity and colinearity assumption was tested by the p-p plot; scatter plot and normal distribution curves as shown in annex, which indicates the suitability of the chosen model to show the relation ship between the dependent variables and independent variables.

3.10. Ethical Considerations

The researcher had taken a formal letter from Wolkite University at the College Developmental studies and Management, to approach different offices. The privacy of participants had been abided by the rule of confidentiality. Audio-tape recording had been made after obtaining the consent of the participants and notes being taken during the interviews and the FGD.

Before starting the interview or the FGD, the purpose of the discussion had been clearly explained to make sure that the participants and discussants could understand the topic to be addressed. Both the interviews and FGD were held in Amharic and at convenient times for the participants. In order to insure confidentiality, the participants weren’t asked writing or telling their names.

Furthermore, the researcher assured participants that their responses for the interview and focus group discussion will be used only for the intended purpose and after completing the research; the researcher will clear away the participants' responses as no more required.

3.11. Data Processing and Analysis

The data gathered through structured questionnaire had been Processed via SPSS version 23(Statistical Package for Social Science) in order to get descriptive statistics. Results have been expressed through descriptive way such as frequency, percent, mean & standard deviation. To show the effects of the independent variables on the dependent variable multiple linear regression model has been used as most of the variables are categorical and some are liker scale data. The qualitative data gathered through interviews, using open ended questions of the questioner and document review was analyzed via categorization or type of the question item as putted in the questionnaire & interview, FGD. In line with the computed spss data on indepth interview triangulation was done in parallel by discussing the views of KII and FGD.

4. RESULTS AND DISCUSSION

4.1. Introduction

In this section the major findings of the research work are presented, interpreted and discussed in logical way. To gather the required information primary data was collected by simple randomsampling method from CBHI beneficiaries after multistage clustering of the district kebeles based on agro ecology and performance criteria. From the planned respondents (316) only 310 response data was used for analysis purpose which covers 98.1 % of planned sampled population. The remaining 6 responses were lost during data handling, transport and storage stage.

Key informant interview, in-depth interview and focused group discussions were conducted with stake holders and target groups for triangulation purpose. During sampling stage, performance of the district kebeles and agro ecological information of the district was taken from the authorized government body and attached at the end of this paper as annex. The data was analyzed, interpreted and discussed using tables, tabulation graphs, frequencies and statistical analysis. Secondary data was used for triangulation purpose. The qualitative data gathered through interviews, open ended questions and secondary data were analyzed in narration & categorized based on the type of questions raised in the study.

4.2. The Socio-Demographic Background Information of the respondents

Table 2.Summary of basic information of the respondents

Basic information of the respondents		Number	%
Sex of the respondents	Male	250	80.6
	Female	60	19.4
Occupational status of the respondents	Farmers	253	81.6
	Merchants	31	10
	Daily laborer	17	5.5
	disability or Bajaj drivers	9	2.9
Age category of the respondents	18-59 years old	197	63.5
	60-64 years old	79	25.5
	>=65 years	34	11
Role of the respondents	Father	220	71
	Mother	59	19
	Sons/daughters	31	10
Educational level of the respondents	Unable to read & write	143	46.1
	Able to read & write	105	33.9
	Primary education complete(1-8)	46	14.8
	Secondary education complete(9-12)& above	16	5.2

Source: field survey 2023

310 respondents were contacted during primary data collection at house hold level, 250(80.6.%) of the respondents were male whereas the remaining 60(19.4%) were female. From this we can conclude that most of the respondents were male participants.

The occupational status of the respondent were 253(81.6%) farmers, 31(10%) merchants, 17(5.5%) daily laborer and the remaining 9(2.9%) were either jobless due to disability or Bajaj

drivers. This shows the majority of the respondents were farmers. This implies that if the health conditions of farmers are improved through CBHI service packages it will have a triple down effect on production &productivity. From the aggregated data 63.5%(197) of the respondents lied in age group18-59 years which is the productive age groups, 25.5%(79) of them are in age group 60-64 years old and the remaining 11% of the participants were in the age group >=65 years. The age output data indicates that the share of productive age group is 63.3% which were much more than the other two categories'. The educational level of the respondent was described as 46.1%of the respondents were unable to read and write, 33.9% of them were able to read and write, 14.8% of them had attained primary school education, 5.2% of them had attained secondary education.

From this summarized data we can conclude that the majority of the households were unable to read & write which might be the other obstacles in convincing the communities to enroll on CBHI programs.

4.3. Type of the respondents' CBHImembershipstatus.

Table 3.Summarizes the participants' CBHI membership status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	indigenous members	70	22.6	22.6	22.6
	Non indigenous members	240	77.4	77.4	100.0
	Total	310	100.0	100.0	

Source: field survey 2023

From the total 310 participated respondents 70 of them (22.6%) were indigenous (poorest of the poor's) members and the rest 240(77.4%) were none indigenousmembers. Indigenous members were identified as poorest of the poorest by the local government in relative comparison of their lower possession of land size which is <02.5 hectares, disability and chronically illness cases that made them slightly lower income groups relative to the other well of households due to resource availability factors.Hence, the cost share for indigenous members relies on the government body. Those of the well of households were still not CBHI members on the district CBHI scheme which contradicts with the principles of financial risk sharing among the households.

4.4. Identification of the available resources that would be necessary in order to successfully implement community based health insurance in Mihur Aklil Woreda.

4.4.1. Data presentation on inefficient utilization of the available resources.

*Table 4.*Compares the utilization level of CBHI board role with other mobilization sessions as information sources to identify beneficiaries concerns on CBHI issues

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	on mobilization stage	123	39.7	39.7	39.7
	on public forum at health facility level	59	19.0	19.0	58.7
	on fee payment for renewal of ID	128	41.3	41.3	100.0
	Total	310	100.0	100.0	

Source: field survey 2023

The participant suggested that only 27% the total respondent agreed on the proper deliver of board role and public forum discussions with beneficiaries' to share their concerns on CBHI related issues with concerned decision making bodies and officials at health facility level. Participation and involvement of beneficiaries at different stage of a program is one determinant factor for the successful implementation of programs which has a profound effect on increasing the low coverage of the districts CBHI performance.

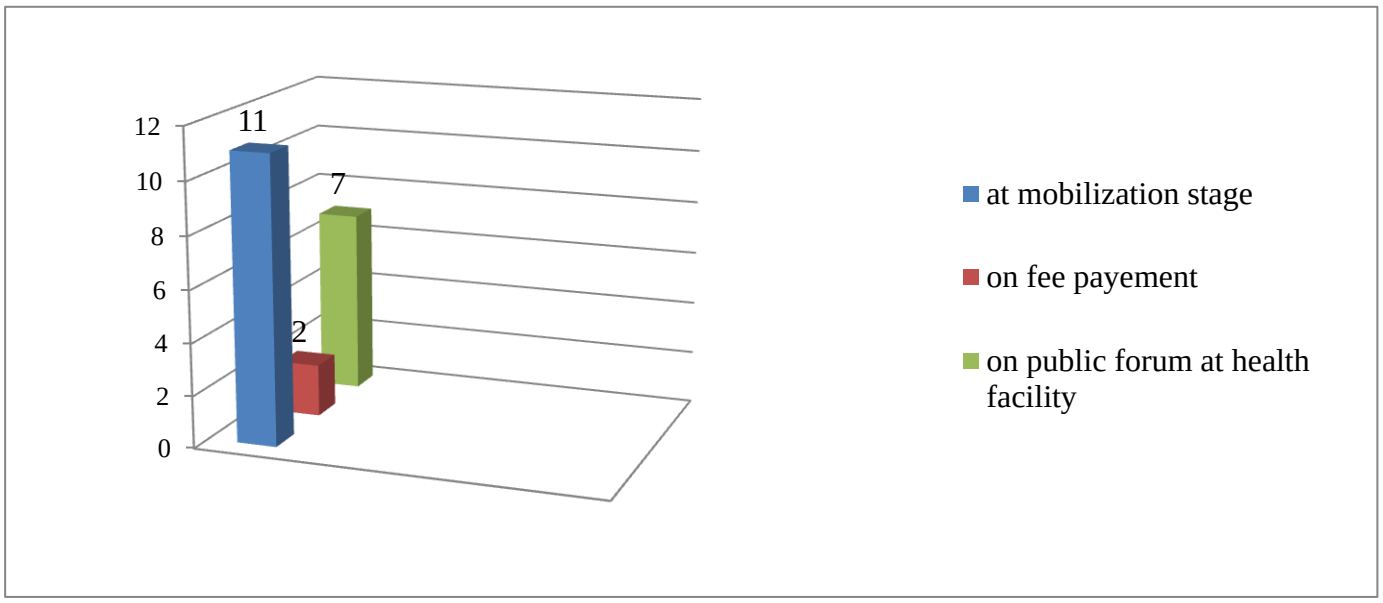


Figure 3.FGD responses on participation with stakeholders/board members.

Source: field survey 2023

From the tabulated data on FGD among the 20 participants only 7 of them which covers 35% of the participants participated on public forum at health facility to share their concerns on CBHI service issues the remaining 65% participated either at mobilization period or on fee payment time. This indicates that the board role was not fully utilized at the study area.

Table 5.Shows efficiency of the district's CBHI scheme in utilizing community networks for CBHI awareness creation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	HAD	62	20.0	20.0	20.0
	Religious leaders	42	13.5	13.5	33.5
	CBOS	23	7.4	7.4	41.0
	CBHI Workers, HEWS	162	52.3	52.3	93.2
	Television & radios	21	6.8	6.8	100.0
	Total	310	100.0	100.0	

Source: field survey 2023

As indicated above on utilization of community networks for CBHI awareness creation, the district was weak in utilizing the capacities of religious leaders and CBOS to convince members to enroll on CBHI program.

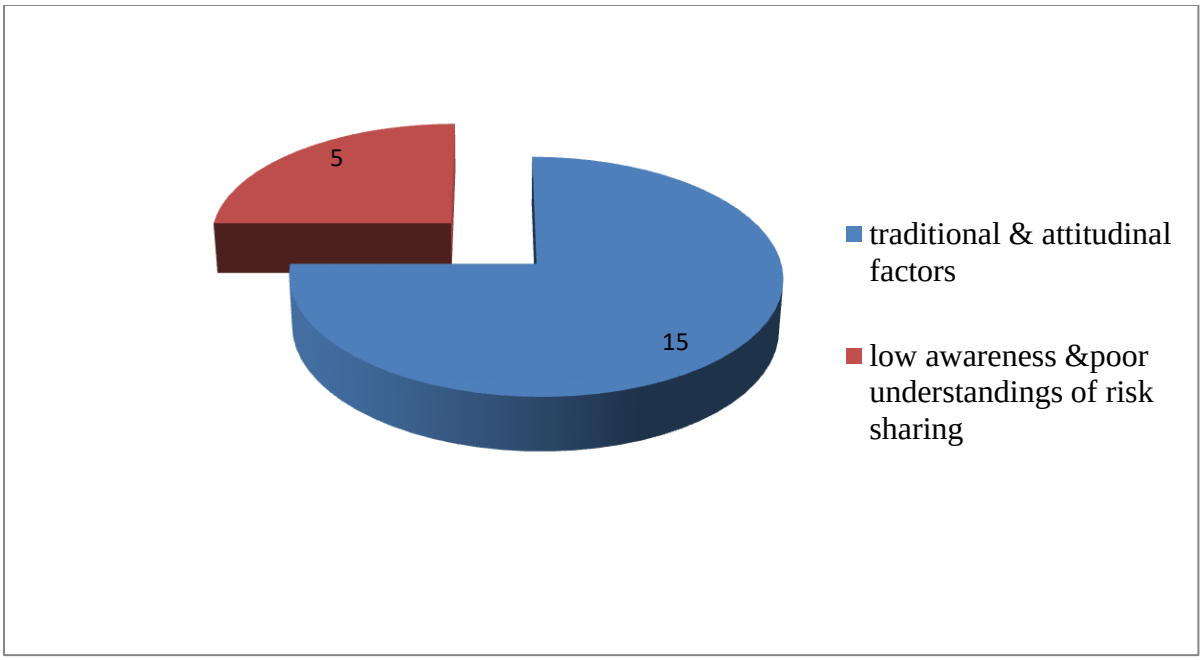


Figure 4.FGD reasons for the low CBHI coverage of the district.

Source: field survey 2023

Among the 8 participants in KII discussions 6 of them replied the causes of low coverage of the district to "traditional and attitudinal factors" attributed to seeking medical care at urban areas because of "urban family relations "&"seeking of rehabilitation & refreshments"? In addition they reasoned out low awareness and poor understanding of risk sharing.

4.4.2. Interpretations of data on the available resources that would be necessary in order to successfully implement community based health insurance in Mihur Aklil Woreda

Data indicating the efficient utilization of available resources were collected as presented above in tables and tabulation graphs. To this level the efficient delivery of board roles and public forums, efficient utilization of the available collected community funds, proper utilization of community capacities to increase the district CBHI coverage were assessed in the study. The participant suggests that only 27% the total respondent agreed on the proper deliver of board role and public forum discussions with beneficiaries'. In addition 48.1% the respondents agreed on the delay of the collected available community funds to be transferred to districts' CBHI account on time varying from 2.3months to more than a year.

As indicated in the participation part above the district was weak in utilizing the capacities of religious leaders and CBOS to convince members to enroll on CBHI programs. From secondary

data taken from health office from the study area .There is a problem of transferring the collected funds to woreda CBHI account ,for instance169 voucher receipts distributed to kebeles to collect CBHI members fees since 2007/2008 fiscal years were not collected until 20111/2012 with an audit deficit of 495,000 Ethiopian Birr. This shows that there was a gap with the attitudes of Keble leaders (KA) and woredaadministrations in understanding the urgency of the CBHI fees; as a result the woreda health office was unable to reimburse the required amount of money to health facilities on time which in turn puts a heavy burden in medical logistic supplies. Primary data collected from KII and FGD confirms this challenge. For example out of the 20participants' inFGD13 of them replied their participation on CBHI issues either at mobilization or fee payment stage. This shows that the board role in identifying &solving routine CBHI implementation bottlenecks was very weak which shows inefficiency in utilizing human resource orcommittee roles.

Participation and involvement of beneficiaries at different stage of a program is one determinant factor for the successful implementation of programs which has a profound effect on increasing the low coverage of the districts CBHI performance.

Hence the respondents were asked their participation level in CBHI related program. Their response was analyzed& the computed data shows 39.7 %(123) of the respondent participated on CBHI related issues with hospital, health center and woreda officers and program managers at mobilization stage, 19 %(59) of the respondents were participated on public forums at health facility level on discussing service provision issues, 41.3 % (128) of the respondents' participated on fee payment stage at house to house level.

Among the 8 participants in KII discussions 6 of them replied the causes of low coverage of the district to "traditional and attitudinal factors" attributed to seeking medical care at urban areas because of "urban family relations" &"seeking of rehabilitation & refreshments"?

In addition they reasoned out low awareness and poor understanding of risk sharing.This shows that the district was inefficient in shaping the attitudes of families living in urban areas by utilizing the full capacities of informal networks like religious leaders&CBOS ,mass medias& political influential bodies for sensitization & mobilization purpose during their visits to rural areas at "Meskel "& "Arefa" festivals.on the other side the communities risk sharing practices in time of sciknesss through the arrangements of local "ediris",i.e.,borrowing was practiced in the societies .This was a good practice and opportunities to divert it to CBHI programs by discussing

the informal leaders through negotiation. This opportunity was inefficiently utilized. According to Ahmed(2018) and Purohit(2014) individuals with better health were less likely to enrolling CBHI schemes. Therefore mandatory enrollment should be started to secure financial protection against the cost of illness, preker,etal(2012). Hence in the study area the coverage of CBHI was not only low due to voluntary membership procedures ,in addition significant numbers of the participants were indigient members or either have chronic family members or disable family members showing the adverse selection of members that contradicts with the priniciples of risk sharing and mutual support.There was also gap in attracting urban area investors to invest on pharmaceutical services and private health services at rural areas of their birth places to solve geographical health facility inaccessibility issues..

4.5. The challenges in implementing community based health insurance in MihurAklilWoreda

4.5.1. Demand side challenges.

One of aim of the study was identifying the demand side challenges as formulated by the study problem statements, objectives & research questions .To this end questions related to demand side challenges were included in the questionnaire and the collected data has been analyzed in logical way here.

4.5.1.1. Inclusion of none basic family members as basic family

Table 6.Family size of the respondents

Basic information of the respondents	Description	Number	%	Remarks
Family size of the respondents	Total family size in the house hold	1611		Average 5.2 per house hold
	Family size >=18 years	760	47.2	
	Family size expected to pay additional CBHI membership enrollment fees	719	44.6	
	Family size that didn’t pay additional fees during CBHI id renewal period	680	94.6	

Source: field survey 2023

The total family size of the respondent was 1611 and in average the family size of a single household has were 5.2.

The total number of family members whose age were>=18 years & expected to pay additional membership fees during the house hold CBHI id renewal or provision time was 719.This information was computed for the purpose of triangulation to one of the objectives of the research question.

