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COMMUNITY-BASED HEALTH INSURANCE IMPLEMENTATION AND CHALLENGES IN ETHIOPIA: CASE OF OROMIA NATIONAL REGIONAL STATE

DOCTORIAL (PHD) DISSERTATION

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SUPERVISOR

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Declaration

I, Gutama Namomsa, hereby declare that the dissertation titled ‘’Community-Based Health Insurance Implementation and Challenges in Ethiopia: Case of Oromia National Regional State’’ submitted to the University of Public Service Ludovika for the award of Doctor of Philosophy (PhD) in Public Administration Science is a record of original research work carried out by me under the supervision of Prof. Dr. Maria Bordas, Doctoral School of Public Administration Science.

I further declare that:

The research work presented in this dissertation is my own, and it has been carried out during the period of 2021 to 2024/2025.

The best of my knowledge, the dissertation does not contain any work which has been submitted for the award of any degree or diploma, in any university or academic institution.

I have acknowledged all the sources of information which have been used in the dissertation by citing them properly.

Any work done in collaboration with, or assistance received from, others has been duly acknowledged in the dissertation.

Signature: _____

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Date:

Signature of the Supervisor

Professor Dr. Maria Bordas

_____

Abstract in English

Ethiopia's healthcare system faces significant challenges due to a sziable informal sector, limited healthcare funding, and restricted access to medical services in rural areas. These issues contribute to a lack of comprehensive healthcare coverage, making it difficult for many citizens, particularly in rural and informal sectors, to access adequate medical care. Informal sectors are the large portion of the economy made up workers and business that operate outside formal, regulated industries and are not registered with government authorties for tax purposes. This sectors typically charactirised by a lack of formal contract, benefits, or social protection, making it difficult to monitor, regulate, or tax. These sectors include street vedors and small traders, agricultural workers and contruction and Day laborers. With assistance from foreign organizations, the Ethiopian government implemented CBHI programs to address these problems. The research objectives include examining the CBHI strategy's impact, community involvement, challenges, administrative capacity, stakeholder coordination, and traditional community support in the West Showa Zone. The main research question was structured around understanding the formulation and implementation of the CBHI strategy in the Oromia national regional state, along with the challenges encountered during the process. This dissertation employs a descriptive-analytic methodology. The researcher employed a mixed-method approach to perform an exhaustive literature review, interviews, and questionnaires, as well as empirical methods to gather and analyse data. The SPSS statistical software, version 27, was used to process and evaluate the questionnaire findings, allowing for a comprehensive exploration of the research topic and leveraging the strengths of each method to compensate for weaknesses. CBHI programs have notably enhanced women's access to healthcare services and financial protection, leading to improved health outcomes in underserved communities. The study found that Community-Based Health Insurance (CBHI) reduced financial hardship and improved community health outcomes, but demand and supply side challenges like poor healthcare quality, facilities, and reimbursement processes, along with limited provider networks and a lack of understanding, hindered community participation. Negotiating contracts with healthcare providers poses challenges for Ethiopia's CBHI programs. Political and bureaucratic processes, bureaucratic barriers like limited awareness, financial constraints, and drug shortages, as well as external factors like economic instability and financial sustainability issues, including low enrolment and government subsidies, financial fragmentation among CBHI schemes, and reliance on out-of-pocket expenses, hinder financial sustainability.

Drawing from the perspectives of the respondents, the results of the survey, and secondary sources, this thesis presents a series of suggestions for policymakers in Ethiopia to consider. The suggestions tackle the shortcomings revealed by this thesis's findings and provide solutions.

Keywords: CBHI, formulation and implementation of CBHI strategy, rural healthcare access, challenges encountered in CBHI implementation.

Abstract in Hungarian

Az Etiópiában megvalósított közösségi alapú egészségbiztosítási (CBHI) program célja, hogy a vidéki és informális területeken élők számára szélesebb hozzáférést biztosítson AZ egészségügyi szolgáltatásokhoz és ehhez a pénzügyi forrásokat megteremtse. Az etiópiai kormány külföldi szervezetek segítségével vezette be a CBHI programot, annak érdekében, hogy ezeket a célokat megvalósítsa. Ennek a kutatásnak a célja, hogy feltárja a CBHI program hatását az etiópiai egészségügy rendszerre, a helyi közösségek szerepét, a program kihívásait, a programban résztvevő szervezetek igazgatási kérdéseit, a programban résztvevő természetes személyek koordinálásának problémáit, és a hagyományos helyi közösségek részvételi hajlandóságát a West Shawa Zone régióban. A kutatás fő problémája az Oromia nemzeti regionális államban a CBHI stratégia megfogalmazásának és megvalósításának, valamint a folyamat során felmerülő kihívásoknak a megértése volt. A disszertáció leíró-analitikai módszertant alkalmaz. A kutató vegyes módszerrel végzett teljes körű szakirodalmi áttekintést, ezen kívül interjúkat és kérdőíveket, valamint empirikus módszereket alkalmazott AZ adatok összegyűjtésére és elemzésére. A kérdőív eredményeinek feldolgozására és értékelésére az SPSS statisztikai szoftver 27-es verzióját alkalmazta a kutató, amely lehetővé tette a kutatási téma átfogó feltárását, amelynek során a kutató az egyes kutatási módszerek erősségeire helyezte a hagnsúlyt, annak érdekében, hogy más kutatási módszerek gyengeségeit kompenzálja. A CBHI-programok jelentősen javították a nők hozzáférését AZ egészségügyi szolgáltatásokhoz és a pénzügyi forrásokhoz, ami jobb egészségügyi ellátást eredményezett AZ egészségügyileg rosszul ellátott közösségekben. A kutatás levonta azt a következtetést , hogy a közösségi alapú egészségbiztosítás (CBHI) csökkentette a pénzügyi nehézségeket és javította a közösségek egészségügyi mutatóit, de a keresleti és a kínálat oldal kihívásai, például az egészségügyi ellátás rossz minősége, az alacsony színvonalú egészségügyi szolgáltatók, és a kifizetett szolgáltatások árának visszatérítése, a korlátozott szolgáltatói hálózattal együtt, , valamint a program megértése és elfogadása akadályozták a közösségi részvételt. AZ egészségügyi szolgáltatókkal kötött szerződések tárgyalásának nehézségei kihívásokat

jelentettek a CBHI programja számára. Politikai és bürokratikus folyamatok, különösen a bürokratikus akadályok, mint például a megfelelő tudatosság hiánya, a korlátozott pénzügyi források és a gyógyszerhiány, külső tényezők, mint a gazdasági instabilitás és a pénzügyi fenntarthatósággal kapcsolatos problémák, ezen belül az alacsony számú jelentkezők a programba, és az elégtelen állami támogatások, mind ahhoz vezettek, hogy a CBHI rendszerek széttagolttá váltak, és a költségek saját finanszírozásban való túlzott bizakodás akadályozta a pénzügyi fenntarthatóságot.

A válaszadók szemszögéből nézve, a felmérés eredményeire és AZ egyéb forrásaira támaszkodva a disszertáció számos javaslatot tesz az etiópiai politikai döntéshozók számára. A javaslatok a disszertáció eredményei alapján feltárt hiányosságokat orvosolják és megoldásokat kínálnak.

Kulcsszavak: CBHI, CBHI stratégia megfogalmazása és megvalósítása, hozzáférés AZ egészségügyi szolgáltatásokhoz vidéki területeken, a CBHI megvalósítása során tapasztalt kihívások

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Glossary of Terms and Abbreviations

CBHI: Community-based health Insurance

SHI: Social health insurance

MDG: Millennium Development Goals

WHO: World Health Organization

UN: United Nation

EHIA: Ethiopian Health Insurance Agency

USAID: United States Aid Organization

HCFS: Health Care Financing Strategy

FMOH: Federal Ministry of Health

SDGs: Sustainable Development Goals

NGOs: Non-Government Organization

ILO: International Labour Organization

GDP: Growth Domestic Product

OOP: Out-of-pocket spending

WB: World Bank

EPRDF: Ethiopian People Revolutionary Democratic Front

HSTP-I: Health Sector Transformation strategy I

GTP II: Growth and Transformation Plan II

UHC: Universal Health Coverage

EFDA: Ethiopia Food and Drug Authority

HAD: Health Development Army

Chapter One: Introductions

This part of the chapter provides an overview of the study's main themes, formulation of the scientific problem, hypotheses, research objectives, and research methods. It explains why certain methods are preferred over others and justifies the methodological strategy employed in the dissertation. The introduction of this study focuses on the critical examination of Community-Based Health Insurance (CBHI) in Ethiopia, particularly within the Oromiya National Regional State. The research is motivated by the pressing need to address the limited access to healthcare services and the financial barriers that many households face in the region.

This Chapter Includes the background of the study, research objectives, formulation of the scientific problem, research questions, hypothesis of the study, description of the variables, significance of the study, scope (delimitation) of the study, and limitation of the study. The study identifies a significant gap in the existing literature regarding the implementation and effectiveness of CBHI schemes in Ethiopia. Despite various health insurance initiatives, there is a lack of comprehensive understanding of how these programs operate and their impact on community welfare and health outcomes. The Ethiopian government, in collaboration with international organizations, has initiated CBHI as part of a broader strategy to enhance healthcare access and quality. This initiative aims to mobilize resources and improve the efficiency of healthcare delivery, particularly for the poorest segments of the population. The study emphasizes that households must be registered through a community-based approach to ensure fair membership selection, which is crucial for the success of the CBHI scheme

The research is significant as it aligns with global health goals, particularly the Sustainable Development Goals (SDGs), which advocate for universal health coverage. By investigating the effectiveness of CBHI, the study aims to provide insights that can inform policymakers and healthcare organizations about the best practices for implementing such systems. The primary objective of this study is to explore the challenges and determinants of CBHI implementation in the Oromiya region. It seeks to understand how these challenges affect the overall effectiveness of the insurance scheme and its ability to reduce financial barriers to healthcare. The introduction also acknowledges the limitations of the study, particularly its focus on the Oromiya National Regional State, which may limit the generalizability of the findings to other regions or contexts with different socioeconomic and cultural dynamics.

1.1. Background of the study

Health is at the heart of the MDGs. The MDGs are eight goals that UN nations have pledged to try to achieve by 2015. The Millennium Declaration of the United Nations, signed in September 2000, commits world leaders to combating poverty, hunger, disease, illiteracy, environmental degradation, and gender discrimination. This declaration is the source of the Millennium Development Goals. Each MDG has 2015 targets and indicators to track progress from 1990 levels. Several of these are directly related to health (World Health Organization, 2018).

Goals 4, 5, and 6 specifically focus on health, but all the MDG had health-related aspects (Haines, 2004; Wagstaff et al., 2006; WHO, 2009). Similarly, Sustainable Development Goal 3 states "ensure healthy lives and promote well-being for all at all ages", sets out nine targets and four means of implementation (Buss et al., 2016; UN, 2015).

According to the MDG report of 2014, Ethiopia had successfully achieved six of the eight Millennium Development Goals. The country had made significant progress on MDG 5, improving maternity health, but did not achieve the target. Now, Ethiopia is implementing the Sustainable Development Goals', with the 10-year development plan (2021-2030) of the Ethiopian government, all achieved and non-achieved MDG. Health-related goals are part of this plan.

There was no or little insurance coverage in Ethiopia. The involvement of the private sector in health was limited. All these circumstances made accessing health care a challenge for many households. To resolve these issues, a health care financing strategy was endorsed by the Council of Ministers in 1998. Its objectives were to mobilize additional resources from both domestic and external sources, improve efficiency, especially by shifting resources to primary care, and ensure the sustainability of quality health care services. It also aimed to enhance community participation and ownership of health services (EHIA, 2015).

Community-based health insurance schemes are promising alternatives for a cost-sharing health care system; the concept of cost sharing is the sharing of the costs of covered health care services between you and your health insurance company. (eHealth Insurance, 2021; Norris, 2023), Deductibles, coinsurance, and co-payments are examples of cost-sharing that you must pay out of pocket (Cost-Sharing Definition | Association Health Plans, n.d.).

Premiums, balance billing, and non-covered services are not included in cost sharing. Cost sharing may differ depending on the type of health insurance plan and the provider network (Cost-Sharing Definition | Association Health Plans, n.d.; Cost Sharing, 2020).

Community-based health insurance leads to better utilization of health care services. Reduce illness-related income shocks and eventually lead to a sustainable and fully functioning universal health care system (Carrin et al., 2005).

Ethiopia introduced the CBHI scheme as a means of health program implementation, particularly universal access to health, in 2010 (EHIA, 2015).

Regarding the organizing, supporting, and funding entities of community-based health insurance in Ethiopia, Since the Community Based Health Insurance (CBHI) initiative was launched in 2011 with the assistance of the Ethiopian Health Insurance Agency (EHIA) (Tilahun, 2022). Both the EHIA and the Federal Ministry of Health (FMOH) serve as the project's supervising and executive units, and smaller national coordinating units have been established to oversee operations (Tilahun, 2022). Regional (districts) and local administrative/village (Ganda) health insurance steering committees have been established (ibid.). These committees are in charge of establishing and operating CBHI schemes (ibid.). The United States Agency for International Development (USAID), CARE Ethiopia, and Abt Associates (a global leader in research and program implementation on health, social, and environmental policy issues) also play important roles in the scheme's design, piloting, and scaling up (Abt Associates, 2019).

Premiums collected by community members are used to fund all health and curative services for families (Yilm et al., 2015). In addition, the government will provide a 25% subsidy (Tilahun, 2022). When these premiums are collected, the funds are transferred directly to the village representatives (usually chosen by community members), who then make payments to the district head offices (Tilahun, 2022). These offices then pay hospitals and health care facilities (Solomon et al., 2019).

Enrollment in the scheme is determined on a household basis rather than individually by government officials (Solomon et al., 2019).

To avoid biased and unfair membership selections, participants must be registered through a household to be recognized as members of the scheme. At the pilot stage, awareness activities give local villages the option of joining the scheme if most villagers support the idea and show interest (ibid.). Aside from that, households can choose whether to participate in the initiative. Once a household applies to participate, kebele officials and the community screen and select the households they believe are the poorest to gain access to the additional 10% provided by the government as a subsidy to poorer community members (Yilma et al., 2015).

A general assembly and board members chosen and elected by the community represent each woreda (Solomon et. al., 2019).

The scheme was introduced by the FMOH in collaboration with USAID, Abt Associates Inc., an international consulting company, and CARE Ethiopia, an international non-governmental organization. The scheme is part of the government's broader health care financing reform strategy, which aims to improve the quality and coverage of health services by identifying alternative healthcare resources (USAID, 2011). The Ethiopian government developed HCFS in 1999. This strategy had four interconnected goals: identifying additional resources for the health sector, mobilizing and deploying these resources to the health sector, improving resource efficiency, and allocating additional resources to improve care quality. Several reforms have resulted from the HCFS, including increases in user fees, fee retention and utilization of generated resources by care providers, and the implementation of health insurance schemes.

Community-based health insurance is also part of the health insurance strategy. Health insurance coverage in Ethiopia has been limited, despite the need for improved citizen health and accelerated socioeconomic development, which necessitates the expansion of health care services. Though the issue of universal coverage in the provision of health care services has been controversial, the cost-sharing strategy between beneficiaries and the government is intended to keep financial problems to a minimum, allowing beneficiaries to obtain sustainable healthcare services while reducing financial barriers at the point of service delivery via health insurance schemes. As a result, social health insurance and community-based health insurance are intended to provide free health care coverage to all citizens at the point of service.

In general, the sources of finance to implement the health policy in Ethiopia are government sources, out-of-pocket payments at the time of service, donor's funds, charity activities, as well as insurance sources (EHIA, 2015). This study explores the overall implementation of the CBHI strategy and the challenges encountered in the implementation of the scheme in Oromia National Regional State.

Ethiopia is working on implementing the SDGs, which are going to end in 2030, and health is one of the 17th UN's SDGs (UN, 2015). Ethiopia developed a ten-year development plan (2021–2030) that deals with improvement and growth in different sectors, including the health sector. In its 10-year development plan, the country aims to achieve universal access to health services, and community-based health insurance is part of the strategy. This research is therefore relevant as it intends to identify challenges in the implementation of CBHI, suggest enough evidence for policy dialogue among stakeholders, and enables them to take proper action to contribute towards the achievement of sustainable development goals and health sector targets in the ten-year development plan.

1.2. Research Objectives

The main goals of the study are outlined below:

- To examine the major contents of the CBHI Strategy and pit falls.
- To analyse the influence of the CBHI strategy on formulation and implementation in the West Showa Zone, Orimiya National Regional State.
- To examine the level of community participation and engagement in the implementation of CBHI in the study areas.
- To identify the challenges of CBHI implantation in the west Showa zone.
- To analyse the effect of administrative capacity, manpower, and resource allocation on CBHI implementation in West Showa Zone
- To examine the status of stakeholder's coordination on implementation of CBHI in the west Showa zone.
- To investigate the influence of the influence of traditional community support systems and local health practices on CBHI implementation.

1.3. Formulation of the Scientific Problem

According to the WHO, one hundred fifty million people globally suffer financial catastrophic shock each year, and one hundred million are pushed into poverty because of direct payments for health services. Community-based health insurance schemes are becoming increasingly recognized as an instrument to finance health care in developing countries, with certain weaknesses such as a low capital start-up base, the small size of the risk pool, a lower level of revenue mobilization, limited management capacity, and isolation from more complete benefits (Kebede et al., 2014).

The main sources of finance for community-based health insurance in Ethiopia are annual contributions from members, general and targeted subsidies, and other innovative income like bazaars and donations.

Targeted subsidy is an amount of money secured for households who are unable to pay (70% of the annual contrition amount from the regional government and 30% from the district). It is only Southern National Nationality People Region (SNNPR) where the district secured all targeted subsidy. The federal government subsidizes 10% of the total contribution to strengthen the financial capacity of the CBHI scheme (EHIA, 2020). Since 2019, the premium payment has been Br. 350 ($6.60) for users living in Addis Ababa, while for other regions it is Br. 240 ($4.53).

There have been various studies conducted by researchers on CBHI, most of which focused on households' willingness to join and associated factors for user droop-out (Shewamene, 2021; Cheno et al., 2021; Thakur, 2016; Onasanya, 2020; Nsiah-Boateng et al., 2019; Nageso et al., 2020; Gutama, 2019; Herberholz et al., 2017; Agago et al., 2014; Deksisa et al., 2020; Garedew et al., 2020; Atnafu and Tariku, 2020; Cheno et al., 2021; Khuwaja et al., 2021; Ashagrie et al., 2020; Eseta et al., 2020)

Those studies conducted on the effect of CBHI on Financial Protection (Abajobir et al., 2021; Nannini et al., 2021; Aikins et al., 2021; Koon et al., 2021; Dwivedi et al., 2020; Bodhisane & Pongpanich, 2019; Mekonen et al., 2018).

The research conducted on the effect of CBHI on Wider welfare as well as economy-wide impacts on risk coping and managing shocks (Hirvonen et al., 2021; Shigute et al., 2020; Erlangga et al., 2019; Nannini et al., 2021; Dror et al., 2016).

However, there is scarce evidence that remains thin on the implementation of CBHI and challenges in Ethiopia, particularly in the Oromiya national regional state, and in terms of the research goals proposed. However, the researcher found few types of research on these issues at hand, among them Habiyonizeye (2013) in her study entitled Implementing Community-Based Health Insurance Schemes: Lessons from the Case of Rwanda. The review found that the main challenges of CBHI are related to insurance risks that include adverse selection and moral hazards. However, this study used extensive literature reviews and informal interviews, so this method is not enough to study the issue at hand and draw conclusions. Mirach et al. (2019) focused on the determinants of community-based health insurance implementation in the west Gojjam zone, Northwest Ethiopia: a community-based cross-sectional study design. The researcher found that this study is closely related to my title; however, the article and most of the above-reviewed research were conducted using quantitative methods only. Analysing the extent of health policy implementation by using quantitative methods may not be enough to stimulate evidence-based policy dialogue. Second, as pointed out already, the CBHI scheme involves multiple actors whose interests can converge or diverge, having an impact on strategy, policy formulation, and implementation. In Ethiopia, however, the role of different actors in CBHI strategy formulation and implementation, as well as the extended support and demand of different actors, including the local community and beneficiaries, have not been well documented.

Besides this, according to Wang et al. (2012), there is no gold standard when it comes to the design of a health insurance system. Within each model, there are substantial differences in its application in each country. This variety is a healthy reflection of policymakers' designing their health insurance scheme for the realities of their situation and adapting the methods to the needs of their country and population.

This study aims to fill this gap in terms of literature, and the nature and design of a health insurance system vary from country to country.

1.4. Research Questions

Based on the previous problem statement, the research questions below have been identified.

The main research question of this study is

- How is the CBHI strategy formulated and implemented in the Oromia national regional state, and what are the challenges of implementation?

Specifically, the following research questions have been identified:

- What is the status of community-based health insurance (CBHI) implementation in different parts of West Showa Zone, Oromiya National Regional State?
- What are the major contents of the CBHI strategy and pit falls, if any?
- What is the effect of CBHI on healthcare access, utilization, and financial protection for vulnerable populations in the West Showa Zone?
- What are the major challenges faced by CBHI programs in Ethiopia, including issues related to governance, financing, administration, and accountability?
- How does the level of community participation and engagement influence the effectiveness of CBHI implementation in different districts of the West Showa Zone?
- How does the regulatory and policy framework in Ethiopia facilitate or hinder the growth and functioning of CBHI schemes?
- What are the key factors influencing the adoption and enrolment rates of CBHI schemes among various socioeconomic groups in the West Showa Zone?

1.5. The Hypothesis of the study

- CBHI programs in Ethiopia cover outpatient and inpatient care, critical drugs, maternity and child health services, and specific diagnostic tests. However, specialized and high-cost medical procedures have limited coverage, requiring beneficiaries to seek additional financial assistance.
- The effectiveness and longevity of the CBHI plan in Oromia National Regional State depend on the level of community engagement and participation in its development.

- The West Shewa Zone of Ethiopia will benefit from improved healthcare access and financial protection through the implementation of community-based health insurance (CBHI), but obstacles will need to be overcome, including inadequate funding, inadequate infrastructure, low enrolment, and participation rates, and a lack of knowledge among the target population about the benefits of health insurance.
- Effective execution of the CBHI strategy in the West Showa Zone relies heavily on coordination and collaboration among various stakeholders, including government agencies, non-governmental organizations, and community leaders.
- In west show zone, incorporating traditional community support structures and local healthcare practices in the CBHI strategy results in higher program adoption and sustainability.

1.6. Description of the variables

1) **Community-based health insurance implementation**: In the West Shewa Zone, this variable describes the introduction and operationalization of community-based health insurance. It involves tasks including creating policies, recruiting members, creating benefit plans, and establishing payment systems.
2) **Healthcare Access**: This variable assesses how easily West Shewa Zone inhabitants can get the necessary medical care. Affordability of services, accessibility to healthcare facilities, and availability of healthcare practitioners are some variables that may contribute to improved healthcare access.
3) **Financial Protection:** This factor evaluates how well residents are shielded from the financial hazards connected to medical costs. Some elements that contribute to financial protection are out-of-pocket costs, health insurance, and the degree of financial risk sharing.
4) **Challenges:** The term "challenges" describes the impediments or challenges encountered in the West Shewa Zone when implementing CBHI. Challenges may include factors such as affordability of premiums, lack of awareness about the benefits of insurance, low participation rates among community members, financial sustainability, insufficient infrastructure, and administrative inefficiencies.

Challenges of CBHI include low enrolment rates, financial sustainability, insufficient infrastructure, administrative inefficiencies, a lack of awareness, and cultural obstacles.

Community-Based Health Insurance (CBHI) in Oromiya National Regional State aims to increase access to healthcare services, lower out-of-pocket expenses, and improve health outcomes. Its effectiveness can be measured through enrolment rates, program utilization, financial security, and health status improvements.

1.7. Significance of the study

Universal health care has gained international attention, and health-related goals are part of sustainable development goals. This thesis is an attempt to fill a gap in the literature on this subject. Moreover, there is scarce evidence that remains thin on the implementation of CBHI and challenges in Ethiopia, particularly in the Oromiya national regional state, and in terms of the research goals proposed. In fact, this dissertation adds to the existing literature in the following ways:

Policy Implications: The study's findings can help policymakers, government agencies, and healthcare organizations that are planning and implementing community-based health insurance systems. Understanding the implementation issues and determinants can lead to informed policy decisions targeted at increasing the effectiveness and sustainability of such initiatives.

Access to Healthcare: Community-based health insurance programs are designed to improve access to healthcare services, especially for disadvantaged and marginalized groups. The research can help develop strategies to guarantee that these initiatives effectively reach and benefit the targeted areas by identifying obstacles and implementation gaps.

One of the primary purposes of community-based health insurance is to decrease financial barriers to healthcare services. The study's findings can shed light on how well these programs are meeting this goal, as well as provide ideas on how to properly organize insurance policies to provide better financial security for participants.

Sustainability and Scalability: Understanding the obstacles encountered during the implementation of community-based health insurance schemes can help to design long-term sustainability and

scalability plans. This can include resolving finance, administrative efficiency, community participation, and local capacity-building challenges.

Community Engagement: The study has the potential to emphasize the significance of community engagement and participation in the success of health insurance schemes. The study can offer recommendations for developing greater community buy-in and involvement by identifying barriers to participation and understanding community perceptions.

Academic Contribution: The study can add to the academic literature by providing empirical evidence and case-specific analyses of the problems associated with community-based health insurance implementation. It can be used as a resource for future academics and scholars interested in this topic.

Lessons from the Case of Oromiya National Regional State: The lessons acquired from the case of Oromiya National Regional State may have ramifications beyond Ethiopia. Other countries and locations facing comparable obstacles in implementing community-based health insurance can benefit from the study's findings and recommendations.

1.8. Scope of the study

This study is scoped geographically, in content, and in duration. The study focuses on the implementation and challenges of community-based health insurance in Ethiopia, in the case of the West Showa Zone. The study covers the period from 2021 to 2025. Geographically, the study is conducted in Ambo town, Oromiya national regional state. A cross-sectional survey will be employed in the area gathered based on the time frame, and a conclusion will be made.

1.9. Limitation of the study

The main limitations of the study are scope, generalizability, and temporal context. Regarding the scope, the study focuses mainly on Ethiopia's Oromiya National Regional State. As a result, the findings and conclusions may not be immediately relevant to other regions of the country or countries with distinct socioeconomic, cultural, and healthcare system contexts. Concerning the time context, the study's findings are limited to the time in which it was done. Factors and conditions may change over time, potentially influencing the study's conclusions' validity and applicability to future scenarios.

Chapter Two: Literature Review

The development of social security programs and systems is one of the most significantsocial policy achievements of the 20th century. Nonetheless, the enhancement and extension of social security will remain major challenges for decades to come (Social Security: A Fundamental Human Right, n.d.).

This part of the dissertation deals with the focal concepts of discussion in this study: social health insurance and social protections.

Introduction

For many years, social protection, also known as social security, has been a significant topic in social policy studies. Debates surrounding social protection have intensified over the years, particularly after World War II, as programs expanded and questions regarding funding, objectives, administration, and coverage emerged (Midgley, 2013).

Social protection dates to the Poor Law of 1601 in England, which aimed to provide work for able-bodied people. Labour regulations safeguarding workers were repealed in the early 19th century, resulting in labour becoming a commodity freely bought and sold in the market. In industrialized countries, social protection includes trade unions, factory laws, labour regulations, and social security contributions to defend employees' interests and provide security. Additional measures such as healthcare, training, and education have been implemented to minimize income insecurity and poverty. Over the last 50 years, government policies involving significant financial transfers have reduced poverty. Favourable macroeconomic policies that promote employment creation also help to reduce worker insecurity (Canagarajah and Sethuraman 2001).

Favourable macroeconomic policies that promote job creation are crucial to reducing worker insecurity. Workers feel insecure due to income instability, requiring social protection to ensure a predictable income. The aim of social protection has shifted from poverty reduction to preventing people from falling into poverty through no fault of their own. Most workers in developing countries work in the informal economy, which lacks traditional social protection measures. Therefore, innovative approaches are needed to reduce income instability risks, especially for low-wage workers in the informal sector (ibid.).

Social security is a mechanism for sustainable economic development and includes income maintenance, social protection, and volunteerism. It aims to protect people from loss of maintenance sources, ensure employment, and secure decent living standards. Social security also promotes social cohesion, growth, equity, and income redistribution. It affects economic behaviour in saving, productivity, and retirement but may have adverse effects on labour supply (ILO, 1999).

Social protection is a type of policy and program that protects people against risk and vulnerability, mitigates the impacts of shocks, and supports those who suffer from chronic incapacities to secure basic livelihoods. It includes social insurance, social assistance, and services such as health and nutrition programs. Social protection is essential for social and economic development, particularly for those experiencing poverty and social exclusion. It can alleviate and prevent poverty, enhance productivity and economic development, and foster social inclusion and participation. However, the definition of social protection can be vague, leading to confusion. It is generally described as the set of mechanisms that protect and prevent individuals and households from suffering the worst consequences of shocks and stresses while also promoting resilient livelihoods. While social protection encompasses a wide range of activities, it is distinct from other social welfare components and has a specific role in fighting poverty and promoting economic growth (Adato and Hoddinott et al., 2008; Devandas, 2017; Ellias et al., 2009; Brunori and O'Reilly, 2010).

In the 1980s, concerns about the sustainability of social protection led some countries to consider privatization. Today, the definition, purpose, and obstacles of social protection are key themes and debates (Midgley, 2013).

2.1. **Social Protection**

2.1.1. Defining Social protection

The insecurity faced by workers in both developed and developing countries is largely due to income inadequacy and variability, which can take different forms. Social protection is now seen as a means of ensuring a minimum and stable income for workers, without the guarantee of the state as in the past. The aim of social protection is not just to alleviate poverty but also to minimize the risk of individuals falling into poverty through no fault of their own. This broader goal of social protection requires action beyond the immediate working environment of workers and is more ambitious than what was originally envisioned under social protection through labour standards.

However, it falls short of providing a social safety net with a minimum income defined in absolute or relative terms. Most workers in developing countries, around 90% of the workforce, are in the informal economy outside the institutional framework and beyond the reach of conventional social protection measures. Innovative mechanisms of social protection are needed to reduce the risks contributing to income insecurity, which are different from those facing workers in the formal sector. The burden of implementing new protective measures largely falls on the workers themselves, who have limited earnings, making the challenge evident (Canagarajah and Sethuraman 2001).

Favourable macroeconomic policies promoting employment reduce worker insecurity. Social security includes income-loss countermeasures, healthcare, and family benefits. It encompasses both government and private systems for economic security; including unemployment insurance, old-age and survivors' pension systems, and social assistance programs (Canagarajah and Sethuraman 2001).

Social protection, often known asum Standards) Convention (No. 102), social security comprises benefits for children and families, pregnancy, unemployment, work injury, sickness, old age, disability, survivors, and health protection. These policy issues are addressed by social protection systems through a combination of contributory programs (social insurance) and non-contributory tax-financed benefits, such as social assistance.

While social security and social protection are often used interchangeably, social protection has become more popular in recent years. There are many different names for social protection, and it lacks a commonly agreed-upon definition. Conditional cash transfers, disaster relief, and agricultural subsidies are all examples of social protection measures (Midgley, 2013).

Most definitions given on social protection in different circulations include three main dimensions: vulnerability and risk, the degree of deprivation deemed unacceptable, and a form of response that is both social and public in character (Lund and Srinivas, 2000).

Social protection refers to the public actions taken in response to levels of vulnerability, risk, and deprivation that are deemed socially unacceptable within a given polity or society (Mulligan and Sala-i-Martin, 1999).

Social protection deals with both the absolute deprivation and vulnerabilities of the poorest and with the need of the non-poor for security in the face of shocks and the demands of different stages of the life cycle (pregnancy and child rearing, marriage, death, and funerals). As such, it

encompasses as its core the two main broad fields of response methods, which are social assistance and social insurance (Van Ginneken, 1999).

When we see the historical background of social security, the work of the Chancellery of Germany's Otto von Bismarck work-based model and Denmark's universal flat rate is very important for the current social protection schemes practices in different nations.

Bismarck's work-based earnings model and Denmark's universal flat-rate model were two social security models instituted in the late 19th century. Bismarck's model was based on work-based earnings, where workers contributed a portion of their earnings towards social security and, in return, received limited coverage and benefits in cases of disability. Danish's model, on the other hand, was based on the principle of universalism or citizenship, where social security benefits were not linked to contributions but were available to all citizens, albeit with meagre benefits. The German Chancellor, following Bismarck's model, enacted a series of bills in the 1880s and 1890s, including the sickness insurance bill in 1883, the accident insurance bill in 1884, and the old age and disability insurance bill in 1889. The German social security scheme had three main features: compulsory insurance, self-financing autonomous pension institutions, and proportionate distribution of benefits based on income levy (Gordon, 1988).

These models and bills served as the basis for the creation of similar social pension schemes in other European countries, such as the British Old Pension Act and Insurance Act, the Swedish compulsory old-age pension, and the Swiss Act.

During WWII, Britain developed a flat-rate social security system as an alternative to the German model, providing universal benefits for all employees through public institutions (Veit-Wilson, 1992; Gordon, 1988).

The Bismarckian model of social security was favoured by most continental European countries due to its decentralized organizational structure, while the Beveridgean model provided benefits close to the poverty level. Scandinavian countries adopted the Danish model but provided versatile universal services to deal with income inequalities (Conde-Ruiz & Profeta, 2003; G. Esping-Andersen, 1990, 1999).

Social insurance programs became positive alternatives to social assistance programs after the First World War and were extended to cover unemployment and occupational disease during the interwar period. The systems became more comprehensive and generous in the 1960s due to sustained economic growth and favourable conditions (Gordon, 1988).

The healthcare system in the United States is predominantly business-oriented, driven by private insurance and market dynamics. However, there are elements of social protection, such as Medicare and Medicaid, which provide essential coverage for the elderly, disabled, and low-income populations (Centers for Medicare and Medicaid Services, 2023). Additionally, hospitals are mandated to offer emergency care regardless of a patient's ability to pay, adding a layer of protection in critical situations. Social aid programs, including financial support for single mothers and disabled individuals, also exist, but are more limited compared to European systems.

In contrast, European countries follow a different model, where social protection, including healthcare, is seen as a constitutional right. In these systems, the state is responsible for ensuring the welfare of all citizens through well-established social welfare institutions (OECD, 2023). This approach creates a stark difference from the U.S., where the responsibility for healthcare largely rests with individuals or private entities, and there is no constitutional guarantee of social protection (Artiga et al., 2020).

While the U.S. includes social programs like Medicare and Medicaid, these are narrower in scope compared to European models, which prioritize universal access to healthcare as part of a broader welfare state.

Neoliberal economic policies in the 1980s led to the privatization of social security schemes and scepticism about their effectiveness in the 1990s, due to growing criticism of development deficiencies (Gordon, 1988). As a result, a new paradigm of development is emerging, which emphasizes the importance of encouraging long-term investment, market sensitivity, human capital, institutions and mechanisms that respond to stimuli, market-friendly state intervention, and social equality for sustainable economic development (Piasecki, 2017).

When we see the defention and concepts of Social protection programs in less developed countries there are few handed literatures states this concept among that.

NGOs and commercial enterprises have expanded social protection programs in recent years, but there are ongoing debates regarding the scope and funding of these initiatives (Barrientos et al, 2016). One of the major challenges lies in the lack of a standardized definition for social protection, which complicates policy development and research in this area (Devereux & Sabates-Wheeler, 2004). Two primary approaches to understanding social protection programs are income or cash transfers and non-traditional programs. These non-traditional initiatives include a wide variety of services ranging from healthcare and education support to employment programs and food

assistance (Mastrorillo et al., 2022). However, the broad scope of these programs creates ambiguity regarding what should be considered social protection. This lack of focus can lead to confusion about the goals and effectiveness of the programs, making it challenging to measure their impact or develop clear policies (World Bank, 2023).

The lack of a standardized definition complicates policy and research on the areas of social protection programs. Two major approaches used to understand social protection programs are income or cash transfers and non-traditional programs include a wide variety of services or initiatives. These could range from healthcare and education support to employment programs, food assistance, and beyond. However, the problem with this approach is that it might be too broad; covering so many different types of programs that it becomes unclear what exactly should be included under "social protection." This lack of focus can lead to confusion about the goals and effectiveness of the programs, making it harder to measure their impact or create clear policies.
Both approaches have limitations. The first approach eliminates certain projects, while the second is overly broad. Some academics and groups focus on specific programs within the larger category of social protection. According to the International Labour Organization (2011), social protection encompasses a wide range of methods and activities for safeguarding individuals from negative consequences. The purpose of social protection is to protect individuals and families from unforeseen events that negatively impact their well-being.
For people all over the world, one of the most pressing social protection issues remains *health care*. In many countries, this has attracted less attention than pensions, but in the early years of the twenty-first century, enhancing social protection and social solidarity may hinge more on reforming health care than on reforming pensions (*ILC87, Report of the Director-General: Decent Work*, n.d.)
Social insurance is social security that is financed by contributions and based on the insurance principle; that is, individuals or households protect themselves against risk by combining to pool resources with a larger number of similarly exposed individuals or households.
Generally, international players have varying views on social protection, with some prioritizing poverty alleviation (UNDP, FAO, and German Federal Ministry for Labour and Social Affairs) (BMAS, 2010; Loewe & Schüring, 2021) and others associating it with risk management (European Commission) (ECHO, 2017; Loewe & Schüring, 2021). Institutional logics and

individual experiences impact social protection in national and international organizations. Despite consensus on definition, there are disparities in institutional approaches, and scholars have differing perspectives on claims' goals, providers, hazards, instruments, financing, and rationale. This highlights the complexity of the concept (Loewe & Schüring, 2021).