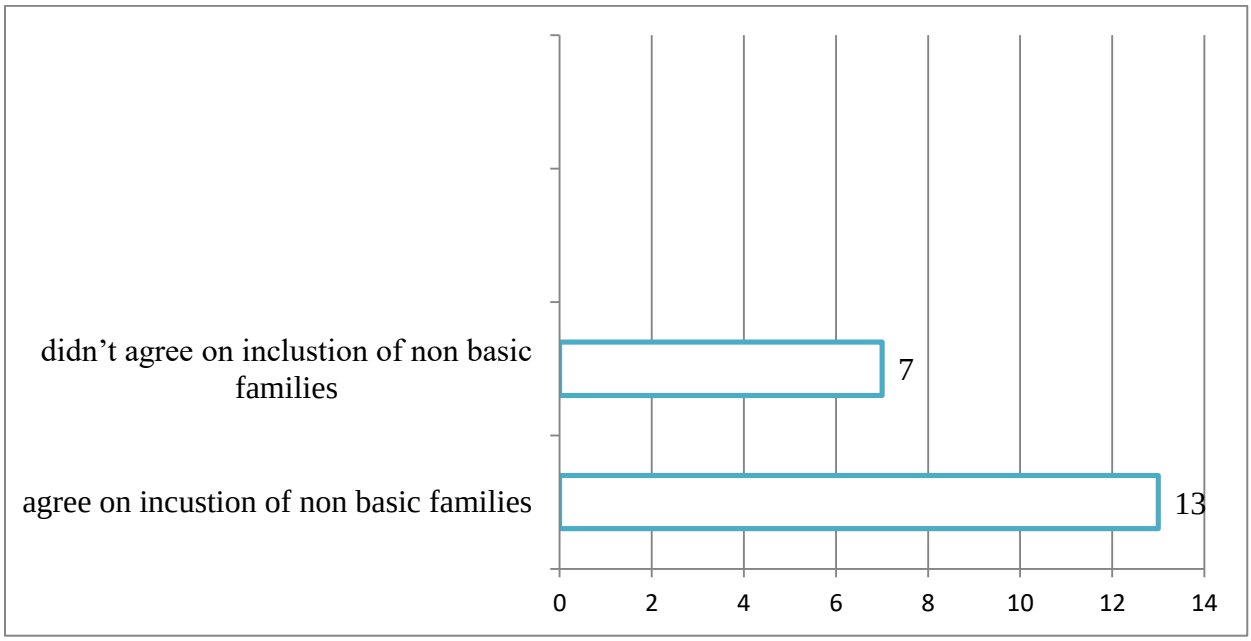


Figure 5.FGD responses on inclusions of non-basic family members on their CBHI id without additional payment.

Source: field survey 2023

Out of the 20 participants in two FGD ,one from the high land area and one from the low land atrea 13 of them replied inclusion of none basic family members on their CBHI id was practiced in their locality without paying additional fees? This shows that there was a gap with the attitudes of KA leaders in understanding the CBHIprinciples of financial risk sharing &mutual support.CBHI can attain sustainability, effectiveness and be long-lasting with the help of social capital in a community; because social capital has a positive influence on the community demand for insurance (Donfouet &Mahieu, 2012).But in this case the principle of social risk sharing was not fully implemented.

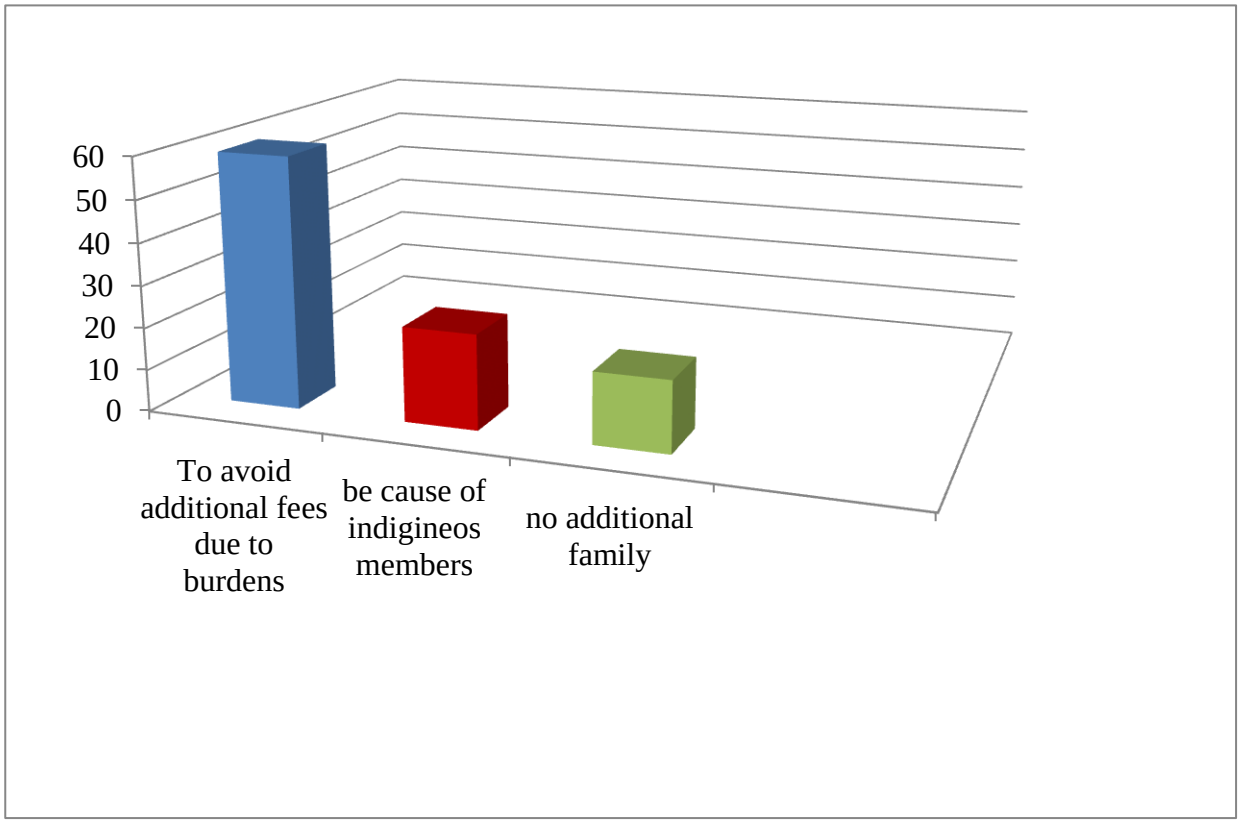


*Figure 6.*Reasons of not paying additional fees for the non-basic family members.

Source: field survey 2023

The respondents were asked for their reason not paying additional fees for the additional families; 59.7%of the respondents say they didn't pay the additional fee "to avoid additional fees" due to financial burden in the season, 17.7%of them replied because we didn't have additional families in the house hold and 22.6% of the respondent says because we were "yedehadeha" or indigenous members (couldn't) afford the fee.

Based on Ethiopian CBHI proclamation NO.213/2000, on article 5 sub article (1) and (6) of the constitution of the Federal Government of Ethiopia "core family" or" basic family "means the spouse and the child of members. "Child" means the natural adopted or stepchild of a member or any child who by acts of the law is under the guardianship of the member and is under the age of 18. Hence from this proclamation a healthy child >=18 years are Expected to pay additional payment in the house hold list. In study problem statement this challenge was articulated as a basic problem in the study area and data was collected to understand the depth of the problem in the district, the analysis was done as follows.

The analyzed output data on the aggregate response of the respondent shows that out of the 719 additional family members 680 of them didn't pay additional fees during CBHI id renewal period which constitutes 94.6% of them. This shows that people are violating the principle of

financial pool risk sharing. The respondents were also asked for their reason not paying additional fees for the additional families and their response is summarized in tabulation graphs. From the tabulation graph 59.7%of the respondents say they didn't pay the additional fee to avoid additional fees due to "financial burden in the season", 17.7%of them replied because we didn't have additional families in the house hold and 22.6% of the respondents say because we were indigenous members (couldn't) afford the fee. From the total population statistics computed data the average family size a single family has was 5.2; hence, one can imagine how much the effect of not paying additional payment was. The KII & FGD discussions data confirms the respondents concern of inclusion of none basic family members on CBHI programs. For example out of the 20 participants in FGD 13 of them replied inclusion of none basic family members on their CBHI id was practiced in their locality.Out of the 8 KII participants 5 of them replied their concern on inculustion of non basic family members in members CBHI id.

*Table 7.*KII and FGD responses on inlustions of non-basic family members on HHS CBHI id without paying additional membership fees

Sn	Data source	Total participants	Did HHS include their non-basic family members without paying additional fees during registration and CBHI ID renewal period		Inclusion rate
			yes	no	
1	FGD	20	13	5	65%
2	KII	8	5	3	62.5%

Source: field survey 2023

As shown in the above table irrational utilization of health sercices were raise by FGD And KII discusstions which affects the financial risk sharing and mutual support priniciples of CBHI implementation programs .Hence, in the long run the financial sustainability might be at risk in the district

4.5.1.2. Starting the program at low CBHI coverage& delay of funds

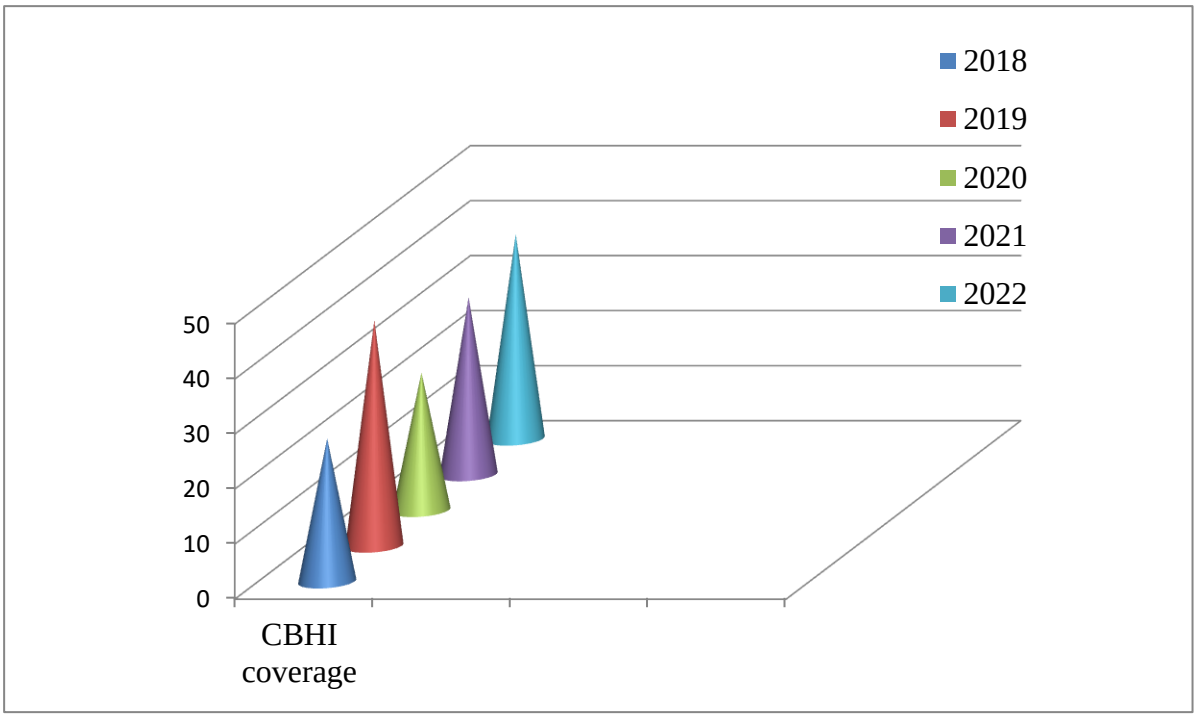


*Figure 7.*Shows 2018-2022 CBHI enrollment data in the district.

Source: Document review information on performance of CBHI on the study area

The graph shows that for consecutive five years (2018-2022G.C) the CBHI coverage of the district is below 50% and it contradicts with the principles of the risk sharing effect of large numbers**.**

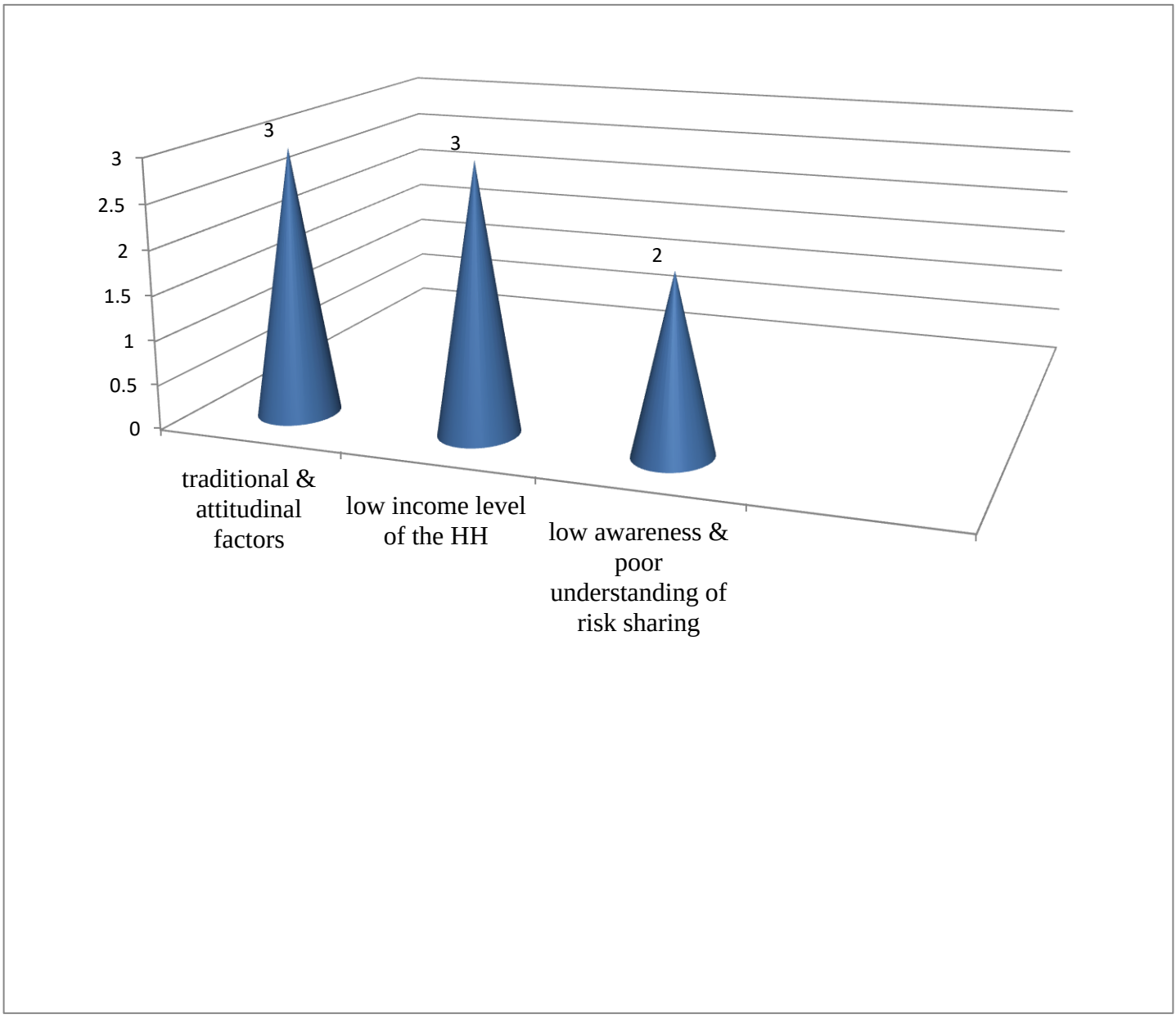


*Figure 8.*KII response on factors associated with low coverage CBHI implementation in the district.

Source: field survey 2023

Among the factors raised by KII to the low CBHI coverage of thedistrict includes “traditional &attitudinal factors”, “low income level of the households” and “low awareness and poor understanding of risk sharing” are the major ones**.**

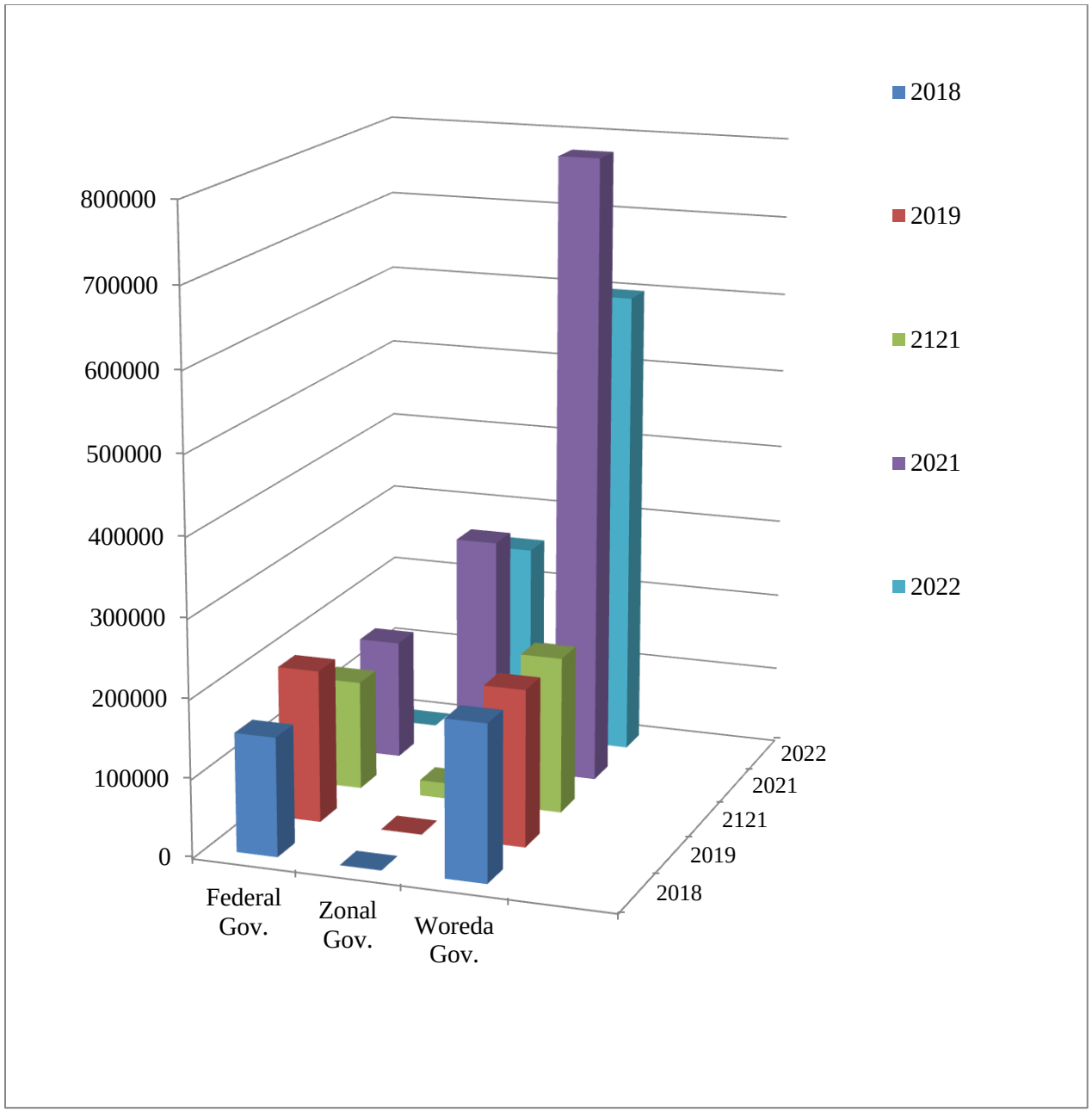


*Figure 9.*Effect of low coverage on budget deficits at each administrative level.

Source: Document review from health office (2014 performance evaluation data)

The graph shows that the role of the woreda government is more than expected in covering the matching funds. There is also a problem of transferring the collected funds at keble level to woreda CBHI account, for instance169 voucher receipts distributed to kebeles to collect CBHI members fees since 2007/2008 fiscal years were not collected until 2011/2012 with an audit deficit of 495,000 Ethiopian Birr. This shows that there is a gap with the attitudes of KA leaders in understanding the urgency of the CBHI fees; as a result the woreda health office is unable to

reimburse the required amount of money to health facilities on time which in turn puts a heavy burden in logistic supplies

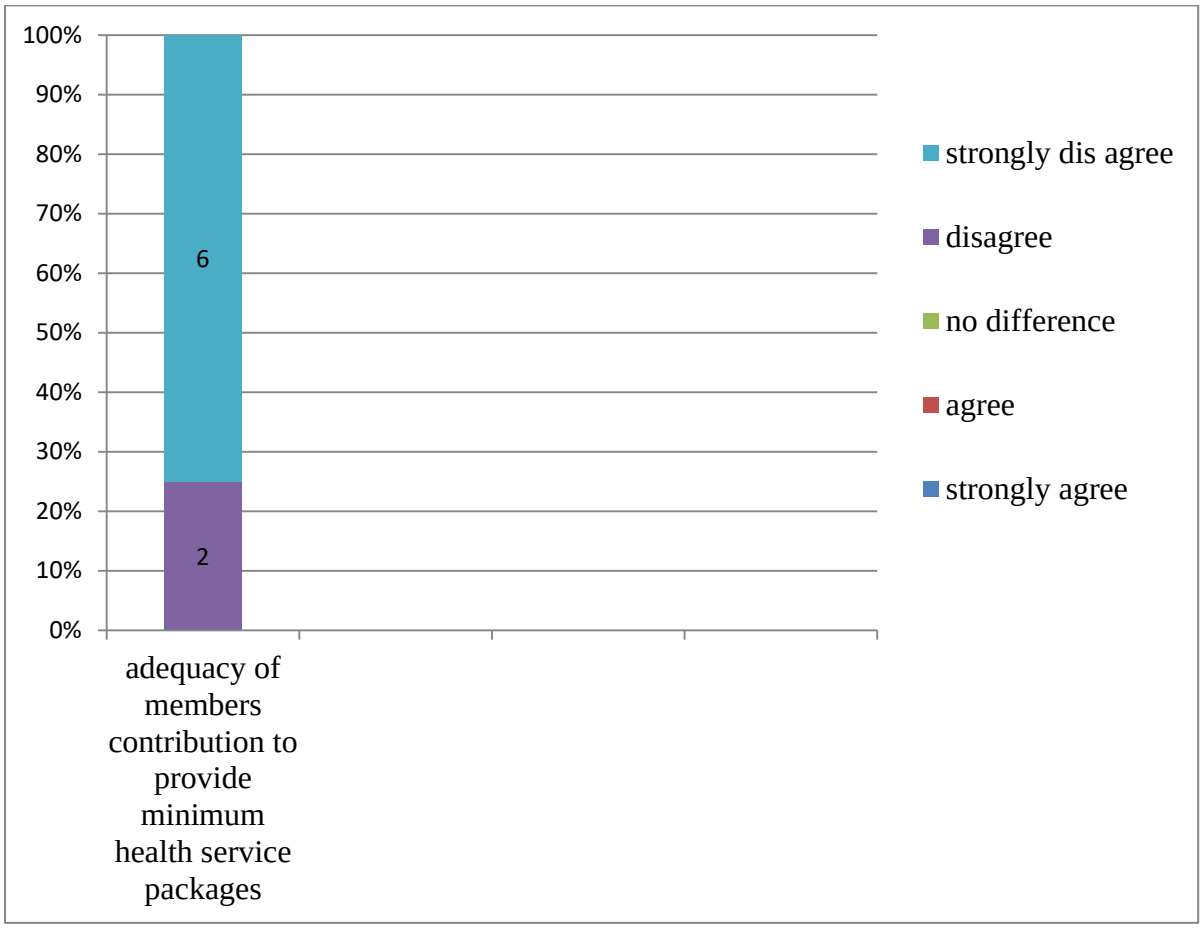


*Figure 10.*Agreement level of KII on adequacy of CBHI members' contribution to provide minimum health service packages.

Source: field survey 2023

Among the 8 KII participants 6 of them strongly disagree with the adequacy of members' contribution to provide minimum health service package based on the standard.

Based on 2014 health sector performance data the CBHI coverage of the district was low which was 37.8% and among the bottom least performed districts in zonal, (zonal evaluation document (2014) data). To understand the effect of low coverage key informant interviewees were asked about the adequacy of members' contribution to provide minimum health service packages. From the aggregate response of the KII participants' six respondents out of eight replied "members' contribution is not sufficient to provide minimum health service packages" Hence the burden of covering the budget deficits relied on government's .In this regard heavy burden lied

on local government at district level. Even if the federal governments & regional governments shares some part of the budget deficit, it was nether sufficient nor on time to solve the emidiate challenges of CBHI members.

4.5.1.3. *Suitability of membership renewal and registration period*

*Table 8.*Suitability of CBHI fund collection and mobilization period

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Suitable	176	56.8	56.8	56.8
	not suitable	134	43.2	43.2	100.0
	Total	310	100.0	100.0	

Source: field survey 2023

From the output data on suitability of mobilization & fund collection period 56.8% the respondent replied the timing of fund collection and mobilization period was suitable for the community because it is a harvesting season, 43.2% of them replied the season is not suitable.

*Table 9.*Recommendation on CBHI membership renewal &mobilization period

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	September-October	114	36.8	85.1	85.1
	starting from November-December	20	6.5	14.9	100.0
	Total	134	43.2	100.0	
Missing	System	176	56.8		
	Total	310	100.0		

Source: field survey 2023

For those respondents who replied not suitable, they were asked to recommend their suitable time to pay the premium fee and their response is summarized. From the summarized data 36.8% of the total respondent recommended the mobilization and renewal period to be launched on September-October, 6.5%of the respondent recommended the mobilization period to be launched from November-December, the remaining 56.8% of them missed to recommend on this topic because they already agreed on the adopted mobilization & renewal period.

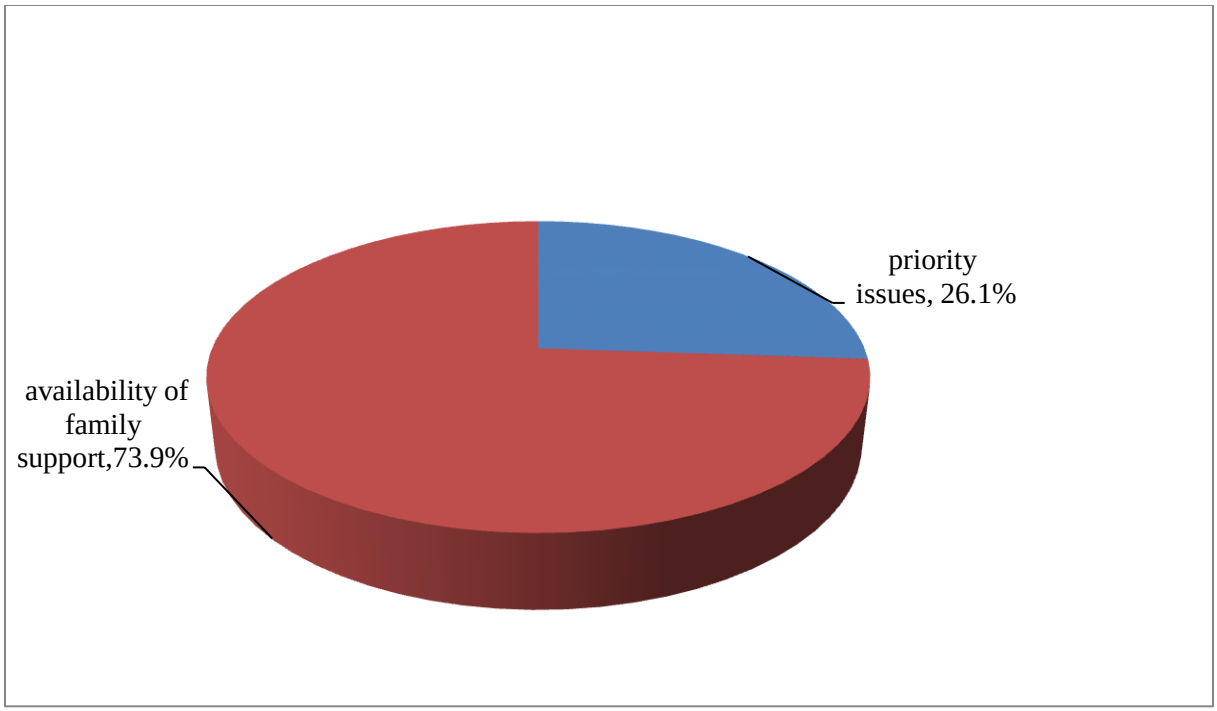


*Figure 11.*Clients' reasons for change of CBHI membership id renewal &mobilization period.

Source: field survey 2023

Those for who recommended to change the mobilization and fund collection period, they were asked to forward their reason for change of mobilization and fund collection period. From the aggregate data 35of them covering 11.3% of the total respondent forwarded their reason because of priority issue in paying school fees, land taxes, sports, harvesting costs and others99% of them which covers 31.9% of the total respondent reason out the availability of family support as their family from urban areas gather together at “meskel” festival during that period and the remaining 176of the participants agreed on the current schedule.

4.5.1.4. *Adverse selection of CBHI members*

*Table 10.*Summarizes the total number of households /respondents /who had disabled family members in their family

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	35	11.3	11.3	11.3
	No	275	88.7	88.7	100.0
	Total	310	100.0	100.0	

The summarized data illustrates the respondents who had disable families irrespective of the size of the family member shares 11.3% of the total participants in the study.

Table 11.Shows the total number of respondents those had chronically ill people in their families

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	38	12.3	12.3	12.3
	No	272	87.7	87.7	100.0
	Total	310	100.0	100.0	

Source: field survey 2023

The analyzed data illustrates the respondents who had chronically ill people in their families' shares 12.3 %irrespective of the size of chronically ill people members.

4.5.1.5. *Attitude on irrational utilization health service through CBHI id*

Table 12.Comparison of health facility visits of clients with their earlier experiences

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Increased more	169	54.5	54.5	54.5
	Increased	36	11.6	11.6	66.1
	the same as before	105	33.9	33.9	100.0
	Total	310	100.0	100.0	

Source: field survey 2023

From this summarized data in average the majority of the respondent increased their visits to health facility for their own reason.

Table 13.Reasons for increasing health facility visits

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no barrier to pay	168	54.2	54.2	54.2
	to use my fee	106	34.2	34.2	88.4
	illness cases	36	11.6	11.6	100.0
	Total	310	100.0	100.0	

Source: field survey 2023

Respondents were asked to reason out their increasing frequency of health facility visits. The summarized data shows 54.2% of the respondent increased their visits because there was no barrier to pay in time of sickness, 34.2% replied they increased their visits because they have the right to utilize their payment, 11.6% of them replied they increased their visits because of illness cases in their family.

One of the principles of CBHI design is to tackle financial bottle necks in the health facility to provide sustainable finance through risk sharing and mutual support of all the members' .If all the households pay the premium the degree and prevalence of sickness and health facility visits of individuals varies from person to person according to his/her own life styles.

To this point the study focused on the availability of chronically ill people, disable families and the share of government sponsored poorest members (indigenous members) in the house hold and the aggregate response of the respondent is summarizedbelow. The summarized data illustrates the respondents who have disable families and chronically ill people irrespective of the size of the family member shares 11.3%and 12.3 % respectively.

In addition the share of government sponsored respondents (indigenous members) covers 26.6%(70) .This shows that the principle of risk sharing and mutual support is in question mark and strategies should be formulated to mobilize and enroll the well of families in the program to assure financial risk sharing. One of the objectives of community health insurance is to increases the health seeking behaviors of individuals when they feel sick.

In the study area there was signals raised by health workers that show irrational utilization of health services by individuals as they went to market areas and the like .To understand the depth of the problem as articulated in the study problem statement, data related to health facility visits before and after enrolling on CBHI program were collected. From the analyzed data 54.5% of the respondent replied their visit frequency increased more, 11.6% of them replied increased more and the remaining 33.9% replied there is no more difference with their earlier visits.

From this summarized data in average the majority of the respondent increased their visits to health facility for their own reason. Following this response respondents were asked to reason out their increasing frequency of health facility visits. Hence the data collected on this variable is summarized. The summarized data shows 54.2% of the respondent increased their visits because there no barrier to pay in time of sickness, 34.2% replied they increased their visits because they have the right to utilize their payment, 11.6% of them replied they increased their visits because of illness cases in their family.

4.5.2. Supply side challenges

4.5.2.1. Quality service provision and accessibility related challenges

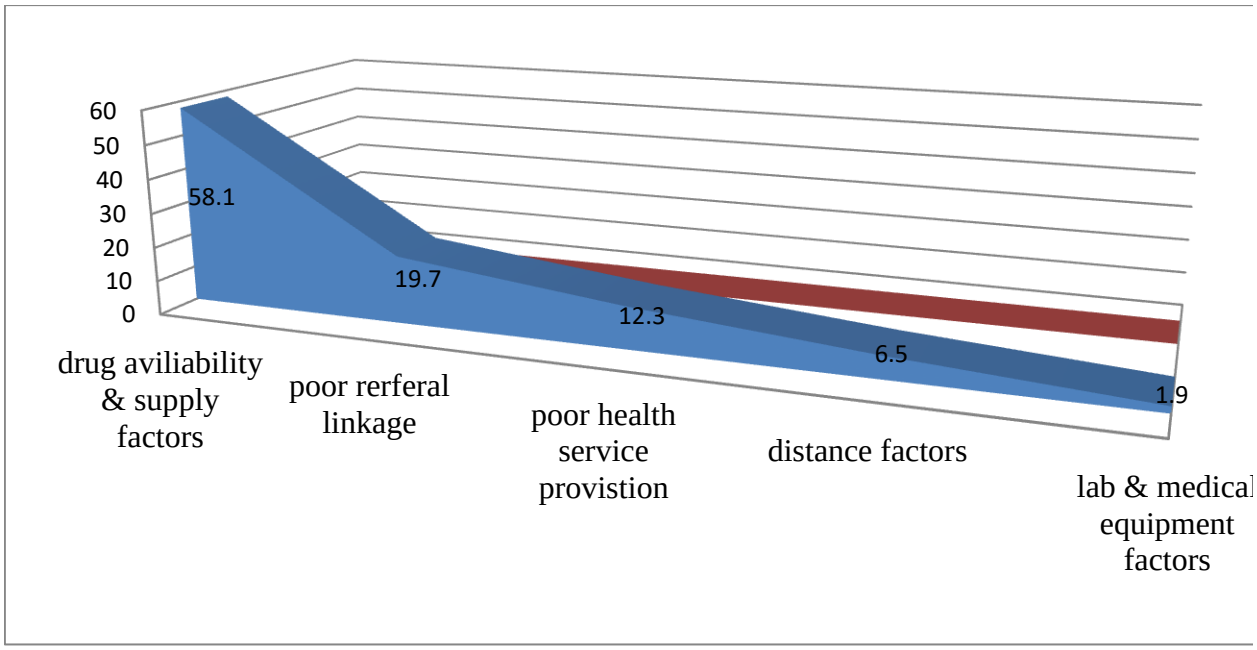


Figure 12.Supply side CBHI implementationchallenges.

Source: field survey 2023

From this summarized data drug availability and poor referral linkage to hospital service were the top two priority supply and access side challenges of the district.

Table 14.Satisfaction level of respondents' on CBHI service provisions

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	175	56.5	56.5	56.5
	Agree	60	19.4	19.4	75.8
	no difference	20	6.5	6.5	82.3
	strongly disagree	35	11.3	11.3	93.5
	Disagree	20	6.5	6.5	100.0
	Total	310	100.0	100.0	

Source: field survey 2023

The participants were asked about their satisfaction level on CBHI service utilization. Out of the total respondent 56.5% replied strongly agree, 19.5% of them replied disagree, 11.5% said strongly disagree, 6.5% replied no difference with earlier service, and the remaining 6.5% disagree.