2.1.2. The Goals of Social protection

The purpose of social protection is interpreted in different ways. Social protection is not a single program but a variety of activities.

There is no agreement on the definition and goals of social protection (Midgley, 2013; Loewe & Schüring, 2021). While some associate social protection with income maintenance programs, others argue it has broader objectives. Social protection aims to safeguard earnings, and a variety of income transfer programs are used, with a preference for social insurance.

Social protection programs aim to prevent poverty and unemployment. Social insurance provides economic support during unforeseen circumstances, but coverage and benefit appropriateness can be problematic. Social assistance programs support low-wage workers and the uninsured but are often limited in scope and underfunded (Midgley, 2013).

The issue of social protection concerns the responsibility of individuals and the government to safeguard income. The World Bank endorsed the marketization of social protection by promoting privately managed retirement plans and limiting direct income transfers. Social funds were created in developing countries to provide emergency relief but were criticized for reducing government spending and social assistance. Politicians may use social protection initiatives to gain support by promising to increase benefits (Midgley, 2013).

Social protection serves as a means of social and political control, according to Marxist and critical views, while normative versions emphasize broader social transformation goals. Transformative social protection aims to address the social conditions that contribute to poverty while also promoting collective action against exploitation and discrimination. Social protection maintains economic stability and growth by acting as an automatic stabilizer and promoting the formation of human capital. Social protection systems serve various purposes and evolve over time. Effective policy formulation requires discussion, analysis, and issue clarification (ibid.).

There are different views on the main objective of social protection. These include reducing vulnerability, fighting poverty, decreasing inequality, promoting social inclusion, enhancing social cohesion, stimulating investment and economic growth, stabilizing societies and polities, legitimizing governments, supporting macroeconomic stabilization, boosting human capital, and other objectives.

In social protection policies, there are four approaches to prioritization: residualism, selectivism, productivism, and universalism. Attributing real social protection systems to any of these theoretical perspectives is problematic.

Table 2.1 Approaches to prioritization of social protection policies

Approach	Region/Model	Key Characterstics
Residualism	Anglo-Saxon or Liberal Model	Means-tested unconditional cash transfer and health/education voucher Narrow focus on low-income groups Emphasizes individual responsibility and minimal state intervention
Selectivism	Conservative, European Continental Model	Linked to social insurance, private insurance, and micro-insurance Focus on managing risks via contribution system
Productivism	East Asian Countries (Singapore, South korea and Japan)	Links social protection with economic productivity and growth Prirotize human capital; education skills, healthcare, labor market, participation

		Focus on employability and compitativiness
Undiversalism	Universalism (Social democratic or Comprehensive (Scandinavian model)	Advocates for universal benefits and redistribution Reghts-based programs: Pensions, child/unemployeement, public health, citizen grants, in-kind services Holistic and transformative approach

Source: Own compilation based on Loewe & Schüring (2021).

Varying countries prioritize different social protection functions, and low and middle-income countries are developing their systems. Different countries adopt various approaches based on their economic resources, political ideologies, and social priorities. While universal approaches prioritize broad coverage and equality, productivity and market-oriented models emphasize economic growth and individual responsibility. Each approach comes with its own strengths and challenges, reflecting the complexities of designing effective and sustainable social protection systems.

2.1.3. **Social Protection practices in developing countries**

Favourable macroeconomic policies that promote employment creation play a vital role in reducing worker insecurity. Social security refers to the protection offered by society through governmental measures to counteract income loss and provide healthcare and benefits for families. It encompasses both governmental and private systems aimed at preserving earning ability and ensuring economic security after retirement. Programs for maintaining earning capacity include health care, social protection during incapacity, maternity protection, and unemployment insurance. Old-age and survivors' pension systems, social insurance, retirement savings schemes, and social assistance programs are all options for maintaining one's level of life after retirement (Canagarajah and Sethuraman 2001).

The Self-employed Women's Association (SEWA) of India has an integrated social security program for informal sector workers, which includes health, life, and asset insurance. Similar programs exist in Bangladesh, the Philippines, Colombia, and South Africa, providing asset and life insurance and pensions. Microfinance institutions offer loans and insurance services to informal sector workers, with mixed results. However, social security programs in developing nations suffer from poor governance and low compliance rates, leading to limited financial support for informal sector workers (Canagarajah and Sethuraman 2001).

Social protection systems differ among countries due to varying government objectives, social conventions, and beliefs. Additionally, historical processes and path dependencies make replacing these systems challenging (Loewe & Schüring, 2021).

Many low- and middle-income countries lack social protection policies. 55% of the world's population is not covered by any social protection benefit, with Sub-Saharan Africa accounting for 87% and Asia and the Pacific accounting for 61% (ILO, 2017).

Developing countries have recently recognized social protection as a crucial aspect of their social and economic policies. Middle-income nations like Brazil, South Africa, and Mauritius have already spent around 3% of their GDP on tax-financed benefits (Kidd, 2014).

Some low-income nations, such as Bangladesh and Nepal, have developed comprehensive social protection systems at a cost of less than 1% of their GDP. Tax-funded social security plans in developing nations have produced significant outcomes in poverty reduction, human capital development, labor market participation, economic growth, social cohesion, and restoring dignity to disadvantaged members of society (Kidd, 2014).

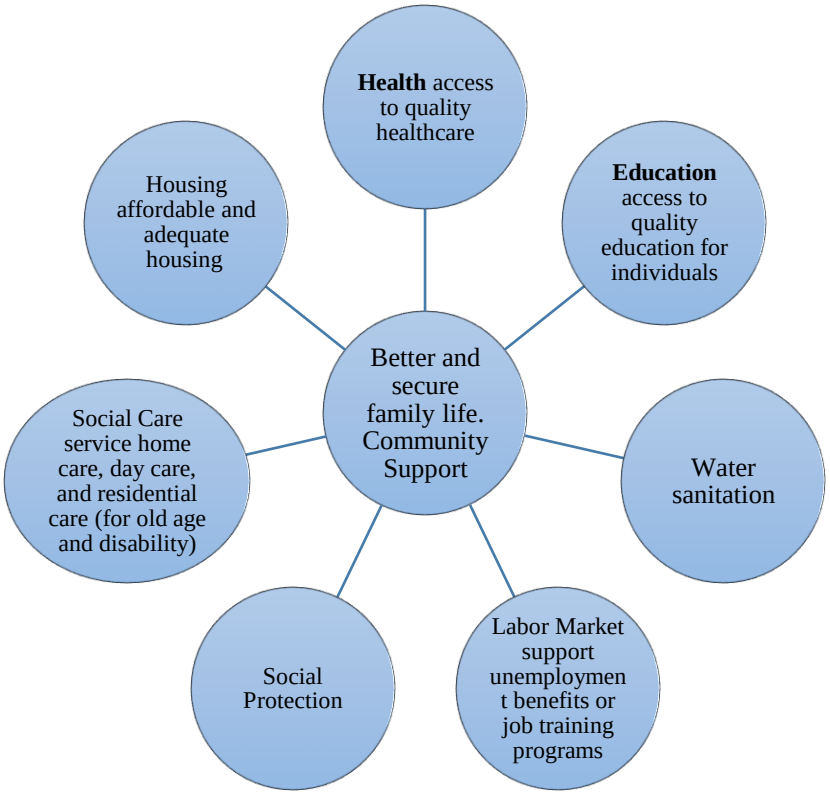


Fig 2.1: Basic social services and its investment

Source: Own compilation of the author based on Kidd (2014)

Investments in social services provide a safety net for individuals and families while also addressing poverty and inequality. Social security spending, funded by the country's GDP, is divided into three categories: government-funded benefits (pensions, disability benefits, and child grants are examples of government-funded benefits), social insurance spending (which includes payments for programs such as unemployment insurance and workers' compensation), and discretionary spending (ibid.).

2.2. Concepts of Community Based Health Insurance

According to the MDG report of 2014, Ethiopia had successfully achieved six of the eight MDGs. The country had made significant progress on MDG 5, improving maternity health, but did not achieve the target. Now, Ethiopia is implementing the SDG with the Growth and Ten-Year Development Plan (2021–2030) of the Ethiopian government, all achieved and non-achieved

MDG. Health-related goals are part of the 10-year development plan (2021-2030) of the Ethiopian government.

There was no or little insurance coverage in Ethiopia. The involvement of the private sector in health was limited. All these circumstances made accessing health care a challenge for many households. To resolve these issues, a health care financing strategy was endorsed by the Council of Ministers in 1998. Its objectives were to mobilize additional resources from both domestic and external sources, improve efficiency, especially by shifting resources to primary care, and ensure the sustainability of quality healthcare services. It is also aimed at enhancing community participation and ownership of health services (EHIA, 2015).

This part of my dissertation explains in detail the major theoretical concepts existing in different schools of thought associated with health insurance, particularly community-based health insurance. Before discussing the theories and schools of thought, it is better to begin discussing the concepts of community-based health insurance.

2.2.1. Concepts of Community-Based Health Insurance

Health is increasingly being viewed not only as an "end" but also as a crucial "input" into the development process. Indeed, a positive link between health and economic growth is widely established, particularly in low-income countries. As these countries embrace market reforms as well as integrate themselves with the world economy, there is a concern about insulating the poor from any possible adverse consequences. While the role of the state is on the decline in most economic spheres, in social sectors such as health, the state's role will continue to be important (Jutting et al., 2003).

According to WHO (1978), in the Declaration of Alma-Ata1, health was described as a human right to which all people were entitled; however, an estimated 1.3 billion people worldwide still lack access to the most basic levels of health care. Although the right to social security and health is well established in international law, governments and international donors are still failing in their responsibility to guarantee these rights to millions of people. In poor countries, the challenge is to finance systems that will deliver that right (Appiah-Denkyira and Preker, 2007).

There is a link between poverty and medical expenses because, in most developed countries, households rely on OOP to cover their medical expenses. In this regard, according to WHO (2013), increased expenditure caused by the need to cope with injury and illness has been identified as one of the main factors responsible for driving vulnerable households further into poverty.

Health insurance can be defined to distribute the financial risk associated with the variation of individual's health care expenditures by pooling costs over time through prepayment and over people by risk pooling (Tapay and Colombo 2004).

Community-financing schemes have evolved in the context of two seats of gap or failure to do by the following bodies:

Government failure to collect taxes and organize public finance, to provide social protection for vulnerable populations, and to exercise oversight of the health sector.

The market failed to offer an effective exchange between supply and demand, partly because of the gap between needs, demand, and the ability to pay and partly because of the prevalence of nonmonetary transactions in the informal sector.

The strengths of community financing in mobilizing and managing health care resources where more formal financing mechanisms have failed are based on three factors:

Social capital is one factor that determines the formal financing mechanisms, and it deals with the fact that, during hard times, family, friends, and community are often the ultimate safety net for low-income groups. The second factor is the pre-existence of some community institutions that organize successful reciprocal arrangements, including microinsurance, among members of the community.

The third factor is the interconnectivity between local communities and external institutions committed to advancing the general welfare of society (Dror and Preker, 2002).

Community financing is defined in Dror and Preker (2002) as "a generic expression used to cover a large variety of health-financing arrangements... micro-insurance, community health funds, mutual health organizations, rural health insurance, revolving drug funds, and community involvement in user-fee management" (Ekman 2004).

Since the late 1990s, in a move away from user fees for health care and with the aim of creating universal access, several low- and middle-income countries have set up community-based health insurance (CBHI) schemes (Mebratie, 2015).

Health financing systems through general taxation or through the development of social health insurance are generally recognized to be powerful methods to achieve universal coverage with adequate financial protection for all against healthcare costs. These systems intend to respond to the goal of fairness in financing, in that beneficiaries are asked to pay according to their means while guaranteeing them the right to health services according to their needs. In tax-funded systems, the population contributes indirectly via taxes, whereas in social health insurance systems, households and enterprises generally pay in via contributions based on salaries or income (WHO, 2003).

Due to the limited ability of publicly financed health systems in developing countries to provide adequate access to health care, community-based health financing has been proposed as a viable option. This has led to the implementation of several community-based health insurance schemes in several developing countries. The review shows that the ultra-poor are often excluded, and at the same time, there is evidence of adverse selection. The bulk of the studies find that access to CBHI is associated with increased health care utilization, especially about the use of relatively cheaper outpatient care services as opposed to inpatient care. The schemes also appear to mitigate catastrophic healthcare expenditures. There are clear links between scheme design and effectiveness, suggesting the importance of involving the target population in designing and implementing CBHI schemes (Mebratie, 2015).

Community-based health insurance (CBHI) is called by many different names, including micro-insurance, community health finance organizations, mutual health insurance schemes, pre-payment insurance organizations, voluntary informal sector health insurance, mutual health organizations and associations, community health finance organizations, and community self-financing health organizations (Tabor 2005).

CBHI is a not-for-profit mechanism based on solidarity among a relatively small group of people. CBHI schemes vary a great deal in terms of who they cover, how, for what, and at what cost. The majority of CBHI schemes operate in rural areas, and their members are relatively poor. The best-

known examples are the schemes in Africa known as mutuelles de santé (Joint NGO, 2008). It represents any non-profit health financing scheme and covers not-for-profit insurance schemes that are aimed primarily at the informal sector, formed on the basis of an ethic of mutual aid and the collective pooling of health risks, and in which the members participate in its management (Musau, 1991).

Hence, CBHIs are praised for their ability to reach low-income people and marginalized groups in society in both rural and urban areas (WHO, 2013; Aggarwal, 2010).

The term community-based health insurance is used in this dissertation to refer to any non-profit health financing scheme that primarily aims at the informal sector and is formed on the basis of mutual aid and the collective pooling of health risks, in which households participate in premium payments.

Table 2.2: Major Types of Health Insurance

Types of Insurance	Financing Source	Management	Countries
National health insurance (NHI)	General Taxes	Public Sector	Canada, UK and Sweden.
Social health insurance (SHI)	Pyroll taxes (employers/ employees)	Non-government/Public	Germany, France and Japan.
Private Health Insurance (PHI)	Voluntary premiums	Private Companies	USA and Swizerland
Community-Based Health Insurance (CBHI)	Voluntary contributions from memebers and governemnt grants.	Community managed and governemnt involved (Case of Ethiopia)	Rawanda, Ethiopia, India and Gahana

Source: Wang, et al. (2012)

There is no gold standard when it comes to the design of a health insurance system. Within each model, there are substantial differences in its application in each country. This variety is a healthy reflection of policymakers' designing their health insurance scheme for the realities of their situation and adapting the methods to the needs of their country and population (Wang et al. 2012).

A common feature of all these programs is the predominant role of collective action in raising, pooling, allocating, purchasing, and supervising the management of the health financing arrangements. Beside this feature, the people covered often have no other financial protection or collective financing arrangement to pay for their health care, and government-provided services do not reach them. The third feature is the voluntary nature of these schemes and the tradition of self-help and social mobilization that are embraced by the poor in many low-income countries (Dror and Preker, 2002).

2.2.2. Determinants of successful resource mobilization, social inclusion and financial protection

Successful community-based health insurance management relies on the degree of resource mobilization, social inclusion, and financial protection. However, these three concepts are determined by factors such as the ability to address adverse selection, accommodate an irregular revenue stream of membership, have good management with strong community involvement, have organizational linkages between the scheme and providers, and have donor support and government funding. The following table will summarize the determinants of effective revenue collection and financial protection:

Table 2.3 Determinants of effective revenue collection and financial protection

Features	**Design characteristics**	
	Supporting effective revenue collection and financial protection	Undermining revenue collection and financial protection
Technical design characteristics	Addressing adverse selection via group membership	Non-compliance, evasion of membership payments

	Accommodating irregular income streams of members (allow in-kind contributions, flexible revenue collection periods) Sliding fees, scales, and exemptions for the poor make schemes more affordable.	Adverse selection Lack of cash income No cash income at collection time
Management characteristics	Community involvement in management can exert social pressure on member compliance with revenue collection rules. Extent of capacity building Information support	Provider capture: the high salary of providers at the expense of service-quality improvement. Weak supervision structures increase the chance of fraud with membership cards. Poor control over providers and members contributes to moral hazard, cost escalation, and undermines the sustainability of the scheme.
Organizational characteristics	Linkages with providers to negotiate preferential rates raise the attractiveness of schemes and contribute to successful membership.	Fragmentation between inpatient and outpatient care leads to inefficiency and waste, ultimately resulting in the loss of membership.

Institutional characteristics	Government and donor support make the schemes more sustainable and pro-poor.	

Source: Adopted from Jakab et al. (2001)

2.3. Demand for health Insurance and related theories

There are various studies conducted on the rationality of demanding health insurance by the community (Besely, 1989; Grossman, 1972).

The willingness to seek health services is derived from the demand for health, and the demand for health insurance is derived from the demand for health services (Grossman, 1971). This implies that people are willing to join health insurance due to seeking health services in their area.

According to Besely (1989), although the level of income earned, level of education, current health status, and other determinants such as aversion to receiving health care, availability, and access to health-related information will each influence the demand for health services.

The assumption of conventional models of demand, which state that individuals will maximize the expected utility within a budget constraint and based on their preferences, may not work in health services due to individuals' health information being focused on asymmetry; hence, the individuals need to consult a third party (a physician) on the quantity and type of health care needed when they are falling sick (Jowett, 2004).

The demand for health insurance is an important part of public health economics since it affects both individual and society health outcomes. Individuals seek health insurance to reduce the financial risks connected with healthcare spending, resulting in improved health management and protection against unexpected medical bills. The need for health insurance can be explained by a variety of economic and behavioral theories, including anticipated utility theory, moral hazard, and adverse selection.

Why are people interested in buying insurance? For this question, scholars such as Besely (1989) designed a theoretical framework according to which the demand for health is modelled much as

the demand for any other commodity. Individuals maximize utility, subject to budget constraints. Human health is not good and cannot? Be purchased and sold directly. Unlike other goods, health is produced using inputs to produce health services using health care It points out that health is not a conventional good that can be directly bought or sold in the market. Unlike tangible products, health cannot be exchanged like consumer goods, which complicates the way individuals approach health-related decisions. Health is produced rather than simply acquired. Individuals must utilize various inputs, including health services and healthcare, to improve or maintain their health. This perspective shifts the focus from merely purchasing health to recognizing the process of producing health through the consumption of healthcare services.

The constraint on individual utility maximization is imposed in the form of technology to produce health the model used to determine individual utility maximization in health care is the so-called household production model (Becker 1965; Gorman 1959). The concept of utility maximization is constrained by the technology available for producing health. This means that individuals must consider the effectiveness and efficiency of the healthcare services they use. The theoretical model suggests that individuals seek to achieve the highest level of health possible given the resources they have and the technology available to them. The model developed by Becker (1965) and Gorman (1959) illustrates how households combine different inputs (like time, money, and healthcare services) to produce desired outcomes, in this case, health. It emphasizes that health outcomes result from a combination of individual efforts and resources, rather than being solely dependent on purchasing healthcare services.

The decision to buy health insurance is influenced by a complex interplay of factors, including the desire to maximize satisfaction within financial constraints, the understanding that health is produced through the consumption of healthcare services, and the limitations imposed by available technology. It underscores the importance of theoretical models in understanding the behavior of individuals in the context of health insurance.

Menwhile the demand for health insurance is shaped by several factors, including individual risk prefernces, income levels, access to healthcare, and governmental policies. Understanding why individuals or groups seek health insurance involves examining both economic and bevioral aspects, particularly in how individuals perceived risks related to health and the financial burden of medical care.

The Expected Utility Theory (EUT) is a key theory that explains the need for health insurance. Individuals, according to this hypothesis, are risk averse and strive to maximize predicted utility rather than expected monetary gains. Health insurance is a risk-reduction instruments that smoothes out potentially big and unpredictable healthcare bills (Arrow, 1963). In this setting, people are willing to pay premiums to prevent the financial burden of catastrophic health events, even if they do not fully recover the costs in medical expenses.

For example, an individual may prefer to pay a set amount in insurance premiums rather than risk incurring a significantly larger medical expenditure. The benefits of health insurance, such as peace of mind and financial stability, frequently outweigh the actual cost of the premiums, particularly for risk-averse individuals.

The concept of moral hazard emerges once a person purchases health insurance. It refers to the greater likelihood of using medical services when the insured party does not cover the entire cost of care. People who are insured may consume more healthcare services than they would if they had to pay the whole cost out of pocket, resulting in inefficiencies in the health system (Arrow, 2004).

The concept of moral hazard arises when a person acquires health insurance. It refers to the increased chance of using medical services when the insured party does not pay for the total cost of care. People who are insured may use more healthcare services than if they had to pay the entire cost out of pocket, resulting in inefficiencies in the health system (Pauly, 1968).

Adverse selection is another important idea that influences health-insurance demand. This idea explains why those with higher health risks are more inclined to get insurance, but healthier people may choose not to buy insurance because they believe the benefits are too low in comparison to the expenses. As a result, insurance pools may become skewed toward high-risk individuals, resulting in higher premiums and potentially unsustainable insurance models (Rothschild & Stiglitz, 1978).

In practice, adverse selection has the potential to disrupt insurance markets. If insurers are unable to differentiate between high-risk and low-risk persons, they may increase prices to cover potential losses, preventing healthier individuals from getting insurance and worsening the problem.

Income elasticity and price sensitivity both have an impact on health insurance demand. According to studies, health insurance demand rises with income, since those with more financial means are more inclined to buy coverage to protect themselves against financial shocks (Cutler & Zeckhauser, 2000). Furthermore, the price of premiums and out-of-pocket payments has a substantial impact on an individual's decision to obtain insurance. When premiums are subsidized, such as in government-sponsored programs, demand for insurance rises.

Understanding the demand for health insurance necessitates an assessment of numerous economic and behavioral variables. Expected utility theory emphasizes the importance of risk aversion, whereas moral hazard and adverse selection expose the intricacies of customer behavior after insurance purchase. Furthermore, income and price sensitivity have a substantial impact on an individual's ability and willingness to buy health insurance. To create health insurance systems that are both accessible and sustainable, policymakers must strike a balance between these elements.

2.3.1. **Risk Aversion and Uncertainty**

One of the primary reasons for the demand for health insurance is to mitigate the financial risks associated with unexpected health problems. People are generally risk-averse, meaning they prefer the certainty of a small, fixed insurance premium over the uncertainty of potentially large, unpredictable healthcare costs (Arrow, 1963). Health insurance acts as a mechanism for risk pooling, spreading the financial burden of illness across many people, which reduces the out-of-pocket expenses for individuals who fall ill.

2.3.2. **Income and Affordability**

Income levels significantly impact the demand for health insurance. Higher-income individuals are more likely to purchase private insurance, while low-income individuals may struggle with the affordability of premiums, even if they understand the benefits of having coverage. Public health insurance programs, such as Medicaid in the United States, address this gap by offering low-cost or free health insurance to low-income populations (Cutler & Zeckhauser, 2000). However, where these programs do not exist, the cost of premiums can deter the purchase of insurance, leading to higher rates of uninsured people.

2.3.3 Moral Hazard and Adverse Selection

The demand for health insurance is also influenced by moral hazard and adverse selection. **Moral hazard** refers to the tendency of individuals with insurance to consume more healthcare services than necessary because they do not bear the full cost (Pauly, 1968). This can lead to increased healthcare costs overall. Conversely, **adverse selection** occurs when individuals who are most likely to need healthcare (e.g., those with chronic conditions) are the ones most likely to purchase insurance, while healthier individuals opt-out, leading to a less balanced risk pool (Rothschild & Stiglitz, 1976).

2.3.4. Policy and Regulatory Environment

Government policies and regulations play a critical role in shaping the demand for health insurance. In countries with compulsory health insurance mandates, such as **Germany**, individuals are required by law to purchase insurance, which guarantees a broad risk pool and minimizes adverse selection (Wagstaff et al., 1999). In contrast, in countries like the **United States**, where health insurance is largely voluntary except for certain mandates (e.g., Affordable Care Act), the demand for insurance can fluctuate significantly based on policy changes, subsidies, and penalties for non-coverage.

2.3.5. Perception of Healthcare Quality and Accessibility

The demand for health insurance is also affected by individuals' perceptions of the healthcare system's quality and accessibility. In countries with strong, well-regarded healthcare systems, individuals are more likely to purchase insurance because they anticipate receiving quality care. Conversely, where the healthcare system is perceived as inadequate or difficult to access, people may feel less compelled to buy insurance (Manning et al., 1987).

2.3.6. Demographic Factors

Age, gender, and family status are key demographic factors affecting the demand for health insurance. For instance, older individuals, who are at higher risk of health issues, typically have a higher demand for insurance than younger, healthier individuals (Feldstein, 1973). Families with children are also more likely to seek health insurance to cover potential healthcare needs for their dependents.

In general, the demand for health insurance is influenced by a combination of economic factors, individual risk preferences, income levels, and governmental policies. While risk aversion and the desire for financial protection drive the need for insurance, challenges like moral hazard, adverse selection, and affordability can complicate the effectiveness of health insurance markets. Policies that promote equitable access and affordable premiums are crucial to ensuring broad coverage, particularly among low-income populations.

2.4. Theoretical Framework

2.4.1. Social Capital Theory

Social capital is defined as those characteristics of social structures, like the level of interpersonal trust and norms of reciprocity and mutual aid that act as resources for individuals and facilitate collective actions (Colrman, 1990; Putnam et. al., 1992). Social capital is determined by the community's level of trust, public engagement, and norms of reciprocity (Putnam et. al., 1992; Lochner et al., 1991). Putman (1993) stated that the two-key theoretical integrities of social capital are general community trust and generalized reciprocity. Further, Woolcock and Narayan (2000) explained that social capital assists the poor to manage risks and vulnerability. Hence, community-based health insurance, which aims at managing risk and vulnerability, may be well accepted by a community that possesses a high stock of social capital. A high level of social capital is associated with a high level of altruism among individuals; this makes it possible to take into consideration the well-being of other members of the group. The presence of social capital always has a positive effect on a community's welfare. (ibid.) Handsome studies suggest that informal risk-sharing mechanisms are more likely to emerge in communities rich in social capital (Jowett, 2004). According to Hsiao (1995), levels of social capital can be used to predict whether risk-sharing for health will emerge voluntarily. Socially cohesive communities recognize the mutual benefits of pooling and are more likely to 'pull together', in order to make a health insurance scheme work. By implication, Hsiao suggests that voluntary risk-sharing is less likely to emerge in less socially cohesive communities.

It is questionable whether any of the arguments based on community structure are relevant in the context of large formal schemes, such as Vietnamese Health Insurance. The institutional design of the scheme (i.e., little community control or involvement in decision-making) is such that inter-

personal trust at the local level would be of less relevance than simple calculations about expected utility. However, if a scheme is perceived to be the embodiment of national social solidarity, social structure, to the extent that it generates norms of behaviour, may influence uptake, even where the scheme is highly centralized. While the sociological literature would probably classify feelings of national solidarity as social capital, given the large number of ideas bundled into it, the two are clearly not synonymous (Jowett, 2004).

There are two common types of social capital: “weak ties” (also called “bridging social capital”) and “strong ties” (also called “bonding social capital") (Woolcock and Narayan 2000). “Strong ties” refers to the close relationship between an individual and his family, friends, ethnic group, etc. This corresponds to intra-community social capital. “Weak ties” refers to the individual’s contacts outside the ethnic group or the family (other entrepreneurs, other ethnic groups, banks, etc.) (ibid).

A strong tie implies a high level of solidarity between the members of the group, which is good for CBHI. However, similitude between members is a flaw for CBHI. For example, if all members engage in risky behaviour, CBHI might not work properly. On the other hand, “weak ties” implies less solidarity, but members are different from each other. Riskier behaviour might be compensated by less risky behaviour. Further studies could investigate which type of social capital has the strongest effect on CBHI. If “weak ties” work better, policymakers might, for instance, decide to start developing CBHI in bigger villages since the level of extra community social capital is high (Donfouet & Mahieu, 2012).

Community member participation represents a bottom-up (or grassroots) approach to program planning and decision-making. The 1978 World Health Organization (WHO) Declaration of Alma Ata recognized that people must be actively involved in the process of promoting and protecting their health (Laverack, 2004).

Several reasons to promote community member involvement in community-based programs have been proposed. Participation is assumed to lead to individual empowerment, as people gain skills in assessing needs, setting priorities, and gaining control over their environment (Kreuter et al.,

2000). The principle of relevance states that change will be greatest when the designed programs start, whereas the community states that change will be greatest (Durham, 1963).

Engagement by community members is a way to incorporate local values and attitudes into the program and to build the layman's perspective into the program. Community member involvement can also provide access to local leaders, resources, and technical skills not otherwise available (Bracht and Tsouros, 1990). Moreover, this participation engenders a sense of identification and continuing responsibility for the program, often referred to as the principle of ownership (Carlaw et al., 1984). Program support by local opinion leaders enhances confidence in the benefits of the program and makes it easier for individuals to accept the program (Nilsen, 2006).

Providing space for community participation may have an impact on the willingness of individuals to buy insurance and the overall performance of the scheme. The review reveals that the participation of the community in design and implementation has a positive impact on healthcare utilization and financial protection. For instance, all 9 schemes in which communities have a role in program design are associated with an increase in access to healthcare, and 4 out of 5 display a reduction in OOP expenditure. The corresponding figures for schemes without such participation are 6 out of 11 and 1 out of 4 for utilization and OOP expenditure, respectively.

Participation of members in management and supervision activities is also linked with increases in access to healthcare services (7 out of 7) as opposed to 9 out of 14 for schemes where members are not involved (Mebratie, 2015).

The following two theories are identified as the most relevant to the success of community-based health insurance.

2.4.2. Social Mobilization Theory

Social mobilization theory has been proven effective for health promotion, especially when people are reluctant to respond positively to health programs. In the case of CBHI, people need to be mobilized to understand and adhere to the program, given the fact that most people do not see the direct benefits of health insurance (Habiyonizeye, 2013).

Community mobilization is a proven development strategy that has helped people around the world identify and address pressing healthcare issues. Community mobilization not only helps people improve their health and living conditions, but by its very nature, it also strengthens and enhances the ability of the community to work together for any goal that is important to its members. The result of a successful community mobilization effort, in other words, is not only a "problem solved" but the increased capacity to successfully address other community needs and desires as well (Howard et al., 2003).

Social mobilization refers to "the use of planned actions and processes to reach, influence, and involve all stakeholders across all relevant, persistent, involved, and concerned sectors, including the national and community level, to raise awareness, change behaviour, change policy, demand a particular development program, or reallocate resources or services" (Russell et al., 2033).

Mobilizing Community is the process in which local individuals, groups, or organizations identify needs, plan, carry out, and evaluate activities on a participatory and sustained basis to build capacity for improving health and other needs, either on their own initiative or simulated by others (Howard et al., 2003). Community mobilization can be rated as passive community community sensitization, or the raising of health literacy) to active mobilization (the adaptation of participatory approaches that target a range of community members) (Haws et al., 2007; Rosato et al., 2008).

The main challenges facing establishing and maintaining effective community-based health and insurance (safety) programs are considerable, and they need sustainable resource investment (Cheadle et al., 1997; Turner et al., 2004; Mittelmark, 1993). According to Niel Mckee (1992), there are different approaches to mobilizing resource investment: political mobilization, government mobilization, community mobilization, corporate mobilization, and beneficiary mobilization.

These seven principles used in community-based health and safety programs are: community focus (the community is both the target and the catalyst for change); community member participation (the involvement of community members in interpreting the health or safety problem and finding solutions); sustainable resource requirements (existing community resources and skills available from outside of the community); and inter-sectorial collaboration (creating community

collaboration between community sectors and organizations established for the same goals) Multifaceted interventions and population outcomes (implementing behavioral and structural interventions) (Nilsen, 2006).

Chapter Three: Research Methodology

This chapter serves as a comprehensive overview of the research methodology employed in this study, focusing on the implementation and challenges of community-based health insurance (CBHI) in the West Shewa zone. The significance of a well-structured research methodology cannot be overstated, as it provides a systematic framework for conducting academic research and guides the researcher in identifying the problem statement, research questions, and the scope of the study. Key components of this chapter include:

Research Design; The chapter outlines the overall design of the research, emphasizing the mixed-method approach that aligns with the theoretical framework of the thesis. This approach allows for a more nuanced understanding of the complexities surrounding CBHI implementation.

Data Collection Methods; A detailed description of the data collection tools is provided, including questionnaires and semi-structured interviews. The questionnaires consist of 90 questions divided into seven categories, targeting various aspects of CBHI, such as implementation challenges and community engagemen.

Ethical Considerations: the chapter highlights the importance of participant privacy, anonymity, and confidentiality in the research process. The researcher has taken steps to ensure secure data storage and limited use of participant data, which is crucial for maintaining trust and integrity in the research.

Study Area: the research is situated in the West Shewa zone, located in the central part of the Oromia region. This area has been selected due to its relevance to the study of CBHI and its accessibility to major market centers, which facilitates the efficient provision of local health products.

Statistical Analysis: the chapter also discusses the statistical analysis methods that will be employed to interpret the data collected, ensuring that the findings are robust and reliable.

This chapter lays the groundwork for understanding the research methodology, providing a clear roadmap for the study's execution and analysis. It emphasizes the importance of a systematic approach in addressing the research questions and achieving the study's objectives

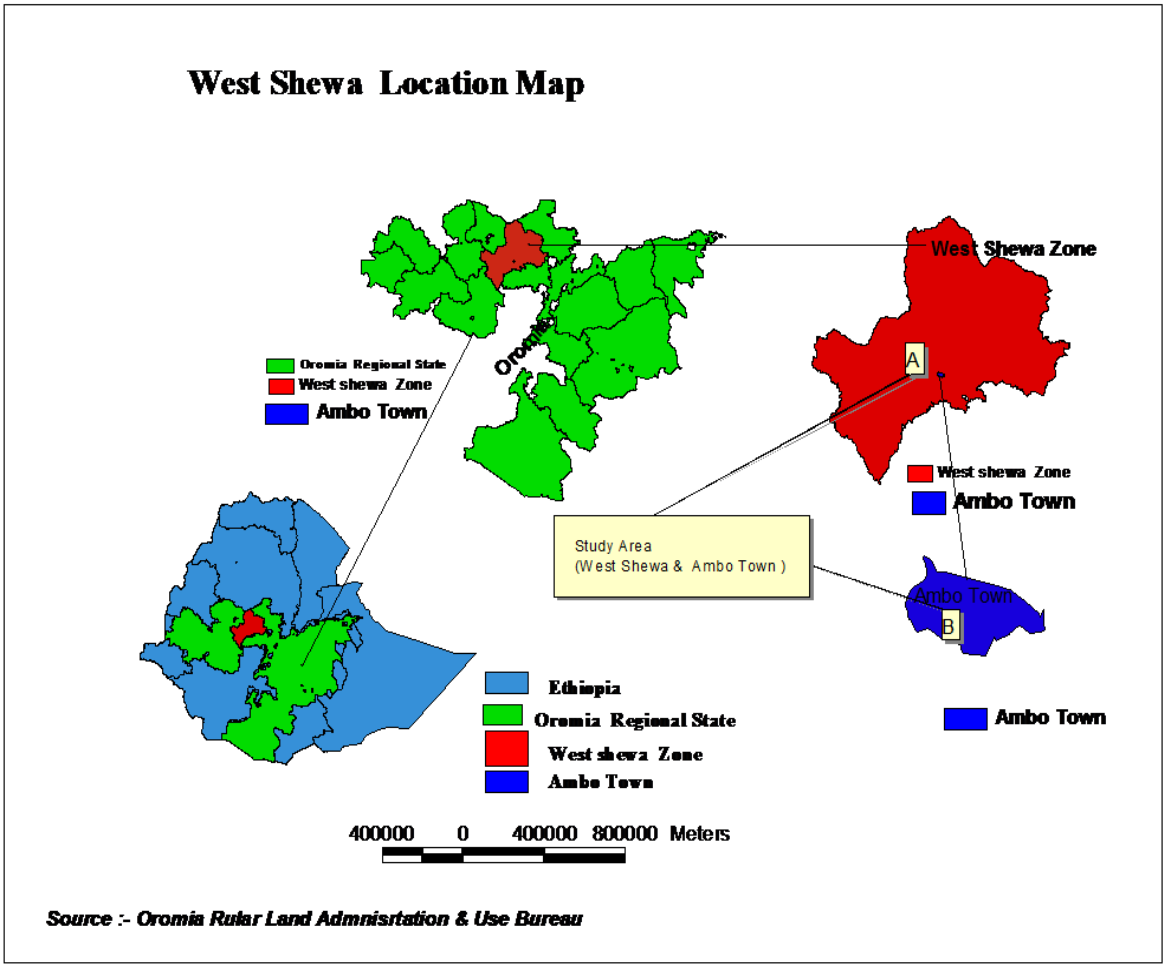
3.1. Description of the study area: West Shewa Zone

The Oromia National Regional State, often referred to as Oromia, is the largest and most populous regional state in Ethiopia, both in terms of size and population. Located in the central and southern part of the country, Oromia plays a critical role in the nation’s economy, politics, and culture (Feyissa, 2011).