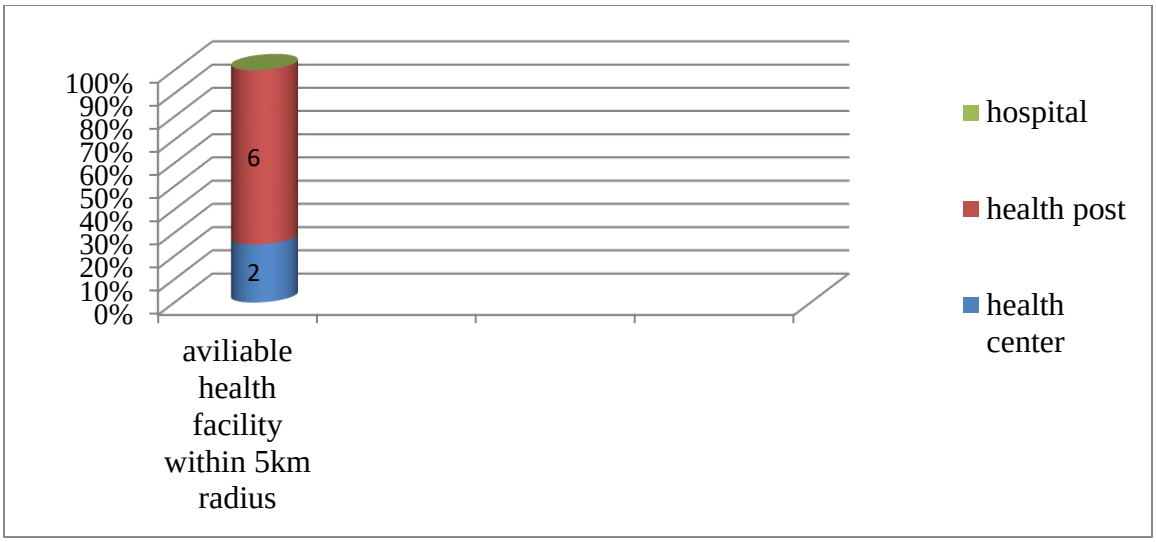
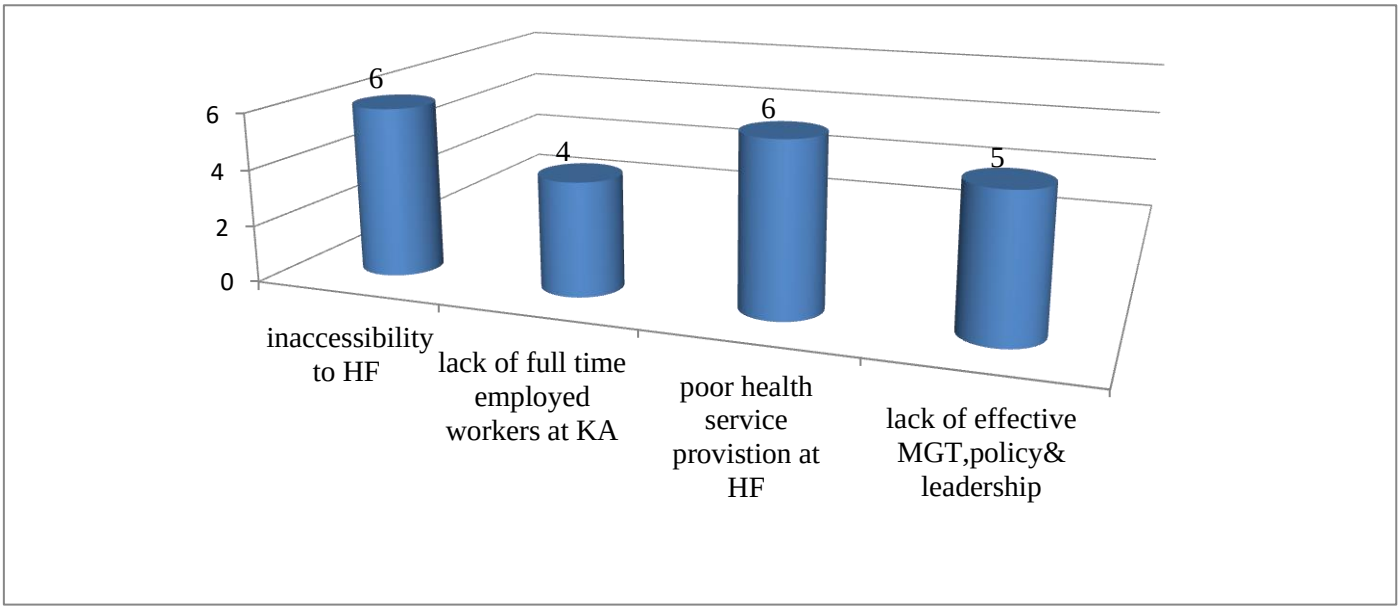


Figure 13.KII responses on availability of health facilities within 5kms from their residence.

Source: field survey 2023

According to KII "due to geographical & distance factors" the district is still in need of additional 3 health centers to provide CBHI service effectively.



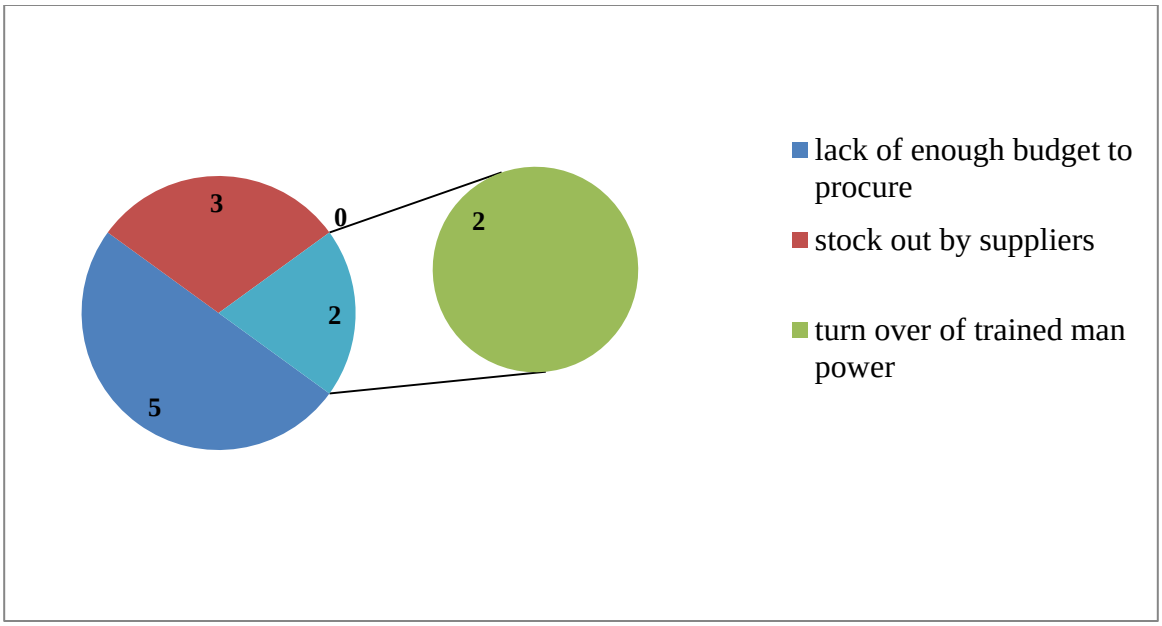


Figure 14.Supply side challenges raised by FGD attributed to the low performance of the district.

Source: field survey 2023

Figure 15.The reasons for shortage of lab service and drugs at health facility level forwarded by key informant participants''.

Source: field survey data2023

Table 15.Availability of health facility within 5kms radius from their residence to deliver CBHI service

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	168	54.2	54.2	54.2
	No	142	45.8	45.8	100.0
	Total	310	100.0	100.0	

Source: field survey data2023

Table 16.Satisfaction level of participants on health service accessibility

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Excellent	129	41.6	41.6	41.6
	very good	38	12.3	12.3	53.9
	Good	18	5.8	5.8	59.7
	Bad	58	18.7	18.7	78.4
	very bad	67	21.6	21.6	100.0
	Total	310	100.0	100.0	

Source: field survey 2023

The effective implementation of community health insurance program needs solving quality and accessibility related challenges. The study focused on investigating the supply side bottle necks in CBHI service implementation programs in the district. The data instrument collected the existing factual information related to the basic supply side implementation challenges and satisfaction level of beneficiaries on CBHI service at their locality.

The analyzed data indicates that related to supply side factors 58.1% of the respondent replied drug availability and supply factors, 19.7% of the respondent replied poor referral linkage to hospital service, 12.3% of the respondent replied poor health service provision factor , 6.5% of the respondent said distance factors to get CBHI service, 1.9% of the respondent said lab and medical equipment shortage and 1.6% of the respondent replied none availability of ambulance service accounts for the supply side challenges . From this summarized data drug availability and poor referral linkage to hospital service are the top two priority supply and access side challenges of the district. The participants were asked about their satisfaction level on CBHI service utilization. Out of the total respondent 56.5% replied strongly agree, 19.5% of them replied disagree, 11.5% said strongly disagree, 6.5% replied no difference with earlier service, and the remaining 6.5% disagree.

KII respondents were asked about accessibility issues related to health facilities, the majority participants replied even if there is no gap from population standard i.e. one health Center for 25,000 population's standard. However, due to geographical & distance factors the district is still in need of additional health centers to provide CBHI service effectively.

CBHI service provision agreement was signed for four of the districts'kebeles out of the districts provenience especially to Ezhaworedaadministration. Hospital accessibility is one of challenges as we discussed above. Most of the Districts households need to get referral service with WKU Specialized hospital but due to prepayment request and budget shortage factors the district is unable to link patients to WKU hospital to provide referral linkage services. Instead CBHI service provisions binding agreement was signed to Butajera General Hospital which is inaccessible in terms of geography and distance factors .This causes most of the households not to enroll on CBHI scheme.

4.5.2.2. *Pharmacy options and availability of full time employed government body*

Table 17.Response of the respondents on availability of optional pharmacyservices and full time employed servants to renew CBHI id,to mobilize and collect funds

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not available	310	100.0	100.0	100.0

Source: field survey data2023

From the computed aggregated data on the response of participants on availability of health facility within 5km radius from their locality 54.2%(168) respondents replied there is access to facility ,45.8% of the respondent replied there is no health facility to provide CBHI services within 5kms radius from their locality. The participants were also asked about their satisfaction on health facility accessibility to provide CBHI related services,41.6% of the participant replied excellent,12.3% replied very good,5.8%good, 18.7% bad, 21.6% replied very bad respectively. From the computed output data on availability of pharmacy services and full time employed human power to mobilize and renew CBHI id all the participants relied no to both of the items.

4.6. Prospects of implementing community based health insurance in Mihur Aklil Woreda.

4.6.1. Data presentation on the prospects of implementing community based health insurance in Mihur Aklil Woreda.

With all its challnges CBHI implementation had played positive impacts on some house holds and their families. To accelerate and achive the objectives of the program, identification of best experinces and positive impacts of CBHI on members were crutial to show the the future prospects of the program implementation and to scale up best practices and lessons from beneficiaries and service providers. Hence, impacts and positive roles of CBHI implementation in the district was assessed and presented as follows to show its future prospects.

Table 18. Impacts of CBHI service on family

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	saving of income	189	61.0	61.0	61.0
	improvement of family health status	83	26.8	26.8	87.7
	increased productivity	38	12.3	12.3	100.0
	Total	310	100.0	100.0	

Source: field survey 2023

The analyzed data suggests that on impact data analysis 61% of the respondents said the program have positive impact on their income, 26.8% of the respondents said CBHI services have improved their family health status, 12.3%of them agree on increased productivity impact of the program. This shows CBHI implementation have future prospects in changing the lives of households and communities at large if it is implemented based on the standard.

*Table 19.*Means of covering health costs before enrolling on CBHI program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	from out of pocket	135	43.5	43.5	43.5
	traditional healers	44	14.2	14.2	57.7
	Borrowing	109	35.2	35.2	92.9
	CBOS&Edirs	22	7.1	7.1	100.0
	Total	310	100.0	100.0	

Source: field survey 2023

Data was collected on the means of covering their health costs before enrolling on CBHI programs. From the aggregated data 43.5% of the respondents were covering their health costs using out pocket expenditures, 14.2% of the respondents were using traditional healers and the remaining 35.2% of them were covering their health costs through borrowing from CBOS and Edris.

4.6.2. Interpretation of data on the prospects of implementing community based health insurance in Mihur Aklil Woreda

Data that indicate future prospects of community health insurance in the district, like impact of community health insurance on family life, agreement level of respondents on the benefit of community health insurance, their means of covering health costs before and after enrolling on community health insurance programs were collected from the respondents. The analyzed data suggests that on impact data analysis 61% of the respondents said the program had positive impact on their income, 26.8% of the respondents said CBHI services had improved their family health status, 12.3%of them agreed on increased productivity impact of the program.

The agreement level on improvement of their health status was assessed the respondents replied32.3% strongly agreed, 11% no difference, 31%agreed and the remaining 25.8% disagreed, respectively. In addition data were collected on the means of covering their health costs before enrolling on CBHI programs. From the aggregated data 43.5% of the respondents were covering their health costs using out pocket expenditures, 14.2% of the respondents were using traditional healers and the remaining 35.2% of them were covering their health costs through borrowing from CBOS and Edris. Hence if the challenges discussed above on supply and demand side implementation barriers are resolved through effective leadership, management

& policy measures. There are indictors listed above which shows prospects of CBHI in the study area.

FGD participants & KII respondents agree on the benefit of CBHI program, i.e. some households who are chronically ill & on need of tertiary medical care could get better medical care through referral linkages to Black Lion Hospital and St. Paulo's Hospital.

4.7. Model interpretation

Because there were several explanatory variables to predict the out come of the response variable (CBHI implementation challenges) by computing explanatory the variables into another four variables MLR model was used to predict the value of the dependent variable based on several independent variables.

The model summary illustrates that the R squared value is 0.950, this shows that 95% of the variance of the independent variable. The R squared value is 0.950 which is largepositive value and near to one, this implies that the linear regression model used in the analysis was better interpreting model to show the effect of the independent variables (supply side CBHI implementation challenge and inefficient utilization of the available resources) on the dependent variable (CBHI implementation challenge).From the model summary the residual standard error is was 0.0000 (significant level)which is almost null, i.e. very small, this confirms that the predictors were better variable to show the relationships at 95% confidence interval. That means supply side CBHI implementation challenge and inefficient utilization of the available resources have significant effect on the district's CBHI implementation program.

The beta coefficients for thevariable inefficient utilization of the available resources and Supply side CBHI implementation challenges are 0.950 and 0.313 when back ward regressed on SPSSrespectively, which was positive value indicating that as the value of the independent variable (inefficient utilization of the available resources and Supply side CBHI implementation challenges) increases the mean of the dependent variable will also increases (CBHI implementation challenges).

But inefficient utilization of the available resources had more effect than the supply side implementation challenges compared to the others. As shown in the back ward effect on regression model, the excluded variable is demand side implementation challenges and prospects' of CBHI .From this it is possible to conclude that demand side CBHI implementation

challenges and prospects of CBHI have less effect on solving the districts CBHI implementation challenges compared to the supply side challenges and inefficient utilization of the available resources. The histogram of the residue is normally distributed and no curve above the graph as shown in histggram graph below.The catter plot shows at all levels the residue is below and above the graph showing that the the residue mean is zero and the linearity assumption was valid.The t value is greater than one and the significance level<0.05, this shows that the independent variable have significant effect on the dependent variables (CBHI participation). From this we can conclude that the regression model best fits the analysis.Hence, the instrument used was valid and reliable.

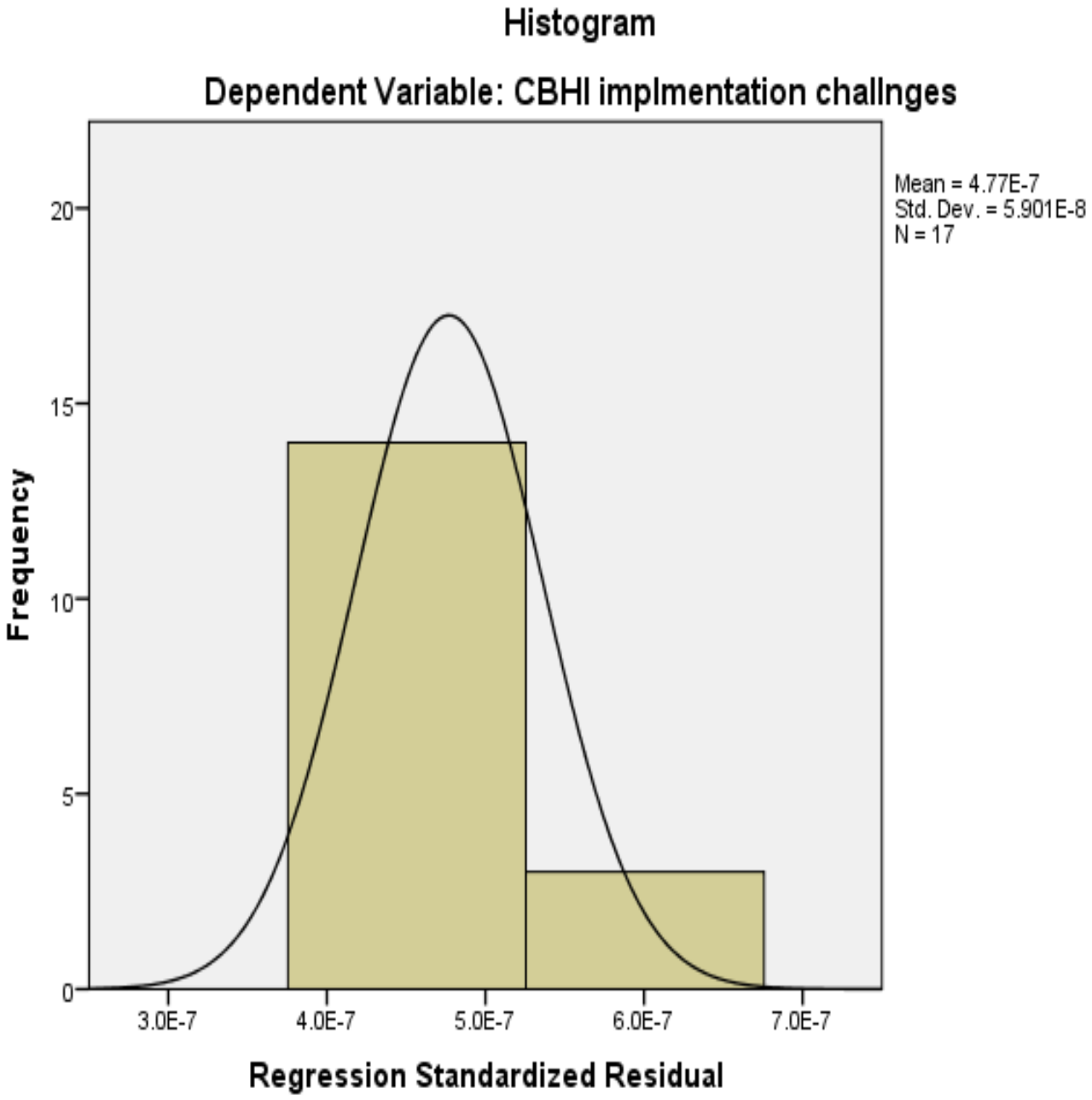


*Figure 16.*Normal distribution histogram curves showing standardized residual regeression.