West Shewa Zone is in the central part of the Oromia Region and is adjacent to Amhara Region, Este Wollega, Horo Guduru, Jimma Zone, south-west Shewa Zone, and north-west Shewa Zone. Due to its geographical location, the zone has easy access to major market centres like Finfinne and Ambo, which allows for the efficient provision of local products to the market and meets the demands of the local communities. West Showa Zone has an area of 15185 km2, suitable for crop production and livestock development, with 18 districts, 1 urban local administration, and Ambo town as the capital (Etefa and Dibaba 2011). Demographics According to the Central Statistical Agency of Ethiopia's (CSA) 2007 Census, this Zone has a total population of 2,058,676, with 1,028,501 men and 1,030,175 women; West Shewa has a population density of 139.21 per square kilometer and covers 14,788.78 square kilometers. The zone is divided into multiple districts, known as woredas, with Ambo serving as the administrative center.

West Shewa's economy is built around agriculture. The region is a major producer of grains such teff, maize, and wheat, as well as coffee, a valuable cash crop. The fertile soil and ideal climatic conditions make the zone one of Oromia's most agriculturally productive regions (Gebre, 2018). In addition to agricultural farming, livestock husbandry is a vital source of income for the rural population.

In recent years, the West Shewa Zone's infrastructure has been steadily developed. It is connected to Addis Ababa and other locations by major highways, which facilitate trade and the flow of products. Ambo University, located in the zone, is an important player in higher education and research, contributing to the region's growth (Hassen, 2015).
To summarize, the West Shewa Zone is an important economic and geographical area in Oromia. Its agricultural output, expanding infrastructure, and strategic location make it a significant contributor to the regional economy and growth.


West Shewa Location Map
Oromia Regional State
West shewa Zone
Ambo Town
West Shewa Zone
A
West shewa Zone
Ambo Town
Study Area
(West Shewa & Ambo Town)
Ambo Town
B
Ethiopia
Oromia Regional State
West shewa Zone
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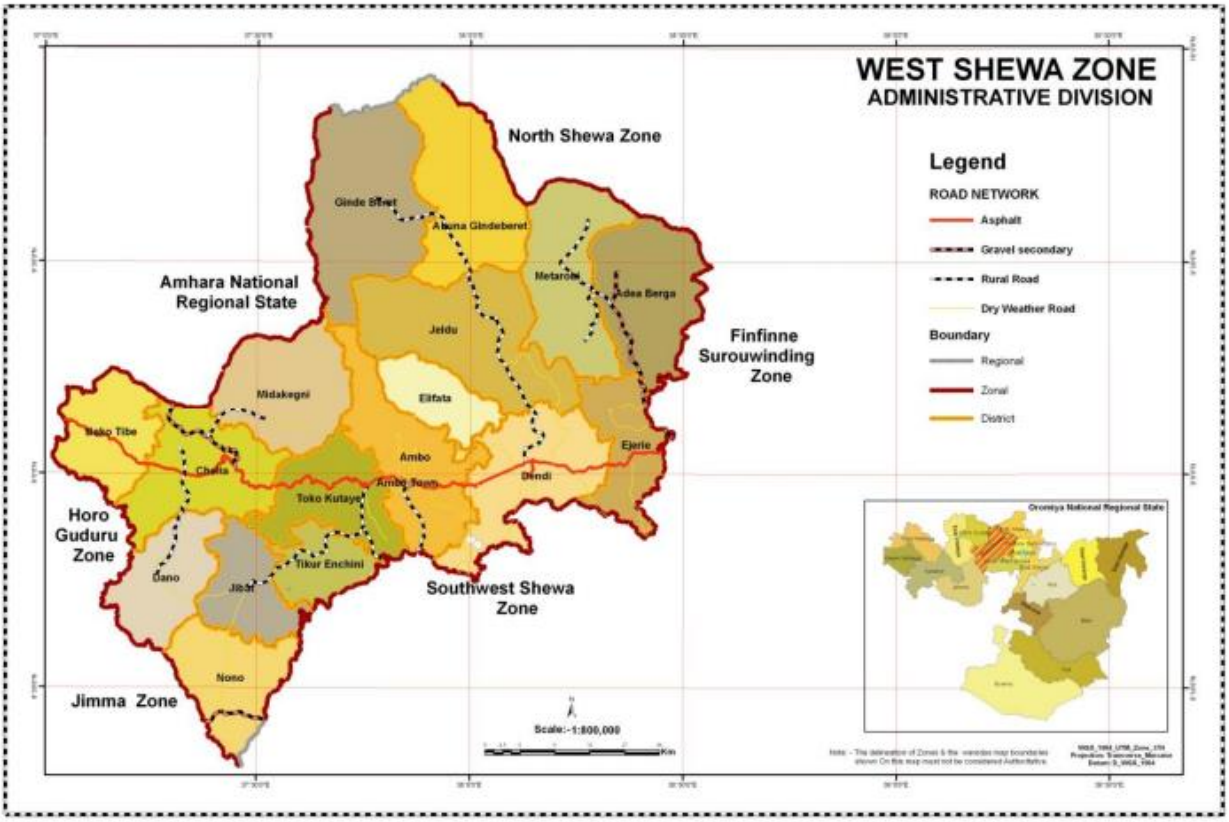

Fig 3.1: Geographical Location of west Shewa zone (Etefa and Dibaba 201

The World Health Organization defines health as not just the absence of disease but also the overall well-being of individuals, which is influenced by economic development and equitable distribution in a society. The health policy in the Oromia Region focuses on providing comprehensive primary healthcare through decentralization, increasing the number of health facilities, personnel, and resources available to the population (Etefa and Dibaba 2011).

In the West Shewa Zone of Ethiopia, health facilities are essential for controlling chronic illnesses like diabetes and hypertension as well as for providing services related to mother and child health. Numerous facets of healthcare delivery are highlighted by studies carried out in the area. It was discovered that public health facilities had high levels of maternal satisfaction with their delivery services, with timing and cleanliness having an impact on satisfaction levels (Etea et al., 2023). Pregnant women's satisfaction with antenatal care services was also not very high, which highlights the need for better patient relations and service quality. In addition, it was observed that a large percentage of diabetes patients visiting local public hospitals had hypertension, which was

linked to the illness by family history, age, and obesity (Bekele et al., 2023). It has also been noted that efficient pharmaceutical inventory management is crucial for maximizing healthcare spending and guaranteeing that critical pharmaceuticals are available in medical institutions (Hirpa and Abdisa, 2023).

Table 3.1 Distribution of health institutions in West Shewa zone

No	West Shewa zone districts	Types of health institution			
		Health Centers	Clinics	Health posts	No of Drug stores
1	Ambo	1	1	13	_
2	Ambo town	1	12	3	13
3	Adea Berga	3	6	17	4
4	Bako Tibe	2	10	20	2
5	Cheliya	1	4	14	3
6	Dano	3	3	9	2
7	Dendi	2	15	11	5
8	Ejere	1	4	9	1
9	Gindebert	2	5	10	2
10	Jeldu	3	8	12	3
11	Nono	2	15	18	_
12	Meta Robi	1	6	40	_
13	Mida Kegn	1	4	10	_
14	Tikur Inchini	0	3	9	2

15	Jibat	2	6	15	1
16	Abuna Gindebert	2	6	15	1
17	Elu Galaan	1	3	13	1
18	Elfeta	1	1	4	1
19	Toke Kutaye	1	12	20	3
	Total	30	121	265	44

Source: Compiled by the researcher from 2009 Zonal Health Office

3.2. Research Design and Strategy

A research design is the arrangement of conditions for data collection and analysis (Kothari & Garg, 2014; McNabb, 2018). The researcher used a descriptive-analytical approach to study relevant sources and collect data for their research. The researcher used both quantitative and qualitative approaches, relying on primary sources such as questionnaires and interviews, and followed Creswell's (2012) steps in scientific research to design and analyse the data.

The study would use both primary and secondary data, and qualitative and quantitative methods would be used to analyse the data. That is, a mixed research design would be used. The primary data is collected from CBHI workers and beneficiaries using questionnaires and semi-structured interviews. In addition, semi-structured interviews would be conducted with officials of the CBHI head office and zonal administration offices.

The secondary data would be gathered from official sources such as Ethiopian government health policy, strategies, CBHI strategies and guidelines, Growth and Transformation Plan II (GTP II), national and international reports on health, as well as academic literature.

A mixed-methods approach is selected because analysing the extent of health policy implementation by using a quantitative method may not be enough to stimulate evidence-based policy dialogue. Second, as pointed out already, the CBHI scheme involves multiple actors whose interests can converge or diverge, having an impact on strategy, policy formulation, and

implementation. In Ethiopia, however, the role of different actors in CBHI strategy formulation and implementation, as well as the extended support and demand of different actors, including the local community and beneficiaries, have not been well documented.

As a study area, Oromiya National Regional State was selected purposefully by the researcher. It is one of the largest regions in terms of geography and the total population of the country (it is more than 60% of the total population) and one of the regions selected as a pilot testing region by the Ethiopian government during the introduction of CBHI implementation. It is also the leading region in terms of enrolment and woreda expansion (2,725,377 households, both indigent and non-indigent, in 2021), so it can be a good region to assess the implementation and challenges of CBHI. This study randomly selects a west show zone as a case study woreda to select beneficiaries of the CBHI. This zone is among the expansion zones selected by the government to scale up CBHI enrollment.

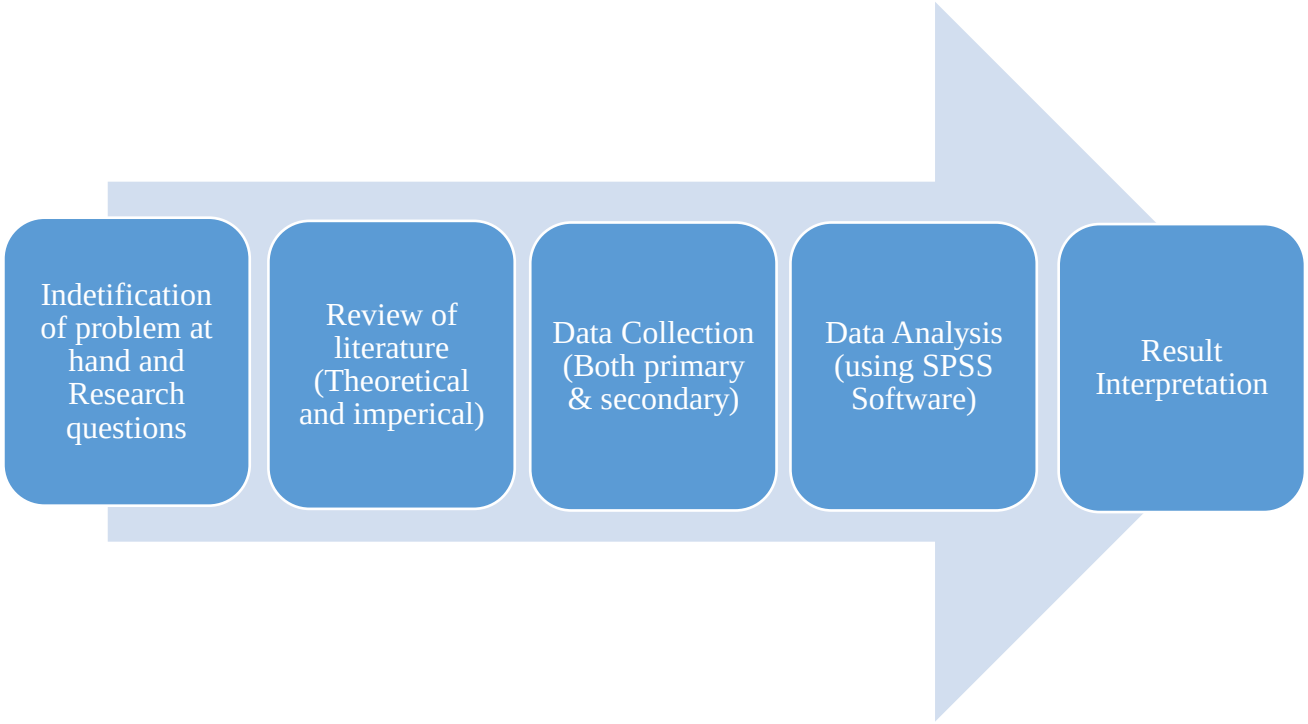

Figure: 3.2 Research Design and steps

Source: Authors own compilation based on research design

3.3. Rational for mixed research methodlogy employeed in this study

A mixed-methods appoarch, integrating both quantitative and qualitative research methods, was adopted for this study. This approach is widely recognized for its reliability and ability to prvide comprehensive insghts into complex research problems (Creswell & Creswell, 2017). By combining these methods, the study benefits from the strengths of both approaches qualitative research offers in-depth contextual understanding, while quantitative research facilitates generalization analysis (Borrego et al., 2009; Frost, 2011; Castellan, 2010).

The selection of the research methodology was guided by the study's primary research queation: How was the Community-based health insurance (CBHI) strategy formulated and implemented in the Oromia national regional state, and what were the challenges encountered during implementation? A through review of exesting literature and the formulation of specific research questions further reinforced the necessity of a mixed-methods approach to ensure a robust and well-rounded investigation.

Mixed-methods research is particularly advantageous as it compensates for the limitations inherent in standalone qualitative or quantitative approaches while enhancing the depth and breadth of thr findings (Creswell et al., 2003). In this study, quantitative data was collected through structured questionnaires to examine relationships between different variables, whereas qualitative data was gathered via interview to extract detailed perspectives from key stakeholders. This dual approach allowed for broader data collection, improved validity, and more generalizable conclusions.

To systematically address the research questions, a combination of quantitative and qualitative methods was employed, as outlined in Table 3.1.

Table 3.2 Research questions and research approach designed to answer them

S.No.	Research Questions	Research Method
1	What is the status of community-based health insurance (CBHI) implementation in different parts of West Showa Zone, Oromiya National Regional State?	Quantitative and qualitative methods
2	What are the major contents of the CBHI strategy and pit falls, if any?	Qualitative
3	What is the effect of CBHI on healthcare access, utilization, and financial protection for vulnerable populations in the West Showa Zone?	Quantitative and qualitative methods
4	What are the major challenges faced by CBHI programs in Ethiopia, including issues related to governance, financing, administration, and accountability?	Quantitative and qualitative methods
5	How does the level of community participation and engagement influence the effectiveness of CBHI implementation in different districts of the West Showa Zone?	Quantitative and qualitative methods
6	How does the regulatory and policy framework in Ethiopia facilitate or hinder the growth and functioning of CBHI schemes?	Qualitative
7	What are the key factors influencing the adoption and enrolment rates of CBHI schemes among various socioeconomic groups in the West Showa Zone?	Quantitative and Qualitative method

Source: Authors own compilation based on research question and approach

3.4. Source of Data for this study

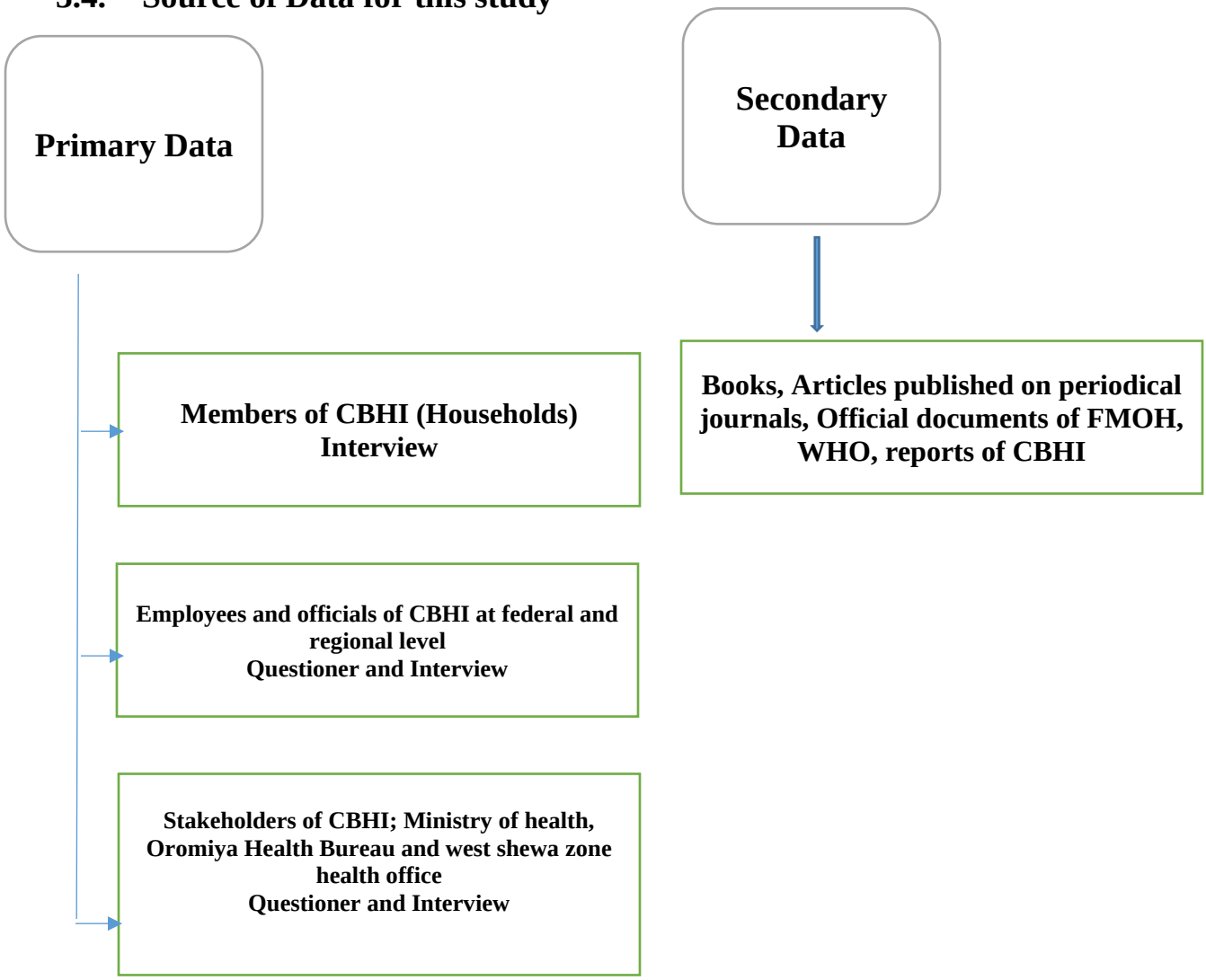

Fig3.3 Source of data

3.5. Data Collection tools

The research method used in this study involved collecting data through questionnaires and semi-structured interviews, focusing on themes such as the background of the respondents, CBHI implementation, contents of community-based health insurance, challenges related to the implementation of community-based health insurance, level of community engagement and participation in the formulation of the community-based health insurance strategy, and the influence of traditional community support systems and local healthcare practices on the community's acceptance of the program.

3.5.1. Primary data collection instruments

In semester five, the main task of the researcher is to develop data collection tools, which are questionnaires and interviews. As per my plan, I am going to use primary and secondary data, and to collect primary data, questionnaires and interviews are the main tools that will be used in my research.

3.5.1.1. Questionnaire

Questionnaires are a useful tool for collecting unbiased data from respondents, as they allow individuals to freely respond without interference from the researcher. The survey questionnaire in this study consists of two distinct versions: one for **CBHI beneficiaries** and another for **CBHI officials**. Both questionnaires were administered as part of a **cross-sectional survey** designed to assess the implementation and challenges of Community-Based Health Insurance (CBHI) in the West Shewa Zone of Ethiopia. The survey questionnaire in this study consists of four parts with various questions.

A self-administered questioner was distributed to 373 households selected based on the sample selection technique outlined in the research plan. Beside these 50 employees were selected and self-administered questioner were distributed to them. The questionnaire has a structured nature and is self-administered. It includes both open-ended and closed-ended questions. Five scales (Likert scale) are used to rate the questions: 1 stands for strongly disagree, 2 stands for disagree, 3 stands for neutral, 4 stands for agree, and 5 stands for strongly agree. The actual data was collected on December 25, 2023, and March 30, 2024. At Ambo town and other neighboring Gandas, or

villages, found in Ambo district, namely Bako Tibe and Chaliya Districts. The data was collected with a printed-out questionnaire, and it was distributed to the respondents.

Survey Methodology

- **Format**: The questionnaires were distributed in **paper-based** format for beneficiaries (face-to-face in selected villages) and via **email** for officials (computer-assisted).
- **Language**: The questionnaires were available in both **English** and **Afaan Oromoo** to accommodate respondents who did not speak English.
- **Question Types**:
    - **Closed-ended questions** (e.g., Likert-scale items, multiple-choice) were used for quantitative analysis.
    - **Open-ended questions** were included to capture qualitative insights where applicable.
- **Scales**:
    - **Likert-scale questions** (1 = Strongly Disagree, 5 = Strongly Agree) were used to measure attitudes and perceptions.
    - **Ordinal scales** (e.g., Very Low to Very High) were used for assessing levels of engagement or satisfaction.

Questionnaire for CBHI Beneficiaries

Part I: Background of the Respondents

- **Question Types**: Closed-ended (multiple-choice).
- **Topics**: Gender, age, education level, marital status, family size, income, membership type, and duration.

Part II: CBHI Implementation

- **Question Types**: Likert-scale (1–5).
- **Topics**: Clarity of policies, enrollment efficiency, benefit packages, payment mechanisms, awareness, and satisfaction.

Part III: Challenges Facing CBHI Implementation

- **Question Types**: Likert-scale (1–5).
- **Topics**: Quality of services, infrastructure, claims reimbursement, awareness, provider networks, and community engagement.

Part IV: Community Engagement in CBHI Strategy Formulation

- **Question Types**: Mixed (ordinal scales and Likert-scale).
- **Topics**: Level of involvement, transparency, influence of community feedback, and perceived representation.

Part V: Influence of Traditional Support Systems

- **Question Types**: Likert-scale (1–5).
- **Topics**: Role of elders, local practices, communication channels, and women's involvement.

Part VI: Contents of CBHI

- **Question Types**: Single-item Likert-scale.
- **Topic**: Coverage adequacy (e.g., outpatient/inpatient care, maternity, high-cost procedures).

Part VII: Financial Protection

- **Question Types**: Likert-scale (1–5).
- **Topics**: Affordability, financial security, coverage adequacy, and household budget impact.

Part VIII: Health Outcomes

- **Question Types**: Likert-scale (1–5).
- **Topics**: Access to preventive care, disease prevalence, health literacy, and service quality.

Table 3.3 Items of the questioner for the CBHI Beneficiaries (See Appendex ''A'')

S. No	Section	Number of questions
1	Questions related to the socio-demographic status of the respondents	Part I (Q1-Q9)
2	Community-based health insurance implementation	Part II (Q1-Q13)
3	Challenges related to the implementation of community-based health insurance	Part III (Q1-Q7)
4	Level of community engagement and participation in the formulation of the community-based health insurance strategy	Part IV (Q1-Q24)
5	The influence of traditional community support systems and local healthcare practices on the community's acceptance of the program	Part V (Q1-Q10)
6	Contents of CBHI	Part VI (Q1)
6	Impact of CBHI on the protection of members from financial hardship	Part VII (Q1-Q6)
7	The impact of CBHI on the community's health outcome	Part VIII (Q1-Q13)

Source: Author's Table made according to the research questions made for the beneficiaries of CBHI.

Questionnaire for CBHI Officials

Part I: Background of the Respondents

- **Question Types**: Closed-ended (multiple-choice).
- **Topics**: Gender, age, education level, designation, and work experience.

Part II: Challenges of CBHI Implementation

- **Question Types**: Likert-scale (1–5).
- **Topics**: Financial resources, infrastructure, awareness, administrative capacity, and political/bureaucratic challenges.

Part III: Influence of Stakeholders

- **Question Types**: Likert-scale (1–5).
- **Topics**: Collaboration, resource distribution, community engagement, and alignment with health policies.

Part IV: Administrative Capacity and Resources

- **Question Types**: Likert-scale (1–5).
- **Topics**: Manpower shortages, district-level disparities, funding adequacy, and equitable resource allocation.

Additional Details

- **Pilot Testing**: Both questionnaires were refined after pilot testing with input from the West Shewa Zone Health Bureau, Ambo Hospital, and other stakeholders.
- **Distribution**: Beneficiary surveys were conducted face-to-face in villages (Ambo, Bako Tibe, Chaliya), while officials received surveys via email.
- **Response Scales**:
    - **Likert-scale**: Dominant for attitudinal questions.
    - **Ordinal scales**: Used for ranking community engagement levels.

This structured approach ensures clarity, consistency, and comprehensive data collection for the study.

Table 3.4 Items of the questioner for the CBHI Officials (See Appendix ''B'')

S.No.	Questioners	Number of questions
1	Background of the respondents	Part I (Q1-Q5)
2	Challenges of CBHI Implementation	Part II (Q1-Q13)
3	Influence of stakeholders on the success of CBHI strategy implementation	Part III (Q1-Q17)
4	Effect of administrative capacity, manpower, and resources on CBHI implementation	Part IV (Q1-Q12)

Source: Author's Table made according to the research questions made for the officials of CBHI

The implementation of CBHI and challenges facing the study area were evaluated using an index of a 128-item scale developed by the researcher.

The questioner was distributed to the respondents by email (officials) and by physical presentation in the selected villages (face-to-face). The questioner for beneficiaries of CBHI includes different types of questions; the fundamentals are closed-ended questions. The answers for this question were on a scale from 1 to 5 (a Likert scale), such that 1 stands for strongly disagree and 5 stands for strongly agree. The second type of question is a closed-ended question, and the answers to this type of question were expressed as very low stands for 1 and very high stands for 5. The third type of question was about the background information of the respondents, which included gender, age, level of education, marital status, family size, income level, type of membership, year of membership, designation, and year of experience.

The questionnaire was designed in both English and Afaan Oromoo languages to accommodate respondents who did not speak English.

The West Shewa Zone Health Bureau, Ambo Hospital, Gedo Referral Hospital, Bako Referral Hospital, Oromia Health Bureau, and Ethiopian Health Insurance Service played a significant role

in distributing the questionnaire among respondents (Beneficiaries and Employees) and it was refined and reviewed through pilot testing before distribution.

3.5.1.2. Semi structured interview

Interviews are an effective method for collecting in-depth information, and two interview protocols were designed for CBHI officials to increase data validity and credibility. The questions were refined through pilot testing to reduce bias and increase reliability.

Among the different methods of interview, researchers preferred the face-to-face method because of its ability to allow participants to provide as much detailed information as they wish and the researcher's ability to follow-up questions in the form of investigative questions. Open-format questions are likely the most frequently used interview format in research studies (Turner, 2010). The biggest drawback, though, is that in-person interviews may be exceedingly costly and time-consuming.

Interviews were conducted with five individuals in the district, the head office (Ethiopian Health Insurance Service), and other stakeholders for triangulation purposes and to answer some other questions that were not addressed by the questioner. Respondents contacted for the in-depth interview were selected purposefully by the researcher as key informants on the basis of their closeness to the implementation (enrolment) of community-based health insurance. Face-to-face interviews were conducted with participants at their office, with a duration of approximately 40 minutes. The researcher followed a protocol for conducting the interviews, which included contacting the interviewees, explaining the objective of the interview, ensuring confidentiality, and recording the interviews (or taking manual notes if recording was refused). The interviews were conducted in English or Afaan Oromo and Amharic, transcribed, and analysed thematically.

The interviews are held on December 28, 2023, and June 3, 2024, at Ambo town and the Addis Ababa head office of the Ethiopian Health Insurance Service, respectively.

The target population of this study is beneficiaries of CBHI living in the West Showa zone. Interviews were conducted with CBHI officials at the federal level and Oromiya national regional state/zonal CBHI officials. The households for questioner purposes were selected with simple

random sampling, whereas the interview participants were selected using purposive sampling based on their knowledge, experience, and responsibility for the issues at hand.

3.6. Target Population and Sampling technique

The target population of this study is beneficiaries of CBHI living in West Shewa zone, selected zones namely Ambo district, Chaliya (Gedo), and Bako Tibe. Interviews will be conducted with policymakers, CBHI officials at the federal level, and Oromia national regional state CBHI officials. The households for questioner purposes are selected with simple random sampling, whereas the interview participants are selected using purposive sampling based on their knowledge, experience, and responsibility for the issues at hand.

Three districts, Ambo Woreda, Chaliya Woreda, and Bako Tibe, were chosen at random from a total of 22 districts in the West Shewa zone. The CBHI office for the west show zone reports that as of 2022, there were 22,667 CBHI members spread throughout three woredas, namely Ambo, Chaliya, and Bako. 7,715 of these homes are impoverished, whereas 14,952 of them are paying members.

The sample size would be determined using the following sample formula:

$$\text{Sample size, } n = N * \frac{\frac{Z^2 * p * (1-p)}{e^2}}{[N - 1 + \frac{Z^2 * p * (1-p)}{e^2}]}$$

Sample Size Formula (Srivastav, 2022)

Where,

Population size, N=22,667

Critical value at 95% confidence level, Z=1.96

Margin of error, e= 5% or 0.05

Sample of proportion (Uncertain) (p) =0.5

$n = 22{,}667 * [1.96^2 * 0.5 * (1-0.5)/0.08^2] / [22667 – 1 + (1.96^2 * 0.5 * (1-0.5)/0.05^2]$

= 22,667*384.16/ 23,050.16

=**377.78 ≈ 378 (members of CBHI)**

Therefore, the sample size (with finite correction) is equal to 378 households.

Plus, 50 employees of CBHI were selected.

3.7. Method of Data Analysis

The study data measured through nominal and ordinal are employed to measure the implementation and challenges of community-based health insurance in the west Shewa district.

3.7.1. Quantitative Data Analysis

The data analysis in this research study involved analysing structured questionnaires and semi-structured interviews using both quantitative and qualitative methods to obtain reliable data.

Researchers use quantitative analysis to estimate unknown parameters and test hypotheses, with data collected through a questionnaire analysed using SPSS (Statistical Package for Social Science). This analysis is very important to interpret the raw data and convert it into a decipherable and manageable manner; therefore, the relationship between the study variable and controllable variables can be easily found. Descriptive statistics evaluated community-based health insurance implementation and associated challenge scores among the sampled population, and various statistical techniques such as standardized regression and Cronbach's alpha were employed to understand the findings of the study.

Table 3.5. The mean score and standard values

No.	Mean Score	Level of CBHI implementation	Standard
1	1-2	Strongly Disagree	One standard deviation below
2	2-3	Neutral/moderate	Mean
3	3-5	Strongly Agree	One standard deviation above

Source: Author's work based on the research methods.

To assess the significance and correlations between the study variables, one-way MONOVA and multiple regression analysis would be used. A regression equation is developed for the purpose of evaluating CBHI implementation and its effects.

The regression equation is

$$\mathbf{Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon}$$

Whereby: **Y:** CBHI implementation

X_1: Access to health care

X_2: Financial protection

X_3: Improve health outcome

Whereas β_1, β_2 and β_3 stands for coefficient of determination

β_0 = is the intercept term- constant which will be equal to the mean if all slope coefficients are 0.

$\boldsymbol{\varepsilon}$ stands for error terms.

3.7.2. Qualitative Data Analysis

The last stage of the interview design protocol involves analysing and interpreting qualitative data by categorizing and interpreting the gathered information and establishing correlations between different attitudes and common themes. Thematic analysis was used to categorize qualitative data,

with the researcher manually transcribing and analysing the interviews to understand attitudes, identify common themes, and establish correlations between different attitudes and themes.

The qualitative data captured through key informant interviews is transcribed, interpreted, and analysed in the form of descriptions and narrations as a more interpretation of quantitative data. In the process of mixed data analysis, quantitative dominant data analysis is employed. In order to complement the information, data was collected by different instruments of data collection. The quantitative data collected through closed-ended questionnaires is analysed with the help of the standard deviation and mean, whereas quantitatively, it is analysed using the narrative method.

3.8. Reliability and validity

Validity and reliability are frequently used in quantitative research; however, the qualitative research paradigm is currently re-evaluating their use (Golafshani, 2003). Reliability refers to the consistency of results over time and their accuracy in representing the total population, with a reliable research instrument producing reproducible results under similar methodology (Joppe, 2000). As Joppe (2000), cited by Golafshani (2003), implies, validity in research refers to whether the research accurately measures what it intends to measure, and researchers determine validity by asking questions and reviewing existing research. Several procedures were used in this investigation to guarantee reliability. First off, the questionnaire underwent numerous tests throughout the piloting phase. Furthermore, the respondents completed the questionnaire voluntarily, free from the researcher's influence or meddling. Lastly, Cronbach's alpha was used to test the survey's reliability to determine its consistency. The instrument sub-scales' Cronbach's alpha ranged from 0.89 to 0.76, demonstrating excellent consistency and dependability.

The questionnaire was validated through a pilot study with 30 participants, confirming its suitability for measuring community-based health insurance implementation and associated challenges.

The interview protocol was refined and updated multiple times, and five semi-structured interviews were conducted to ensure validity and reliability, which many scholars consider enough. However, there is no consensus on the ideal number of interviews. Some academics, such as Morse (1994), argue that six interviews are necessary for credible results. In contrast, Mason

(2010) suggests that using multiple methods and conducting in-depth interviews with the same participants may require fewer participants.

3.9. Ethical Consideration

It is necessary to obtain ethical approval before doing research on people, animals, or the environment. It guarantees that research is carried out responsibly and within reasonable bounds (Farin et al., 2022). It is the application of moral principles to choices made during the planning, execution, and dissemination of research findings (McNabb, 2017).

In this study, the researchers obtained informed consent from participants before involving them in the study. This was done by providing participants with information about the study purpose, procedures, risks, and benefits and ensuring that they voluntarily agreed to participate.

The process of getting approval from an ethics committee or review board prior to starting a research study with human subjects is known as ethical clearance (Farin et al., 2022); Therese, 2013; Cleaton-Jones and Curzon, 2012; Rizka et al., 2022). To ensure this, an ethical clearance letter was written from the Oromiya Health Bureau.

In order to assure searchers confidentiality, protect the confidentiality of participant information by ensuring that data is stored securely and anonymized. The participants were assured that their information would not be shared or disclosed without their consent. In order to verify that the respondents' involvement is voluntary and private, a consent letter was written in Afaan oromoo and given to them. In the letter, those who responded were reassured that their privacy would be guaranteed and that the data obtained would be kept private.

The researcher prioritized participant privacy, anonymity, and confidentiality when disseminating the study's findings, ensuring secure data storage and limited use of participant data.

3.10. Summary of this Chapter

This chapter outlined the techniques applied to this thesis and provided arguments in favour of a mixed-method approach. The mixed-method technique was selected to align with the thesis' theoretical framework.

The research study focuses on the implementation and challenges of community-based health insurance in the West Showa district. The study area is the West Shewa zone, located in the central part of the Oromia region, adjacent to Amhara Region, Este Wollega, Horo Guduru, Jimma zone, south-west Shewa zone, and north Shewa zone. The study employs a mixed approach, combining quantitative and qualitative methods, to obtain reliable data. Data collection methods include structured questionnaires and semi-structured interviews. The West Showa zone has an area of 15185 km2, suitable for crop production and livestock development, with 18 districts and 1 urban local administration. The zone has easy access to major market centres like Finfinne and Ambo, facilitating the efficient provision of local products to the market.

This chapter offers a thorough synopsis of the procedures, methodology, design, and statistical analysis of the research project. It highlights the significance of research technique as a methodical framework for carrying out scholarly investigations and directs the researcher in determining the problem statement, research questions, and study scope. The research approach is explained in this chapter, along with the instruments employed, the selected research plan, the techniques for gathering and analysing data, and the chapter's conclusion. Utilizing a hybrid research design, the investigator integrated both qualitative and quantitative methodologies. Questionnaires and semi-structured interviews with CBHI employees, beneficiaries, representatives from the CBHI headquarters, and zonal administration offices were used to gather primary data. Secondary data was obtained from official sources, including academic literature, national and international health reports, CBHI strategies and guidelines, Growth and Transformation Plan II (GTP II), and health policies and strategies of the Ethiopian government. Figure 3.1 provides an illustration of the processes and research design. The chapter also describes the research method selection, arguing that a mixed strategy combining quantitative and qualitative methodologies yields more comprehensive information for solving difficult problems and is thought to be more dependable. Table 3.1 contains a list of the individual research questions as well as the research methodology created to address each research issue.

The study's data gathering techniques and instruments, such as semi-structured interviews and questionnaires, are also covered in this chapter. The questionnaire, which has 90 questions overall and is divided into seven categories, whereas 54 questions were designed for officials of CBHI, covers a range of subjects on the implementation and difficulties of CBHI. In-depth information is gathered through interviews with key informants and CBHI personnel. In addition, the target population and sampling strategy, data processing techniques, validity and reliability of the research tools, ethical considerations, and a list of recommended readings are covered in this chapter.

Chapter Four: Community Based Health Insurance Programs in Ethiopian Context

4.1. Public Service Delivery in Ethiopia

Ethiopia elected subnational politicians at the regional and district (or "woreda") levels to implement political decentralization. An essential step towards decentralization in Ethiopia was administrative decentralization, which involved the transfer of planning and administrative duties to regions of expenditure. The main decentralization measures were the transfers of spending in large social service sectors, including healthcare, education, and agriculture. A sizeable amount of the national budget was redistributed to several regions beginning in 1992 and reaching the woreda level in 2001 (Lee, 2013).

In Ethiopia, decentralization seeks to improve accountability at the regional and sub-regional levels of government, encourage citizen participation, and guarantee efficient and responsive public service delivery (MOI, 2004).

If decentralization brings government closer to the people and encourages community participation (Ackerman, 2005), the main goal of local participatory development is to build an effective local civic sphere (Mansuri & Rao, 2013, as quoted in Terefe, 2014). However, decentralization does not guarantee increased civil society participation or government accountability (Mansuri & Rao, 2013). However, due to a lack of funding and inadequate capacity, most regional governments have had trouble implementing policies (Lee, 2013).

The provision of essential services seems to have improved with the transfer of authority and funding from the federal and local governments to woredas. According to beneficiary surveys, recipients believe that the quality and coverage of services have increased. In education, beneficiary satisfaction has significantly increased; in water and health services, it has not changed significantly (Garcia & Rajkumar 2008).

To enhance the provision of public services, Ethiopia has instituted extensive public sector capacity building initiatives, such as the Public Sector Capacity Building Programme Support Project (PSCAP) (World Bank); beside this, a number of tools for public service reform have been implemented by the Ethiopian government, including deliverology, fast wins, management by objective, business process reengineering (BPR), balanced scorecard (BSC), public service change

army, and the Citizens Charter (Debela, 2009). However, Ethiopia's public service delivery is hampered by ineffective accountability, responsiveness, and transparency mechanisms, as well as the incapacity of public agencies (Teshome et al., 2012).

When we see how effective community-based approaches to public service delivery are in improving access and efficiency in Ethiopia,

In Ethiopia, community-based approaches such as the Health Extension Program (HEP) and Community-Based New-born Care (CBNC) have proven to be helpful in enhancing public service access and efficiency. The HEP used Health Extension Workers (HEWs) to successfully implement evidence-based interventions, resulting in considerably increased under-5 mortality intervention coverage (Drown et al., 2024). However, issues such as low intervention fidelity in CBNC implementation have been discovered, pointing to limitations in effective intervention delivery (Molla et al., 2023). On the other hand, efforts such as the TESFA program have established long-term and scalable approaches for delivering reproductive health programs through peer-based solidarity groups, resulting in improved health outcomes and participant empowerment (Chowdhary et al., 2022). Furthermore, the adoption of Community-Based Health Insurance (CBHI) has demonstrated encouraging outcomes in reducing gaps in modern health service consumption, underscoring the relevance of such community-based programs in improving healthcare access and equity (Geta et al., 2023). Efforts to address barriers to HEW service consumption, such as demand- and supply-side problems, are critical for increasing the effectiveness of community-based approaches in Ethiopia (Miller et al., 2021).

In general, Ethiopia's public sector faces a wide range of obstacles to providing effective and efficient services. The primary issues of public service delivery were a need for more accountability, a readiness to give service as requested, a sense of belonging, discrepancies in rules and regulations, and a lack of integration among various government service providers. (Hailu & Shifare, 2019). Furthermore, concerns such as a lack of professional leadership, corruption, infrequent consultation with stakeholders, and poor automation impede service delivery in public enterprises (Seyoum, 2021). Furthermore, issues in pharmaceutical procurement processes, such as lengthy procurement procedures, a lack of employee competency, and inadequate procurement planning, influence service delivery at health institutions such as Jimma University Specialized Hospital (Gadisa & Zhou 2021). Addressing these difficulties through capacity building, improved

planning, and improved governance procedures is critical for improving public service delivery in Ethiopia.

Specifically, the effectiveness of public service delivery in the Ethiopian health sector is influenced by maternal age, educational levels of mothers and partners, household affluence, exposure to mass media, antenatal care visits, and contraceptive use (Gebrekrstos et al., 2023). Factors influencing the acceptance of delivery services include the mother's residency and the number of antenatal care visits (Tafere et al., 2023). Maternal satisfaction with delivery services is influenced by factors such as education level, monthly income, prenatal care, fetal outcome, birth location, and admission duration (Argawu and Erena, 2023).

In the preceding sections of this research, we examined public service delivery operations in Ethiopia and the reforming instruments utilized to provide effective and efficient public service to the general population. The following sub-section of this chapter will look at Ethiopia's health-care reforms.

4.2. Health policy in Ethiopia

Ethiopia established modern medicine in the 16th century, with a focus on giving prompt primary healthcare to citizens injured in accidents. Later, in 1886, Swedish doctors served as medical staff in western Ethiopia, offering primary healthcare as charity work. Ethiopia adopted its first comprehensive health strategy in 1993, with a focus on democratization, decentralization, inter-sectoral collaboration, and the development of preventive and promotional healthcare components (Barnabas and Zwi, 1997).

Ethiopia's health strategy includes establishing a national Health Technology Assessment (HTA) system, community-based health policies, maternal, new-born, and child health (MNCH) policies, and implementing private sector health policies in public hospitals. The country has underlined the significance of institutionalizing HTA and increasing national capability for HTA (Ararso, 2022). Furthermore, community-based health strategies have been implemented to improve primary health care in rural regions through grassroots mobilization (Tefera, 2022). While progress has been made in MNCH policies, there are persisting imbalances that must be addressed to achieve health equity (Rono et al., 2022). Furthermore, the implementation of private-wing health

programs confronts obstacles such as inadequate collaboration among units, emphasizing the need for greater policy formation procedures and coordination structures (Dessie and Getinet, 2023).

The main objective of this sub-topic is to answer the following questions: What are the current health policies being implemented in Ethiopia? How have Ethiopia's health policies evolved over the past decade? And what challenges does Ethiopia face in implementing effective health policies?

Ethiopia is currently pursuing several health policies aimed at various elements of healthcare. The country has implemented innovative community-based health initiatives to improve basic health care at the grassroots level (Tefera, 2022). Efforts are being undertaken to enhance maternal, new-born, and child health (MNCH) through strategic frameworks and policies that prioritize equity (Rono et al., 2022). There are other interventions aimed at integrating mental health and substance abuse (MH/SA) services into primary care, with a focus on multidimensional methods and stakeholder involvement (Gebremedhin et al., 2021). In response to the COVID-19 epidemic, public health interventions have been implemented, such as increasing hand-washing and social distancing, particularly in rural regions where resources may be limited (Baye, 2020). These programs seek to improve health outcomes, reduce inequities, and strengthen Ethiopia's entire healthcare system.

Ethiopia's health policy has improved over the last decade, with a focus on maternal, new-born, and child health (MNCH) equity (Rono et al., 2022). Adolescent and youth health (AYH) issues have been addressed, with initiatives focusing on sexual and reproductive health (SRH) (Admassu et al., 2022). The country has also sought to incorporate comprehensive sexual and reproductive health and rights (SRHR) services into the UHC benefit package (Berhan et al., 2022). Furthermore, efforts have been made to build a national Health Technology Assessment (HTA) framework, highlighting the significance of HTA in health decision-making (Höstlund, 2022; Ararso, 2022). Despite these advances, there is a need for more coordinated, evidence-based, and well-funded national solutions to address young people's complex health needs and promote fairness in health policies for long-term development. Even if Ethiopia has been showing robust progress in the past decades, the following challenges have been faced in the execution of formulated health policies: Challenges such as gaps in digitalizing healthcare systems (Biru et al., 2022), insufficient training and supervision of health workers, particularly in non-communicable

disease services (Tesema et al., 2022), and obstacles to implementing electronic community health information systems (e-CHIS) due to heavy workloads and limited resources (Namomsa, 2023). Potential solutions include strengthening ICT infrastructure, boosting health worker training quality, implementing supportive supervisory methods, streamlining performance reviews, and ensuring consistent supply and service availability (Tesfahun et al., 2023; Mengistu et al., 2021). In Ethiopia, effective policy implementation and healthcare system development require increased government commitment, resource allocation, capacity building, and community engagement.

Ethiopia's health strategy prioritizes enhancing access to healthcare and health outcomes, in line with global equitable objectives. The country faces issues with geographic access to healthcare, particularly in rural and low-income areas (Assebe and Norheim). Efforts such as the Ethiopian Essential Health Service Package (EHSP) have had a positive impact, improving health fairness and financial protection (Nathaniel et al., 2023). However, gaps remain, with prevalent childhood ailments unevenly distributed across the country, influencing service consumption (Daraje, 2023). While Ethiopian policies encourage equity in maternal, new-born, and child health (MNCH), interventions' implementation and monitoring might be improved (Defar, 2023). Ethiopia's emphasis on equity and access to healthcare stands out among low-income countries, but more work is needed to reduce spatial disparities and ensure effective policy implementation for better health outcomes.

Ethiopia's health-care system has substantial financial, access, and coverage issues. Ethiopia has a mixed health financing system that includes government support, out-of-pocket payments, donor contributions, and community-based health insurance (CBHI). It is not a tax-based system in which all citizens are automatically entitled to free health care. Here are significant facts concerning Ethiopia's healthcare system:

Regarding health care financing in Ethiopian health care system; Ethiopia's health care finance is generally derived from four sources: government spending (including taxes), out-of-pocket payments by people, external donors, and community-based health insurance programs. Government funding for public health services is complemented by considerable contributions from international donors, such as the World Bank, USAID, and the Global Fund. In 2019, government spending on health as a proportion of GDP was approximately 3.3%, lower below the Sub-Saharan Africa average of 5% (World Bank, 2022). This shows that there are minimal

domestic resources available for health. Out-of-pocket payments (OOP) account for around 31% of health care financing, putting a strain on individuals, particularly in rural areas (WHO, 2021).

CBHI is a voluntary program aimed at improving access to health care for the informal sector and rural communities. CBHI members pay a nominal annual subscription to get basic health care in public facilities. By 2020, CBHI would cover around 49% of districts (Ministry ministry of health, Ethiopia, 2021). Although CBHI focuses on low-income populations, coverage is restricted, and many citizens continue to pay out of pocket.

Menwhile Ethiopia has made progress toward universal health coverage (UHC), yet there are still substantial gaps. The Health Sector Transformation Plan (HSTP) seeks to increase access to quality health care, particularly among the poor. However, UHC is not legally guaranteed, and access to health-care services is frequently determined by an individual's financial means (USAID 2020). The Ethiopian constitution protects the right to health, but it does not guarantee free or universal access. Some services are subsidized, particularly for vulnerable groups; others require direct payment (World Bank, 2021).

Primary health services, such as maternal and child health care, are more accessible in cities, but rural areas suffer from significant facility and health professional shortages. Ethiopia had only 0.8 health workers per 1,000 people in 2020, significantly below the WHO have recommended level of 4.45 (African Health Observatory, 2020). This deficit has a substantial impact on the quality of treatment provided in rural areas.

In Ethiopia, out-of-pocket charges for health services vary according to the type of care provided. Primary care services at government facilities are significantly subsidized or free for certain categories (e.g., children and pregnant women). However, more advanced services usually demand payment. CBHI members pay a yearly premium of roughly 240-360 ETB (about USD 2-3), whereas those who are not enrolled must fund the entire cost of care (Ministry of Health, Ethiopia, 2022).

To sum up Ethiopia's health-care system is not tax-supported, and universal free access to health services is not guaranteed. The system is funded through a combination of government grants, donor aid, CBHI, and individual contributions. While CBHI has increased access for some low-

income groups, considerable hurdles remain in obtaining universal health coverage, particularly in rural areas.

4.2.1. Health Care reform In Ethiopia

In recent years, Ethiopia has prioritized healthcare reform. Various measures have been taken by the government to strengthen its healthcare system. The growth of primary health care, which has been acclaimed as a model in Sub-Saharan Africa, is one way (WB, 2019). Among this reform work in Ethiopia is the training and deployment of health extension workers, as well as the construction of health clinics and village-level health posts (WB, 2017). This community-based health care reform implementation was initiated by the Ethiopian government. This program has increased access to health care while decreasing out-of-pocket expenses. Nonetheless, obstacles remain, such as fragmented healthcare systems in public hospitals and limited effects on certain metrics of health system performance. Overall, the Ethiopian health-care reform has improved access to care, but there is still potential for improvement.

This section discusses the healthcare reforms implemented in Ethiopia under various regimes.

4.2.2. Pre-revolution, Haile Sellasie period to 1974

Emperor Haile Selassie focused on bringing foreign-inspired civilization to Ethiopia after granting amnesty to Italian forces. He introduced political reforms, built a modern medical system, and prioritized education. Medical diplomacy followed, with Russia, Britain, and America competing for influence through hospitals and training schools. Tension arose between Haile Selassie's desire for a physician training school and foreign donors' preference for lower-level training programs. The American Point IV program set up a public health training college in Gondar, focusing on preventive health (Weis, 2015).

The beginning of modern medicine in Ethiopia has a long history, dating back to Emperor Libne Dingel's reign. Emperor Libne Dingel (also known as Emperor Lebna Dengel) ruled Ethiopia from 1508 to 1540. While his reign was marked by numerous political and military problems, including the development of the Adal Sultanate by Ahmad ibn Ibrahim al-Ghazi, it is frequently included in discussions of Ethiopia's historical engagement with European countries. During Libne Dingel's rule, Ethiopia began to strengthen its links with the Portuguese, particularly with the entry of Portuguese envoys and missionaries. These exchanges created the framework for

Western influence in Ethiopia, particularly in medicine and healthcare. The Portuguese dispatched medical missionaries, some of whom introduced early European medical procedures to the Ethiopian court. Although these early contacts did not result in widespread healthcare modernization during Libne Dingel's reign, they did mark the start of Ethiopia's engagement with Western medicine, which would grow significantly in the nineteenth and twentieth centuries, particularly under later emperors such as Menelik II and Haile Selassie (Pankhurst, 1990).

Haile Selassie established the Ministry of Public Health in 1947, which played a critical role in the country's development of modern medicine. The emperor developed basic health services after 1946, with a focus on public health and preventative medicine. While traditional medicine was still widely used, mission health services provided modern healthcare in remote regions. Beside this, with the help and technical assistance received from international actors such as WHO, USAID, UNICEF, and other countries, Ethiopia established the first medical schools and hospitals. Ethiopia developed basic health services after 1946, with a focus on public health and preventative medicine. While traditional medicine was still widely used, mission health services provided modern healthcare in remote regions. Hospitals received a major share of Ethiopia's medical care expenditure in 1972. In terms of healthcare resources and money, there was a significant discrepancy between urban and rural communities (Kloos, 1998).

The goal of the fourth Five-Year Plan (1974-78) was to formalize community contributions to developing health stations and clinics. However, due to the revolution that occurred during this period, the plan could not be implemented. Between the late 1960s and 1974, an estimated 15-20% of Ethiopia’s population was served by basic basic health care (Kloos, 1998).

While initial expansion efforts boosted coverage marginally from 15-20% under Haile Selassie's government, the overall proportion of the population provided by basic healthcare during the Derg period remained very low. By the late 1980s and early 1990s, the number of individuals with reliable access to healthcare had most likely plateaued or even decreased as a result of the regime's economic struggles and political instability. Healthcare coverage under the Derg regime most likely increased from about 15-20% in the early 1970s to over 30% in the 1980s, although the quality and reliability of these services were frequently inadequate due to recurring problems. By the time the Derg was deposed in 1991, the healthcare system was overburdened, and the population's access to effective care remained limited Kloos, 1998).

4.2.3. Derg Regime (1974-1991)

Even though Ethiopia's national literacy drive raised health awareness and consumption of health services, family planning visits and rural health care remained low during this socialist rule. In Ethiopia, accessibility and affordability were major hurdles to healthcare access, with high costs deterring a significant proportion of sick people from seeking treatment. The worsening of primary healthcare facilities throughout the conflict resulted in poorer child immunization rates, tuberculosis cases, and child nutrition, while bureaucratic and authoritarian tendencies inhibited people's empowerment and participation (Kloos, 1998).

4.2.4. Post Derg (EPRDEF)

Health facilities in Ethiopia were damaged during the 1991 power shift, resulting in poor immunization rates and the need for repair and restoration. The new government's health policy prioritized decentralization, partnerships with the corporate sector and non-governmental organizations, and lowering baby and under-5 mortality. Ethiopia's healthcare reform has laid the groundwork for future healthcare system improvements (Manyazewal & Matlakala, 2018). However, the execution of the health program was hampered by bureaucratic bottlenecks, the closure of private clinics, and a difficult relationship between the government and non-governmental organizations.

Major components of health care reform during the EPRDF regime were:

Equity, efficiency, quality, finance, and sustainability are all components of health sector reform that play a vital role in identifying and correcting problems in the health system in a way that policymakers can easily understand (Darling, 2010).

4.2.5. Current Regime (Prosperity Party)

EPRDF launched health-care changes, which are now being implemented by the present leadership. Among those reforms, the HSTP-I is a five-year health sector strategy that runs from 2015/16 to 2019/20 (HSTP-I, 2015). Life expectancy, maternity and child mortality rates, and communicable disease control all improved because of HSTP-I.

According to World Bank data, the under-five mortality rate (the likelihood of dying before the age of five per 1000 live births) fell from 123.2 in 2005 to 46.8 in 2019 (WB). The infant mortality

rate (the probability of dying before the age of one per 1000 live births) fell from 77.1 in 2005 to 29.5 in 2019 (WB). These are considerable improvements, although they remain higher than the global norms of 38.6 and 28.8 in 2019. The global norms for determining mortality rates can be determined by combining data from various international organizations such as the World Health Organization, the United Nations Children's Fund (UNICEF), the World Bank, the Global Burden of Diseases (GBD) study, and the country's Demographic and Health Survey.

Maternal education, birth order, birth interval, place of delivery, antenatal care, and immunization are some of the factors associated with under-five mortality in Ethiopia (Kitila et al., 2021). Ethiopia's government has launched several actions to minimize child mortality, including building health facilities, educating health professionals, encouraging community-based health services, and increasing immunization coverage (Indicators, 2019).

Non-communicable illnesses and neglected tropical diseases continue to be a source of worry. There have been reductions in unsafe sex behaviour and malnutrition, but issues persist in water, sanitation, and hygiene.

Health-care utilization, contraception, prenatal care, and skilled birth delivery have all increased.

Health sector reform is a government-guided process that seeks to improve the health sector's operation and performance by addressing fairness, efficiency, quality, financing, and sustainability in healthcare delivery and policy implementation (WHO, 2000).

Less developed countries frequently focus on the content of health sector reform, risking equating it with specific measures such as market mechanisms, user charges, and public sector reduction while ignoring the feasibility of implementation, emphasizing the importance of understanding reform processes alongside reform content for effective strategies and planning (WHO, 2000).

Ethiopia has been implementing a variety of healthcare changes to improve access and quality. Initiatives such as Community-Based Health Insurance (CBHI) and the Private Health Sector Program (PHSP) have sought to solve issues in the healthcare system (Zarepour et al., 2023; Israel et al., 2023). The implementation of mandatory Social Health Insurance (SHI) for formal sector employees is a suggested reform to increase healthcare access (Ali et al., 2022). Health insurance plans have been proven in studies to have a good influence on universal health coverage, lowering

catastrophic health expenditures, and enhancing health service quality (Bayked et al., 2023). Despite these efforts, difficulties like underfunding, high out-of-pocket payments, and variations in service quality continue (Debie et al., 2022). To achieve universal health coverage and improve health care results, Ethiopia should consider expanding national health insurance programs, strengthening public-private partnerships, and increasing funding.

Ethiopia's healthcare system has made improvement thanks to efforts such as Community-Based Health Insurance (CBHI) and planned Social Health Insurance (SHI), which target the informal and formal sectors, respectively. About 32.2 million people has been enrolled in CBHI program by 2021, which may roughly accounts about 36% of population in informal sector, despite the government's objective of covering 80% of the population. This program is critical for persons in the informal economy, which includes non-government-regulated economic activity (EHIA, 2021). Meanwhile, just around 4% of the population has private health insurance, owing to its high cost and limited availability (Debie et al., 2022). The informal sector encompasses economic operations that are unregulated by the government and frequently lack formal contracts or legal protections. Workers in this sector typically do not have access to benefits such as health insurance unless they participate in initiatives like CBHI.

4.3. Overview of health status in Ethiopia

Ethiopia has made substantial healthcare improvements over the years. The country's primary healthcare expansion plan, which began in 2004, includes training over 30,000 health extension workers and building multiple health facilities, demonstrating strong leadership and political commitment (Croke, 2020). Furthermore, the establishment of community-based health insurance schemes and the projected social health insurance program for formal sector employees are intended to improve healthcare access and utilization (Zarepour et al., 2023).

Furthermore, public-private partnership has been critical in tackling public health priorities, with the Private Health Sector Programme emphasizing leadership, governance, access to pharmaceuticals, human resources, and funding in private health facilities (Ali et al., 2022). The decentralization of health system responsibilities to local levels, combined with well-functioning governing boards, has been proven to increase health centre performance against reform standards, underscoring the significance of ongoing capacity building (Rono et al., 2022). Finally, programs such as the Primary Healthcare Transformation Initiative have shown improvements in managerial

capacity at the district and health centre levels, emphasizing the importance of extensive mentorship and teaching in reform efforts (Tefera, 2022).

The Ethiopian government is making strides in the healthcare system to address concerns including mental health disorders, vision problems, infectious and non-infectious diseases, and communicable diseases. To control the registration, importation, and quality control of medications, supplies, and equipment in the Ethiopian market, EFDA is being reinforced. By employing a "zero backlogs" approach for pharmaceutical registration and licensing operations, EFDA hopes to guarantee the availability of necessary medications without experiencing stock shortages. Ethiopia Pharmaceuticals Supplies Agency (EPSA), which oversees the procurement of medical equipment and supplies in Ethiopia, has made enhancements to boost productivity and accessibility of goods in the public sector (Ethiopia: Healthcare, 2024).

To address domestic demand and lessen out-of-country medical tourism, the Ethiopian government is encouraging the private sector to get involved in healthcare and working with the private sector to build modern facilities (Ethiopia, Healthcare, 2024).

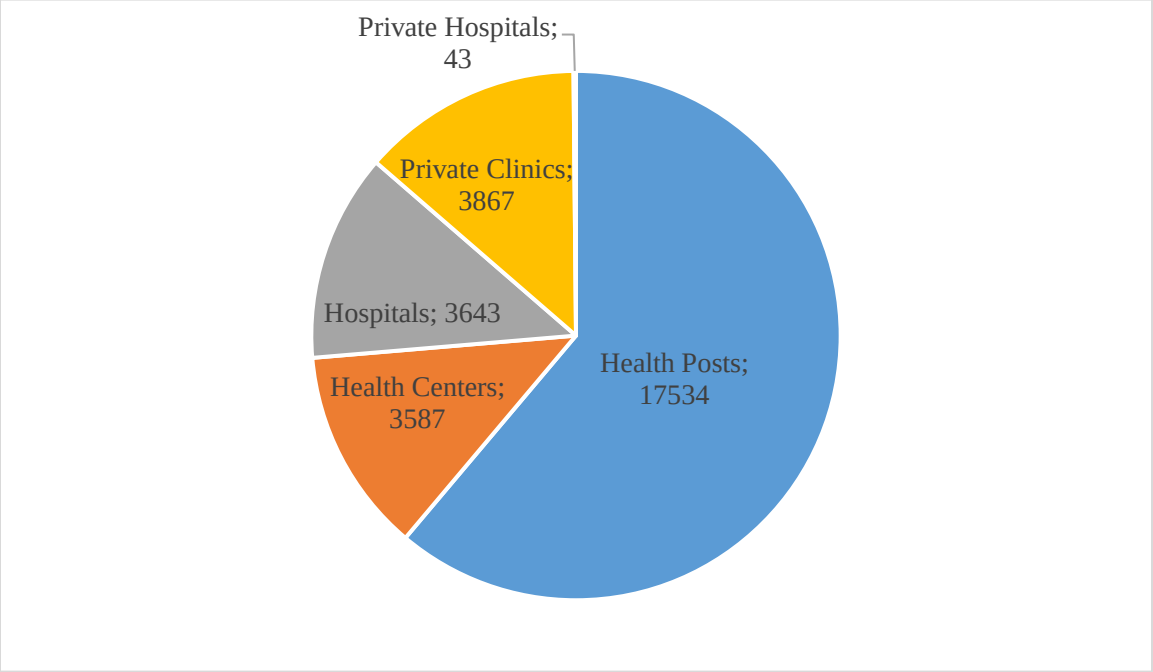

Fig4.1: Health care facilities available in Ethiopia

Source: Compiled by the Author (2024)

Ethiopia currently has 57 hospitals under construction, 89 health centres, and 77 health posts under construction. West Showa Zone has a population of more than 2.5 million and 7 hospitals, namely Ambo University Referral Hospital, Ambo General Hospital, Ginchi Hospital, Gedo Hospital, Guder Hospital, Jaldu Hospital, and Ejere Hospital (FMOH, 2017).

Access to inexpensive healthcare in Ethiopia is restricted, particularly in rural areas. The government relies largely on external financing and out-of-pocket health expenditure (OOPHE), with donor sources accounting for around 34% and OOPHE accounting for 31% of total health spending (Alebachew et al., 2023). This means that a large proportion of the population must pay for healthcare services themselves, which can be a huge financial strain.

The average cost of primary healthcare per capita is much lower than the standard cost required to deliver high-quality services. For example, the actual cost per capita varies between $4.7 to $20.2, whereas the normative cost is calculated at $38.5 (Alebachew et al., 2023). This financial shortfall suggests that many people may struggle to finance critical medical treatment.

4.3.1. Health Sector Transformation Plan I and II

Ethiopia's transformation plan intends to enhance access to healthcare services in various ways. Initiatives such as the Integrated Periodic Outreach Service (IPOS) focus on hard-to-reach locations, improving access to healthcare for pastoralists and rural people (Hendrix et al., 2023). Furthermore, initiatives to improve the quality and use of health management information system (HMIS) data at the point of service delivery are critical in identifying gaps in healthcare and monitoring improvements, resulting in higher-quality health services for the community (Tsegaye et al., 2022). Furthermore, the implementation of Community Based Health Insurance (CBHI) and the projected Social Health Insurance (SHI) program aim to improve access and utilization of healthcare services, particularly for formal sector employees, by providing financial assistance with healthcare costs (Tilahun et al., 2022). These collaborative projects prioritize fairness, greater spatial access, and improved management techniques to alleviate gaps and improve healthcare access across Ethiopia's many demographic groups.

Building on the achievements of the HSTP-I phase (July 2015–June 2020), the Health Sector Transformation Plan 2020/21–2024/25 (HSTP-II) incorporates the lessons learned from its execution. The Woreda Transformation, the Information Revolution, the Quality and Equity Transformation, and the Compassionate, Respectful, and Caring Health Workers agendas were the four transformation agendas that were put into practice during HSTP-I (FMOH, 2017).

The Health Sector Transformation Plan I in Ethiopia sought to improve the quality and use of Health Management Information System (HMIS) data at the point of service delivery. Key tactics included the Connected Woreda concept, capacity building, performance monitoring teams, and motivational rewards (Tilahun et al., 2022). The plan aimed to improve equity in Maternal, Newborn, and Child Health (MNCH) policies, with the Ethiopia Health Sector Transformation Plan (2016–2020) being the most comprehensive in addressing health equity issues (Rono et al., 2022). The plan also underlined the necessity of eliminating data falsification in healthcare facilities to enable accurate reporting and decision-making (Estifanos et al., 2022). Furthermore, the Private Health Sector Program (PHSP) worked with private facilities to strengthen the health system by addressing leadership, access to pharmaceuticals, human resources, service delivery, and financial issues (Ali et al., 2022). Overall, these programs sought to improve healthcare delivery, management methods, and performance across multiple levels of Ethiopia's health system.

HSTP I made major contributions to maternal and child health. Ethiopia has made significant progress in reducing maternal and infant death rates. According to the Ministry of Health (MoH), the maternal mortality ratio (MMR) would fall from 412 deaths per 100,000 live births in 2016 to 401 deaths per 100,000 live births by 2020 (MoH 2020). Furthermore, the under-five mortality rate decreased from 67 deaths per 1,000 live births in 2016 to 55 at the completion of the plan (MoH, 2020). These gains were mostly due to increased availability to prenatal care, competent birth attendance, and immunization programs.

The plan provided much more healthcare coverage. Health facility infrastructure has been expanded, with over 3,600 health centers and more than 400 primary hospitals expected by 2020 (MoH, 2020). The proportion of the population residing within a 10-kilometer radius of a health center increased to 92%, providing improved access to vital health services.

Ethiopia has achieved great success in communicable disease control, specifically HIV, tuberculosis (TB), and malaria. The HIV prevalence rate stayed constant at 0.9%, but TB treatment success rates increased to 90% by 2020 (FMOH, 2019). Malaria morbidity and fatality rates have also decreased due to increased availability of insecticide-treated bed nets and improved diagnostic services. The development and implementation of the electronic Health Management Information System (eHMIS) and District Health Information Software (DHIS-2) marked an important milestone in HSTP I. These solutions increased data quality and use for decision-making at the service level. Data accuracy improved, with report completion rates rising from 83% in 2016 to 94% by 2020, and data use in district and facility planning improved significantly (Teklegiorgis et al., 2017).

Health financing also made advances. The introduction and expansion of community-based health insurance (CBHI) has helped lower out-of-pocket healthcare costs, with enrollment increasing from 3.5 million in 2016 to 9.2 million by 2020 (MoH, 2020). This expansion helped low-income people get more financial protection and access to healthcare services.

4.4. What are the main barriers to accessing healthcare services in Ethiopia and how does the transformation plan address them?

In Ethiopia, challenges to accessing healthcare services include limited spatial access, staffing shortages, inadequate infrastructure, and poor data quality (Derso et al., 2022; Hendrix et al., 2023; Tilahun et al., 2022). The country's Health Sector Transformation Plan seeks to solve these issues by emphasizing data quality and utilization at the point of care delivery through initiatives such as Connected Woreda, capacity building, and performance monitoring teams (Bogale et al., 2023). Furthermore, the plan stresses investments in new health facilities, staffing, and equitable expansion of the healthcare system to decrease gaps between rural and urban areas, with the goal of improving access to healthcare services and lowering poverty (Tsegaye, 2022). Efforts to improve data-use practices, increase capacity, and overcome infrastructure constraints are critical components of the transformation plan for providing better-quality health services to the population.

4.4.1. The challenges of Health sector Transformation plan I

Ethiopia's Health Sector Transformation Plan experienced several problems. One important concern was the purposeful falsification of maternal and new-born health data by healthcare

practitioners, which was driven by a system that promoted service quantity over accuracy (Tilahun et al., 2022). Furthermore, the plan experienced challenges such as duplicate data gathering tools, insufficient health information system infrastructure, staffing shortages, and negative attitudes among health workers toward data (Estifanos et al., 2022). Furthermore, problems such as weak ICT infrastructure, a lack of computer skills, budget shortages, and management issues hampered Ethiopia's digitalization of its healthcare system, a critical component of the transformation plan (Tsegaye et al., 2022). These problems reflect the complexities and diversified character of Ethiopia's Health Sector Transformation Plan I obstacles.

4.4.2. Elements of Health Sector Transformation plan I

Ethiopia's Health Sector Transformation Plan I aimed to improve the quality of Health Management Information Systems (HMIS) data and its application at the point of health service delivery. The Connected Woreda strategy, capacity building, performance monitoring teams, and motivational rewards were among the key initiatives for improving data quality and utilization (Tilehun et al., 2022). Furthermore, the plan sought to address equity in Maternal, New-born, and Child Health (MNCH) policies, highlighting Ethiopia's Health Sector Transformation Plan (2016–2020) for its high ranking in enforcing equity principles (Rano et al., 2022). Moreover, the plan acknowledged the significance of eliminating data falsification in maternal and new-born health (MNH) statistics by separating rewards and punishments based on normal HMIS data (Estifanos et al., 2022). The plan also highlighted the country's expanding burden of non-communicable diseases (NCDs) and established ambitious targets to minimize the prevalence of major risk factors such as tobacco use and alcohol consumption (Marquez et al., 2018).

The Health Policy and Systems Research Initiative (HTSP-I) identified important priorities related to the Sustainable Development Goals (SDG). These priorities include improving access to health care through social protection systems, encouraging cross-sectorial collaborations for health, and establishing more participatory and accountable institutions (Sachs and Sachs, 2021). Furthermore, addressing the tobacco pandemic under SDG 3 via the Framework Convention on Tobacco Control (FCTC) is critical, emphasizing the importance of multi-sectorial collaboration to boost tobacco control efforts (Qiu, 2018). Furthermore, the SDGs emphasize the need to prioritize and strengthen co-beneficial targets for effective achievement, with nations' income levels and geographic locations playing a key role in total SDG attainment (Bennett, 2020). These

priorities highlight the linked nature of health, social protection, and sustainable development within the SDG framework.

Ethiopia has made significant strides in improving healthcare access through social protection systems under the Health Transformation and Social Protection Initiative (HTSP-I). This initiative has been pivotal in enhancing health service delivery, particularly for vulnerable populations, by integrating community-based health insurance and health extension programs.

Launched in 2011, CBHI aimed to cover 80% of districts and populations by 2020.

It has mobilized community resources, improved access to health services, and provided financial protection, particularly empowering women (Mulat et al., 2022).

Early pilots and strong political support facilitated its scale-up, demonstrating the importance of community engagement in health financing (Mulat et al., 2022).

Since 2003, the health extenstion program (HEP) has significantly improved maternal and child health, communicable diseases, and health-seeking behaviors (Assefa et al., 2019). The program adapts to community needs, enhancing local ownership and participation in health initiatives (Assefa et al., 2019). Despite successes, challenges remain, including the productivity of health extension workers and the capacity of health posts (Assefa et al., 2019).

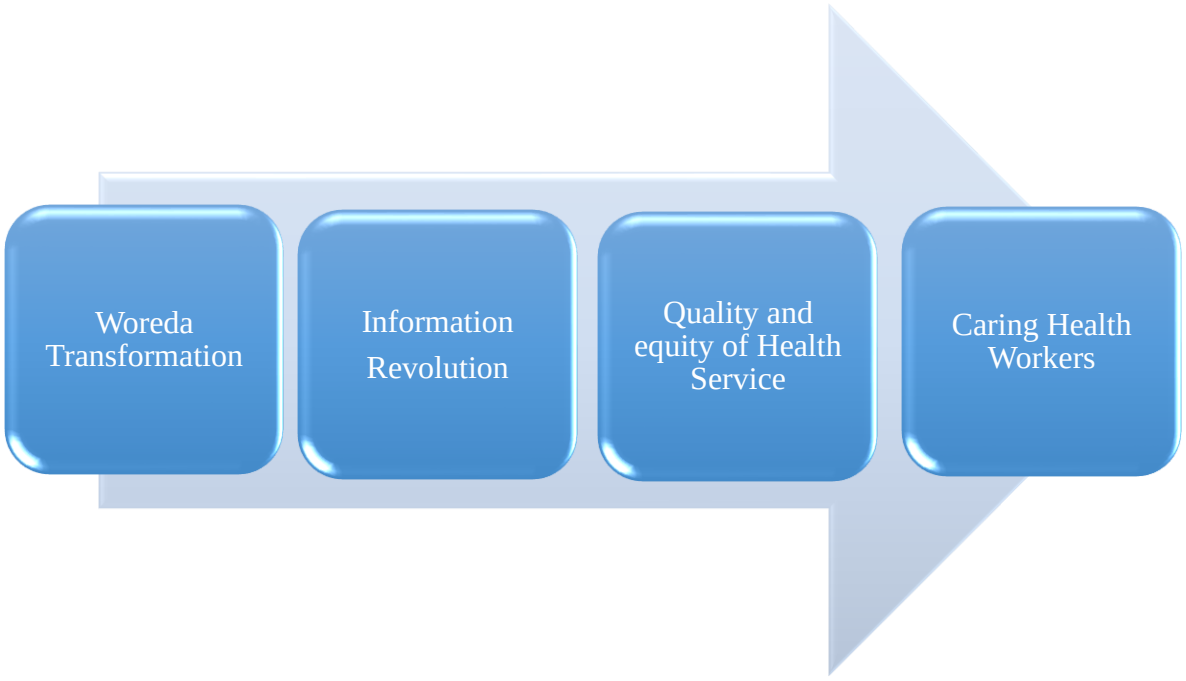

Fig 4.2: Four Priorities of HTSP-I

Compiled by Researcher (2024)

1. **Woreda Transformation**

The Ethiopian Federal Democratic Republic has 12 semi-autonomous administrative regions (the constituent units of the federation) and two chartered cities, Addis Ababa (Finfinne) and Diredawa, with decentralized zonal and woreda structures that are tiers of local government. Further Woredas are decentralized to Kebeles (villages), which are the lowest administrative structures in Ethiopia.

The Prosperity Party's (PP) domination of government institutions at the municipal and constituency levels has a considerable impact on democratic representation in Ethiopia. This domination reveals itself in the concentration of authority, which undermines local autonomy and accountability, both of which are necessary for effective democratic governance.

The PP's transition from a coalition to a more unified party structure has led to increased centralization, diminishing the autonomy of regional and local governments (Gemechu, 2023). Local governments often function as extensions of the party rather than independent entities, limiting their ability to represent local interests (Fiseha, 2020) (Fessha & Debela, 2023). Local

councils lack genuine authority and accountability, often prioritizing party interests over community needs, which stifles grassroots representation (Fiseha, 2020) (Fessha & Debela, 2023). The need for a restructured local governance framework is evident, emphasizing the importance of inclusive decision-making processes to enhance democratic representation (Fiseha, 2020).