As shown in the distribution histogram the predicted value is on the horizontal line and the residue is on the vertical line.The histogram curve is normally distributed, i.e no curve above the graph.This shows that the histogram of the residue is nofrmally distributed and hence the assumption MLR is valid.

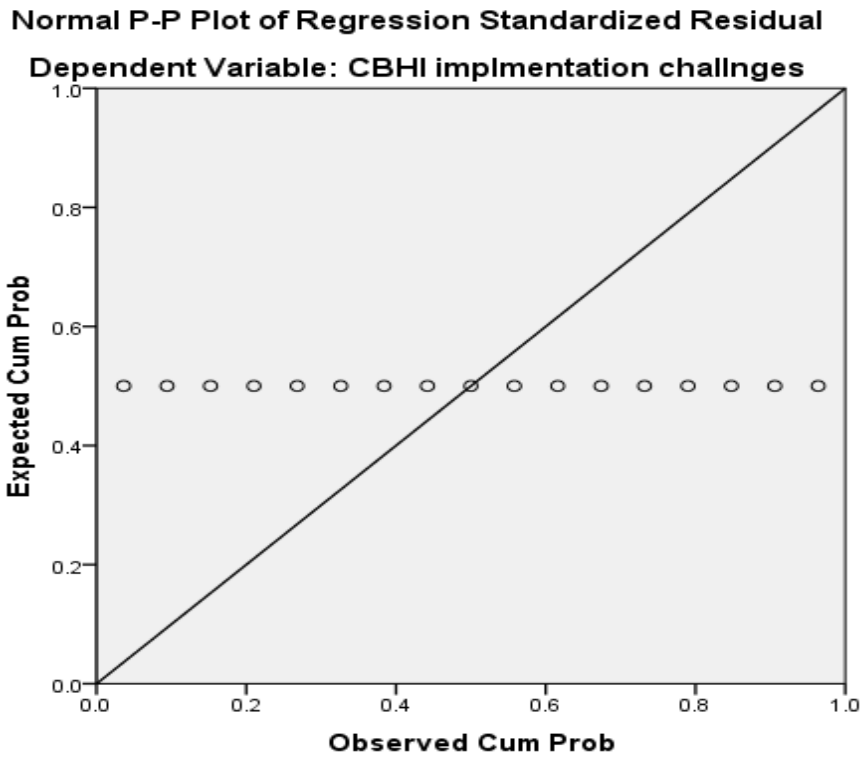


Figure 17.Normal p-p plot of regression standardized residual.

The p-p plot curve shows the direct relation ship between the dependent and independent variable and the mean of the residue is zero because the average residue lies on the horizontal line

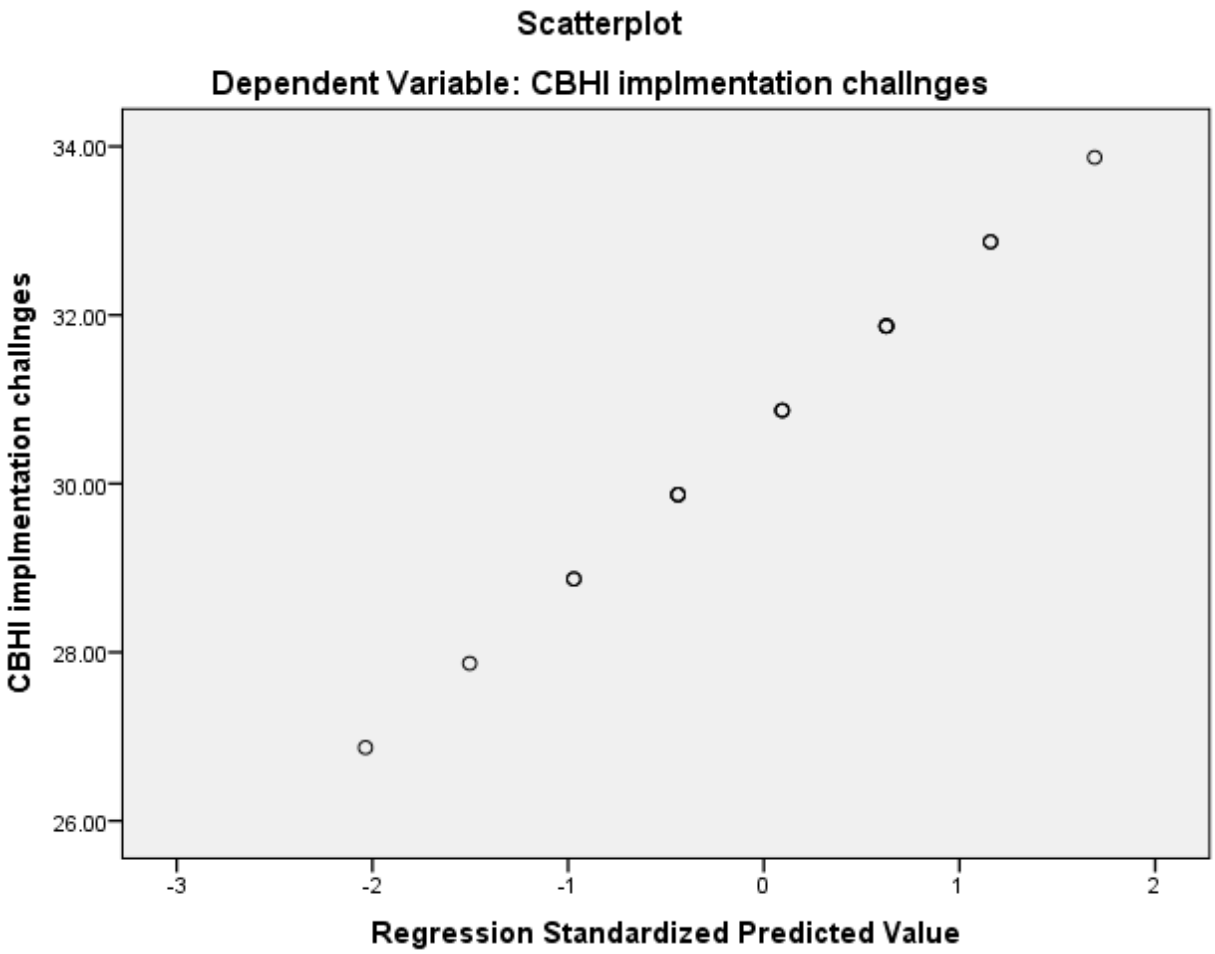


*Figure 18.*Scatter plot of standardized predicted value.

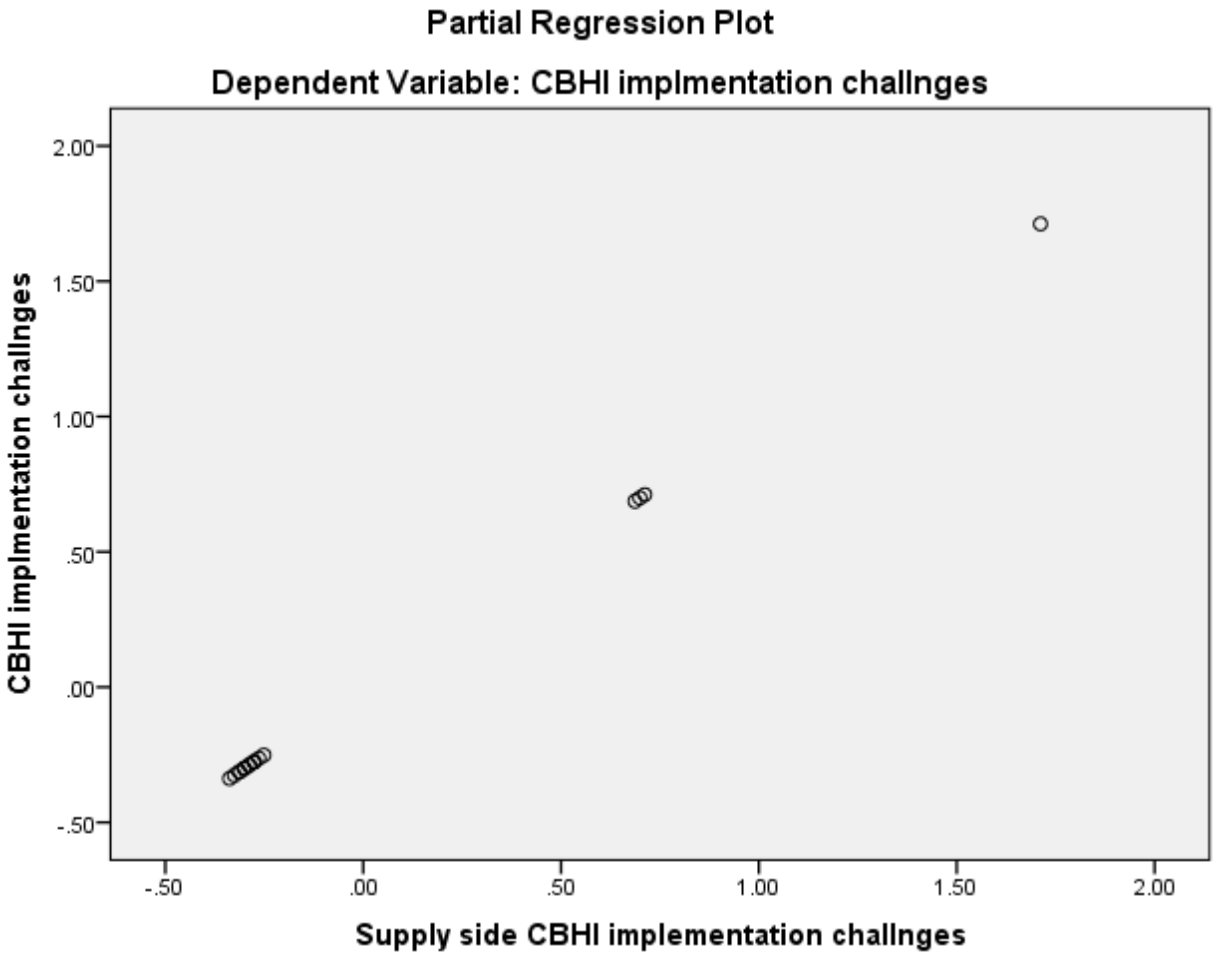


*Figure 19.*Partial regression plots on CBHI implementationchallenges.

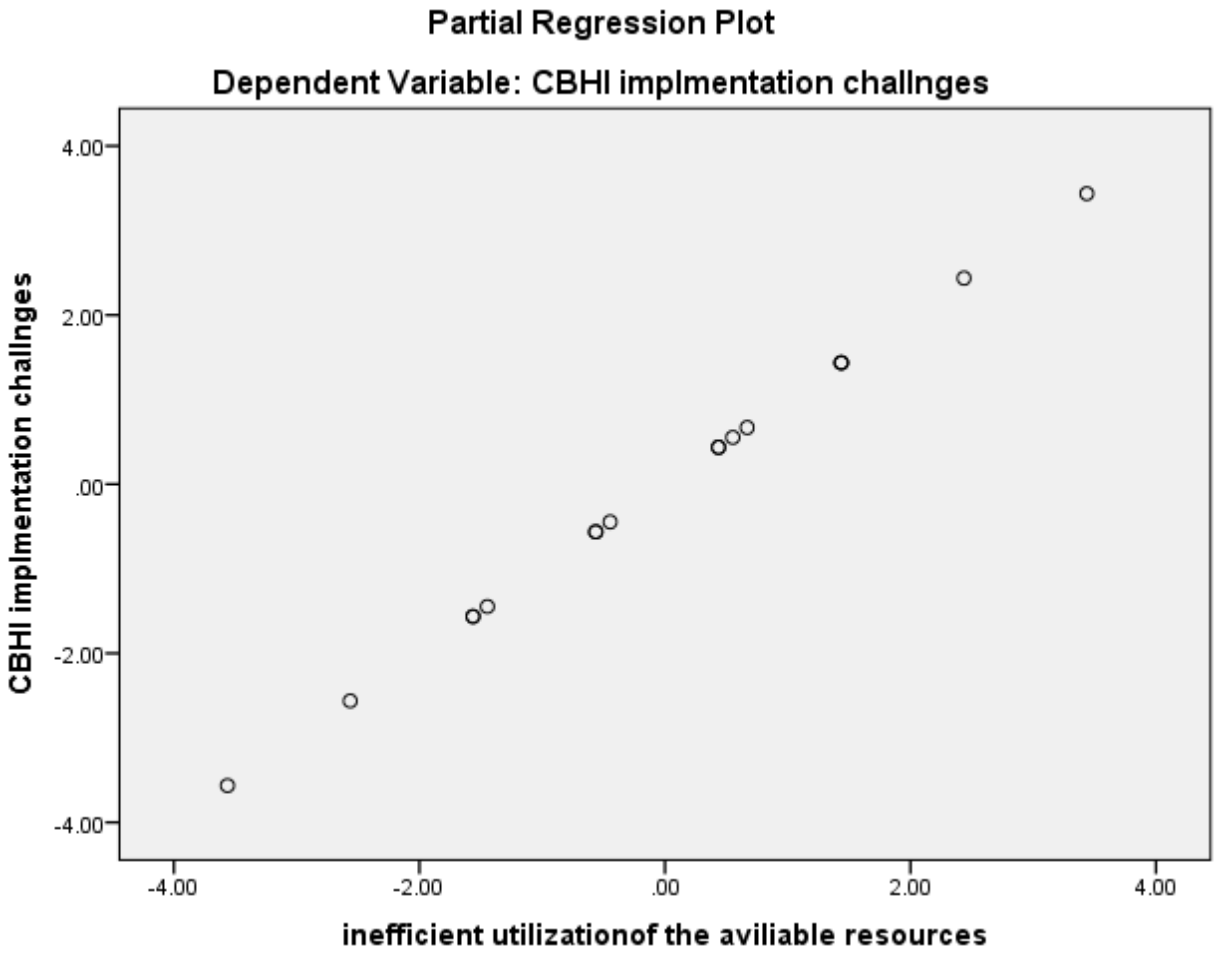


Figure 20.Partial regression plot of inefficient utilization of the available resources.

Table 20.coefficients

Model	Un standardized Coefficients		Standardized Coefficients	T	Sig.	Correlations		
	B	Std. Error	Beta			Zero-order	Partial	Part
(Constant)	20.787	.855		24.322	.000			
inefficient utilization of the available resources	.988	.084	.950	11.765	.000	.950	.950	.950
(Constant)	12.226	.000		132287592.446	.000			
inefficient utilization of the available resources	1.000	.000	.962	305252873.186	.000	.950	1.000	.961
Supply side CBHI implementation challenges	1.000	.000	.313	99315539.094	.000	.276	1.000	.313

a. Dependent Variable: CBHI implementation challenges

4.8. Discussion

The general objective of this study was to assess the challenges and prospects of community health insurance implementation in one of the districts in Guragezone atMihurAklil district.Primary data from CBHI beneficiaries who had more than one years' experience on the program was collected. The study included the concerns and opinions of beneficiaries through two focused group discussions & in-depth interviews. A key informant's interview from 8 key stake holders was conducted to triangulate the primary data.The design of the data collection instruments was focused on the specific objectives of the study on challenges of community based health insurance implementation, available resources not fully utilized to strengthen the program and performances showing the future prospects of the program .Hence the major findings are discussed below.

From the aggregated data 80.6% of the respondents were males and 19.4% were females. This shows mostly data was collected from the house hold heads. Data on occupational status of the respondents shows 81.6%farmers, 31% merchant, 5.5% daily laborers and 2.9% bajaj drivers/disable households. The age composition data was categorized in three age groups ,18-59 years age groups covers 63.5%,60-64 age groups covers 25.5% and the remaining 11% covers age groups >=65years old. The age group data shows the majority of the respondent lies on the productive age group categories, i.e. 18-59 years. From this fact one can conclude that productive age groups have positive effect on CBHI enrollment.

From the survey data most of the households didn't pay additional CBHI membership fees for the none-basic family member which contradicts with the CBHI priniciple of financial risk sharing and mutual support.The total family size of the respondent was 1611. This signifies that on average the family size of a single household/respondent had was 5.2. This contradicts with the average numbers of asingle household would have according to the Ethiopian DHIS survery data.Hence, total of 719 peoples were in age group >=18 years, among them 680 of them didn't pay additional CBHI membership fee on enrolling on the household CBHI list.