Ethiopia's Woreda Transformation plans are in line with the country's national development goals, concentrating on key areas such as boosting competitiveness, increasing resilience, lowering vulnerabilities, and promoting long-term economic growth. These plans are part of Ethiopia's larger Growth and Transformation Plans (GTPs), which seek to promote innovation, infrastructure development, and poverty reduction (Kuriakose et al., 2016; Gizaw, 2017). The GTPs' emphasis on green and climate-resilient structural change demonstrates Ethiopia's commitment to sustainable development (Medhin and Mokonnen, 2019). Furthermore, infrastructure expenditures are critical to enabling economic growth and poverty reduction and have made major contributions to Ethiopia's economic trajectory during the 1990s (Nuru, 2019).

This study focused on health institutions at the local level. Based on the health system of Ethiopia, on average, woreda have 20 health posts, one primary hospital, and four health centres.

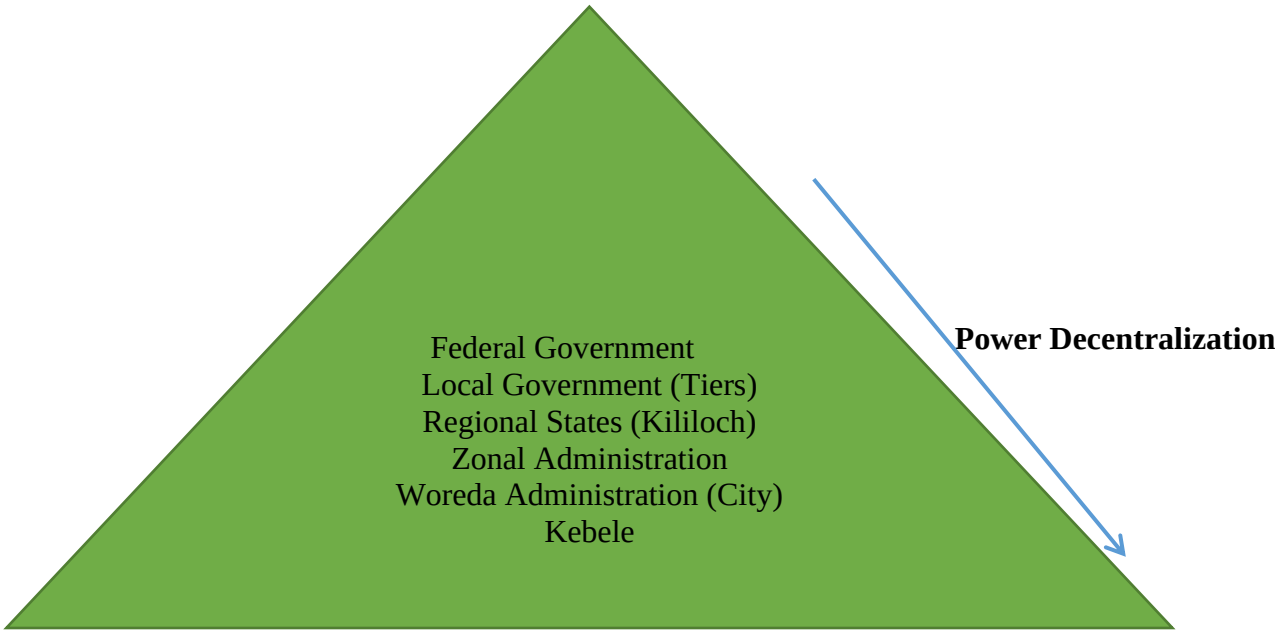

Fig4.3: Government Structure of EFDR

Source: Compiled by the researcher (2024)

In Ethiopia, zonal administration is the administrative system that connects the regional and district (woreda) levels. Zones are subregional subdivisions in charge of organizing and guaranteeing the implementation of regional government policies and directives at the woreda level. Each zone is administered by a zonal council and administration, which oversee managing local public services like as health, education, and infrastructure (Bach, 2011).

A kebele is Ethiopia's lowest administrative unit, serving as a neighborhood or village council. It oversees executing policies and programs at the grassroots level, as well as dealing with local governance concerns like community mobilization, basic service delivery, and local security (Vaughan & Tronvoll, 2003). Kebele administrations play an important role in connecting the public to higher levels of governance.

The Ethiopian decentralized system makes the woreda central to development efforts. According to regional state constitutions, woredas are governed by locally elected governance structures and district councils; their major responsibilities are planning, resource allocation, execution, and monitoring and evaluation of primary health care services and other social services. Woreda is the most comprehensive political and administrative unit accountable for the provision of basic social services, including health services. That is why woreda transformation was included as part of HSTP.

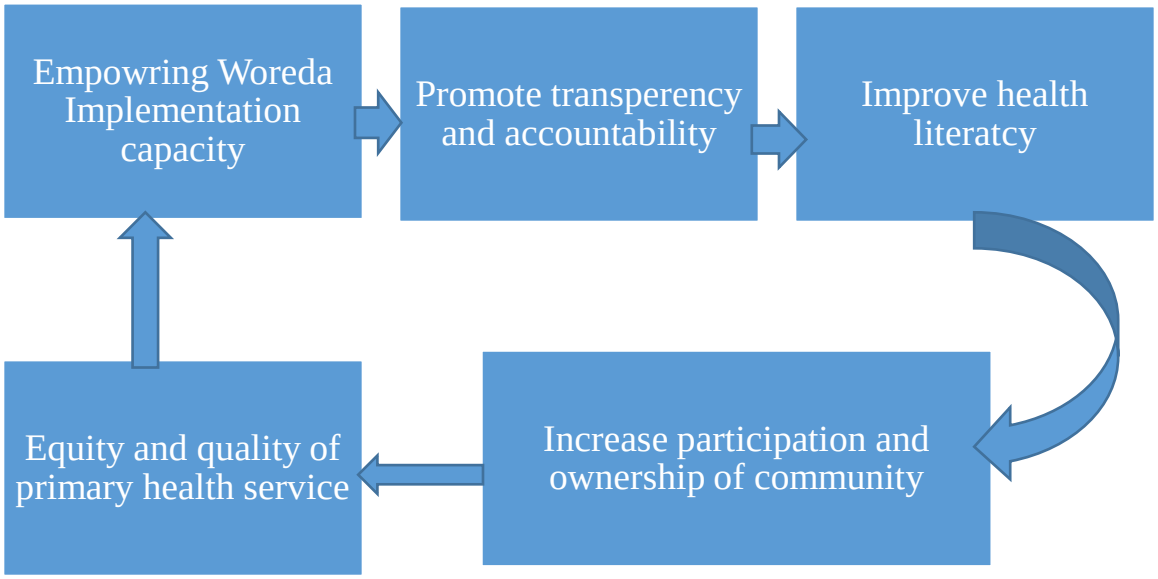

Fig4.4: Objectives of Woreda transformational

Source: compiled by the researcher (2024)

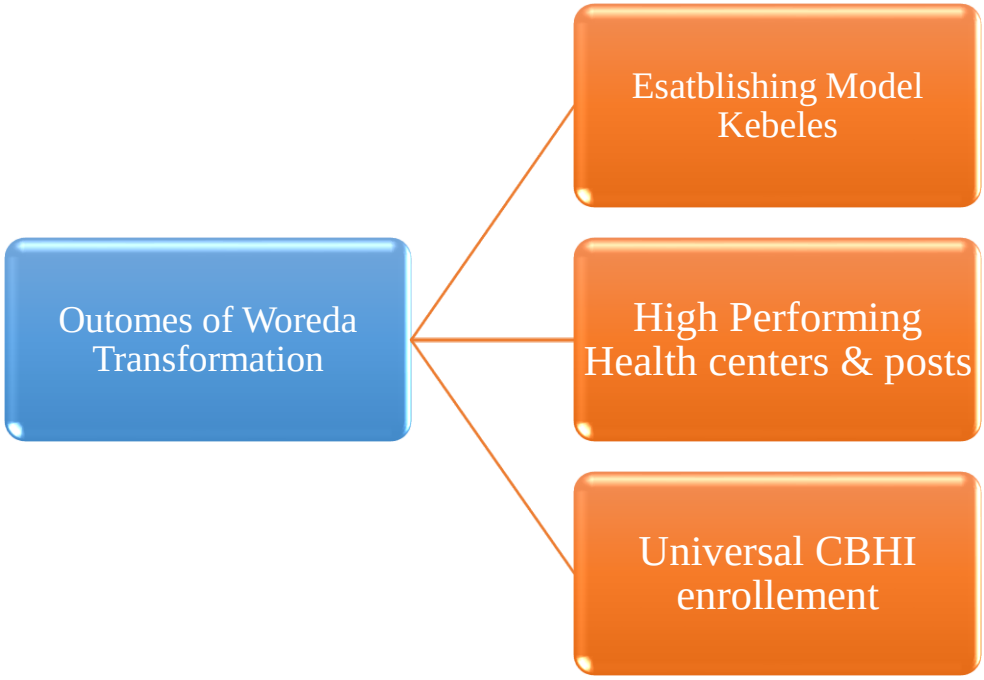

Fig4.5: Consequences of woreda Transformation

Source: Compiled by the researcher (2024)

i. Model Kebeles

The notion of model kebele was proposed based on diffusion of innovation theories; it refers to having households within the kebele fulfil model family status individually to establish a socially responsible, organized, and long-term transformation of society's health. Using this technique, even though significant progress was made across the country, it revealed gaps in obtaining the target level of performance. That is how the government has implemented a CBHI strategy to address the problem. A scale-up plan is a methodical technique intended to extend effective programs, initiatives, or behaviours to a wider geographic region or population. The objective is to expand the reach and sustainability of programs to improve their impact and efficacy. Important components of a scale-up plan frequently consist of Assessment of successful models, adaptation and planning, resource allocation, stakeholder's engagement, montering and evaluation and sustainability.

The scale-up plan promotes women's participation in the health development armey (HAD), which has increased the construction of model families at the kebele stage while also addressing training and implementation shortages.

The main criteria used for selecting this model kebeles are that more than 85% of the households in the community have achieved model family status, home delivery-free kebeles, open defection-free kebele and full coverage of CBHI.

In Ethiopia, a kebele is the lowest administrative unit that operates at the local level. Kebeles are essential local governance organisations in charge of carrying out government policies and programs, such as those pertaining to development, education, and health. They are essential in addressing local problems and encouraging community involvement. By enabling grassroots participation in decision-making, the kebele system gives communities a say in how they are governed. It is easier for local leaders to interact with residents and promote programs like the Health Development Army (HDA) and the model family concept, which aim to improve health outcomes, because each kebele is usually composed of multiple neighbourhoods or groups of households (Ethiopian Ministry of Health, 2018).

The model kebele verification process started with PHCUs corroborating them and sending them for approval to kebele councils. Finally, regional health bureaus and zonal health departments will select a sample of model kebeles, and then they will verify their model status. Based on the sated criteria, the woreda-level committee assesses the kebeles performance and provides their status.

Table4.1. Woreda Transformation Indicators and measurements

S.No.	Items	Measurements
1	Model Kebele	No. of model kebeles divided by No. of kebeles
2	CBHI coverage	No. families enrolled in CBHI divided by families not enrolled
3	High performing PHCUs	No. of high performing PHCUs divided Number of PHCUs in the woreda

Source: Compiled by the researcher from MOH (2017)

Model kebeles within woredas are levelled as high (green colour), medium (yellow colour), and low performing (red colour) based on their scores.

Table4.2. Woredas Transformation performance

Woredas Performance	Points scored in Percentage	Status in colour
High	>=85%	
Medium	60-84%	
Low	<=59%	

Source: Compiled by the researcher from MOH (2017)

ii. Establishing high performing PHCUs

To guarantee that communities have access to a basic range of healthcare services, Primary Health Care Units (PHCUs) are set up at the woreda level. With the goal of providing comprehensive primary health services to fulfil the requirements of the local people, each PHCU is made up of a health centre and connected health posts (Admasu, 2016). With an emphasis on attaining high satisfaction within the served populations, these units aim to enhance community participation in health efforts in addition to providing vital health services (Erku et al., 2023).

iii. Community-based health insurance

It is the third element of a Woreda transformation plan. Among the HSTP-I CBHI are parts of the HSTP-II, and they are still implemented in different parts of the country.

In Ethiopia, CBHI is a voluntary program created to increase access to and affordability of healthcare (Daraje, 2022). Families must pay for healthcare services, and the government is considering making SHI for workers in the formal sector mandatory (Zarepour et al., 2023). By promoting risk-sharing between affluent and underprivileged households, CBHI lowers the cost of healthcare (Getahun et al., 2023). Age, educational attainment, land ownership, and scheme awareness all affect CBHI utilization (Belayneh, 2023). CBHI is more affordable for low-income individuals since, in contrast to traditional models, it places a higher priority on cost-sharing, community involvement, and risk-sharing (Zepre, 2023). The success of the plan hinges on factors

like home contentment, comprehension of the advantages of CBHI, and backing for the initiative's management.

As part of Ethiopia's efforts to achieve universal health coverage, the CBHI scheme intends to offer cheap health care to most Ethiopians who work in the informal sector. Nearly every district in the nation is now covered by the program, which charges a nominal premium to members in exchange for a notable rise in medical consultations. CBHI beneficiaries are served by a vast number of hospitals and health centres under contract; some of these institutions collaborate with outside suppliers to guarantee the supply of necessary medications (WHO, 2022).

By putting in place a community-based health insurance program to shield citizens from financial hardship and guarantee access to essential services without forcing them into poverty, Ethiopia is moving closer to achieving universal health care. To guarantee the effective execution of the community-based health insurance program in the country. The ministry of health and EHIS have received assistance and training from the World Health Organization (WHO, 2022).

The development and operation of community-based health insurance (CBHI) programs in Ethiopia are significantly influenced by laws and policies. To address the low health-seeking behaviour observed in rural areas, the government implemented voluntary CBHI (Zarepour et al., 2023) (Daraje, 2022). Increased coverage and improved healthcare utilization are the goals of policies like the Social Health Insurance (SHI) program that are required for workers in the formal sector (Getahun et al., 2023). Studies indicate that being a part of the CBHI positively influences the behaviour of people seeking medical attention, especially those from vulnerable households, encouraging them to use healthcare facilities (Mussa et al., 2023). These regulations seek to lower out-of-pocket expenses, guarantee equitable access to medical treatment, and assist Ethiopia in realizing its objectives for universal health coverage (Tefera and Ayele, 2022). These actions can strengthen CBHI support and enhance health outcomes by proactively integrating private healthcare institutions and addressing quality issues in public facilities. In addition, there is resistance to the introduction of a Social Health Insurance (SHI) program for workers in the formal sector because of worries about the affordability of premiums and the restricted coverage provided by contracted institutions. Efforts aimed at increasing awareness, improving service quality (including that of private healthcare providers), and addressing the concerns of different income

levels should be made to generate broader acceptance and support for these initiatives to increase sustainability and scalability.

4.4.3. Ethiopian Health sector Transformation plan (HSTP-II)

The overarching goal of HSTP-II is to enhance population health through quickening the transition to universal health coverage, safeguarding communities in the event of an emergency, modernizing woredas, and enhancing the responsiveness of the healthcare system (MOH, 2017).

Ethiopia has made great strides in improving the health outcomes of its population. Despite limited implementation capacity, low enrolment in community-based health insurance (CBHI), shortages and insufficient distribution of personnel, and lack thereof, performance gaps across states, woredas, and health infrastructures make it difficult to provide equitable and quality basic health services for all segments of the community (ibid.).

The Health Sector Transformation Plan II in Ethiopia seeks to increase healthcare access and quality. Community-Based Health Insurance (CBHI) programs have been implemented to lower out-of-pocket costs and increase healthcare utilization (Pham et al., 2023; Geta et al., 2023). Studies in Ethiopia have demonstrated that CBHI considerably boosts modern health care (MHS) utilization among insured households, eliminating inequities based on wealth status and family size (Dagnaw et al., 2022; Tefera and Ayele, 2022). The CBHI program has been effective in improving healthcare service utilization among enrolled households, particularly those with under-five children, a higher wealth index, and chronic illnesses (Gutama, 2023). However, issues such as poor enrolment owing to lack of awareness, budgetary constraints, and dissatisfaction with services have been observed, emphasizing the need for ongoing improvement and growth of the CBHI scheme.

Because of user fees or high out-of-pocket health expenditures, the per capita health service utilization in Ethiopia was 0.48 visits per year in 2017, which is much lower than the 2.5 visits per year target, set by the World Health Organization. By taking the experience of various countries and with the help of different stakeholders like the ABT association and USAID, the Ethiopian government formulated a new health care financing strategy (HCFS) in 2008 that includes a health insurance strategy, namely social health insurance (which is payroll-based and mandatory for government and private employees; however, this type of insurance is not yet implemented in

Ethiopia) and community-based health insurance (which targets people engaged in the informal sector of the economy and has been implemented since 2013). The main aim of introducing this new HCF is to mobilize revenue and protect vulnerable groups in the community from catastrophic health expenditures. Within this reform, Ethiopia is planning to achieve universal health coverage (UHC). According to USAID (2017), countries can meet the UHC by equitably addressing access to health services and financial risk protection. This means that everybody, regardless of their level of income, is freed from financial catastrophic spending during access to health services.

The level of contemporary health care services was greatly raised as a result of the CBHI scale-up, and gaps in utilization across wealth status and family size discrepancies were decreased (Geta et al., 2023). The execution of CBHI is a vital part of the Woreda transformation Increasing enrolment, having a transparent and easily understood process, and ensuring the financial and institutional sustainability of the scheme (MOH, 2017).

4.4.4. Priorities of HSTP-II

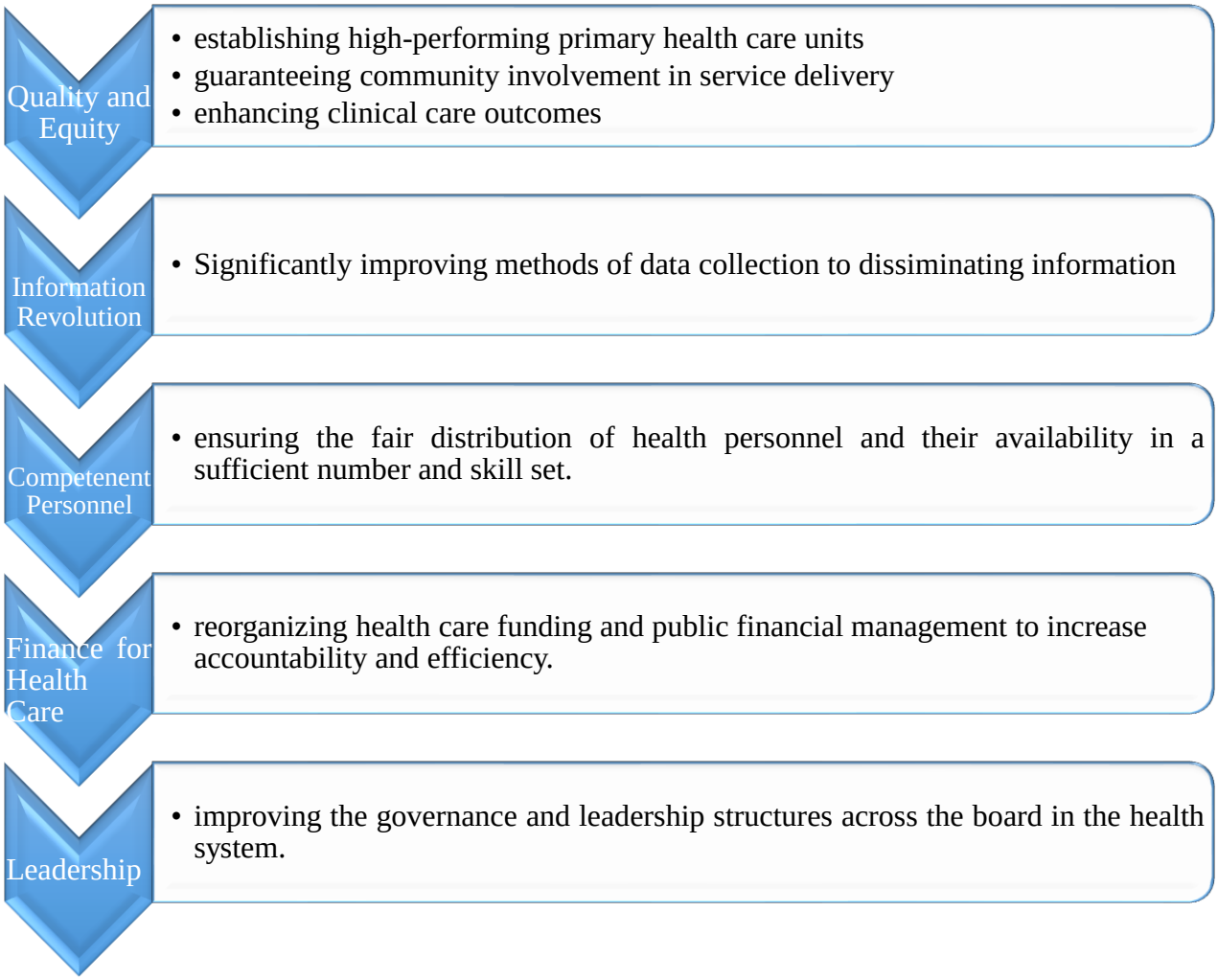

Fig4.6: Elements of HSTP-II Source

Compiled by the researcher (2024)

4.4.5. How will the adoption of community-based health insurance affect the overall efficacy of the Health Sector Transformation Plan II?

The adoption of community-based health insurance (CBHI) has a substantial impact on the overall effectiveness of the Health Sector Transformation Plan II. According to studies conducted in Ethiopia and Vietnam, CBHI membership enhances health service utilization, lowers financial risks, and improves health outcomes. In Ethiopia, CBHI members had more outpatient department (OPD) visits, cheaper out-of-pocket payments, and lower catastrophic health costs than non-

members (Alemayehu et al., 2023; Edosa et al., 2023; Pardoel et al., 2023). Similarly, in Vietnam, the establishment of Intergenerational Self-Help Clubs (ISHCs) resulted in improved health outcomes and high member satisfaction, demonstrating the beneficial effect of community-based support for health promotion (Alemayehu et al., 2023). These findings imply that combining CBHI and community-based support models can improve the efficacy of health sector transformation initiatives by encouraging healthcare consumption and financial risk management.

Implementing community-based health insurance (CBHI) coincides with the goals of Health Sector Transformation Plan II by improving health outcomes and lowering healthcare expenditures (Eze 20203; Ntube, 2023; Kassa 2023; Mussa et al., 2023; Edosa et al., 2023). CBHI schemes in low- and middle-income countries improve healthcare consumption, particularly outpatient services, while also providing financial risk protection by lowering out-of-pocket health expenditure and catastrophic health expenditure. CBHI enrolment also improves the use of curative care and health professional services, which helps to achieve universal health coverage and health equity. Furthermore, insured households are more likely to use modern health services, showing a decrease in inequities and increased access to healthcare. As a result, by encouraging healthcare utilization and financial protection, CBHI contributes to the Health Sector Transformation Plan II's goal of improving health outcomes while lowering healthcare expenditures.

4.4.6. What are the best practices for designing and implementing community-based health insurance schemes to ensure their sustainability and effectiveness in achieving the goals of the Health Sector Transformation Plan II?

Community-based health insurance (CBHI) programs have demonstrated potential for providing inexpensive and accessible healthcare to underserved communities in low- and middle-income nations. Several approaches, including cooperative healthcare (CH) (Eze et al., 2023), have proven effective in boosting healthcare utilization and financial risk protection (Edosa et al., 2023). Studies in Ethiopia have shown that CBHI has a positive influence on lowering gaps in contemporary health service consumption among families (Hsiao and Yip, 2024). Furthermore, research in South Central Ethiopia shows that rural households are prepared to pay for CBHI schemes, highlighting the significance of modifying contribution amounts to ensure affordability

(Kaso et al., 2022). Furthermore, a study in Addis Ababa found that CBHI adoption had a favourable impact on healthcare-seeking behaviour, with characteristics such as family size and living conditions playing important roles (Getahun et al., 2024). Overall, these findings highlight the potential of CBHI schemes to improve healthcare access for marginalized populations in LMICs.

Designing and executing successful community-based health insurance (CBHI) programs necessitates careful consideration of a variety of issues. For starters, significant national support is required to secure funds and ensure long-term viability (Donessouné et al., 2023). Second, incorporating CBHI into existing organizational systems and aligning aims with host structures is critical to long-term success (Namyalo et al., 2023). Addressing financial difficulties, such as insufficient reserves and reinsurance, is crucial for financial viability (Kakama et al., 2022; Hussien et al., 2022). Educating and engaging communities through door-to-door visits and promotional programs can increase population coverage while also combating difficulties such as adverse selection and moral hazards (Nurnabi et al., 2022). Finally, incorporating community leaders in planning and implementation, harnessing community values and traditions, and ensuring adherence to societal norms can all greatly contribute to the success of CBHI programs in terms of healthcare fairness and sustainability.

4.4.7. What are the probable problems and constraints of implementing CBHI to achieve the goals of the Health Sector Transformation Plan II?

Ethiopia's implementation of community-based health insurance (CBHI) suffers from several problems that prevent it from meeting the goals of the Health Sector Transformation Plan II. Challenges include poor enrolment due to lack of information, budgetary constraints, and dissatisfaction with healthcare services (Gutama, 2023). Financial viability is a major worry, with schemes reporting negative net income and substantial losses, limiting their ability to protect members against out-of-pocket payments (Tefera and Ayele, 2022). Inadequate population coverage, adverse selection, and moral hazard behaviours all complicate CBHI implementation (Sheikh et al., 2022). Furthermore, impediments such as inadequate ICT infrastructure, a lack of computer skills, financial constraints, and management styles impede the successful integration of ICT into the Ethiopian healthcare system, hurting CBHI operations (Hussien et al., 2022).

Addressing these problems is critical for CBHI to effectively contribute to meeting the Health Sector Transformation Plan II objectives.

To improve the effectiveness and sustainability of Ethiopia's community-based health insurance (CBHI) programs, the government and stakeholders should prioritize several essential strategies. To begin, addressing poor health-seeking behaviour among formal sector employees by enhancing healthcare quality and aggressively incorporating private health facilities into the system is critical (Daraje, 2022). Second, improving beneficiary satisfaction through higher service quality and coverage can enhance overall plan performance (Bayked et al., 2023). Furthermore, measures to increase household awareness of CBHI advantages, encourage role modelling for rural health extension programs, and assure the availability of prescribed medications are critical for boosting scheme satisfaction and sustainability (Zarepour et al., 2023). Finally, encouraging equitable premium structures, affordability, and willingness to pay among beneficiaries will help overcome obstacles and ensure the long-term success of CBHI programs in Ethiopia.

In addition, the participation of multiple stakeholders is critical to the efficacy and sustainability of CBHI programs. The sustainability of Ethiopian community-based health insurance (CBHI) programs depends on stakeholders (Daraje, 2022; Getahun et al., 2023). Increasing household knowledge of the CBHI program, helping them act as role models for rural health extension programs, and ensuring the fulfilment of the CBHI promised package are ways to boost their engagement (Geta et al., 2023). Moreover, enhancing the financial viability of CBHI schemes requires addressing problems such as moral hazard behaviours, medicine shortages, adverse selection, delays in service provider claims payment, and low insurance premiums (Zepre, 2023). The CBHI plan should be improved, with a focus on the location and educational attainment of households, to improve the utilization of contemporary health services and eradicate disparities (Mohammed et al., 2022). To surmount financial barriers and improve the healthcare-seeking behaviour of households involved in CBHI schemes, stakeholders must work together.

4.5. The Impact of International Organization on Health care reform and policies and practices in Ethiopia

International organizations and foreign aid have a considerable impact on healthcare reform policies and practices in Ethiopia (Vernaelde, 2022; Teshome & Hoebink, 2018; Disha et al., 2022; Le Mat, 2020). For example, the United States government has been a significant donor to

Ethiopia's healthcare sector, particularly in sexual and reproductive health (Heyi, 2022). Furthermore, programs such as the Private Health Sector Program (PHSP), sponsored by the United States Agency for International Development, have enabled public-private partnerships to address the country's varied health concerns. These measures have contributed to strengthening various parts of the healthcare system, including leadership, access to drugs, human resources, and service delivery. Furthermore, the implementation of performance management innovations through initiatives such as USAID's Transform: Primary Health Care project has had a favourable influence on the quality of primary healthcare facilities in Ethiopia.

International organizations have had a considerable impact on healthcare reform and policies in Ethiopia. The Private Health Sector Program (PHSP), financed by the US Agency for International Development, has pioneered public-private partnerships to address public health goals while improving leadership, governance, and service delivery (Ali et al., 2022). Furthermore, the United States' Global Gag Rule influences Ethiopian sexual and reproductive health services, hurting non-governmental organizations and service delivery (Kebede et al., 2023). Furthermore, programs led by the Federal Ministry of Health and sponsored by international organizations have integrated mental health and substance abuse services into primary care, resulting in improved service quality and health outcomes (Vernaelde, 2022). These collaborations demonstrate international organizations' effect on Ethiopian healthcare practices, policies, and changes, emphasizing the need for long-term cooperation in achieving public health goals.

4.6. Stakeholders involved in the Community-based health insurance in Ethiopia

In Ethiopia, governing boards, families, and healthcare practitioners are usually the main participants in Community-Based Health Insurance (CBHI) initiatives (Daraje, 2023; Zepre, 2023). As CBHI scheme participants, households are vital, and their satisfaction levels have a direct bearing on the program's performance (Belayneh, 2023; Asfaw et al., 2023). In order to deliver services covered by the CBHI plan and to influence the standard of care beneficiaries get, health care providers are crucial stakeholders (Bayked et al., 2023). Governing boards supervise the CBHI programs' management and decision-making procedures, guaranteeing openness, responsibility, and efficient execution to improve beneficiary satisfaction and program sustainability. The success and efficacy of CBHI programs in Ethiopia, which seek to increase

access to necessary health services and avoid financial problems associated with medical treatment, are largely attributed to these players.

The following are the main stakeholders involved in community-based health insurance (CBHI) in Ethiopia:

1. Government: By providing policy direction, regulatory monitoring, and occasionally financial support, the Ethiopian government contributes significantly to the execution of the CBHI. Creating and executing plans to increase the number of people covered by health insurance is the responsibility of government organizations like the Ministry of Health.

2. Community Members (CBHI members): One of the main CBHI stakeholders is the community itself. They take part in the planning, execution, and administration of CBHI programs. In addition to making monetary contributions through premiums, community members frequently donate their time to help with the scheme's management.

3. Healthcare Providers: Clinics, hospitals, and other healthcare establishments are crucial CBHI stakeholders. They supply enrolled members with healthcare services, and the CBHI schemes reimburse them for those services. Effective cooperation between healthcare providers and CBHI initiatives is essential for their success.

4. Non-Governmental Organizations (NGOs): NGOs are frequently helpful in putting CBHI into practice. For community-based organizations and government agencies taking part in CBHI projects, they might offer financial support, technical help, and capacity building.

5. International Development Partners: To support the creation and execution of CBHI programs in Ethiopia, international organizations and donor agencies, including the World Bank, WHO, and bilateral aid agencies, may offer money, technical help, and experience.

6. Research Institutions: To improve program efficacy, inform policy decisions, and produce evidence-based recommendations for scaling up CBHI projects, academic and research institutions participate in CBHI by conducting studies, evaluations, and assessments.

7. Insurance Companies: Private insurance providers may occasionally participate in CBHI programs by offering their technical know-how in insurance administration and. Private

Management. In Ethiopia, private insurance firms may participate in Community-Based Health Insurance (CBHI) initiatives, frequently by offering important technical assistance in fields such as insurance management and administration. Particularly in putting in place efficient financial management systems and guaranteeing effective premium collection and claims processing, this collaboration can support the CBHI programs (Worku, 2023).

8. Civil Society Organizations (CSOs): CSOs can represent marginalized groups' and vulnerable populations' interests during the planning and execution of CBHI programs. To encourage enrolment and involvement in CBHI programs, they could also take part in community mobilization and awareness-raising initiatives.

9. Financial Institutions (Payor): The financial components of the policy framework are operationalized by payers. Patients are enrolled as beneficiaries by payers. In the interest of their patient beneficiaries, they purchase healthcare services from the providers. They are also required to assume the actuarial responsibility of guaranteeing the care program's financial viability. Policy makers receive their reports from them. Entails the analysis and compilation of data on healthcare expenses, service utilisation, and program performance by payers, including insurance companies and financial entities. These studies help policymakers understand the present status of healthcare programs, including areas that require improvement, access to care, and financial sustainability. By consistently providing this data, payers encourage strategic planning and evidence-based policy modifications, assisting in the development of future health policies that can better serve the requirements of the populace, increase cost effectiveness, and improve health outcomes.

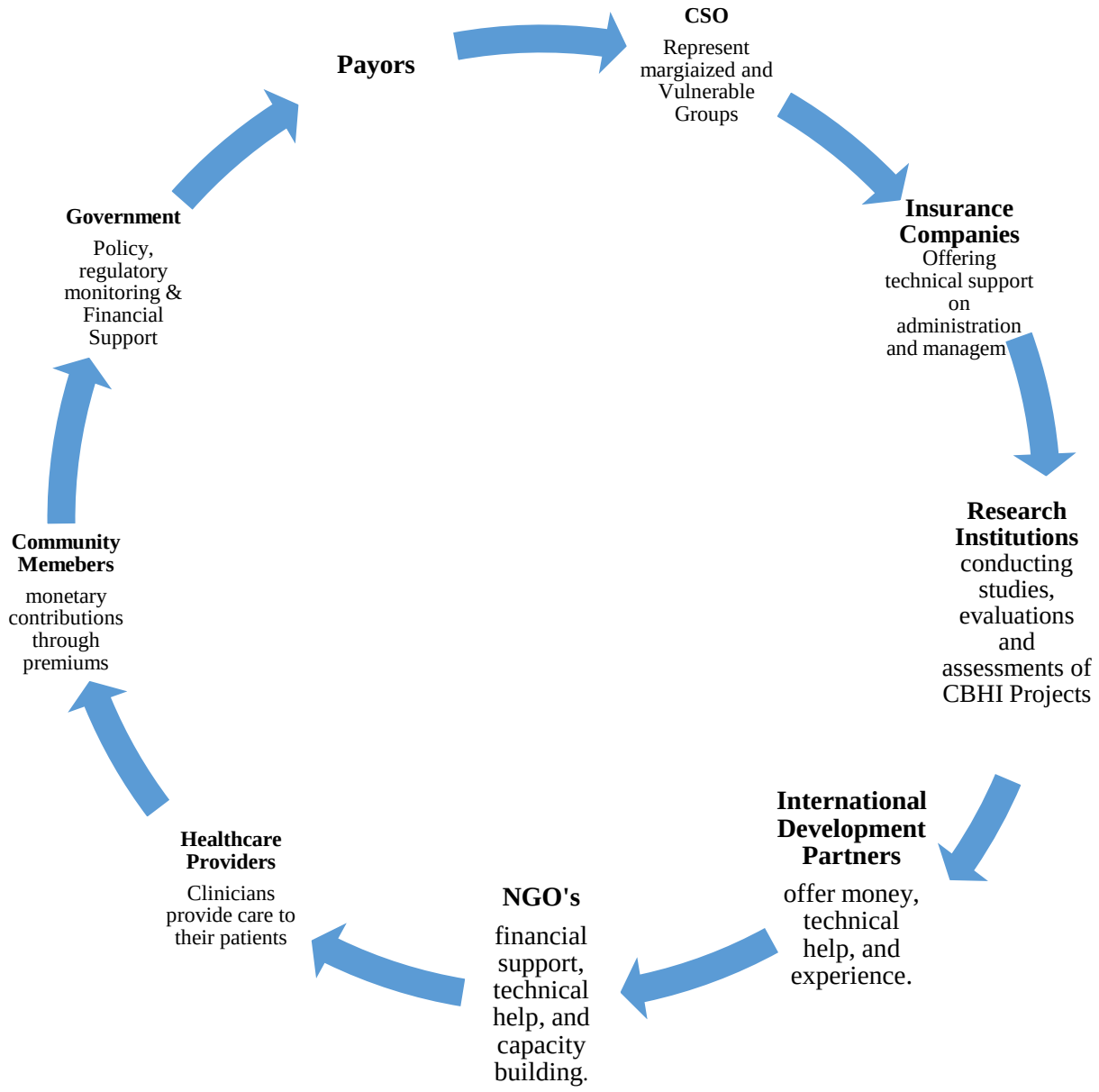

Fig4.7: Stakeholders Involved in the Community-based health insurance of Ethiopia

4.6.1. The role of CBHI stakeholders

In this study, the 4P's of CBHI stakeholders, namely policymakers (government), patients (CBHI members), payers (financial institutions), and providers (health centers and hospitals), are considered the primary stakeholders of CBHI in Ethiopia.

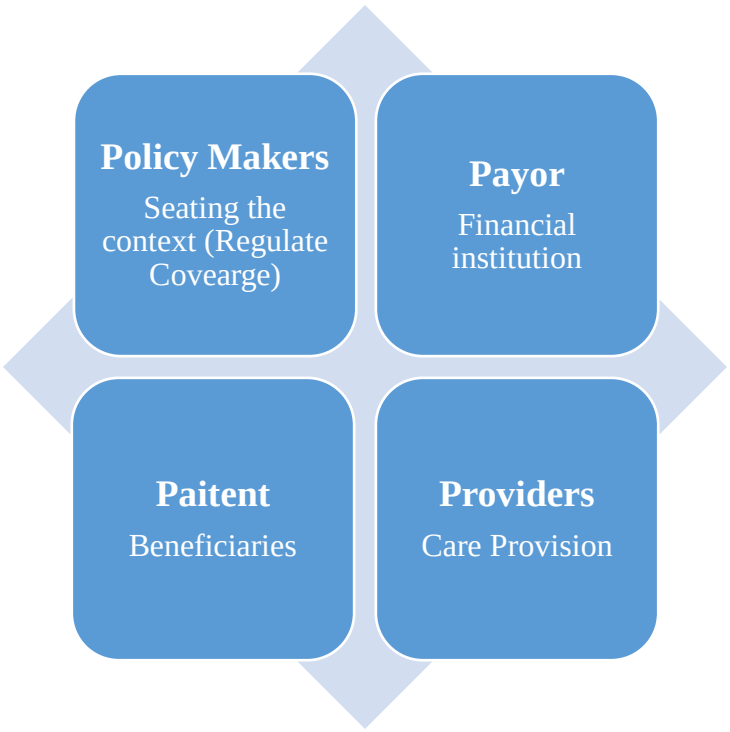

Fig4.8: The relationship between the 4ps of CBHI

Source: Adopted from Data (2014)

The framework in which the health care system functions is established by policymakers. These policies govern how providers and payors conduct themselves, and they follow them. Within the limits of the nation's finances and resources, the policies are ideally created to optimize population health.

4.6.2. Policy Makers (Federal ministry of health)

The framework in which the health care system functions is established by policymakers. These policies govern how providers and payors conduct themselves, and they follow them. Within the limits of the nation's finances and resources, the policies are ideally created to optimize population health.

The following diagram shows the relationship between the primary stakeholders of CBHI from the perspective of policymakers.

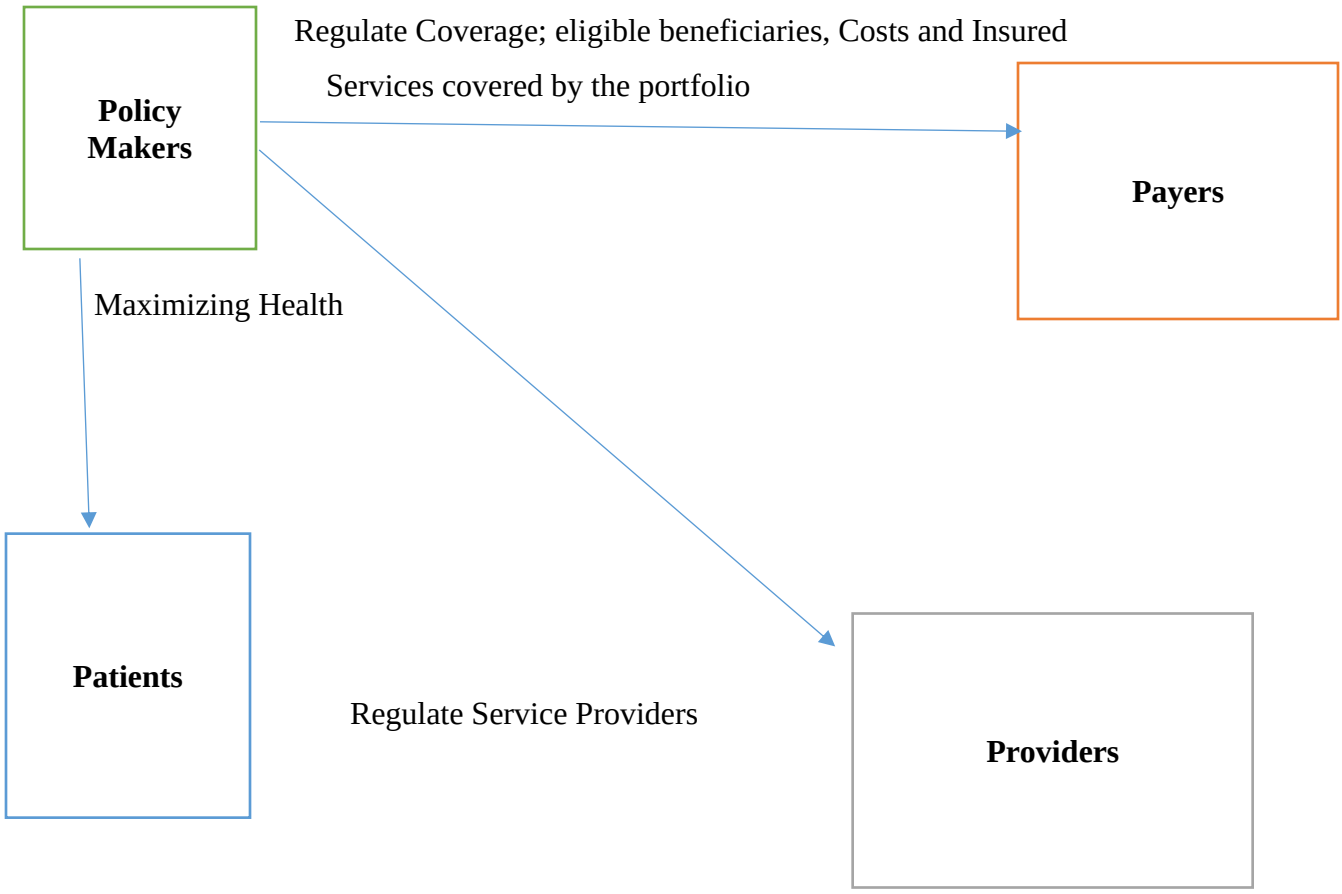

Fig4.9: The relationship between primary stakeholders in health insurance from Policy maker's perspectives

Source: Compiled by the researcher (2024)

As shown in the above fig4.9 Payers and policymakers, like the Ethiopian Health Insurance Service, have a cooperative and regulated relationship. Legislators create rules and policies that specify the extent of coverage, including the covered healthcare services that must be provided, service fees, and qualified beneficiaries. In turn, payers follow these rules while administering health insurance coverage, guaranteeing that the intended beneficiaries of the policy framework obtain the designated treatments at the regulated prices. A unified approach to health insurance is made possible by this organized relationship, which synchronizes coverage criteria with both financial sustainability and national health goals.

Maximizing health outcomes and guaranteeing fair access to healthcare services are the main goals of the partnership between patients (users) and policymakers, such as the Ethiopian Health

Insurance Service. To improve population health and well-being, policymakers create frameworks and policies that put patients' needs first. This entails establishing eligibility requirements, choosing benefit plans, and making sure that everyone can access and afford healthcare services. Policymakers govern service delivery in respect to providers (hospitals) through agreements they have made with these organizations. By following this rule, hospitals are guaranteed to provide the services that were agreed upon, uphold quality standards, and stay within the budgetary parameters specified in their contracts. Policymakers seek to preserve the integrity of the healthcare system by keeping an eye on performance and compliance, guaranteeing that patients receive the care they require while efficiently allocating funds and resources. In the end, this triadic link supports Ethiopia's healthcare system's overall sustainability and efficacy.

4.7. Insured Service Covered by CBHI in Ethiopia

At the health centre level, CBHI typically provides fundamental health service packages. Both inpatient and outpatient services are covered by the coverage. CBHI schemes cover all kinds of necessary medical services that would be paid for out of pocket in the event of illness (Ethiopia Scales Up Community-Based Health Insurance | HFG, n.d.).

The coverage of community-based health insurance (CBHI) plans varies based on the structure and environment of the program. But they cover a wide range of crucial medical services meant to advance primary care and attend to common health needs in the neighbourhood. The following are a few typical medical services that CBHI may offer:

1. **Preventive care**: To promote healthy behaviours and avoid diseases, preventive care services include vaccines, screenings (for diabetes, hypertension, cancer, etc.), and health education.
2. **Primary Health Care**: CBHI frequently covers primary care physicians' basic medical services, which include examinations, diagnoses, and treatments for common ailments and accidents.
3. **Maternal and Child Health Services**: Immunizations, growth monitoring, postnatal care, birthing, and prenatal care may all be covered.
4. **Essential Medicines**: A lot of CBHI plans cover essential medicines, guaranteeing that participants have access to the drugs they need to address a range of illnesses.

5. **Emergency Care**: Ambulance services, ER visits, and urgent care may all be covered under this type of coverage.
6. **Maternal and Child Health Services**: Immunizations, growth monitoring, postnatal care, birthing, and prenatal care may all be covered.
7. **Essential Medicines**: A lot of CBHI plans cover essential medicines, guaranteeing that participants have access to the drugs they need to address a range of illnesses.
8. **Emergency Care**: Ambulance services, ER visits, and urgent care may all be covered under this type of coverage.
9. **Rehabilitation Services**: For people recuperating from injuries or managing chronic ailments, coverage may include rehabilitation services including physical therapy, occupational therapy, and speech therapy.
10. **Mental health treatments**: A few CBHI plans cover psychiatric drugs, psychotherapy, and counselling, among other mental health treatments.

In Ethiopia, community-based health insurance (CBHI) plans may not usually cover the following services:

1. **Cosmetic procedures**: Plastic surgery and other elective cosmetic procedures are typically not covered because they are largely performed for aesthetic reasons.
2. **Non-essential therapies**: You might not be paid for services or treatments regarded as experimental or exploratory or not judged medically necessary.
3. **Expensive treatments**: Certain CBHI plans may restrict coverage of expensive procedures or treatments that cost more than a predetermined amount.
4. **Pre-existing conditions**: Certain plans may not cover pre-existing conditions for a set amount of time following enrolment.
5. **Alternative medicine**: Some services, like homeopathy or acupuncture, may not be covered because they are classified as complementary or alternative medicine.
6. **Prescription-free over-the-counter drugs**: Certain over-the-counter drugs might not be covered.
7. **Long-term care**: CBHI plans might not cover long-term care or nursing home care services.
8. **Dental and vision care**: more comprehensive or specialist services might not be covered, but certain fundamental dental and vision care services might (Teklehaimanot et al., 2016).

4.8. European health care insurance model and Ethiopian health insurance model

In many developing nations today, community-based health insurance (CBHI) programs are the main source of funding for medical care. These programs are often funded by general tax income or contributions from social insurance groups (Carrin, 2003). The CBHI program was established in Ethiopia as a community-based health project that collects member fees into a fund to pay for essential medical expenses. As a result, members have access to nearby medical facilities whenever they become ill (Ethiopia Scales Up Community-Based Health Insurance | HFG, n.d.).

There are various ways in which the Ethiopian health insurance model and the European health insurance model are different. European models, which strive for universal coverage and high-quality treatment, usually combine public and private insurance programs. Ethiopia, on the other hand, focuses on community-based health insurance (CBHI) to increase access, lower out-of-pocket costs, and raise the standard of care (Geta et al., 2023). While Ethiopia's CBHI has demonstrated notable improvements in health facility revenues, patient happiness, and treatment quality without increasing wait times (Debie et al., 2022). Furthermore, even with CBHI coverage, discrepancies in the use of contemporary health services remain in Ethiopia, highlighting the necessity of addressing variables like residency and educational attainment to improve service utilization and lessen inequities (Adam et al., 202).

4.9. European Health care Insurance model Vis-à-vis Ethiopian health insurance model

The health insurance systems in Ethiopia and the United States are very different from one another. The Community-Based Health Insurance (CBHI) program in Ethiopia strives to increase health care accessibility, lower out-of-pocket costs, raise funds, and raise the standard of care (Tefera et al., 2021; Shigute et al., 2020). Without significantly increasing wait times, the CBHI program in Ethiopia has demonstrated favourable effects on outpatient visits, patient satisfaction, quality of care, and health facility revenues (Shigute et al., 2020). However, United States has multiple health care systems that cater to various demographic groups rather than one. Most Americans are covered by commercial health insurance, but Medicare and Medicaid, two significant federal government health insurance programs, provide healthcare services for some of the poor and near-poor, respectively, and coverage for seniors and some disabled people. While this is a significant

increase over the 17% rate before the major elements of the Affordable Care Act were put into effect in 2014, about 10% of the population still lacks health insurance, which is exceptional for high-income nations (Rice et al., 2020).

In contrast to the diversified and multi-payer system in the US, the Ethiopian CBHI program places a strong emphasis on community engagement, financial security, and enhancing the quality of health services.

The researcher used funding mechanisms, scheme contents/health service coverage, scheme management/administration equity, accessibility, challenges, and opportunities as yardsticks to compare the USA health insurance model with the Ethiopian CBHI model.

1. **Source of Finance for health coverage**

USA Model: In the US, government programs like Medicare and Medicaid, employer-sponsored insurance, private health insurance, and out-of-pocket expenses are the main sources of funding for healthcare. Although it did not create a universal healthcare system, the Affordable Care Act (ACA) increased access to health insurance through Medicaid expansion and insurance exchanges (Davis et al., 2014). Enacted in March 2010, the Affordable treatment Act (ACA), also referred to as Obamacare, aims to lower healthcare costs in the US, improve treatment quality, and increase access to healthcare. Many of the ACA's main provisions went into force by 2014, drastically altering the healthcare system in the United States (Duston, 2016). The number of Americans with health insurance had climbed dramatically by the end of 2014. An estimated 10 million people obtained coverage because of Medicaid expansion and the health insurance markets (Garfield et al.,2019). With more people having access to preventive care and fewer people without insurance, the Affordable Care Act also improved health outcomes.

Ethiopian CBHI: A large section of the population does not have access to official health insurance, meaning that the country's healthcare system mostly depends on out-of-pocket expenditures. A sizable section of Ethiopia's population, according to current estimates, does not have access to government health insurance. As of 2020, about 86% of Ethiopians lacked health insurance, according to the Ethiopian Health Insurance Agency. This indicates that most healthcare treatments for around 90 million Ethiopians were paid for out of pocket. By combining resources

from member contributions and, in certain situations, additional government funding, community-based health insurance (CBHI) programs seek to offer financial security (FMOH, 2016a).

Although the effects can differ by location and demographic circumstances, Ethiopia's Community-Based Health Insurance (CBHI) initiatives have significantly reduced the percentage of the people without health insurance. Although it can be difficult to determine specific numbers about the percentage decrease in uninsured rates brought on by CBHI, the following important elements shed light on how successful these initiatives are:

When we examine the increase in coverage an estimated 13.5 million persons were covered by CBHI programs by 2020, which equates to roughly 10-12% of the overall population (roughly 90 million people) (Muleta et al., 2022). For people who previously relied only on out-of-pocket expenses, this signified a significant increase in access to health insurance (Tefera & Ayele, 2022).

Regarding the reducation in unsured rates About 86% of Ethiopians lacked health insurance prior to the introduction of CBHI. The percentage of people without insurance is thought to have dropped by roughly 10% to 12% since the implementation of CBHI, particularly in rural regions, as CBHI programs gained popularity (World Bank, 2017). Insured households are four times more likely to utilize modern health services compared to uninsured households (Geta et al., 2023). CBHI members reported an average of 2.09 outpatient visits per capita annually, significantly higher than non-members (Alemayehu et al., 2023). The overall CBHI enrollment in Ethiopia stands at approximately 45.5%, with rural areas showing higher engagement (Tahir et al., 2022, Habte et al., 2022).

2. The Scheme Contents

USA Model: Depending on insurance policies, healthcare coverage in the US varies greatly. While some people are covered by comprehensive employer-sponsored plans, others may only have limited coverage or not have insurance at all. Although the ACA sought to attain universal coverage, it was unable to increase coverage or provide essential health benefits (Davis et al., 2014).

Ethiopian CBHI: Primary care, maternity and child health services, and certain outpatient services are among the fundamental healthcare services that are usually the focus of CBHI

programs in Ethiopia. Depending on the scheme and its resources, coverage may change (FMOH, 2016a). Financial resources, administrative effectiveness, community involvement, policy support, and the makeup of the covered population are some of the interrelated factors that affect CBHI coverage in Ethiopia (The scheme depends on). For Ethiopia's rural and low-income inhabitants to have more complete health coverage and financial security, it is imperative that these areas be strengthened to increase the extent and caliber of CBHI services.

3. Scheme Management/Administration equity

USA Model: A combination of commercial insurance firms, governmental organizations such as the Centres for Medicare & Medicaid Services (CMS), and healthcare providers oversee healthcare management in the US. The administrative intricacy and substantial overhead expenses of the US healthcare system are frequently mentioned as obstacles (Health Insurance Coverage of the Total Population | KFF, 2021). Administrive intricacy implies that Private insurance companies, government programs (such as Medicare and Medicaid), hospitals, private clinics, and pharmaceutical corporations are some of the many entities that make up the U.S. healthcare system. Every organization has its own set of rules, regulations, and invoicing specifications. Because of this intricacy, healthcare professionals must deal with various billing codes, paperwork, and rules for every payer. For instance, hospitals must have specialized billing departments to manage the range of insurance claims and reimbursements, which makes the process convoluted and time-consuming. Patients frequently become frustrated and postpone care as a result of this complexity when attempting to comprehend their insurance coverage, co-pays, deductibles, and eligibility for different therapies (Cutler & Ly, 2011). About 25–30% of all healthcare spending in the United States is attributed to overhead costs related to this complexity, including marketing, coding, billing, and legal fees. This percentage is significantly greater than in other high-income nations with more efficient systems (Himmelstein et al., 2014). In addition to raising prices for insurers and patients, these overhead expenditures take resources away from providing direct patient care, which lowers the affordability and accessibility of healthcare services (Hackbarth, 2012).

Ethiopian CBHI: Community-based health initiative programs in Ethiopia are often run by regional associations or cooperatives. Volunteers from the community may assist with

administration, with assistance from NGOs and government organizations. The administration of the program oversees payments to healthcare providers (FMOH, 2016a).

4. Equity and accessibility of health services

USA Model: Several factors, including insurance coverage, income, geography, and institutional disparities, affect access to healthcare in the United States. Inequalities in health outcomes and access continue, especially for marginalized communities (Baciu et al., 2017). Socio-economic barriers and racial minorities are the two major factors contributed institutional disparities; Institutional inequities have a major impact on access to healthcare in the United States, especially for low-income and racial minority communities. Socioeconomic position, health insurance coverage, and institutional racism are some of the systemic barriers that contribute to these discrepancies and prevent equitable access to healthcare. These important points are covered in more detail in the sections that follow. According to a study, over 14% of Americans have limited access to healthcare facilities because of income differences, and low-income individuals frequently reside farther away from these services (Guo et al., 2022). Minorities have higher percentages of uninsured people due to economic restrictions; minority groups account for 62.3% of uninsured nonelderly adults (Pollock, 2024).

Systemic problems in maternal healthcare are highlighted by the fact that maternal morbidity rates among African American women are twice as high as those among white women (Sun, 2022). The disproportionate number of minorities among the uninsured is proof that institutional racism sustains healthcare disparities (Pollock, 2024).

Ethiopian CBHI: The goal of Ethiopia's CBHI programs are to increase access to healthcare, especially for underprivileged and rural communities. CBHI seeks to lower barriers to healthcare access and offer financial protection by combining resources at the community level (FMOH, 2016b).

5. Challenges and Opportunity

USA Model: Exorbitant expenses, intricate administrative procedures, and health disparities are just a few of the major issues facing the American healthcare system today. Comprehensive reforms aimed at reducing costs, increasing coverage, and enhancing health outcomes are needed to address these problems. Important areas for improvement are outlined in the sections that follow (Squires and Anderson, 2015). Despite having the largest per capita spending in the world, the U.S. healthcare system faces challenges with high out-of-pocket expenses and inefficiencies (Rice et al., 2020). Innovative strategies, such Methodist Le Bonheur Healthcare's "Power of One Idea" program, have shown promise for significant cost reductions through operational improvements and employee engagement, resulting in $17 million in savings (Wharton & Jacobs, 2023). Many Americans now have much better coverage thanks to the Affordable Care Act, but there are still gaps, especially for low-income groups (Rice et al., 2020). Since vulnerable groups are disproportionately affected by severe cost-sharing requirements, ongoing efforts are required to lower the uninsured rate (Rice et al., 2020).

Health disparities are exacerbated by healthcare delivery fragmentation, which calls for improved communication and integration between the public and private sectors (Lu & Young, 2023). To increase access and lower avoidable hospitalizations, reforms should give priority to primary care and preventive services, especially for low-income households (Goujard & Kergozou, 2023). Although these reforms offer a chance to create a healthcare system that is more equal, their implementation and efficacy may be impacted by the political climate, underscoring the necessity of consistent lobbying and cross-sector cooperation.

Ethiopian Model: The high incidence of communicable diseases, inadequate infrastructure, and scarce resources confront Ethiopia's healthcare system. Although CBHI offers a chance to increase healthcare access and harness community resources to fortify the health system, scalability and sustainability continue to be major obstacles (FMOH, 2016b).

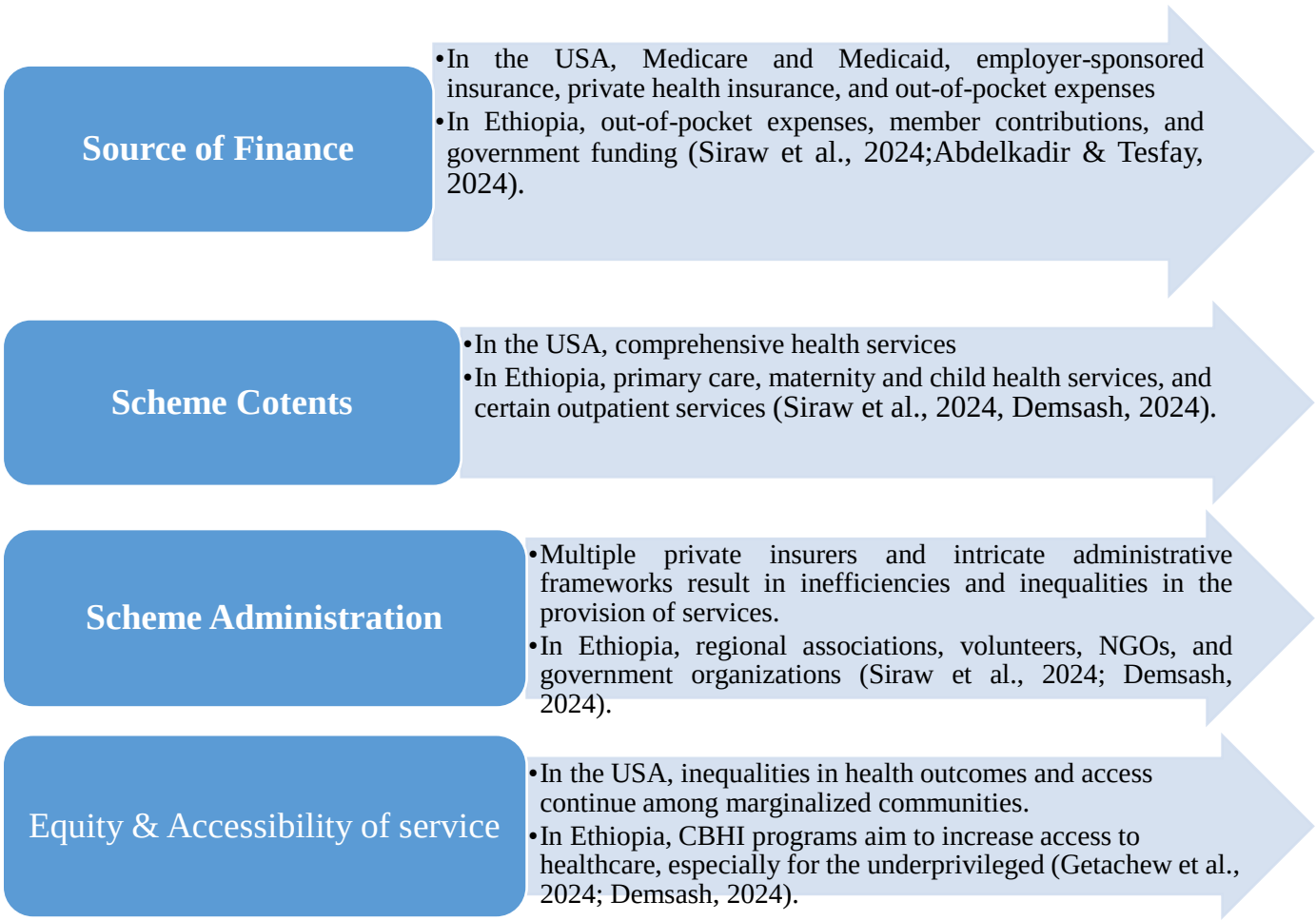

Fig4.10 USA model of insurance Vis-à-vis Ethiopian CBHI

Source: Compiled by the researcher (2024)

4.10. A comparative analysis of the health insurance systems in Ghana, Ethiopia, Rwanda, and Thailand

Ghana, Ethiopia, Rwanda, and Thailand were chosen for a comparative study of health insurance systems because of their different strategies for attaining universal health coverage (UHC) and the different obstacles they encounter. Every nation represents a different stage of the implementation of health insurance and provides a varied perspective on how well these systems work to improve healthcare outcomes and access.

Various Models of Health Insurance

Ghana: Research shows that insurance status does not significantly affect healthcare-seeking behavior in rural areas, despite the National Health Insurance Scheme's (NHIS) goal of lowering financial barriers (Kumah et al., 2024).

Ethiopia: Although finance and research capacity are still issues, Ethiopia has made progress in expanding health insurance coverage despite having a weak capacity for health policy research (Tangcharoensathien et al., 2022)

Maternal health treatment utilization is a problem in Rwanda, a country that is well-known for having an efficient health insurance policy. This illustrates the paradox that insurance does not always translate into better health outcomes (Malik & Alemu, 2023).

Thailand: As an example of how comprehensive insurance can improve access to healthcare services, Thailand's health system is frequently mentioned as a successful model for UHC (Fenny et al., 2021).

The attainment of UHC is hampered by issues that all four nations face, including fragmented insurance plans and inadequate coverage among disadvantaged people (Fenny et al., 2021). Finding best practices and lessons learnt through comparative analysis can help other low- and middle-income nations improve their policies. The complexity of healthcare access and utilization shows that insurance alone is insufficient to provide fair health outcomes, even though various nations' health insurance systems show differing degrees of success. The interaction between sociocultural elements and healthcare delivery systems in these settings requires more investigation.

Health insurance schemes in Ghana, Rwanda, Thailand, and other countries are not the same as Ethiopia's Community-Based Health Insurance (CBHI) program. Thailand's Universal Health Coverage (UHC) program offers all citizens comprehensive coverage, guaranteeing access to high-quality medical care and financial security (Shigute et al., 2020). Ghana's National Health Insurance Scheme (NHIS) attempts to lower financial barriers and increase access to healthcare; nonetheless, there are issues with service sustainability and quality (Tefera et al., 2021). The Mutuelles de Santé program in Rwanda emphasizes fairness and financial risk protection through community-based insurance (Mulat et al., 2022). However, in contrast to previous systems in Sub-Saharan Africa, Ethiopia's CBHI scheme has demonstrated success in improving health facility

income, quality of care, and patient satisfaction (Geta et al., 2023). Every nation has a different model that shows how it plans to solve healthcare issues and attain universal health coverage.

1. **Funding Mechanisms**

Thailand: The country has three main insurance programs that are funded by taxes: The Social Security Scheme (SSS) for employees in the formal sector, the Civil Servant Medical Benefit Scheme (CSMBS) for civil servants, and the Universal Coverage Scheme (UCS) for the majority of the population (Tangcharoensathien et al., 2018).

Ghana: The country's National Health Insurance Scheme (NHIS) is financed by a combination of government subsidies, designated taxes, and payments from employees in the formal sector. The impoverished and those employed in the unorganized sector are not required to pay premiums (Agyepong and Adjei, 2008).

Rwanda: The country runs the Mutuelles de Santé community-based health insurance program, which is financed by member payments, government grants, and outside funding. Most people are covered by the program, with the poorest people receiving exceptions (Lu et al., 2009).

Ethiopia: With a large percentage of the population without access to official health insurance, the country's healthcare system primarily depends on out-of-pocket payments. The goal of community-based health insurance (CBHI) programs is to offer financial security by combining resources from member contributions, which are occasionally augmented by government subsidies (FMOH, 2016b).

2. **Coverage**

Thailand: Primary care, hospital services, preventative care, and necessary prescription drugs are all covered by the country's comprehensive universal healthcare program. Except for some populations, like refugees, coverage is almost universal (Tangcharoensathien et al., 2018).

Ghana: Pregnancy care, inpatient and outpatient care, as well as certain medications, are all covered by the NHIS in Ghana. However, coverage may differ depending on the location and type of facility, and some services might not be available (Agyepong and Adjei, 2008).

Rwanda: Primary care, maternity and Pediatric healthcare, and certain outpatient services are all covered by the country's CBHI program. The entire population is intended to be able to afford and obtain coverage (Lu et al., 2009).

Ethiopia: Primary care, maternity and child health services, and certain outpatient services are among the essential healthcare services that are usually the focus of CBHI schemes in Ethiopia. Depending on the scheme and its resources, coverage may change (FMOH, 2016b).

3. **Scheme Administration**

Thailand: The Ministry of Public Health oversees the country's healthcare system, which is administered by a combination of public and private organizations. Numerous government departments and groups oversee insurance programs (Tangcharoensathien et al., 2018).

Ghana: The National Health Insurance Authority (NHIA), which oversees enrolment, premium collection, claims processing, and provider payment, oversees managing Ghana's NHIS. District and regional offices are involved in implementation as well (Agyepong and Adjei, 2008).

Rwanda: Local Mutual Health Insurance (MHI) schemes, overseen by community-based committees, are responsible for managing Rwanda's CBHI program. Supervision and assistance are given by the Ministry of Health (Lu et al., 2009).

Ethiopia: Community-based health initiative (CBHI) programs are often run by local cooperatives or NGOs. Volunteers from the community may assist with administration, with assistance from NGOs and government organizations. The management of the plan oversees payments to healthcare providers (FMOH, 2016b).

4. **Accessibility and Equity**

Thailand: Regardless of wealth or location, all Thai people should have fair access to healthcare services thanks to the country's universal healthcare program. Disparities in care quality and accessibility, however, continue, especially for disadvantaged groups (Tangcharoensathien et al., 2018).

Ghana: The National Health Insurance Scheme (NHIS) of Ghana seeks to give poor and vulnerable people better access to healthcare services and lower financial obstacles. Nonetheless, obstacles, including uneven healthcare facilities across regions and delays in claim processing, might affect accessibility (Agyepong and Adjei, 2008).

Rwanda: The country's CBHI program has greatly increased access to medical care, especially for those living in rural areas. By lowering rates for the lowest-income people and guaranteeing that services are inexpensive and available to all participants, the program fosters equity (Lu et al., 2009).

Ethiopia: The goal of CBHI programs there is to increase access to healthcare, especially for underprivileged and rural communities. CBHI seeks to lower barriers to healthcare access and offer financial protection by combining resources at the community level (FMOH, 2016b).

5. Challenges and Opportunities

Thailand's healthcare system faces difficulties with financing, unequal resource distribution, and rising medical expenses. Among the areas that could use improvement are personnel shortages, improving health information systems, and bolstering primary care (Tangcharoensathien et al., 2018).

Ghana: Concerns about sustainability, inefficiencies in the processing of claims, and problems with care quality are among the challenges facing Ghana's NHIS. There are prospects for enhancement in terms of revenue collection, governance and accountability, and coverage expansion to disadvantaged people (Agyepong and Adjei, 2008).

Rwanda's healthcare system has difficulties related to inadequate funding, a shortage of health personnel, and insufficient facilities. Enhancement prospects encompass fortifying health funding systems, allocating resources towards the advancement of healthcare personnel, and broadening the reach of specialized services (Lu et al., 2009).

Ethiopia's healthcare system has difficulties due to a high prevalence of communicable diseases, inadequate infrastructure, and scarce resources. Although CBHI offers a chance to increase

healthcare access and mobilize community resources to fortify the health system, scalability and sustainability continue to be major obstacles (FMOH, 2016a).

The European healthcare insurance model, which differs from nation to nation but frequently combines public and commercial systems, is contrasted with Ethiopia's health insurance model, with a special emphasis on community-based health insurance (CBHI):

1. **Source of Funding**

European Model: Primarily financed by employer contributions and taxes, guaranteeing a wide financial foundation. This is known as the European model. Governments frequently have a big say in how healthcare is financed, regulated, and offered to citizens and residents through insurance.

Ethiopian Model: Most people in Ethiopia do not have access to official health insurance; hence, the country's healthcare system primarily depends on out-of-pocket expenses. CBHI programs pool resources through member payments and, in certain situations, add government subsidies to give communities financial protection. Funded through premiums paid by community members, often supplemented by government support, which can limit financial sustainability (Abdelkadir & Tesfay, 2024).

2. **Reportage of the service**

European Model: Primary care, hospital care, prescription medication, and occasionally dental and eye care are among the many services that are covered by healthcare in European nations. In general, coverage varies in depth and is available to all citizens and residents. **Ethiopian Model**: Primary care, maternity and child health services, and certain outpatient treatments are among the fundamental healthcare services that are typically the focus of CBHI programs in Ethiopia. Depending on the scheme and its resources, coverage may change (Getachew et al.,2024).

3. Health Care/ Scheme Administration

European Model: Managed by national or regional health authorities, ensuring standardized care across regions. In Europe, the administration of health insurance is typically centralized or semi-centralized, and state regulatory frameworks frequently guarantee the provision of high-quality and equitable healthcare. For instance, Germany has a fragmented system of statutory health insurance funds, whereas the United Kingdom's National Health Service (NHS) functions under a single national system (Thomson et al., 2013).

Ethiopian Model: Community-based health insurance programs in Ethiopia are usually run by regional cooperatives and administered at the community level (Siraw et al.,2024). Usually, CBHI programs are run locally, with finances being managed by cooperatives or other local organizations. Although more direct community involvement is possible with this decentralized strategy, quality and efficiency may vary (FMOH, 2016a).

Equity and Accessibility of health service

European Model: To promote equity and solidarity, European healthcare systems typically seek to offer healthcare services to all citizens. The goal of the egalitarian European health systems is to provide universal coverage with low out-of-pocket costs. Subsidies for low-income people are one way to guarantee access for vulnerable groups (Thomson et al., 2013).

Ethiopian Model: CBHI programs aim to increase underprivileged and rural communities' access to healthcare services. CBHI seeks to lower barriers to healthcare access and offer financial protection by combining resources at the community level.

4. Challenges and Opportunities

European Model: Aging populations, differences in access to and quality of care, and growing healthcare expenses are potential issues facing European healthcare systems and Long wait periods also make it difficult for some nations to get timely care (Thomson et al., 2013). To solve these issues, opportunities exist in utilizing technology, enhancing productivity, and encouraging preventive care. Enhancing productivity (Reducing expenses) and lessening the effects of healthcare worker shortages can be achieved by increasing personnel productivity through

automation, training, and optimized workflows. In order to maximize service delivery, this also entails effective resource allocation (European Observatory on Health Systems and Policies, 2017).

Ethiopian Model: The high incidence of communicable diseases, inadequate infrastructure, and scarce resources confront Ethiopia's healthcare system. Although CBHI offers a chance to increase healthcare access and mobilize community resources to fortify the health system, scalability and sustainability continue to be major obstacles.

Overall, Ethiopia's health insurance model, particularly CBHI, emphasizes community involvement, financial protection, and basic service coverage that is tailored to local needs and resources. In contrast, the European healthcare insurance model tends to be more comprehensive and centrally administered, with a focus on universal access and social solidarity.

4.11. The Current state of Health care Infrastructure in West shew zone

There are several issues and potential areas for development with the West Shewa Zone's healthcare system in Ethiopia. Research conducted in the area has brought attention to several topics, including preconception care, medication inventory management, and maternal satisfaction with labour and delivery services. Preconecption care refers to a series of prenatal health interventions given to women and couples to enhance the health of both mothers and unborn children. Risk factors that may affect subsequent pregnancies are evaluated, counseled, and managed as part of this care. Preconception care covers a range of topics, such as mental health, chronic disease management, dietary status, lifestyle choices, and physical health (WHO, 2013). Improving preconception care is crucial for bettering the health of mothers and children. Low awareness, insufficient prenatal testing, and a lack of reproductive health education are among the current issues. By filling these gaps, community health initiatives may be able to enhance family planning methods and prevent difficulties for mothers and newborns (Bekele et al., 2020).

Around 60.8% of mothers were said to be satisfied with the delivery services, with issues including support during childbirth, accessibility, and cleanliness (Bulto et al., 2020; Deressa et al., 2022). A review of pharmaceutical inventory management showed that a goods accounted for the bulk of all pharmaceutical expenditures, underscoring the need for improved control and management (Fekene et al., 2020). Furthermore, only 14.5% of women used preconception care, showing a

deficiency in the promotion of health and wellbeing before pregnancy (Argawu & Erana, 2023). All these results point to the necessity of extensive upgrades to the West Shewa Zone's healthcare system and service provision.

The West Shewa Zone's health outcomes are significantly influenced by the quantity and caliber of its medical facilities. Maternal satisfaction with delivery services in public health facilities is important, and total satisfaction is influenced by things including the availability of services and cleanliness (Etea et al., 2023). Furthermore, empowered pregnant women exhibit better nutritional status during pregnancy, which is another important factor in enhancing maternal nutrition outcomes (Argawu & Erana, 2023). Additionally, given that the degree of dissatisfaction with antenatal care services was found to be relatively high, it is imperative that pregnant women feel satisfied with these services. This underscores the need for enhanced communication and care quality in healthcare facilities (Bekele et al., 2023). To guarantee that necessary pharmaceuticals are available for the population's medical needs, effective pharmaceutical inventory management in these healthcare facilities is also vital (Deressa et al., 2022).