Based on Ethiopian CBHI proclamation NO.213/2000, on article 5 sub article (1) and (6) of the constitution of the Federal Government of Ethiopia "core family" or" basic family "means the spouse and the child of members. "Child" means the natural adopted or stepchild of a member or any child who by acts of the law is under the guardianship of the member and is under the age of

18. Hence from this proclamation a healthy child >=18 years are expected to pay additional payment in the house hold list. In the study problem statement this challenge was articulated as a basic problem.

Priory studies conducted by Hussien,etal (2022) and Nana(2020) on challenges of CBHI implementation focus only on awareness, quality service, quality of drugs& affordability issues .Hence challenges related to enrollment implementation challenge especially on inclusion of non-basic family members or non-core family members were not considered. This study shows that participants were violating the principle of financial pool risk sharing. The respondents were also asked for their reason not paying additional fees for the additional families and their response is 59.7%of the respondents say they didn't pay the additional fee to avoid additional fees due to financial burden in the season, 17.7% of them replied because we didn't have additional families in the house hold and 22.6% of the respondent says because we are indigenous members (couldn't) afford the fee. This signifies that the financial risk sharingprinciples of the program was in questions.

Focusing on the possible reasons to the low CBHI coverage of the district data was collected on suitability of timing of CBHI mobilization and fund collection time, 56.8% of the respondent said the mobilization period was suitable, 43.3% them replied the mobilization period was not suitable due to agro ecological differences in costing harvesting costs, over burden of additional fees like school fees, taxes and others. The data collected on participation and involvement of beneficiaries on CBHI planning, monitoring and evaluation programs indicates only 19% of the participants were participated on health service provision issues with mangers and CBHI board members on public forum at health facility level. This shows there was a gap in conducting public forum programs on CBHI issues in the district. According to Criel (1998) success & viability of CBHI depends in design and management of the scheme, community participation, and regulations at the level of health care providers, quality of services & on the socio economic cultural context.Hence, consequently, not conducting public forums & board meeting createdimplementation challenges in regulations, quality of care, fund management &reimbursementof the requested fund to health facilities.

One of the principles of CBHI is to increase the health seeking behavior of people in time of sickness but in the contrary there were concerns raised by health professionals that show

irrational utilization of health services by some members as they cross the health facility for different reasons like “market visits”. Data was collected to know the frequency of respondents’ health facility visits and the reason behind their visits.

Respondents were asked to compare their health facility visits before and after enrolling on CBHI program .From the computed aggregate data 54.2% of the respondents replied their visit frequency increased more, 11.6% replied increased more and the rest 33.9% said there is no difference with their earlier visits. For those respondents who said my frequency of health facility visits increased and increased more, they were asked to reason out increasing their frequency of health facility visits. 54.2% of the respondents reason out because there is no barrier to pay during sickness, 34.2% replied to use my fee, 11.6% of them reason out illness cases.

This indicates some households (11.6%) are visiting health facility because they were not sick but to use their paid fee. This attitude contradicts with the principles of mutual support. According to literature review by Ahmed (2018); Purohit (2014) individuals with better health were less to enroll in CBHI schemes. Hence this article suggests that voluntary enrollment to CBHI members is a risk factors of adverse selection that may challenge the financial sustainability of the schemes.

In addition according to Purohit (2014), fixed and prepayment premium to CBHI scheme leads to more frequent utilization of health care services and less delay in seeking care and members of the schemes are unlikely to borrow and go into in order to cover health care costs debit.

Hence focusing on low income members, chronically ill people & the indigenous families and challenges related to more frequent utilization of health services due to fixed & prepayment premium attitudes causes financial incapability to procure the necessary drug &logisticsupply.

To identify implementation gaps related to channel of communication respondents were asked their source of information 53.5% of the respondent got information on CBHI from HEWS& CBHI workers, 13.5% got information from religious leaders, 7.4%got information from CBOS and the remaining 6.8% got information from local radios and televisions.

According to social mobilization theory social mobilization is an effective instrument for health care promotion especially when people are reluctant to respond positively to health programs .Hence gaps in mobilizing the informal networks like CBOS, religious leaders & HDAS causes implementation challenges with regard to CBHI coverage in the district.

From supply side challenges raised by respondents the upper three most supply issues were 58.1% drug availability, 19.7% issue of poor referral linkage to the nearby hospital and 12.3% poor health service provision issues. On line with this, respondents were asked to forward their satisfaction level on service provision and quality issues at their locality,56.5% replied strongly agree, 19.4agree, 6.5 no difference, 11.3 strongly disagree and the rest 6.5% of the respondent replied strongly disagree.

The accessibility of health facility to provide health service is one determinant factor for the enrollment of members on CBHI program. In this regard respondents were asked about the availability of health facility to provide CBHI services within 5kms radius from their locality. 54.2% of the respondent replied there is accessible health facility within 5kms radius from their locality, 45.8% of the respondent replied there is no accessible health facility to provide CBHI services within 5kms radius from their locality. Analysis of data on availability of optional pharmacy services and full time employed body to renew and mobilize CBHI services at kebele level shows that all respondents replied no optional pharmacy and no full time employed workers at the their locality respectively.

To assure the quality of services at health facility public forum and board role plays a vital role. But the data analyzed on board and public forum discussions' shows the district was not efficiently used the strategy. Inefficient utilization of the available resources was also observed, like delay of the available CBHI funds, not utilizing the full potential of religious leaders, CBOS, &HDAS. According to studies conducted by Namomsa (2019), absence of nearby hospital was one of the implementation challenges cited in CBHI implementation but in this study it was not only the distance factor but also financial incapability of the district to bind agreements to the nearby WKU Specialized Hospital due to high medical service cost requirements by the hospital which was unaffordable by the current CBHI risk pool because of its low coverage was mentioned by FGD& KII participants.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1. Conclusions

Community health insurance is a new health sector initiative program being implemented in Ethiopia since 2011.The aim of the program is to prevent households & their families from catastrophic health and increase the health seeking behavior of individuals or citizens in time of sickness as a result increase their productivity. The principle of CBHI works with large number that means as enough number of households becomes members on the scheme it increases mutual support and strengthens financial risks. Successful implementation of the program needs identifying & analyzing implementation challenges.

The study was conducted to identify and analyze the challenges in implementing community health insurance in MihurAklildistrict of Gurage zone. The major findings of the study shows the district started the program at low CBHI Coverage attributed to demand side factors such as suitability of timing of mobilization& fund collection period, inclusion of non-basic family members on the household id without additional payment, poor participation & involvement of beneficiaries on public forums, adverse selection of members, weakness in utilizing informal community organization for mobilization and awareness creation purpose.

on the supply side factors drug availability issues, poor referral linkage to the nearby hospitals, poor health service provision practices, geographical inaccessibility of health facilities, absence of optional pharmacy services inefficient utilization the available community funds, delay of matching funds at regional level and benefit, policy and job structure related issues on the scheme were the major findings of the study.

5.2. Recommendations

From the major findings of the study with all its challenges there are clues in CBHI implementation that show the future prospects of CBHI program on saving of income ,improving the health status and productivity of families. Hence the researcher recommends the following points to improve the coverage and existing implementation challenges of the district.

The district administration & health office should utilize the full potential of CBOS, religious leaders and HDAS to mobilize and enroll enough number of members on scheme to strengthen mutual support. The district should also bind CBHI service provision agreement with the nearby WKU specialized hospital to solve the referral linkage issues. Behavioral change communication should be conducted with the community to avoid miss utilization of CBHI services and inclusion of non-basic family members as a basic family. Timing of mobilization should be flexible. Increasing board roles in public forums shold strengthened to takle the routine CBHI service relate issues like delay of collected funds at kebele levels.

Private investment on pharmacy services &health facility expansions programs to solve the geographical health facility accessibility challenges should be considered by the concerned stake holders.CBHI matching funds should be transferred on time from the federal to the district administration level so as to procure drugs on time.

Structure, human resource, leadership and benefit related issues should be revised by the concerned authority.Depth of poverty to afford the service on community side, effectiveness of fund collection strategy and management issues should be considered at policy level

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7. APPENDICES

7.1. Appendix A: English version Questionnaires

Dear respondents,

I, DessieGebreKerga, am a prospective graduate of Masters of Arts in Wolkite University**,** College of Social Science and Humanities at Department of Governance and Development studies, dealing with my Master's thesis.AS you are well aware the health seeking behaviors of the rural community is mainly dependent on the ability to pay out of pocket expenditure and varies from individual household attitudes, awareness and accessibilities of health facilities. Taking this fact into consideration the government of Ethiopia is implementing community health insurance program since 2011 but the implementation level varies from place to place and culture to culture. Therefore this questionnaires is designed with the overall objectives of identifying the implementation challenges and prospects of community health insurance implementation in MihurAklilworeda .The output of the study is important for implementers at woreda level, decision makers, researchers and policy makers at large to overcome the challenges of the program. I would like to assure you that the information you are going to provide will be exclusively used for academic purpose and will remain confidential.

Thank you!!

Researcher administered questionnaires

Introduction

After reading the questions carefully to the participants encircle the best responses from the given alternatives. For the items that require detailed explanation, you should write their comments or suggestion in the space provided. In some cases respondents may respond two or more alternatives to a single question. In some cases you may tick their response as "X"

I. BACKGROUND INFORMATION OF THE RESPONDENT

1. Sex: Male------- Female--------- Kebele ---------- village----------

2. Age A. 18-59 years B. 60-64years C. Above 65years

3. What is the position of the respondent within the house hold?

A. head (Father) B.head (Mother) C. Child D. other (child in law) ----------

4. Marital Status of the respondents.

A. Single B.Married C.Windowed D.Divorced

5. Occupation of the respondents.

A. Farming B.Merchant C.Laborer D.Government employee E. Student F. other------

6. Educational Status of respondents' A. IlliterateB. Read &write C. primary educationD. Secondary education E. Diploma/Degree /above

7. What is the family size of the house hold? (Total people living in the house hold)

1-5: Male---- Female ---- 6-18: Male---- Female---- 18 and above: Male---- Female----

8. Number of families Age (<18) ---Age (>=18) ----------

9. IS there any disable family member in your family? A. yes B.No

10. Are there any family members in your family who have chronic disease? A.yes B.No

Part II. Questions related to Demand &supply side implementation challenges of CBHI

A.AWARENESS RELATED IMPLEMENTATION CHALLENGES

1. Do you know Community Based health insurance? (By asking the importance, principles, the rights and responsibilities) A. Yes B. No

2. If your answer for the above question No. 1 is „Yes" from who do you got information?

A. Health development armyReligiousinstitutions C.Ikub&Idir associations

D. Woreda CBHI workers, HADs & health extension workers E. TV, Radio

B.ISSUES RELATED TO PARTICIPATION BARRIERS on CBHI

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

A.Before four years B.Before three years C.Before two years

2. Do you attend on CBHI planning, mobilization and evaluation programs? A. Yes B. No

3. If your answer to question no 2 is "yes" at which stage do you participate on the program?

A.CBHI membership mobilization B. evaluation of quality service provisions at public forum

C. Payment of premium ---------D. others --------

4. Do you get the chance to discuss with hospital officials or woreda officials to discuss on CBHI ISSUES? A. yes B. NO

5. Which type of member you are? A. Indigent Member B. Non-indigent Member

6.How many of your families members aged (>=18) other than husbands'& wife's pay additional payment for CBHI enrollment----------if not insured why ---------- how they can get medical treatment in time of sickness

C.QUESTIONS RELATED TO BENEFITS, SERVICE QUALITY, SATISFACTION, AND COMMUNITY ATTITUDES ON CBHI IMPLMENTATION ISSUES.

1. As a member of CBHI what are challenges you are currently facing on CBHI program?

A. Absence of availability of medicine B. Absence of laboratory equipment (reagents)

C. Lack of ambulance service D. Poor service delivery E. Poor referral linkage to hospital F. If any other specify it----------

2. How do you compare you visit to health facilities after you join CBHI membership and before joining the scheme?

A. Most frequently B. Frequently C. The same as before D.IF other---- ----------

3. If your answer to question number 2 is "most frequently" or "frequently ", why?

A. Because it removes my barriers to pay B. Because I have the right to over utilize the service C. Specify it if any other----------

4. Did you get any advantage in enrolling in the Community Based Health Insurance scheme?

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

5. Have you started to get health service via your membership? A. Yes B. No

6. If your answer to question number 5 is "No" why?

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

D. Questions showing implementation challneges on leadership, fund collection and management of cbhi.

1. Who is responsible to collect the community fund for CBHI scheme at your locality?

A. Health extension workers B. DAS C.KA leaders D. Village representatives E. IF any other specify it----------

2. Is the time of CBHI fund collection suitable for your community? A. yes B. no

3. If you answer to question no.2 is “no” when &why is the appropriate time----------
---
---

4. Does the collected CBHI fund at kebele level transferred to the woreda CBHI account on time?

A.Yes B.No

5. If your answer to question no.4 is “NO”, how long does it delay on average and why?

A. 2-3 months B. 4-6 months C. > 6months but less than 1 year D.Greater than 1 year

Possible reasons----------

Part III: Questions related the availability of resources necessary for the successful implementation of community health insurance

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

A. Health center B. Hospital (Government) C.IF other specify it----------

2. Are there any alternative pharmaceutical services for referral prescription in your locality?

A.No B.Yes

3. Is there appropriate full time employed, accessible &responsible body to collect and renew you CBHI ID in your locality? A. Yes B.No

4. How do you feel about the accessibility of health facility in your locality?

A. Excellent B. Very good C. Good D. Bad E. Very bad

5. If your answer to question no.4is “bad” or “very bad” how much time is required for around trip to the health center on foot----------on horse-back----------on car----------

PART IV: Questions showing the prospects of community health insurance implementation

1. Does your health status is improved after you enrolled on the CBHI scheme?

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

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

A. Out of pocket coverage B. Using traditional way of treatment C. Borrowing D. viaIkub&Idir E. Government/free

3. Being a member of CBHI schemes what kind of benefits did you get?

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

4. Are you very happy with current premium level?

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

5. Are you planned to continue to renew membership on CBHI after wards?

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

6. If your response for the above question number „5 is "strongly disagree"/ "disagree" what is your reason?

A. Poor Quality of health service at facility level B. Absence of Medicine C. Lack of medical equipment (Lab diagnosis) D.Cost of premium is not affordable E. Lack of referral linkage to nearest hospital F.If any other specify it----------

7. In CBHI service what potential experiences do you observe that may strengthen its sustainability----------?

The end

Thank you for your Participation & Cooperation!!!

Interview guide for KII

Name of Interviewees---------- Position ---------- phone no----------

Name of facilitator---------- Education status--------- Telephone----------

Place of interview---------- Time of interview---------- Duration of interview----------

1. How you evaluate the current status of CBHI coverage enrolled in the program at your district? (Very Good, Good, Satisfactory, Poor)

2. If your answer to question No1 is "poor" what are the basic reasons associated with the low performance? And how it can be solved?

3. Among the enrolled CBHI members what percent of them are indigent and non-indigent members? ----------

4. Is the coverage of CBHI membership enough to start the program in your district? Yes/no

5. If your answer to question no 4 is "No", what negative effects did it have on the program implementation? (Very high, high, medium, low)

6. What are major problems currently you are facing while implementing CBHI in your district?

Demand side----------

Supply side----------

7. What strategies /method's you are using in order to handle the above listed problems?

8. When does collection of premium is takes place/timing of collecting the premium/?

9. Does the period of collection of CBHI premium appropriate for members? If not, why? What effect does it have on the program Implementation?

10. Does the collected CBHI fund transfer to the woreda CBHI account on time? If not on average how long does it delay on average? What are the reasons for the delay? And what effects does it have on the program implementation?

11. Do you agree that the collected premium fees enough to provide health services to CBHI members? (Strongly agree, agree, neutral, disagree, and strongly disagree)

12. If your answer to question No 11 is disagree or strongly disagreewho is responsible to cover the budget deficit? ----------

---

What challenges did you face in this respect? ----------

From your experience what solutions do you recommend to solve the budget deficit in the future?----------

---

13. How you are creating and increasing level of awareness of households "especially those of not yet enroll?

14. What is the level of drooping rate of the household's from the program in your district? What is the immediate reason for it?

15. What activity is performed by your office in order to reduce drooping rate of the member?

16. Do you have signed agreement for patient referral case with nearby hospital? A.Yes B.No

17. If your answer to question no 16 is 'yes "what health services are covered for patients?

18. If your answer to question NO16 is "no" and what is the reason for not signing agreement with the nearby hospital?

19. Is the availability of laboratory services and medicines sufficient in your health facilities? If

Not what are the challenges and how it can be solved?

20. Do all the non-basic family members within the house hold pay additional fees? If not how do you express the severity of the problem? Very high/high/low

21. If your answer to question no 20 is 'high'/"very high' what are the basic reasons? And how it can be solved?

22. Do all the indigent members get free service in your district? If not why?

23. Are there any issues related to health center and hospital accessibility in your locality? If yes in which areas are the gap observed? And how it can be solved?

24. Besides accessibility and supply issues is there any factor that positively or negatively affect the community not to be or to be members of CBHI? If your answer is yes list them?

25. Is there identified model kebeles (best performed) in enrollment of CBHI? What makes them model?

Interview guideline

Name of Interviewees---------- Position ---------- phone no----------

Name of facilitator---------- Education status--------- Telephone----------

Place of interview---------- Time of interview---------- Duration of interview----------

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

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

3. After you joined the CBHI schemes what kind of benefits did you get?

4. Are you very happy with current premium level?

5. Which challenges you are currently identifying as beneficiary?

6. What is the nearest conventional health institution to your home? How far is it from your home?

7. Are CBHI members renew their &their family's' membership ID timely?

8. Are decided to resign my membership from CBHI or planned to continue?

9. How do you explain your participation on CBHI program?

10. What you recommend to increase the sustainability of the scheme

Guide for Focus Group Discussion (FGD)

Facilitator ----------position----------co facilitator----------position----------

Duration of the discussions: discussion started----------discussions ended time----------Place: ---

Name of Interviewee	Position/role	Sex	Education status	Kebele	Address number

1. Do know about community health insurance?
2. Who have the right to be included in a single house hold premium payment as basic family members?
3. How do you evaluate the accessibility and quality of CBHI services in your locality at health facility level?
4. How do evaluate the performance CBHI coverage in your locality? WHY?
5. How do you explain your participation on CBHI program beside, paying the premium?
6. How do you evaluate effectiveness of the collection & management of CBHI funds in your locality?

7. What are the challenges you are identifying in enrolling in CBHI and utilizing the services?

8. What prospects and benefits do you observe in CBHI implementation program in your community?

9. What strategies do you recommend to overcome the challenges in CBHIimplementation?

7.2. Appendix B: Amharic version questionnaire

በወልቂጤ ዩኒቨርሲቲ

በሶሻል ሳይንስ እና በደቨሎፕመንት እስተዲስ ኮሌጅ

በደቨሎፕመንት ፕላኒንግና ማኔጅመንት ፕሮግራም ለሁለተኛ ዲግሪ ሚሚያነት የተዘጋጀ

የምርምር ጥናት መጠይቅ

<u>ውድ የመጠይቁ ተሳታዎች</u>

እኔ ደሴ ገብሬ ኬርታ በ2016 በጀት አመት በወልቂጤ ዩኒቨርሲቲ በደቨሎፕመንትና ማኔጅመንት የትምህርት ክፍል የደቨሎፕመንት ፕላኒንግና ማኔጅመንት እጩ ተመራቂነኝ።

የዚህ ጥናት ዋና አላማ ለመመረቂያነት መሆኑንና ሌላ አላማ እንደሌለው ተረድታችሁ የጥናቱ ውጤት በጥሬ ሀቅና በትክክለኛ መረጃ የተደገፈ ከሆነ ለሌሎች ተመራማሪዎችም ሆነ ወሳኔ ለሚሰጡ አካላት ጠቃሚ ስለሚሆን የጥናቱ አላማ የአካዳሚ ጉደይ መሆኑን ተረድታችሁ ትክክለኛና ሀላፊነት የተሞላበት ምላሽ በመስጠት መጠይቁ እንድትሞሉ እየጠየቅሁኝ መረጃው የሞላው አካል ሚስጢራዊነት የተጠበቀ መሆኑን ለማረጋገጥ እወዳለሁኝ።

መረጃው በመሙላትና በመሳተፍ ለምታደርጉት ቀና ትብብር ምስጋናዬ የላቀነው!!

በተመራማሪው መሪነት የሚሞሉ መጠይቆች

መጠይቅ

መግቢያ

በማኅበረሰብ ጤና መድህን ዙሪያ የተዘጋጁ ከታች የተዘረዘሩ መጠይቆች በጥንቃቄና በትኩረት ካነበባችሁ ወይም ካደመጣችሁ በኋላ ለእያንዳንዱ ጥያቄ ተገቢውን ምላሽ የያዘውን ፊደል አማራጭ በማክበብ ወይም በመናገር ምላሽ ስጥ/ጪ።።አጭር መልስና ማብራሪያ ለሚፈልጉ ጥያቄዎች በተሠጡ ክፍት ቦታዎች ተገቢውን ምላሽ በጹሁፍ ስጥ/ጪ ወይም በቃል ለአወያዩ ተናገር/ሪ።።ምልክት የሚፈልጉ ቦታዎች ተገቢውን አድርግ /አድርጊ (x)፣ከአንድ በላይ ምላሽ መስጠት ለሚፈልጉ አማራጮች ከአንድ በላይ አማራጮች ማክበብ ይቻላል::

ማሳሰቢያ ማንበብና መጻፍ ለማይችሉት መረጃ ሰብሳቢው በመጠየቅ መሙላት ይጠበቅበታል::

ክፍል አንድ፡አጠቃላይ መረጃ

1.ጾታ፡ወንድ---------- ሴት----------ቀበሌ----------መንደር----------

2.እድሜ፡ሀ. ከ18-59አመት ለ.ከ60-64 አመት ሐ.ከ65 አመትበላይ

3. መጠይቁ የሞላው አካል በቤተሰቡ ውስጥ ያለው ሀላፊነት?

ሀ. አባት ለ.እናት ሐ.ልጅ መ.ሌላ (የልጅልጅ፣ሰራተኛ፣የመሳሰሉት) ከሆነ ይገለጽ------

4. መጠይቁ የሞላው አካል የጋብቻ ሁኔታ?

ሀ. ያላገባ ለ.ያገባ ሐ. ባል የሞተባት መ.የፈታች/ታ

5. መጠይቁ የሞላው አካል የስራ ሁኔታ? ሀ.ገበሬ ለ.ነጋዴ

ሐ. የቀን ሰራተኛ መ.የመንግስትሰራተኛ ሠ.ተማሪ ረ.ሌላከሆነይገለጽ------

6. መጠይቁ የሞላው አካል የትምህርት ደረጃ?

ሀ. መጻፍና ማንበብ የማይችል ለ.ማንበብናመጻፍ የሚችል ሐ. አንደኛ ደረጃ ያጠናቀቀ/1- 8/ መ.ሁለተኛ ደረጃ ያጠናቀቀ/ች/9-12/ ሠ.ዲፕሎማ፣ዲግሪና ከዛ በላይ ያለው/ያላት

7. በአባወራው ስር የታቀፉ የቤተሰብ አባላት ብዛት ስንት ነው?

1-5 አመት: ወንድ---- ሴት ---- 6-18 አመት: ወንድ---- ሴት---- 18 እናበላይ: ወንድ--ሴት---

8.ከ18 አመት በታች እድሜ ክልል ያሉ የቤተሰብ አባላት ብዛት----------

18 እና ከዛ በላይ እድሜ የሆኑ የቤተሰብ አባላት ብዛት----------

9. ከቤተሰቡ ውስጥ የአካል ጉዳት ያለባቸው አባላት አሉን? ሀ. አዎአሉ ለ.የለም

10. ከቤተሰቡ አባል ውስጥ የጠና ህመም ያለበት የቤተሰብ አካል አለን? ሀ.አዎአሉ ለ.የለም

ክፍልሁለት: ከአቅርቦትና ፍላጎት ጋር የተያያዙ የማህበረሰብ አቀፍ ጤና መድህን ትግበራ ተግዳሮች የሚያመላክቱ የጥናት ጥያቄዎች በተመለከተ

ሀ.ተጠቃሚው ማህበረሰብ በማህበረሰብ አቀፍ ጤና መድህን ዙሪያ ያለው የግንዘቤ ደረጃ የሚያመላክቱ ጥያቄዎች

1. ማህበረሰብ አቀፍ የጤና መድህን ምን እንደሆነ ተረድተዋል? ማአጤመ ምን እንደሆነ አወያዩ በጥያቄ መልክ ለተሳታው አቅርቦ በሚሰጥ ምላሽ ይወሰናል።(ጽንሰ ሃሳቡ፣ጠቀሜታው፣ የአገልግሎት ወሰን)

ሀ. አዎግንዛቤው አላቸው ለ.የለም ግንዛቤው አልተፈጠረላቸውም

2.ለተራቁጥር1 የተሰጡት ምላሽ አዎ ከሆነ ግንዛቤው ከየት አገኙ? ሀ.ከተደራጀጤናልማትሰራዊት

ለ. ከሀይማኖት አባቶች ሐ.በእድርና በእቁብ አደረጃጀት በኩል

መ. ከማህበረሰብ አቀፍ ጤና መድህን ሰራተኞች፣ከጤና ኤክስቴንሽን ሰራተኞች
ሠ. ከቴሌቪዥንና ሬድዮ

ለ.ከማህበረሰቡ ተሳተፎ ጋር ያሉ ማነቆች የሚዳስሱ ጥያቄዎች

1. **የማህበረሰብ ጤና መድህን አባል የሆኑት መቼ ነው?**
2. **ሀ.ከ 4 አመትበፊት ለ.ከ3 አመትበፊት ሐ.ከ 2አመትበፊት**

3. በማህበረሰብ አቀፍ ጤናመድህን እቅድ፣ንቅናቄና የግምገማ መድረኮች ይሳተፋሉ?

ሀ.አዎ ለ.አይደለም

4. ለተራቁጥር 2 የሰጡት ምላሽ አዎ ከሆነ በየትኛው ምእራፍ ተሳትፈው ያወቃሉ?

ሀ. በንቅናቄ መድረኮች ለ. በጤና ተቋማት በሚደረግ የአገልግሎት አሰጣጥ ግምገማ መድረኮች

ሐ. የአባልነት ክፍያ በመፈጸም መ.ሌላ ካለ ይግለጹት --------

5. በማህበረሰብ አቀፍ ጤና መድህን ማእቀፍ በሚሰጡ አገልግሎቶች ዙሪያ ከሆስፒታል ወይም ከወረዳ ቦርድ አባላት ውይይት አድርገው ያውቃሉ? ሀ. አዎ ለ.አይደለም

6. በየትኛው የጤና መድህን የአባልነት አይነት ነው በአባልነት የታቀፉት?

ሀ. መክፈል በማይችሉት ምድብ ለ. በመደበኛ ከፋይ አባልነት

7. **እድሜአቸው 18 አመትና ከዛ በላይ የሆኑ ተጨማሪ ክፍያ የተከፈለላቸው የቤተሰብ አባላት ስንትናቸው? ----------ካልተከፈለላቸው ለምን አልተከፈለላቸውም?----------**

ህመም ሲገጥማቸው እንዴት ይታከማሉ?----------::

ሐ.ከአገልግሎት ተጠቃሚነት ፣ ጥራት ፣እርካታና ከማህበረሰብ አመለካከት ጋርያሉ ማነቆዎች የሚያመላክቱ ጥያቄዎች

1. **እንደ የጤና መድህን አባልነቶ በአሁን ስአት በአካባቢዎ በማህበረሰብ አቀፍ ጤና መድህን ላይ የሚስተዋሉ ችግሮች ምንድ ናቸው? ሀ. የመድሃኒት አቅርቦት ችግሮች**
   ለ. የላቦራቶሪና የህክምና መመርመሪያ መሳሪያዎች እጥረት
   ሐ. የአንቡላን ስአቅርቦት ችግሮች መ. ደካማ የህክምና አገልግሎት አሰጣ ጥሂደት
   ሠ. ደካማ የጤናጣቢያ ሆስፒታል የሪፈራል ቅብብሎሽ ስርአት
   ረ.ሌላ ያልተጠቀሰ ከሆነ ይጥቀሱት----------.
2. **በማህበረሰብ አቀፍ ጤና መድህን አባልነት ከታቀፉ በኋላና በፊት ያለው የጤና ተቋም ጉብኝትዎ እንዴት ያነጻጽሩታል? ሀ.እጅግ በጣም ጨምሯል**
   ለ. ጨምሯል ሐ.ከበፊቱ ምንም ለውጥ የለውም

3. ለጥያቄ ቁጥር 2 የሰጡት ምላሽ እጅግ በጣም ጨምሯል ወይም ጨምሯል ከሆነ ለምን ጨምሯል? ሀ. ክፍያ ስለማልጠየቅ ለ.የአባልነት መዋጮ ስለከፈልኩኝ ሐ. ሌላ ካለ ይገለጽ--

4. በማህበረሰብ አቀፍ ጤና መድህን ኢንሹራንስ ፕሮግራም በመታቀፍዎ ተጠቅሜአለሁ ብለው ያደስባሉ? ሀ. አዎ በጣም እስማማለሁ ለ. እስማማለሁ ሐ. ልየነትየለውም

መ. በጣም አልስማማም ሠ. አልስማማም

5. የጤናመድህን አባል ከሆኑ በኋላ በጤና ተቋማት አገልግሎት ማግኘት ጀምረዋልን?

ሀ. አዎ ጀምሬአለሁ ለ.አይ አልጀመርኩም

6. ለተራቁጥር 5 የሰጡት ምላሽ አይአልጀመርኩም ከሆነ ለምን አልጀመሩም?

ሀ. ህመም ስላልገጠመኝ ለ.ጤናተቋማት በቂ ህክምና ስለማይሰጡ

ሐ. በጤና ተቋማት የላቦራቶሪ ምርመራ ስለሌለ

መ.የጤናተቋማት የህመምተኛ አያያዝ ጥሩ ስላልሆነ

መ.የማህበረሰብ አቀፍ ጤናመድህን አመራርና ገንዘብ አስተዳደር የሚያመላክቱ ጥያቄዎች

1. በአካባቢህ/ሽ/ የአባላት የማህበረሰብ አቀፍ ጤና መድህን መዋጮ በማን አማካይነት ይሰበሰባል?

ሀ.በጤናኤክስቴንሽን ሰራተኞች ለ. በግብርና ባለሙያዎች ሐ.በቀበሌ አመራሮች

መ. በጎጥ አመራሮች ሠ. በሌላ አካል ከሆነ ይጥቀሱት----------

2. የማህበረሰብ አቀፍ ጤናመድህን መዋጮ የሚሰበሰብበት ወቅት ለማህበረሰቡ አመቺ ነው ብለው ያሰባሉ? ሀ. አዎ ለ.አይደለም

3. ለተራቁጥር 2 የሰጡት ምላሽ አይደለም ከሆነ መቼ ቢሆን የተሻለ ይሆናል? ---------- ለምን?----------

4. ለማህበረሰብ አቀፍ ጤናመድህን አገልግሎት ከአባላት የሚሰበሰበው የአባላት መዋጮ በወቅቱና በጊዜ ወደ ወረዳ ማህበረሰብ አቀፍ ጤና መድህን ቋት ገቢ ይሆናል?

ሀ. አዎይ ሆናል ለ.አይ ይዘገያል

5. ለተራቁጥር 4 የሰጡት ምላሽ አይ ይዘገያል ከሆነ በአማካይ ለምን ያህል ጊዜ ይዘገያል? ለምን?

ሀ.ከ2-3 ወራት ለ.ከ 4-6 ወራት ሐ.ከ6 ወር በላይ ነገርግን ከአንድ አመት በታች

መ. ከአንድ አመት በላይ

ለምን ይዘገያል----------

ክፍል3. የጤናመድህን አገልግሎት በተገቢው ለማሳለጥ ከሚያስፈልጉ ግብአቶችና መሰረተ ልማቶች ጋር የተያያዙ ጥያቄዎች

1. በአቅራቢያዎ ያለ የጤና አገልግሎት መስጫ ተቋም ምን አይነት ነው?

ሀ.የመንግስት ጤና ጣቢያ ለ.የመንግስት ሆስፒታል ሐ.ሌላ ካለ ይግለጹት----------

2. በጤና ተቋማት የመድሀኒት እጥረት በሚከሰትበት ጊዜ በአቅራቢያዎ አማራጭ የመድሀኒት አቅርቦት የሚያገኙበት አማራጭ አለ? ሀ.አዎ ለ.አይደለም

3. የማህበረሰብ ጤና አገልግሎት ስራ ለማህበረሰብ ለማዳረስ፣መታወቂያ ለማደስ፣የአባለት መዋጮ ለመሰብሰብና ሌሎች መሰል ስራዎች ለመከወን የተቀጠረ የሙሉ ጊዜ ሰራተኛ በአካባቢዎ አለ? ሀ. አዎ ለ.አይደለም

4. በአካባቢዎ የጤና ተቋማት ተደራሽነት ላይ ያሎት ስሜት እንዴት ይገልጹታል?

ሀ. እጅግ በጣም ጥሩ ለ. በጣም ጥሩ ሐ. ጥሩ መ. መጥፎ ሠ. በጣም መጥፎ

5.ለተራቁጥር 4 የሰጡት ምላሽ መጥፎ ወይም በጣም መጥፎ ከሆነ በደርሶ መልስ ጉዞ ምን ያህል ስአት ይፈጃል በእግር ከሆነ----------በፈረስ ከሆነ----------በመኪና ከሆነ----------

ክፍልአራት፡የማህበረሰብ አቀፍጤና መድህን ትግበራ ቀጣይነትና የወደፊት እጣ ፈንታ የሚያመላክቱ መጠይቆች በተመለከተ

1. የጤናመድህን አባል ከሆኑ በኋላ የጤናዎ ሁኔታ ተሻሽሏል ብለው ያምናሉ?

ሀ. አዎ በጣም እስማማለሁ ለ.ልየነት የለውም ሐ. እስማማለሁ

መ. አልስማማም ሠ. በጣም አልስማማም

2. በማህበረሰብ አቀፍ ጤናመድህን ከመታቀፎ በፊት ሲታመሙ የሚገጥሞት የህክምና ወጪ እንዴት ይወጡት ነበር? ሀ.ከኪስ በሚወጣ ወጪ በመሸፈን ለ.ባህላዊ ህክምና በመጠቀም ሐ.በብድር በመሸፈን መ. እቁብና እድሮች በመጠቀም ሠ. መንግስት ይሸፍንልኝ ነበር

3. የጤና መድህን አባል በመሆኖ ምን አይነት ጥቅም አግኝተዋል?

ሀ. ከኪስ የሚወጣው ወጪ ቀንሶልኛል ለ. የጤናዬ ሁኔታ ተሸሽሏል ሐ.ምርታማነቴ ጨምሯል መ የአደጋ ተጋላጭነቴ ቀንሷል

4. ለአባልነት በሚከፈለው ክፍያ ላይ ደስተኛ ኖት?

ሀ. አዎ በጣም እስማማለሁ ለ. ልየነት የለውም ሐ. እስማማለሁ

መ. አልስማማም ሠ. በጣም አልስማማም

5. በቀጣይነት የጤና መድህን አባልነትዎ ለማስቀጠልና ለማሳደስ ወስነዋል?