In the West Shewa Zone, several initiatives have been put in place to improve access to healthcare services. Different aspects have been the focus of both government and non-governmental organizations. The government has addressed issues including cleanliness and the availability of facilities to increase mother satisfaction with delivery services (Argawu & Erana 2023). Furthermore, efforts have been undertaken to safeguard healthcare personnel at public hospitals by offering PPE and assistance (Chaka et al., 2022). Initiatives have also been made to support the provision of respectful maternity care throughout labor and delivery, with a focus on elements such as informed consent and decision-making engagement (Etea et al., 2023). In addition, obstacles to the use of maternal health services in rural areas have been noted, such as ignorance, false information, and transportation issues (Bulto et al., 2020). The goal of these coordinated initiatives is to improve West Shewa Zone access to and delivery of healthcare services overall.

4.12. Summary of this chapter

To increase access and quality, the Ethiopian government is putting several healthcare reforms into effect. Aiming to remedy problems in the healthcare system are programs like the Private Health Sector Program (PHSP) and Community Based Health Insurance (CBHI); The goal of Private health sector program is to increase and fortify the role of the private healthcare industry

in providing medical care. The program reduces the burden on public health facilities and expands access to healthcare, particularly in impoverished areas, by collaborating with private physicians. To guarantee that private healthcare institutions offer reasonably priced, high-quality care, PHSP supports capacity-building programs, quality enhancement, and regulatory control. To improve access to healthcare, it is also recommended that Social Health Insurance (SHI) be made mandatory for workers in the formal sector which is optional and not yet implimented. Ethiopia has improved its healthcare system significantly through strategic efforts, staff training, and infrastructural development. Access to healthcare has increased, especially in rural regions, thanks to the building of several health facilities nationwide and the training of health extension agents. Public-private partnerships complement this strategy by enhancing service delivery, leveraging resources, and bolstering the resilience of the health system.

The Primary Healthcare Transformation Initiative (PHTI), which aims to improve management and leadership at the local level, is one noteworthy initiative. The program has enhanced healthcare institutions' managerial capabilities through focused training and assistance, which has improved patient outcomes and the efficiency of healthcare delivery. Improved health center operations and health professionals' capacity to effectively address community health needs are two examples of PHTI's influence (Federal Ministry of Health, 2020). These developments demonstrate Ethiopia's dedication to putting public health first and creating a long-lasting healthcare system that can meet the demands of its people.

Poor data quality, inadequate infrastructure, staffing shortages, and restricted spatial access are some of the obstacles to receiving healthcare services in Ethiopia. To solve these problems, the Health Sector Transformation Plan places a strong emphasis on the use and quality of data, investments in new medical facilities and workforce, and the equitable growth of the healthcare system. Data falsification, redundant data collection instruments, inadequate infrastructure for health information systems, and managerial concerns were among the obstacles encountered during the Health Sector Transformation Plan's initial phase. The plan sought to boost the private health sector, address equality in Maternal, Newborn, and Child Health (MNCH) policy, and increase data quality and utilization Healthcare services for mothers and children have greatly improved because of the HSTP. Ethiopia has lowered maternal and infant death rates through programs like increased prenatal care, skilled birth attendance, and vaccination campaigns. The

plan's main objective has been to improve and extend the nation's healthcare system, particularly by constructing new hospitals and health centers in underprivileged areas. Millions of people now have better access to healthcare because to this expansion, which has also addressed geographical imbalances and increased service coverage, especially in rural and isolated areas. The HSTP launched extensive health worker training and recruitment initiatives to overcome staffing shortages, especially for health extension workers (HEWs), who are essential to providing primary care. This has reinforced Ethiopia's community-based health strategy, which is crucial for early intervention and preventive care, and increased the availability of qualified staff in different locations. Because of the HSTP's emphasis on data quality and utilization, health information management has advanced. Decision-making was enhanced, and data discrepancies were decreased with the advent of digital tools and methodical data collection techniques. These modifications have made it easier to track health outcomes and allocate resources, which has resulted in more informed and responsive healthcare delivery. To increase service capacity and lessen the strain on public facilities, the HSTP promoted collaborations with private health providers, acknowledging the importance of the private sector. Both urban and rural people have benefited from this partnership's efforts to increase service quality and accessibility, which has strengthened the healthcare system's resilience.

Through programs like the Connected Woreda idea, capacity building, and performance monitoring teams, the plan aimed to improve data quality and use. It also sought to do away with data fabrication and address equity through in MNCH policies; this was done via data verification and quality control measures: to detect and lessen cases of data fabrication, the HSTP established stringent data verification procedures and quality inspections throughout healthcare facilities, training and capacity building: To inform administrators and healthcare professionals about the value of data integrity, the HSTP placed a strong emphasis on capacity-building initiatives, Connected Woreda Program and Digital Health Initiatives: The Connected Woreda (degitalizing health records).

Given the increasing public health burden of diseases like cancer, diabetes, cardiovascular disease, and chronic respiratory conditions, Ethiopia's Health Sector Transformation Plan (HSTP) established specific goals to reduce important risk factors linked to noncommunicable diseases (NCDs). Given how urbanization and dietary changes continue to impact health outcomes in

Ethiopia, this revision recognizes the growing incidence of lifestyle-related diseases as a serious problem.

Ethiopia's Woreda Transformation plans seek to improve Ethiopia's competitiveness, resilience, and vulnerability reduction while fostering sustained economic growth. The plans are cantered on sustainable development, poverty alleviation, and infrastructure development. Important components of the Woreda Transformation include community-based health insurance, high-performing primary health care facilities, and Model Kebeles.

The Health Sector Transformation Plan's second phase seeks to improve public health via woreda modernization, emergency preparedness, universal health coverage, and increased responsiveness of the healthcare system. Its main themes are equity and quality, the digital revolution, skilled workers, healthcare finance, and leadership. The Health Sector Transformation Plan II's overall efficacy is greatly impacted by the implementation of community-based health insurance (CBHI). Membership in CBHI improves health outcomes, reduces financial risk, and increases use of health services. Because it reduces healthcare costs and improves health outcomes, it is consistent with the plan's objectives. The implementation of Community-Based Health Insurance (CBHI) and the potential and problems facing the healthcare system are the main topics of discussion in this chapter of the report on Ethiopia's efforts to reform its healthcare system. It emphasizes how crucial it is for CBHI programs to have national backing, engage the community, and deal with budgetary challenges.

This chapter also makes comparisons between the health insurance systems in Ghana, Rwanda, and Thailand, as well as European health insurance models and the Ethiopian CBHI model. In Ethiopia's health insurance model, it highlights the need for community involvement, financial security, and customized service coverage. It also covers Ethiopia's Health Sector Transformation Plan, which attempts to enhance healthcare quality and accessibility through programs like the Private Health Sector Program and CBHI. It draws attention to the difficulties encountered during the plan's first phase as well as the second phase's main objectives, which include enhanced healthcare system responsiveness, emergency readiness, and universal health coverage. The significance of community-based strategies, decentralization initiatives, and the inclusion of mental health and reproductive health services in primary care are also mentioned. Overall, the paper highlights the difficulties and endeavours involved in Ethiopia's health care reform, with an emphasis on enhancing healthcare services' accessibility, quality, and equity.

This chapter has covered Ethiopia's current efforts to reform the country's health care system, with a focus on the introduction of Community-Based Health Insurance (CBHI) programs and the Health Sector Transformation Plan. It highlights how crucial customized service coverage, financial security, and community involvement are to the accomplishment of these programs. The difficulties encountered in putting the changes into practice are also covered in the document, as is the necessity of ongoing efforts to increase equity, quality, and access to healthcare services. All things considered, it shows how determined the Ethiopian government is to modernize the medical system and enhance the general health and welfare of its people.

Chapter 5: Data presentation and Analysis

5.1. Demographic characteristics of the respondents

Three hundred seventy-eight respondents participated in this study's survey question. The sample distribution shows that, among 378 CBHI members, 197 were males, which represents 52.12% of the sample and 181 were females, representing 47.88% of the sample. From the percentage indicated in Table 5.1, one can compute that the membership and participation of the family in the CBHI are almost the same as those of the male. In most developing countries, it is very difficult to access health care services for marginalized groups of the community and for women. However, the CBHI is changing this trend in most developing countries, for instance in Ethiopia. According to the 2019 Mini Ethiopian Demographic and Health Survey, community-based health insurance is essential to enhancing reproductive-age women's access to healthcare in Ethiopia (Handebo et al., 2023).

Women's access to healthcare services and financial protection is greatly enhanced by community-based health insurance (CBHI) (Handebo et al., 2023; Thomas et al., 2022; Getahun et al., 2023; Musa et al., 2022; Koch, 2022). Studies from Ethiopia and India emphasize that women have distinct challenges in acquiring health insurance, and community involvement activities can boost their utilization of health insurance. In Ethiopia, factors like family size, household head gender, and geography influence women's membership in health insurance. Overall, community-based health insurance schemes are vital for ensuring women's financial security and access to quality healthcare services, contributing significantly to the objective of universal health coverage. This objective can be meet via collective risk sharing, women, who often face economic disadvantages and higher healthcare needs, can benefit from this shared risk, making healthcare more affordable, affordable premiums and comprehensive coverage.

Concerning the age of the respondents, out of 378 total respondents, 67 were over 61 years old, which represents 17.72% of the sample. Whereas 57 of them were found between 51 and 60 years old, which represents 15.08 percent of the sample. While 94 of them and 116 of them were between 41 and 50 and 31 and 40 years old, respectively, the rest of the percentage is held by respondents ages 18–30 years old. This implies that as people get older, they are more inclined to enrol in the CBHI.

Age is a major factor when applying for and using community-based health insurance (CBHI). Research conducted in Ethiopia indicates that older people are more likely to sign up for CBHI,

especially those who are 35 years of age or older (Belayneh, 2023; Handebo et al.). Age groups between 35 and 54, 55 and 74, and 75 and older are linked to greater rates of CBHI utilization (Musa et al., 2022). Furthermore, those over 60 who are exposed to the media are more likely to sign up for health insurance (Moyehodie et al., 2022). These results imply that age has a role in the decision to participate in CBHI, as older people have higher participation rates. Understanding the influence of age on enrolment is essential in formulating focused tactics to enhance CBHI coverage, particularly in the elderly demographic.

The adoption of Community-Based Health Insurance (CBHI) is influenced by age. Research indicates that people aged 30 to 49 years old are more likely to follow health insurance plans (Ntube et al., 2023). Younger spouses who are under 60 years old are also more likely to sign up for CBHI for senior family members (Archibong et al., 2023). On the other hand, reproductive-age women in Ethiopia who are in the age range of 20 to 34 years old are less likely to enroll in health insurance than younger women (Handebo et al., 2023). In addition, in Katsina State, Nigeria, the average age of CBHI-enrolled households was higher than that of non-enrolled households, suggesting a possible relationship between age and CBHI utilization (Achibong et al., 2023). These results underscore the significance of considering age demographics when advocating for and executing CBHI initiatives.

Table 5.1 Sample distribution by Gender and Age

Demographic Vraiable	Category	Frequency (n)	Percetage (%)
Gender	Male	197	52.12
	Female	181	47.88
Age	18-30	44	11.64
	31-40	116	30.69
	41-50	94	24.87
	51-60	57	15.08
	61+	67	17.72

Source: Own survey data (2024)

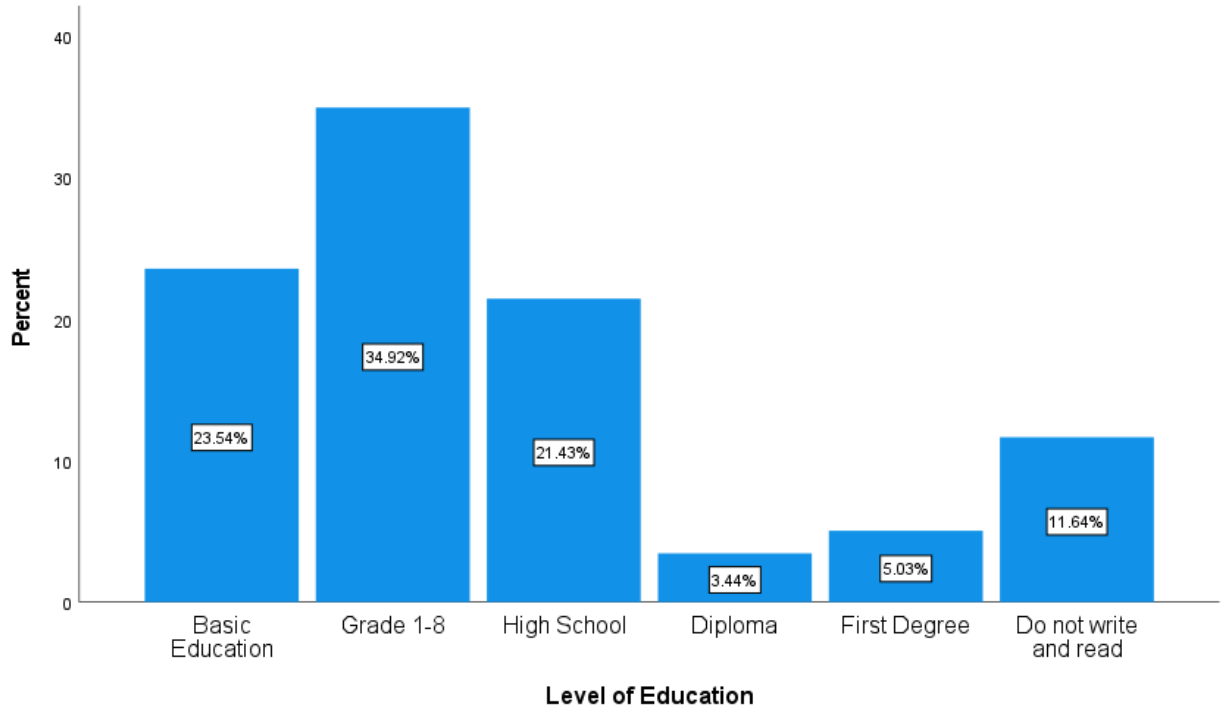

Fig 5.1 Sample distribution by Level of education

Source: Own survey data (2024)

In terms of level of education, most respondents (56.35%) completed primary and secondary school, whereas only 44 (11.6%) of them were not able to write or read. Having formal education is very important for CBHI enrolment and to have high knowledge levels and awareness of CBHI. This finding is supported by other findings conducted in Ethiopia and Indonesia.

A major factor in the efficiency and uptake of community-based health insurance (CBHI) programs is education. Research from Indonesia and Ethiopia demonstrates how schooling affects CBHI. According to a survey conducted in Indonesia's Umbulsari B sub-village, most respondents had high knowledge levels and answered knowledge points accurately (Hafidz et al., 2023). Similarly, in Ethiopia, awareness and credit availability were found to be important determinants of insurance coverage under CBHI systems, in addition to education (Mussa et al., 2023). Furthermore, a study carried out in Ethiopia's Gida Ayana district discovered that insured households were four times more likely to use contemporary health services, highlighting the beneficial impact of CBHI on minimizing differences in healthcare consumption according to educational attainment (Asfaw et al., 2022).

Additionally, higher education levels are linked to a greater understanding of CBHI programs, which increases the enrolment and use of health services (Odima et al., 2023). A family's history of illness, understanding of the program, and opinion of the insurance system all have an impact on how effective CBHI is (Elegbede et al., 2022). All things considered, education plays a critical role in determining how effective community-based health insurance (CBHI) is by raising people's awareness, knowledge, and engagement levels, which in turn helps these programs succeed.

Thus, education is essential to improving awareness, participation, and healthcare utilization within CBHI programs.

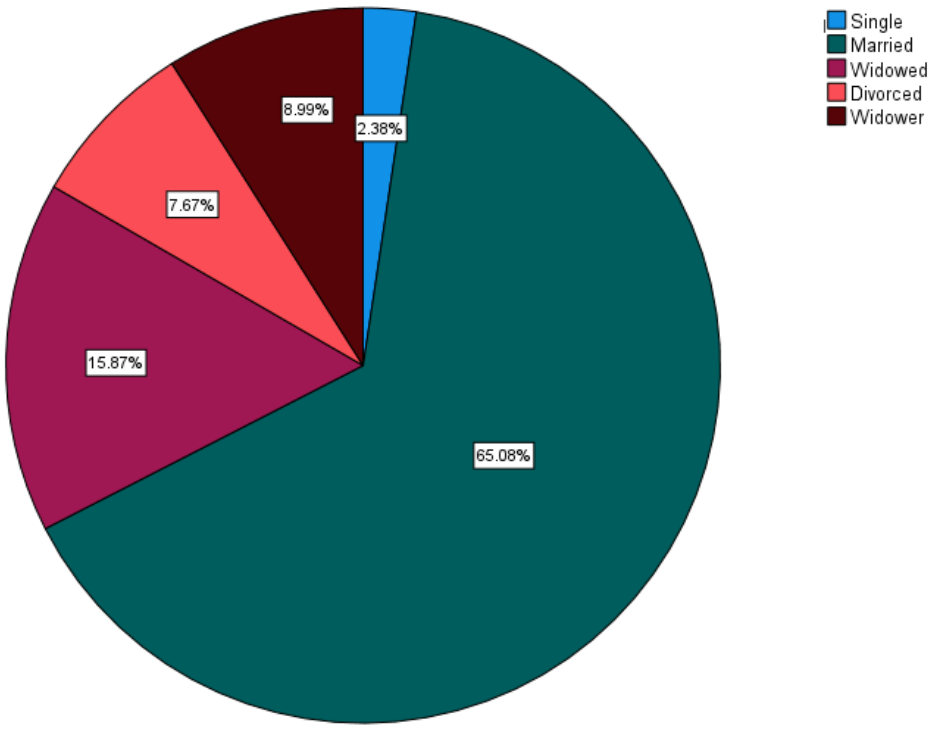

Fig 5.2 Sample distribution by Martial status

Source: Own survey data (2024)

Concerning the martial status of the respondents' majority, 246 (65.08%) of them were married. From this, we can conclude that the majority of CBHI members were married.

When discussing Community-Based Health Insurance (CBHI), one important factor is marital status. Research indicates that those who are married experience greater health and well-being than

single people do. Marriage is linked to better survival rates for several diseases, including colorectal neuroendocrine neoplasms and cervical cancer (Desi et al., 2014; Mastekaasa, 1993). Furthermore, studies show that hospitalization patterns are influenced by marital status, with married women with insurance having higher hospitalization rates than women without insurance, even when their morbidity patterns are similar (Xiao et al., 2020). The complexity of the relationship between marital status and health in the context of CBHI, including elements like treatment options, social support, and healthcare access, highlights the significance of considering marital status when developing healthcare policies and interventions (Patel et al., 2010).

A major factor in community-based health insurance programs is marital status. Marital status is a predictor of when people will leave these schemes, according to research (Hussien et al., 2022), with married people adhering to these programs for longer. This research implies that a person's marital status affects how long these insurance programs can last. Furthermore, research conducted by Bodhisane and Pongpanich (2017) indicates that insured families, regardless of their marital status, have better access to healthcare services and are less likely than uninsured households to experience a financial catastrophe. Therefore, regardless of marital status, having insurance offers better access to healthcare and financial security, even though it may shorten the length of participation in community-based health insurance schemes. Financial protection from unforeseen medical costs is provided by health insurance, which can be disastrous for uninsured people and families. CBHI plans assist in protecting participants from the financial shocks related to medical expenses by distributing the financial risk among members (Habib et al.,2016).

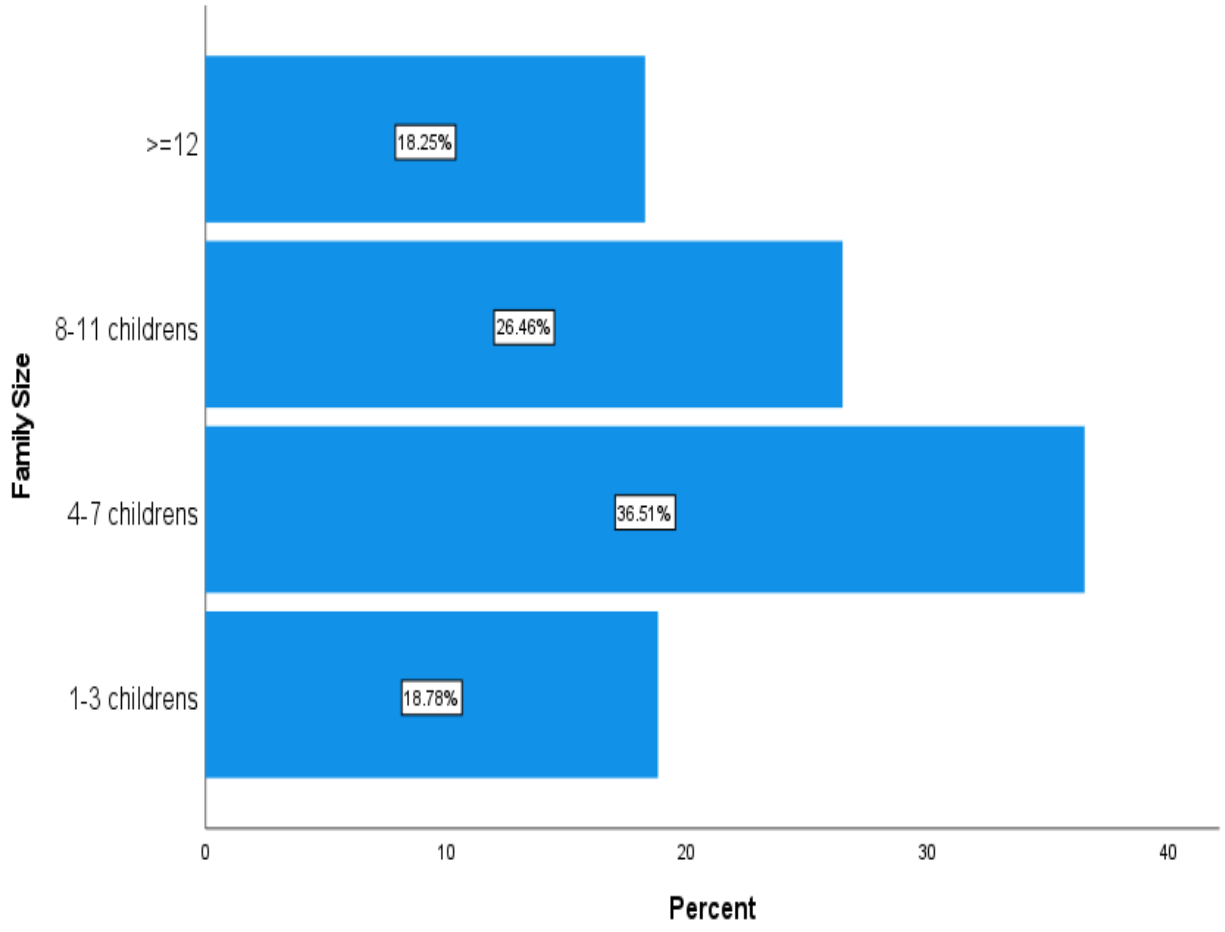

Fig 5.3 Sample distribution by family size

Source: Own survey data (2024)

In terms of the family size of the respondents, all of them have children, and among this, 307 of them, which accounts for 81.5% of the sample, have four or more children. Family size is significantly associated with CBHI enrolment and renewal of membership. Family size plays a crucial role in determining the level of participation in community-based health insurance.

The number of children and the use of community-based health insurance (CBHI) are significantly correlated. Larger families are positively correlated with CBHI membership renewal (Gashaw et al., 2022), CBHI utilization (Geta et al., 2023), and appropriate healthcare-seeking behaviour among CBHI users (Belayneh, 2023). According to studies conducted in a variety of circumstances, more specifically, households with four or more members are more likely to use CBHI systems for healthcare services. This association can be explained by larger families having

more healthcare demands, which encourages them to sign up for and maintain CBHI memberships. To improve healthcare access and utilization among communities with diverse family sizes, it is imperative that the requirements of larger families be considered within the CBHI framework. There is a stronger need for health insurance coverage among households with more dependents, as seen by their higher enrolment in CBHI schemes (Moyehodie et al., 2022). To protect themselves from future medical expenses, families with more members typically prioritize health insurance, which makes CBHI more accessible and inexpensive for them (Daraje, 2022). This emphasizes how crucial it is to consider family size when developing and executing CBHI programs to guarantee inclusivity and efficacy in offering healthcare coverage to households with a range of dependents.

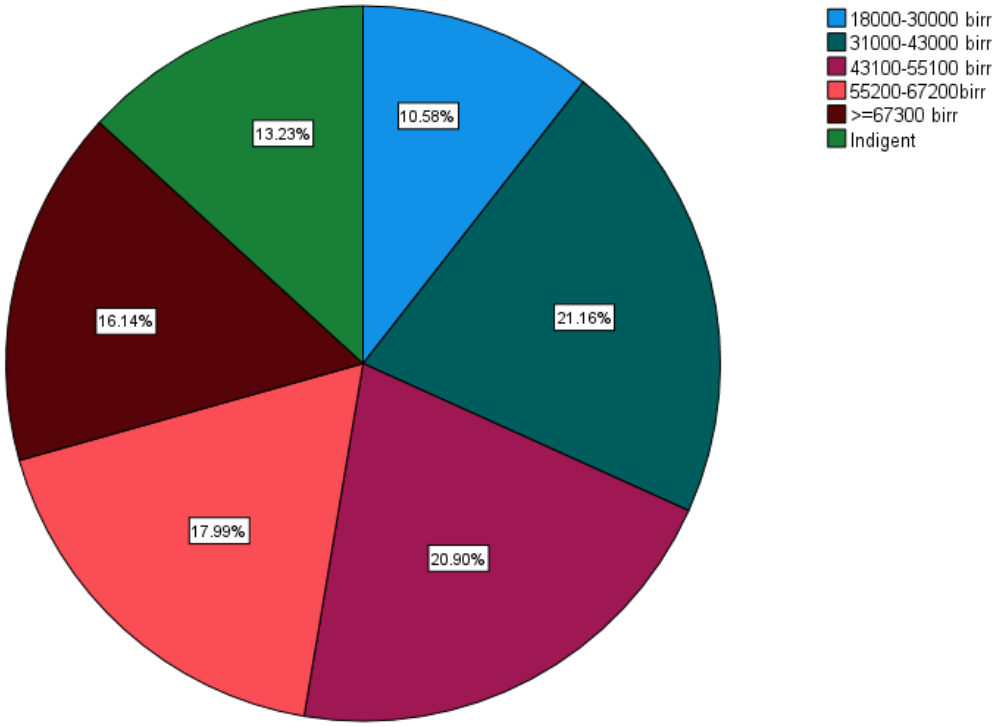

Fig 5.4 Sample distribution by income Level per year

Source: Own survey data (2024)

Concerning the income level of the sample respondents, 318 of them have their own income, which accounts for 86.8% of the sample of respondents, whereas 50 (13.23%) of them do not have their own monthly or yearly income. They are living with the aid and SafetyNet program of the government, and they are non-paying members of CBHI, hence they are assessing the health

service freely without paying the health insurance premium. This implies that there are high income disparities among CBHI members.

The willingness to pay (WTP) for community-based health insurance (CBHI) significantly correlates with income level. Income level was found to be a predictor of WTP for CBHI in studies conducted in Lahore and Ethiopia, with lower-income households being less inclined to pay for such schemes (Sana, 2020; Sam, 2020). Furthermore, studies conducted in rural Rwanda revealed that, even in the presence of CBHI, there are still persistent differences in household catastrophic health spending and medical care utilization between residents in poverty and those who are not, suggesting that income disparities have an impact on healthcare affordability and access (Geta et al., 2023). Further highlighting the complex interaction between income, health insurance, and healthcare outcomes is a Ugandan study that stressed the significance of including environmental health in CBHI to address the health issues low-income people experience (Liu et al., 2019).

CBBHI members are supposed to pay. A minor annual premium payment of 500 Ethiopian Birr (about US$10) is paid by members, while dependents who are older than 18 pay a reduced charge of 240 Ethiopian Birr (around US$5).

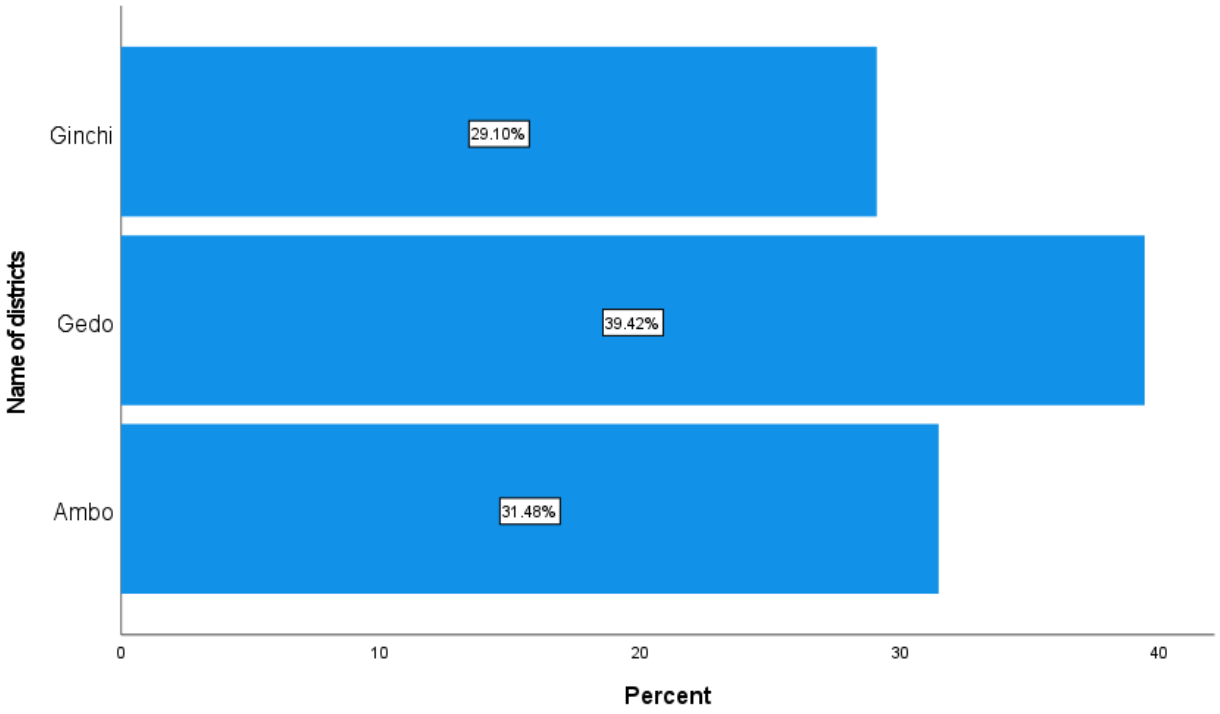

Fig 5.5 Sample distribution by Districts where the respondents are living

Source: Own survey data (2024)

This data was collected from households living in Oromiya National Regional State, West Show Zone, and three districts were selected randomly. As the data in Fig. 5.5 shows, among the total respondents, 119 were from Ambo, which accounts for 31.48% of the sample, and 149 were from Gedo, which represents 39.42% of the sample, whereas 110 were from Ginchi, which represents 29.10. Since 2013, the Ethiopian government has been working on scaling up CBHI to expand the scheme to different parts of the region. According to Mussa et al. (2023), the use of healthcare services in Ethiopia rose dramatically once CBHI was extended to 770 districts. Most of the respondents considered in this research live in rural parts of the districts.

The main demographics that CBHI programs in Ethiopia aim to serve are low-income and rural people who might not have access to official health insurance programs (Tahir et al., 2022; Tefera and Ayele, 2022; Mulat et al., 2022; Kaso et al., 2022).

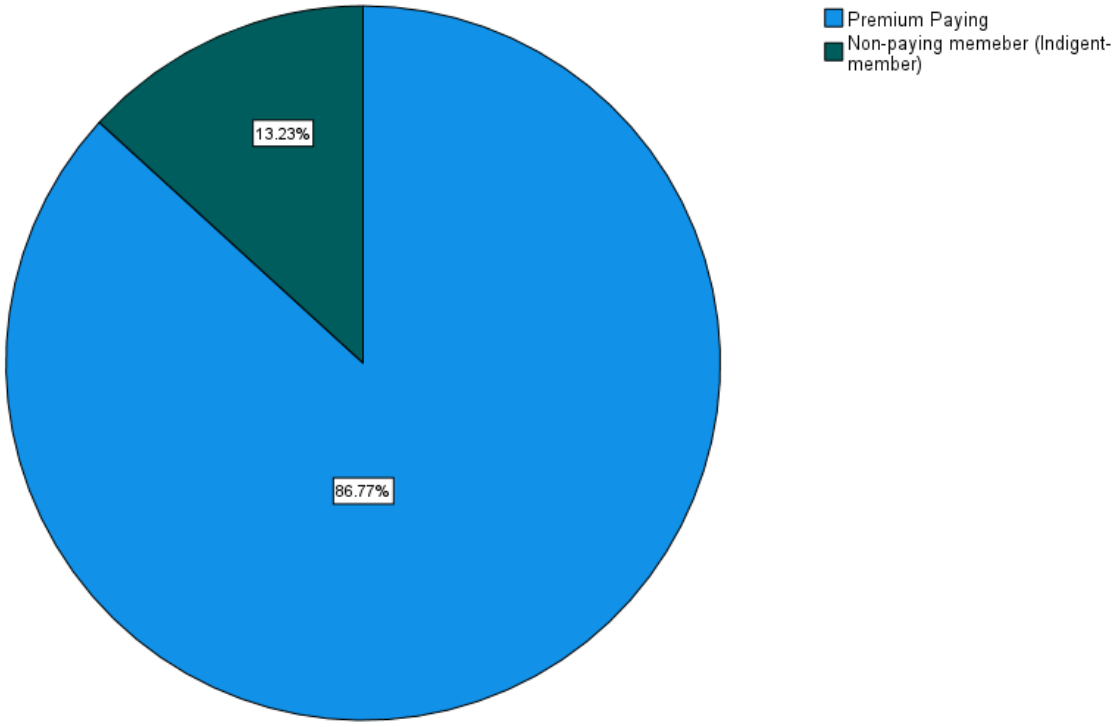

Fig 5.6 Sample distribution by CBHI membership type

Source: Own survey data (2024)

Regarding the type of CBHI membership, of the total respondents, 328 are premium-paying members, which accounts for 86.8% of the sample, whereas 50 of them are non-paying members of CBHI (ultra-poor). The cost of these non-paying members (the ultra-poor) is covered by the federal and regional governments through the general subsidy budget. This implies that most of the respondents are fee-paying members, which has a positive impact on the CBHI pooling scheme and sustainability. CBHI is also not left behind by the marginalized group in the community.

The kind of Community-Based Health Insurance (CBHI) membership, whether paying or non-paying (poor), has a big influence on Ethiopians' use of health care services and financial security. Better health, lower catastrophic health costs, and more outpatient department visits are all experienced by paying members, which improves their financial security against medical expenses (Daraje, 2022; Degefa et al., 2023; Zepre, 2023). However, non-paying members of the CBHI also gain from it because it protects them from unforeseen medical expenses, improves their health, and provides insurance for their families, all of which lessen dropout rates and increase the scheme's sustainability (Alemayehu et al., 2023). Promoting universal health coverage and

lowering the prevalence of catastrophic health expenditures among households, especially those with chronic conditions, require both kinds of membership to be very effective (Mussa et al., 2023).

One of non-paying member of CBHI in the open-ended questioner she stated that

I am a non-paying member of CBHI (Ultra-Poor). I have admitted one of my 2-year-old babies here at Ambo General Hospital. They are treating her by giving her medication; they saved her life. The main challenge is that there is a shortage of medicines within the hospital, so they usually tell me to buy from a private pharmacy. I am asking for help from the people to buy medicines for the baby, and ultimately, when I ask the CBHI authority for refunding the money, they are not giving me back (CBHI beneficiaries at Ambo Hospital).

Differential access to healthcare services between paying and non-paying members can potentially lead to variations in health outcomes. To guarantee that each member experiences equitable health outcomes, it is critical to track and resolve any disparities.

Both types of membership play a crucial role in promoting universal health coverage and reducing the incidence of catastrophic health expenditures among households, particularly those with chronic conditions (Mussa et al., 2023).