ሀ. አዎ በጣም እስማማ ለ.ልየነት የለውም ሐ. እስማማለሁ

መ. አልስማማም ሠ. በጣም አልስማማም

6. ከላይ በተራቁጥር 5 የሰጡት ምላሽ በጣም አልስማማም ወይም አልስማማም ከሆነ ምክንያቶ ምንድ ነው?

ሀ.በጤና ተቋማት የሚሰጡአገ/ቶችጥራት የጎደላቸው ስለሆነ

ለ. በጤና ተቋማት የመድሀኒት እጥረት ስላለ ሐ.የተሟላ የህክምናና የላቦራቶሪ ግብአት በጤና ተቋማት ስለሌለ መ.ለአባልነት የሚከፈል ክፍያ ከፍተኛ ስለሆነ ሠ. የሪፈራል አገልግሎት ደካማ ስለሆነ ረ. ሌላ ያልተጠቀሰ ካለ ይጠቀስ----------

7.በእርሶ ተሞክሮ በማህበረሰብ ጤና መድህን ኢንሹራንስ አተገባበር ሂደት የፕሮግራሙ ቀጣይነት ሊረጋግጡ የሚችሉ ምን ምን ተሞክሮዎች አስተውለዋል ----------

አበቃ!!

ላደረጉት ተሳትፎና ቀና ትብብር ከልብ እናመሰግናለን!!

Interview guide for KII

ለተጽኖ ፈጣሪና ለባለድርሻ አካላት በማህበረሰብ አቀፍ ጤና መድህን ዙሪያ የሚደረግ ጥናት የውይይት ነጥቦች

ክፍል አንድ ፡ አጠቃላይ መረጃ

የተሳታፊው ስም---------- ሃላፊነት---------- ስልክ ቁጥር-------

አወያዩ ስም---------- የትምህርት ደረጃ--------- ስልክ ቁጥር----------

ውይይቱ የተካሄደበት ቦታ---------- የተጀመረበት ስዐት--------- የፈጀው ስዐት------

1. **የወረዳችሁ የማህበረሰብ አቀፍ ጤና መድህን ሽፋን ምን ደረጃ ላይ ይገኛል?**
   ሀ. በጣም ጥሩ ለ.ጥሩ ሐ.አጥጋቢ መ.ዝቅተኛ
2. **ከላይ በተራ ቁጥር 1 የሰጡት ምላሽ ዝቅተኛ ከሆነ ዝቅተኛ የሆነበት መሰረታዊ ችግር ምን ድ ነው? እንዴትስ ማሻሻል ይቻላል?----------**

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3. በማህበረሰብ አቀፍ ጤና መድህን ከታቀፉ አባላት ውስጥ የመደበኛ ከፋይ አባልና በመንግስት ሽፋን የተደረገላቸው መክፈል የማይችሉ አባላት ንጽጽር ምን ያህል ነው? ----------

4. የወረዳችሁ የማህበረሰብ አቀፍ የጤና መድህን ሽፋን ፕሮግራሙ ለማስጀመርና የፕሮግራሙ የመረዳዳት እሳቤ ለማሳለጥ በቂ ነው ብለው ያምናሉ? ሀ. አዎ ለ. አይደለም

5. ከላይ በተራቁጥር 4 ለተጠቀሰው ጥያቄ የሰጡት ምላሽ አይደለም ከሆነ የሽፋኑ ዝቅተኛ መሆን በፕሮግራሙ ላይ ያሳደረው ተጽኖ ምን ያህል ነው?

(በጣም ከፍተኛ፣ , ከፍተኛኛ, መሀከለኛኛ, ዝቅተኛ)

6. በአሁኑ ስአት በወረዳው በማህበረሰብ አቀፍ ጤና መድህን ትግበራ ሂደት የገጠሙ ተግዳሮቶች ምንድናቸው?

ከማህበረሰብ ፍላጎት ጋር የተያያዙ ካሉ ----------፡ ፡

ከአቅርቦት ጋር የተያያዙ ካሉ ----------: :

7. ከላይ የተዘረዘሩ ተግዳሮቶች ለመቅረፍ ምን አይነት ስልት ዕየተጠቀማችሁ ነው? ----------

----------: :

8. የማህበረሰብ አቀፍ ጤና መድህን ንቅናቄ ና የአባልነት ክፍያ ወቅት በወረዳችሁ መቼ ይደረጋል? ----------

9. የማህበረሰብ አቀፍ ጤና መድህን ንቅናቄ ና የአባልነት ክፍያ ወቅት ለማህበረሰቡ ምቹ ነው ብለው ያምናሉ? ሀ. አዎ ለ.አይደለም

ካልሆነ ለምን----------: :

ወቅቱ ተስማሚ ባለመሆኑ ምን ተጽእኖ ፈጥሯል ብለው ያምናሉ ----------

----------: :

10. ከአባላት ለማህበረሰብ አቀፍ ጤና መድህን ኢንሹራንስ የሚሰበሰበው መዋጮ በተገቢውና በወቅቱ ወደ ወረዳ የማህበረሰብ አቀፍ ጤና መድህን ኢንሹራንስ አካውንት ገቢ ደረጋል? ---------

ካልሆነ በአማካይ ለምን ያህል ጊዜ ይዘገያል?----------

ለምንስ ይዘገያል ----------: :

በመዘግየቱ ምን ተጽእኖዎች አሳድሯል?----------: :

11. ከአባላት የሚሰበሰበው የማዐጤመ መዋጮ የጤና አገልግሎት ለአባላት ለመስጠት በቂ ነው ብለው ያምናሉ?

ሀ. አዎ በጣም እስማማለሁ ለ. እስማማለሁ ሐ. ልዩነት የለውም

መ አልስማማም ሠ. በጣም አልስማማም

12. ከላይ በተራ ቁጥር 11 ለተጠቀሰው ጥያቄ የሰጡት ምላሽ አልስማማም ወይም በጣም አልስማማም ከሆነ የበጀት ጉድለት በሚገጥም ስዐት ጉድለቱ ማን ይሸፍናል? ----------

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ከዚህ ተግዳሮት ጋር የገጠማችሁ ችግር ካለ ይገለጽ----------

----------: :

ከእርሶ ተሞክሮ የበጀት ጉድለት እንዳይገጥም ምን መፍትሄ ቢወሰድ መፍትሄ ይሆናል ብለው ያስባሉ?----------: :

13. በአባልነት ያልታቀፉ የ ማህበረሰብ ክፍሎች የጤና መድህን ኢንሹራንስ ተጠቃሚ እንዲሆኑ ምን እርገጃ እየወሰዳችሁ ነው? ----------: :

14. እንደ ወረዳ በአሁኑ ወቅት ከአባልነት የወጡ የጤና መድህን ኢንሹራንስ ተጠቃሚዎች ምን ያህል ናቸው? ----------ከአባልነት የሚወጡበት መሰረታዊ ችግር ምንድ ነው ?--: :

15. አቋራጭ የማህበረሰብ ጤና መድህን ኢንሹራንስ ተጠቃሚዎች ከአባልነታቸው እንዳይወጡ ምን የመፍትሄ እርምጃ እየወሰዳችሁ ነው? ----------: :

16. በአቅራቢያችሁ ካለ ሆስፒታል ጋር የጤና መድህን ኢንሹራንስ ተጠቃሚዎች የሪፈራል አገልግሎት ለማሳለጥ የውል ስምምነት ተደርጓል? ሀ. አዎለ. አልተደረገም

17. ከላይ ለጥያቄ ቁጥር 16 የሰጡት ምላሽ አዎ ከሆነ ለምን አይነት የጤና አገልግሎቶች ውል ተገብቷል? ----------: :

18. ከላይ ለጥያቄ ቁጥር 16 የሰጡት ምላሽ አይደለም ከሆነ ከአቀወራቢያ ሆስፒታል ጋር ውል ለመግባት ተግዳሮት የሆኑ ምክንያቶች ምንድናቸው? ----------: :

19. በጤና ተቋማት የሚሠጡ የላቦራቶሪና የመድሀኒት አቅርቦት አገልግሎቶች በቂ ናቸው ብለው ያስባሉ? ------በቂ ካልሆነ መሰረታዊ መንስኤዎቹ ምንድናቸው?----------::

መፍትሄዎቹ ምንድናቸው ----------: :

20. በአንድ አባወራ ወይም ከፋይ ስር ያሉ 18 አመትና በላይ የሆናቸው እንዲሁም ከ18 አመት በታች ሆነው የመሰረታዊ የበተሰብ አባል ያልሆኑ ተጨማሪ አካላት የጤና መድህን ኢንሹራንስ የአባልነት ክፍያ ይከፍላሉን? ሀ. አዎ ለ. አይከፍሉም

ማስታወሻ መልሱ አይደለም ከሆነ የችግሩ ጥልቀት እንዴት ይገለጹታል?

ሀ.በጣም ከፍተኛ ለ.ከፍተኛ ሐ.ዝቅተኛ

21. በተራ ቁጥር 20 ማስታወሻ ስር የሰጡት መልስ ከፍተኛ ወይም በጣም ከፍተኛ ከሆነ የችግሩ መንስዔ ምን ይመሥላችኋል?

ምክንያቶች----------: : መፍትሄዎች----------: :

22. በማህበረሰብ ጤና መድህን ኢንሹራንስ መክፈል የማይችሉ ተብለው የተለዩ የህብረተሰብ ክፍሎች ሁሉ የጤና አገልግሎት ያገኛሉ ብለው ያስባሉ? ----------ለምን?----------: :

23. በወረዳችሁ ከጤና ተቋማት ተደራሽነት ጋር ተያይዘው የሚነሱ የጤና አገልግሎት ተደራሽነት ችግር የሚፈጥሩ ተግዳሮቶች አሉ? ሀ. አዎ ለ.የሉም

መልሶ አዎ ከሆነ ችግሩ የት አከባቢ ይስቷላል?----------መፍትሄዎቹ ምንድናቸው?-----: :

24. ከጤና ተቋማት ተደራሽነት ባሻገር የጤና መድህን ኢንሹራንስ ተደራሽነት በአሉታዊም ሆነ በአወንታዊ መልክ አስቷጽኦ የሚያደርጉ የማህበረሰቡ ልማዶች አሉ? ሀ. አዎ ለ. የሉም

መልሶ አዎ ከሆነ ይግለጾአቸው----------: :

25. በጤና መድህን ኢንሹራንስ በሞዴልነት የሚጠቀሱና ከፍተኛ አፈጻጸም ያላቸው ቀበሌዎች አሏችሁ? ሀ. አዎ ለ. የሉም

መልሶ አዎ ከሆነ ከሌሎች ቀበሌዎች በተለየ ሞዴል የሆኑበት ምክንያቶች ምንድናቸው?------: :

ላደረጋችሁት ተሳትፎናቀናትብብርበጣምእናመሰግናለን!

(Guide for Focus Group Discussion (FGD)

በማህበረሰብ አቀፍ ጤና መድህን አገልግሎት ጥናት ዙሪያ ከማህበረሰብ ወኪሎች ጋር የሚደረግ የቡድን ውይይት ማወያያ ቼክሊስት

የአወያዩስም----------የትምህርት ደረጃ--------- ስልክ ቁጥር----------

ረዳት አወያይ ስም ----------የትምህርት ደረጃ --------ስልክ ቁጥር--------

ውይይቱ የተካሄደበት ቦታ ---------- የተጀመረበት ስአት------- የፈጀው ስአት------

ተ.ቁ	የተሳታፊው ስም	ሃላፊነት	ጾታ	የትምህርት ደረጃ	ቀበሌ	አድራሻ/ስልክ
1.						
2.						
3.						
4						
5.						
6.						
7.						
8						
9.						
10.						

1. ስለ ማህበረሰብ አቀፍ ጤና መድህን ምን ያውቃሉ?

2. በአንድ አባወራ ክፍያ በአባልነት የሚካተቱት የቤተሰብ አባላት እነማን ናቸው?

3. በአቅራቢያዎ ባሉ ተቋማት ለማህበረሰብ አቀፍ ጤናመድህን አባላት የሚሠጡ የጤና አገልግሎት ተደራሽነትና የአገልግሎት ጥራት ላይ ምን አስተያየትአሎት? እንዴት ይገልጹታል?

4. የወረዳችሁ ወይም የአካባቢያችሁ የጤና መድህን ኢንሹራንስ ሽፋን እንዴት ይገልጹታል? ለምን?

5. ከክፍ ያባሻገር በማህበረሰብ ጤና መድህን አገልግሎት ላይ መቼ? ከማንጋር? እናበምን ዙሪያ ውይይት ያደርጋሉ ?

6. የማህበረሰብ አቀፍ ጤናመድህን መዋጮ አሰባሰብና ገንዘብ አስተዳደር ላይ ምን አስተያየት አሎት?

7. በማህበረሰብ አቀፍ ጤናመድህን አባልነት በመታቀፍዎና የአገልግሎቱ ተጠቃሚ በመሆኖ ወይም ባለድርሻ በመኖኖ በትግበራ ሂደት ያስተዋሉት መሰረታዊ ተግዳሮቶች ምንድናቸው?

8.የማህበረሰብአቀፍጤናመድህንእንዲስፋፋናየወደፊትየፕሮግርሙስኬትየሚያሳዩምንጥሩሰራዎችአስተውለዋል?

9. በማህበረሰብ አቀፍ ጤናመድህን ትግበራ ሂደት የገጠሙ ተግዳሮቶች ለመቅረፍና ወደፊት ፕሮግራሙ ውጤታማ እንዲሆን ለማድረግ ምን አይነት ስልቶችና መፍትሄዎች ያስፈልጋሉ ብለው ያምናሉ?

ANNEIX C.Mihuraklilworeda 2013E.C CBHI enrolment status

Table 21.Mihur Aklil woreda 2013E.C CBHI enrollment status (taken from WorHO)

Rank category, <35%covergae low, 35%-45% coverage medium, > 45% coverage high

Sn	Name of kebele	Total population	Insured by Govenment		Total	Agro ecology	coverage	Remark
			Self insured					
1	Daba	700	160	87	247	Dega	35.3	Medium
2	Kechine	620	65	88	153	Dega	24.8	Low
3	Megeran	568	145	70	215	Dega	37.9	Medium
4	Anzire	644	207	70	277	Dega	43	Medium
5	Abeje	1076	345	85	430	Dega	40	Medium
6	Chinbe	543	218	83	301	Dega	55.4	High
7	t/haymanot	1255	470	97	567	Dega	45.2	Medium
8	Furcha	694	153	90	243	Dega	35	Low
9	Yekote	880	176	72	248	Dega	28.2	Medium
10	Yasinawera	709	130	92	222	Dega	31	Medium
	Sub Total	7689	2069	834	2903		38	
11	Wokiye	971	388	103	491	Weyna dega	50.6	High
12	Dengeze	961	145	80	225	Weyna dega	23.4	Low
13	Batenayekeras	529	71	80	151	Weyna dega	28.5	Low
14	Yebejeche	455	93	77	170	Weyna dega	37.4	Low
15	Yewegrawo	439	123	67	190	Weyna dega	43.3	Medium

16	Feresgura	387	132	89	221	Weyna dega	57	High
17	Echene	1413	127	105	232	Weyna dega	16.4	Low
18	Cheza	942	119	62	181	Weyna dega	19.2	Low
19	Korer	1196	124	80	204	Weyna dega	17.1	Low
20	Selam	629	140	59	199	Weyna dega	31.6	Medium
21	Ginab	865	123	65	188	Weyna dega	21.7	Low
22	Yeshehara	797	242	67	309	Weyna dega	38.8	Midium
23	Hawariat	214	102	28	130	Weyna dega	60.75	High
24	Wuranfuna	893	235	66	301	Weyna dega	33.7	Medium
25	Zenabener	878	485	102	587	Weyna dega	66.9	High
26	Seba	606	133	85	218	Weyna dega	36	Medium
27	Chiret	777	378	84	462	Weyna dega	59.5	High
28	Mekorkor	592	376	60	436	Weyna dega	73.6	High
29	Chebo	607	269	61	330	Weyna dega	54.4	High
30	Atat	629	188	67	255	Weyna dega	40.5	Medium
	Grand total	22555	6062		8383	Weyna dega	37.1	

ANNEIX D.KII&FGD participants‘profile

*Table 22.*KII participants profile

Name of participant	Sex	Education level	Responsibility/position
1	Male	Degree holder	Head of the district health office
2	Male	Diploma holder	District CBHI coordinator
3	Male	MSC	Head the District BOFED
4	Male	Diploma	Head of Hawariat health center
5	Male	Degree holder	Head of Wukiye health center
6	Male	Degree holder	Head of Megeran health center
7	Male	Degree holder	District’s CBHI finance officer
8	Male	MSC	Head of the districts’ administration office

*Table 23.*Profile of FGD participants' 1 & 2

Name of participant	Sex	Education level	Responsibility/position
1	M	9-12 grade complete	KA leaders
2	F	Degree	DAS
3	F	10+3	HEWS
4	M	Able to write & read	Religious leaders
5	M	Able to write & read	Elders
6	M	Able to write & read	CBOS
7	F	Able to write & read	Women representatives
8	M&F(forFGD1,2)	Primary education	Youth representatives
9	F	Able to write & read	HDA
10.	F		HW

*Table 24***.**Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.950[a]	.902	.896	.60671	.902	138.414	1	15	.000
2	1.000[b]	1.000	1.000	.00000	.098	.	1	14	.

Source: Statistical output data on SPSS

a. Predictors: (Constant), inefficient utilization of the available resources

b. Predictors: (Constant), inefficient utilization of the available resources, Supply side CBHI implementation challenges

Table 25.Excluded Variables

Model		Beta In	T	Sig.	Partial Correlation	Co linearity Statistics
						Tolerance
1	Supply side CBHI implementation challenges	.313[b]	104611865.615	.000	1.000	.999

a. Dependent Variable: CBHI implementation challenges

b. Predictors in the Model: (Constant), inefficient utilization of the available resources dependent Variable: CBHI implementation challenges