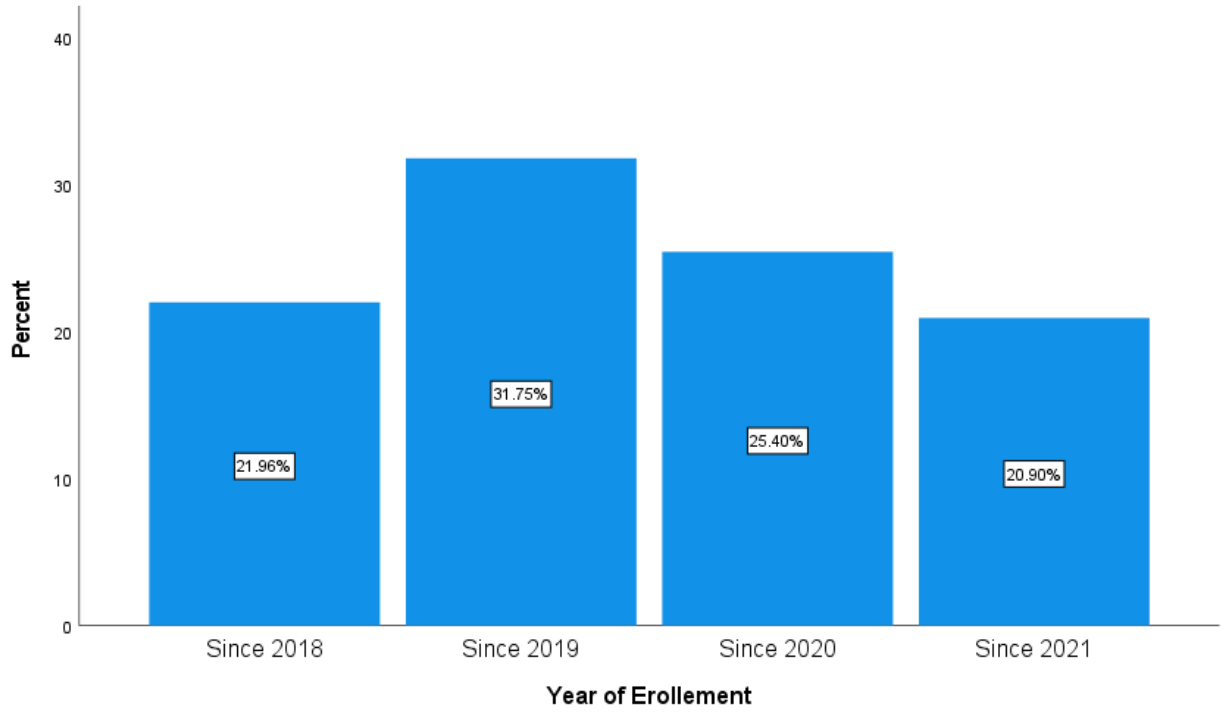

Fig 5.7 Sample distribution by enrolment year in CBHI

Source: Own survey data (2024)

Regarding the year of membership enrolment, of the total respondents, 83 of them have been members of CBHI since 2018, which accounts for 22% of the sample. Whereas 120 (31.7%) have been enrolled in CBHI since 2019, 96 (25.4%) and 79 (20.9%) of them have been enrolled since 2020 and 2021, respectively. The year of enrolment varies across each district.

This implies that respondents have experience and know how to provide genuine information for this study.

5.2. Implementation of CBHI and challenges hindering it

Table 5.2 Challenges facing CBHI implementation

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
The quality of healthcare services under CBHI coverage can be inconsistent, leading to member dissatisfaction.	378	1	5	4.06	1.107
Inadequate infrastructure and healthcare facilities in certain regions impact the effectiveness of CBHI.	378	1	5	4.15	1.056
The process of claims reimbursement within CBHI systems can be complex and time-consuming.	378	1	5	4.40	1.177
Lack of awareness about CBHI options hinders enrolment among community members.	378	1	5	4.35	1.124
Limited healthcare provider networks are hindering access to quality services under CBHI.	378	1	5	4.39	.936
CBHI programs struggle to accommodate the diverse healthcare needs of the community.	378	1	5	4.03	1.268
Limited understanding of insurance concepts and procedures has made it difficult for the community to engage with CBHI.	378	1	5	4.05	1.111
Valid N (listwise)	378				

Source: Own survey data (2024)

In the above table, 5.2 beneficiaries were asked to respond to the fact that the quality of healthcare services under CBHI coverage can be inconsistent, leading to member dissatisfaction. As a result, the data below represents beneficiary input regarding the challenges of CBHI.

Two factors were considered to determine the point for each key component: the weight assigned to each significant element and the score assigned to each significant element within the factor. A perfect score of 5 would indicate that you strongly agree with the element; a score of 4 would indicate that you agree with it; a score of 3 would indicate that you are neutral; a score of 2 would indicate that you disagree; and the final score would be 1 (strongly disagree) and would yield 1 mark.

The mean value (n) for quality of health services is 4.06, which indicates that most of the respondents strongly agree that there is inconsistent quality of health service provision as a member of CBHI, causing dissatisfaction among CBHI members. This inconsistency in the quality of services is leading to dissatisfaction among CBHI members. Essentially, the findings suggest that CBHI members are experiencing varying levels of service quality, which affects their overall satisfaction with the health insurance scheme. This could imply issues such as uneven distribution of resources, differences in healthcare provider performance, or variability in service delivery standards within the CBHI framework. Addressing these inconsistencies is crucial for improving member satisfaction and the overall effectiveness of CBHI programs.

The main factors that lead to inconsistent quality of health provision are the small fragmented risk pool at the district level; CBHIs are set up as separate programs, which leads to disparities in contribution rates and coverage. The second one is inadequate financial resources because of poor funding, low enrolment rates, poor financial management, cheap premiums, and a lack of government assistance (EHIA, Provider Affairs, and Quality Assurance Senior Officer).

There are various findings that support this finding, among them:

Community-based health insurance (CBHI) programs may be severely impacted by inconsistent quality of care (Hussien et al., 2022; Tefera et al., 2021). Research has demonstrated that CBHI enrolment and retention are significantly influenced by healthcare quality (Lakew et al., 2023). The introduction of CBHI is intended to increase access to healthcare and decrease out-of-pocket expenses; nevertheless, several localities have reported difficulties, including low diagnostic test capacity, insufficient drug supply, and inadequate service quality standards (Gashaw et al., 2022). Additionally, it has been discovered that there are notable differences between CBHI and non-

CBHI districts in terms of elements like provider-client communication and client satisfaction (Bayked et al., 2023). To ensure beneficiary satisfaction and advance universal health coverage, addressing these disparities in service quality discrepancies is imperative to improve the efficacy and sustainability of CBHI programs.

There are several reasons listed in the study articles for the uneven service quality in community-based health insurance programs. This problem is exacerbated by issues with health care quality, insurance holders' reimbursement of claims, governance procedures, acceptance, and community awareness (Hussien et al., 2022). In addition, factors that have been identified as influencing the consistency and quality of services in community-based health insurance schemes include low community engagement, inadequate infrastructure, low awareness, restricted benefit packages, high premiums, low-quality healthcare services, shortages of supplies, and a lack of incentives for healthcare providers (Odima et al., 2023; Gashaw et al., 2022). Improving the quality and sustainability of community-based health insurance programs requires addressing these issues through focused interventions and improved policies.

Concerning the availability of infrastructure, the data found in the above table 5.1 shows that the average value of the respondents is 4.15. The research result shows that most respondents believe that inadequate infrastructure is negatively impacting the effectiveness of community-based health insurance (CBHI) in the West Showa Zone. This means that essential components such as health facilities, medical equipment, transportation, and basic utilities may be insufficient or substandard. Such inadequacies hinder the delivery of quality healthcare services, making it difficult for CBHI programs to operate effectively and meet the needs of their members. As a result, the overall effectiveness of the CBHI in providing accessible and reliable healthcare is compromised, leading to potential dissatisfaction among the insured community. Improving infrastructure would be key to enhancing the performance and trustworthiness of the CBHI system in the region.

The following previously conducted studies support the result of this study:

The efficacy of Community-Based Health Insurance (CBHI) programs are greatly impacted by inadequate infrastructure and healthcare facilities. Studies conducted in Uttarakhand, India, Nigeria, and Zambia show how inadequate infrastructure affects healthcare delivery. Patients with mental illnesses in Zambia have suffered, as has society at large, from a lack of adequate health facilities (Chilufya, 2022). Like this, insufficient infrastructure in Nigeria, such as a lack of hospital beds and a variable electrical supply, makes it difficult to successfully execute healthcare

programs, including CBHI initiatives (Joshi et al., 2020). Moreover, vulnerability evaluations conducted in Uttarakhand underscore the significance of seismic resilience in healthcare establishments to avert post-earthquake disturbances that may compromise the operation of CBHI programs (James et al., 2008). Thus, closing infrastructural gaps is essential to improving the usability and efficacy of CBHI programs across different areas.

One major obstacle to the success of community-based health insurance (CBHI) programs in Ethiopia is the deficiency of infrastructure in healthcare institutions. The effective application of CBHI is hampered by inadequate infrastructure, which includes bad internet connections, tight budgets, and outdated management techniques (Namomsa, 2023). The report also emphasizes how healthcare facilities lack the infrastructure to set up local area networks that work and the personnel to maintain digital technologies (Mekonen and Tedla, 2022). This insufficient infrastructure affects the calibre of services offered under CBHI by causing ancillary issues such as medication shortages, drawn-out reimbursement procedures, and a high patient volume (Getachew et al., 2022). The inadequate infrastructure in healthcare institutions undermines the efficacy of the CBHI program, even while it improves access to healthcare and lowers out-of-pocket costs (Tefera et al., 2021).

Regarding the process of claim reimbursement, the data in the above Table 5.1 show that the research results indicate that respondents perceive the claim reimbursement process in the Community-Based Health Insurance (CBHI) system as moderately complex and time-consuming. This means that, while the process is recognized as having some difficulties and delays, it is not seen as extremely problematic. The moderate rating suggests that there are notable issues with how claims are processed, such as bureaucratic hurdles, paperwork, or lengthy approval times, that could be improved to enhance efficiency. However, these issues are not overwhelmingly severe, indicating that there is room for improvement but that the process is somewhat manageable as it stands. Simplifying and streamlining the reimbursement process could potentially lead to greater satisfaction and more efficient service for CBHI members. There are various studies conducted in different countries that support this finding, among them:

Community-based health insurance (CBHI) program members may suffer negative effects from intricate and drawn-out claims reimbursement procedures (Mussa et al., 2023). Healthcare facilities may experience financial strain because of reimbursement delays, which could compromise their long-term viability and efficiency (Asfaw et al., 2022). This can, therefore,

impair the standard and availability of vital health services for participants in the program (Ranson et al., 2007). Furthermore, the financial management of healthcare institutions may suffer due to reimbursement delays, which could impact the system (Nasage, 2020). It is imperative to tackle these obstacles by guaranteeing the prompt and efficient distribution of claims to preserve the credibility and efficiency of CBHI programs in offering fair and universal access to medical care (Nshakira-Rukundo et al., 2019).

Communities may be significantly impacted by intricate and time-consuming claims reimbursement procedures (Lim, 2005; Modlin and Wilson, 2007; Collie et al., 2015; Ranson, 2002; Ranson et al., 2007). Among these effects are difficulties in guaranteeing equitable remuneration for providers because it is hard to assess health care outcomes using claims data. Such procedures may also have an impact on patient happiness, the sustainability of compensation schemes financially, and the general effectiveness of health care utilization in local communities. For example, patients may have financial hardships because of reimbursement delays, which may lead to expensive hospital stays and destitution. Therefore, to lessen these negative effects and guarantee improved healthcare outcomes as well as financial stability within communities, it is imperative to streamline and enhance the effectiveness of claims reimbursement systems.

In terms of how lack of awareness about CBHI options hinders enrolment among community members, the average value of the respondents was 4.35. This shows that lack of awareness about Community-Based Health Insurance (CBHI) options is a significant factor contributing to low enrolment rates in the West Showa Zone. This means that many potential enrolees are either unaware of the existence of CBHI programs or do not have enough information about how these programs work, their benefits, or how to enrol. This lack of awareness acts as a barrier, preventing people from taking advantage of CBHI schemes. Improving outreach and educational efforts to raise awareness about CBHI options could help increase enrolment and ensure that more people can benefit from the insurance and the health services it provides. This conclusion is supported by several studies that have been done in many nations on the impact of a lack of awareness on not enrolling in the CBHI.

Lack of awareness of CBHI schemes, misunderstandings about the program, and insufficient information campaigns were factors affecting not enrolling in the CBHI (Archibong et al., 2023; Odima et al., 2023).

Enrolment in Community-Based Health Insurance (CBHI) is greatly impacted by a lack of knowledge about available options (Daraje, 2022; Khuwaia et al., 2021). Low enrolment rates are caused by several factors, including inadequate knowledge of the program, unaffordable premiums, and deceptive marketing by dropouts (Archibong et al., 2023). Furthermore, the significance of financial literacy and awareness in augmenting the real payments for CBHI is underscored, underscoring the necessity of enhancing community comprehension of the program (Preker and Dror, 2020). Additionally, the study conducted in Northwest Ethiopia highlights the favourable correlation between awareness and enrolment rates and identifies knowledge and information (awareness) on CBHI as critical elements determining enrolment (Atafu and Know, 2018). Therefore, to increase CBHI participation rates and guarantee greater access to healthcare services, raising awareness through efficient communication tactics and community engagement is crucial.

Concerning healthcare provider networks in CBHI, the research results indicate that a significant majority of respondents, with a mean score of 4.29 on a scale (presumably out of 5), believe that a limited healthcare provider network is a major hindrance to accessing quality services under the Community-Based Health Insurance (CBHI) scheme in their areas. This high mean score reflects a strong consensus among the respondents that the scarcity of healthcare providers within the CBHI network restricts their ability to receive adequate and timely medical care. This limitation can lead to longer travel distances, extended waiting times, and potentially lower quality of care, ultimately undermining the effectiveness of the CBHI program in delivering its intended benefits to the community. Expanding the network of healthcare providers participating in CBHI could significantly improve access to quality health services for the insured members. There are studies conducted in the USA and Uganda that support this result.

Access to high-quality treatments may be impacted by narrow healthcare provider networks, such as those seen in Community-Based Health Insurance (CBHI) programs. Studies on CBHI programs, such as Uganda's Kisiizi Hospital CBHI, show that although these initiatives lower out-of-pocket costs and increase access to healthcare, there are still obstacles because of small networks (Vargas et al., 2015). Comparably, research on limited network plans in the US reveals that although they can reduce costs by shifting money from downstream to primary care, they may limit patient access to specialists and hospital care (Schleicher et al., 2016; Gruber and Mcknight, 2016). This implies that while restricted networks may be financially advantageous, they may also

impair the quality of services provided by CBHI schemes and make it more difficult for patients to receive specialized care.

Concerning the respondent's response rate to CBHI programs on accommodating the diverse health care needs of the community, the data found in 5.1 shows that the respondents agreed that the services covered by the scheme are not comprehensive. The main reasons why the CBHI program fails to accommodate the diverse health care needs of the community are due to competing demands from society, and most of the services covered by the scheme are not comprehensive health services, limited coverage, a poor health system, a failure to ensure financial sustainability, and a lack of quality of health care services.

There are few studies that support the result of this findings.

Ethiopian Community-Based Health Insurance (CBHI) systems struggle to provide for the wide range of healthcare demands of the populace. The willingness to pay for CBHI programs is high, but many households would find it difficult to cover the premiums (Kaso et al., 2022). Ethiopia's overall CBHI enrolment coverage is just about 45%, which is less than the 80% national target (Tefera and Ayele, 2022).

Ethiopian Community-Based Health Insurance (CBHI) initiatives struggle to meet the wide range of healthcare demands in the area. These issues include underserved and rural populations, as well as restricted coverage of services, particularly for chronic diseases and specialized care. Concerns over the availability of qualified healthcare professionals, the sufficiency of infrastructure, and medical supplies are among the other problems with the quality of treatment offered under CBHI systems (Zarepour et al., 2023; Geta et al., 2023).

Regarding the level of understanding of insurance concepts and engagement with CBHI, the data in the above table 5.1 shows that most respondents agree that a limited understanding of the concepts and procedures of community-based health insurance (CBHI) contributes to low community engagement in the CBHI program. This suggests that many community members lack adequate knowledge about how CBHI works, its benefits, and the steps required to enrol in and utilize the services. This knowledge gap results in less participation and involvement in the CBHI scheme, as people may feel uncertain, sceptical, or uninterested in joining due to their lack of understanding. Addressing this issue through targeted education and awareness campaigns could help increase community engagement, ensuring that more individuals can benefit from the insurance program and the healthcare services it provides. Community engagement with

Community-Based Health Insurance (CBHI) schemes is negatively impacted by a lack of awareness of insurance ideas and procedures. Research indicates that insufficient understanding of CBHI results in reduced enrolment rates (Odima et al., 2023; Desalegn et al., 2023).

Generally, the CBHI faced several major obstacles, including uneven healthcare service quality, poor facilities and infrastructure, a difficult and drawn-out claim reimbursement process, and a lack of knowledge about CBHI alternatives, which prevented people from enrolling. With a restricted network of healthcare providers, CBHI programs struggle to provide for the diverse healthcare needs of the population; inadequate understanding of insurance concepts and procedures has hindered community involvement with CBHI.

5.3. Person correlation between awareness campaign and CBHI implementation

Table 5.3. The relationship between creating awareness of community on CBHI and Implementation of CBHI

Correlations

		CBHI Implementation	There is enough awareness and knowledge about CBHI among residents in the West Shewa Zone.
CBHI Implementation	Pearson Correlation	1	.571**
	Sig. (2-tailed)		.000
	N	378	378
There is enough awareness and knowledge about CBHI among residents in the West Shewa Zone.	Pearson Correlation	.571**	1
	Sig. (2-tailed)	.000	
	N	378	378

**. Correlation is significant at the 0.01 level (2-tailed).

Source: Own survey data (2024)

The Person correlation between CBHI implementation and community's awareness and knowledge on CBHI is 0.51 which implies that positive and moderate correlation.

The sig. (2-tailed) value is less than 0.05 which CBHI implementation and community's awareness and knowledge creation is significantly correlated. The research results indicate that there is a Pearson correlation coefficient of 0.51 between the implementation of Community-Based Health Insurance (CBHI) and the community's awareness and knowledge of CBHI. This value implies a positive and moderate correlation. In practical terms, it suggests that as the community's awareness and knowledge about CBHI increases, the effectiveness of CBHI implementation also tends to improve, and vice versa. However, the correlation is moderate, meaning that while there is a significant relationship, other factors also play a substantial role in the implementation success of CBHI. Enhancing community awareness and knowledge about CBHI is likely to positively impact its implementation, but additional strategies may be needed to address other influencing factors.

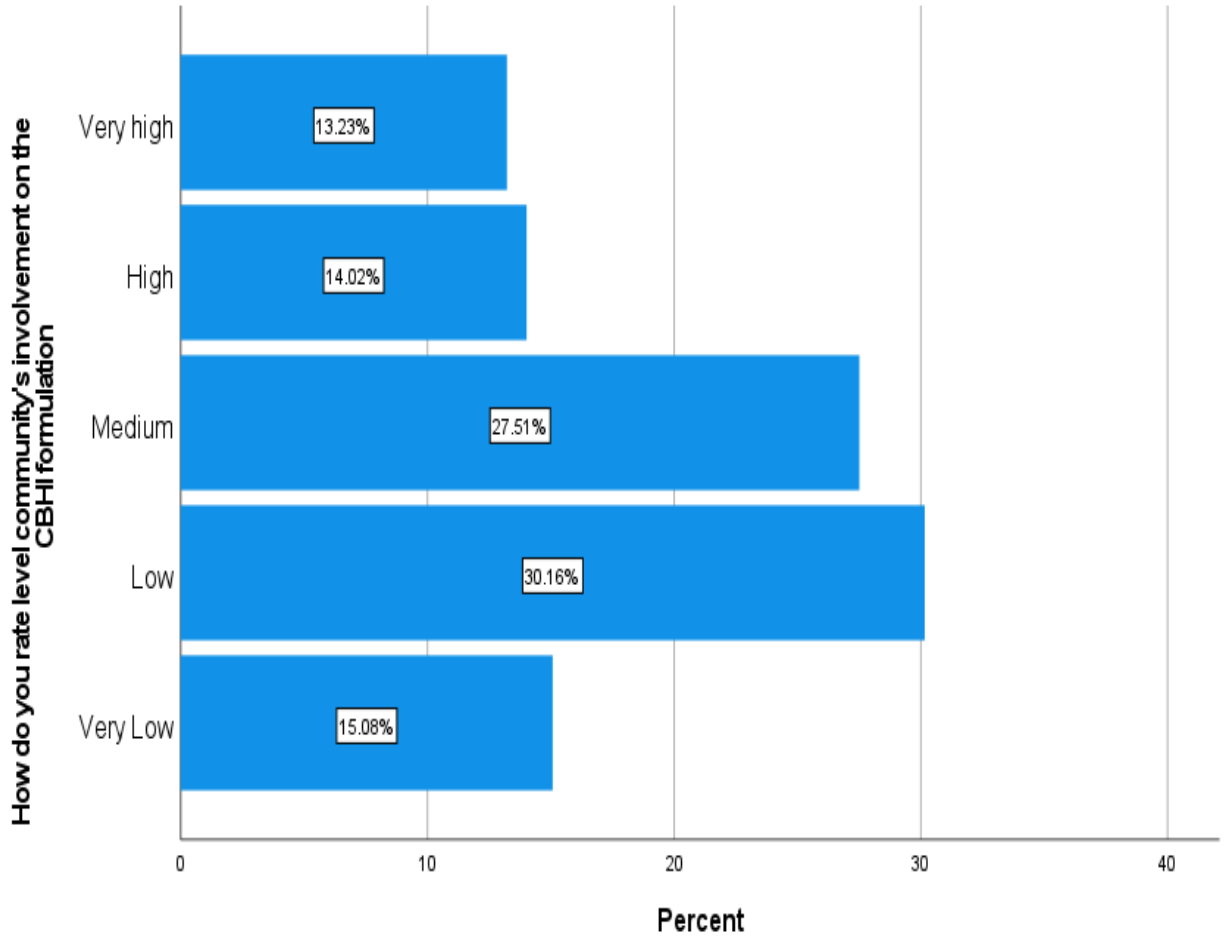

Fig 5.8 Sample distribution by involvement level of the community in the CBHI formulation

Source: Own survey data (2024)

The research results, as depicted in Figure 5.8, show disparities in the level of community involvement in the formulation of Community-Based Health Insurance (CBHI) policies. This means that the extent to which different community members or groups participate in the development and planning of CBHI varies significantly. Some segments of the community might be more actively involved, providing input and helping shape the CBHI policies, while others are less engaged or entirely excluded from the process. These disparities can lead to an uneven representation of community needs and priorities in CBHI policies, potentially affecting the program's overall effectiveness and equity. Addressing these disparities by promoting more inclusive and participatory approaches could enhance the relevance and acceptance of CBHI

policies among all community members. This is due to the CBHI settings in which strategy formulation is a top-down approach, in which the target population or members of the CBHI may not get an opportunity to directly participate in the process of its strategy formulation.

There are various studies conducted in different countries that support this finding, among them:

The degree of community participation in the development of Community-Based Health Insurance (CBHI) varies depending on the context. CBHI programs in Nigeria have encountered difficulties such as low participation rates and inadequate community involvement (Odima et al., 2023). Comparably, in Colombia, user associations meant to encourage citizen participation in healthcare organizations frequently suffer from a lack of active public participation and public knowledge, which compromises their efficacy (Bolivar-Vargas et al., 2022).

Other studies identified that both demand- and supply-side challenges are responsible for varying the level of the community's involvement in CBHI.

The level of community involvement in designing Community-Based Health Insurance (CBHI) schemes varies across different contexts. Research indicates that although there is a desire to engage in CBHI (Bolivar-Vargas et al., 2022; Sana et al., 2020), there are obstacles such as low awareness (Mebratie et al., 2013), the exclusion of the extremely poor (Ebrahim et al., 2019), and the restricted efficacy of user associations (Mebratie et al., 2013). The following variables affect community involvement: health, income, education, and awareness of CBHI benefits. Raising public knowledge of the advantages of CBHI is essential to improving community involvement. Furthermore, the target population's involvement in the planning and execution of CBHI programs is crucial to their success. Overall, increasing community involvement in CBHI design will require resolving awareness gaps and ensuring inclusivity, even though there is a willingness to engage.

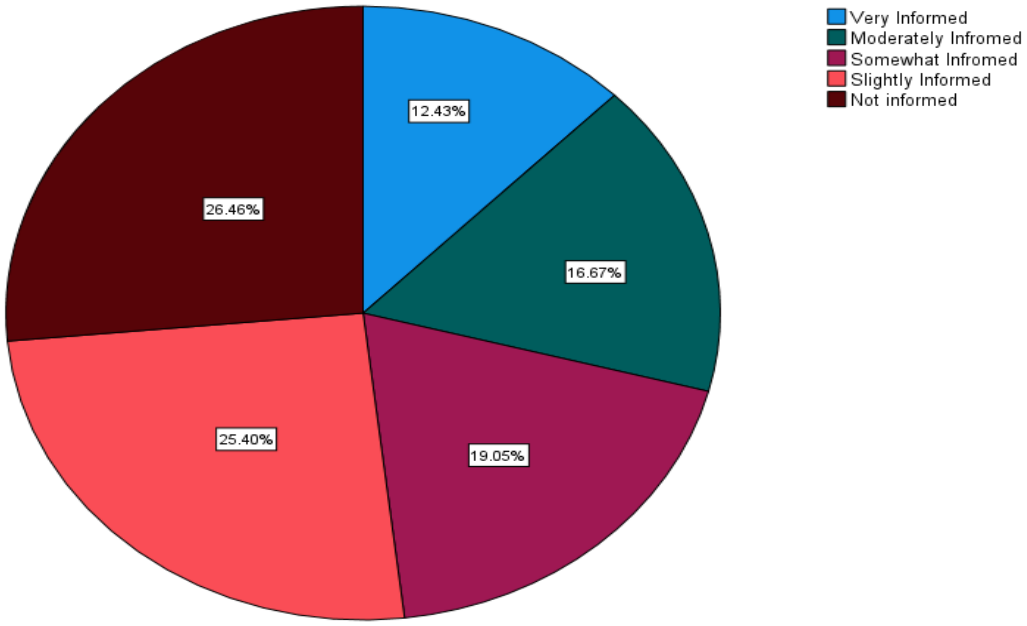

Fig5.9 Sample distribution on level of community's awareness on decisions made during the formulation of the CBHI strategy

Source: Own survey data (2024)

Concerning respondents' awareness of decisions made during the formulation of the CBHI strategy, as shown in Fig. 5.9 The research results indicate significant disparities in the community's awareness about the decisions made during the formulation of the Community-Based Health Insurance (CBHI) strategy. Specifically, 44.45% of the respondents have poor awareness of these decisions, while 26.46% are completely unaware of them. This means that over 70% of the community lacks adequate knowledge or information about the CBHI formulation process and the decisions that have been made.

Such a high level of unawareness suggests a communication gap between policymakers and community members. This gap can lead to a lack of trust, reduced engagement, and potential resistance to the CBHI program, as community members may feel excluded or uninformed about important developments that affect them. Enhancing transparency, improving information dissemination, and actively involving the community in the decision-making process could help address these disparities and foster a more inclusive and well-informed community, ultimately leading to a more successful CBHI implementation.

There are various studies conducted in different countries, like Nigeria, Cameroon, and Ethiopia, that support this finding.

Various regions have various levels of community awareness regarding decisions made during the development of Community-Based Health Insurance (CBHI) programs. Research from Ethiopia Wortley et al. (2016), Nigeria Noubiap et al. (2014), and Cameroon Odima et al. (2023) shows that community members levels of awareness differ. Only 1.2% of workers in Cameroon's informal sector were enrolled in a CBHI scheme, indicating little knowledge of these programs among this group (Workneh et al., 2017). On the other hand, despite low awareness, a sizable percentage of traders in Nigeria showed a solid understanding of CBHI programs, indicating the possibility of higher membership with further effort (Sujarwoto & Maharani, 2020). The relatively high degree of compliance with CBHI regulations in Ethiopia suggests that community members have a certain understanding of and adherence to the plan.

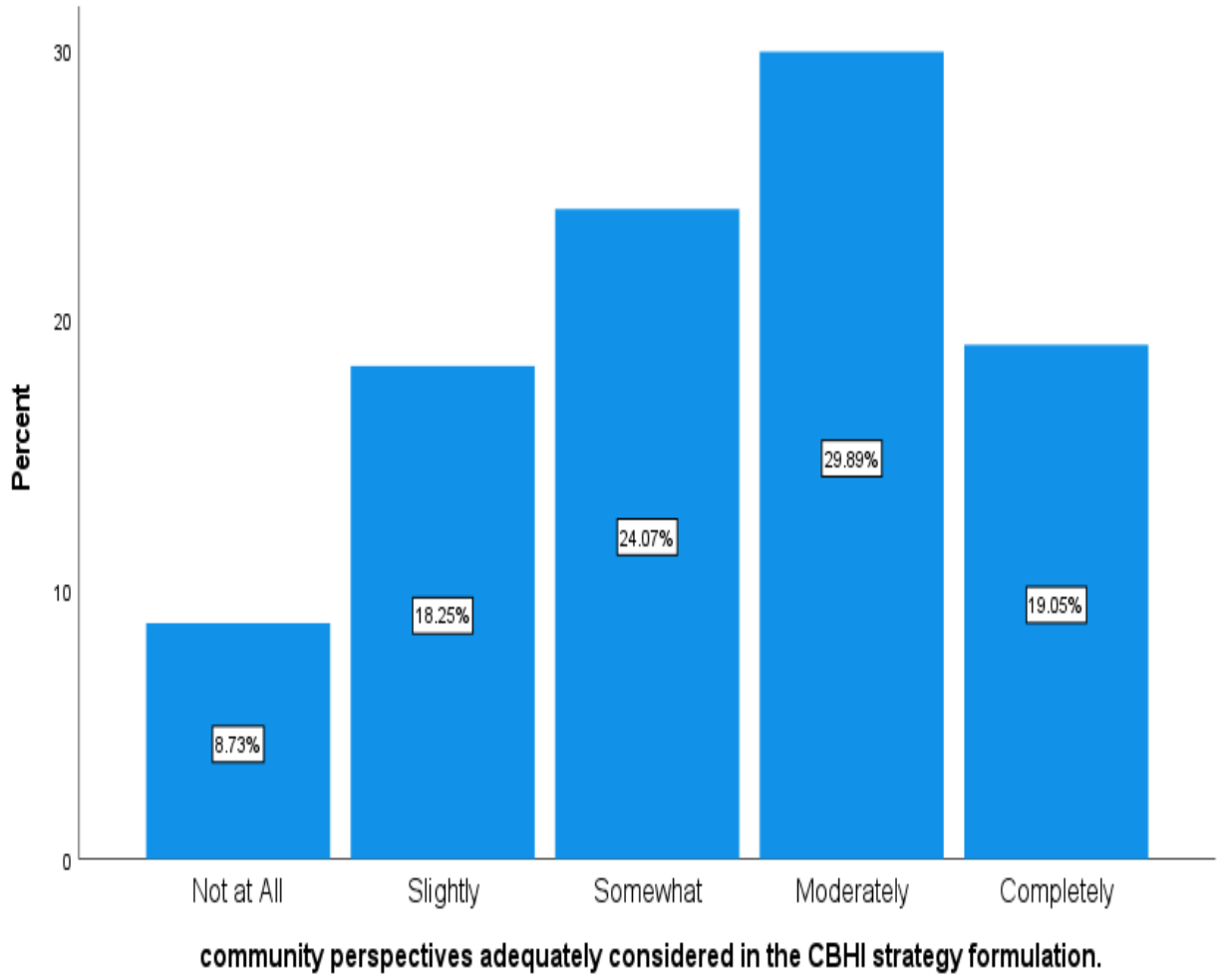

Fig5.10 Sample distribution on the extent to which CBHI considered the community's perspectives

Source: Own survey data (2024)

Concerning the respondent's feedback on the extent to which CBHI considered the community's perspectives, the result in Fig. 5.10 shows that there is a disparity of responses on the community's perspectives that is adequately considered in the CBHI strategy formulation. From the total respondents, 42.32% of them stated that there is a poor level of community's perspective consideration in CBHI strategy formulation; only 19.05% of them responded that the community's perspectives have been considered by CBHI. CBHI is targeting the informal groups of the community, mostly those living in rural parts of the country; however, the design and formulation of the policy in Ethiopia are not initiated at the grass-roots level; rather, it is from the top (designed)

to the community. The national health insurance policy of Thailand was designed with the direct participation of the target community, so it was initiated at the gross root level.

This conclusion is supported by several studies carried out in different nations, including Colombia, Bangladesh, Senegal, Indonesia, and Ethiopia.

The opinions of the community are very important in determining health insurance policies. Taking community opinions into account while developing community-based health insurance (CBHI) initiatives is a major difficulty. Research reveals several challenges, including high rates of membership dropout brought on by issues like perceived service quality, knowledge gaps, and pricing (Kaso et al., 2022). CBHI implementation in Bangladesh is further hampered by issues such as low population coverage, ignorance of health insurance, and poor outside support (Sheikh et al., 2022). Another issue with schemes in Ethiopia is their financial viability; they struggle to shield members from out-of-pocket costs and have negative net income (Hussien et al., 2022). Furthermore, the functional sustainability of CBHI schemes in Ethiopia is hampered by irregular enrolment trends and problems with healthcare quality, claims reimbursement, governance, and community awareness (Hussien et al., 2022). Improving community attitudes and guaranteeing the effectiveness of CBHI programs depend on addressing these issues.

Research from Senegal (Negera & Abdisa, 2022). Colombia (Bolivar-Vargas), Indonesia (Sundoro, 2023), and Ethiopia (Aboagye et al., 2021) demonstrate how community attitudes affect health insurance programs. User associations are intended to serve the interests of the populace and facilitate decision-making in Colombia. However, they encounter difficulties because of poor awareness and participation (Boyer et al., 2021). Participation in Indonesia's National Health Insurance Plan is influenced by several factors, including the environment, expectations, requirements, and public knowledge. The willingness of rural Ethiopian households to pay for community-based health insurance is impacted by awareness, education, and money. Senegal's restricted information availability has an impact on people's awareness of and enrolment in health insurance, with risk preferences and geographic location being major variables. In general, community viewpoints have a big impact on how health insurance policies are created, implemented, and performed.

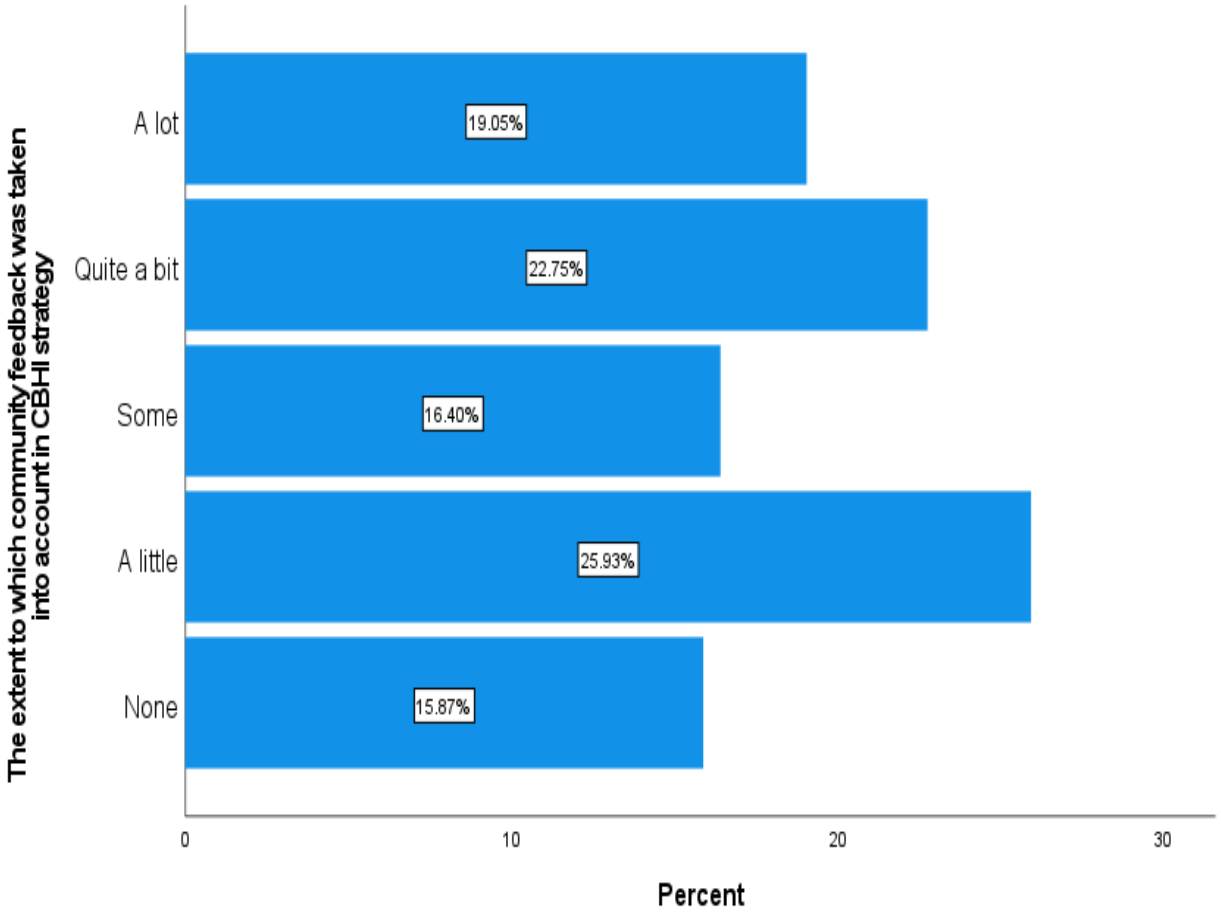

Fig5.11 Sample distribution on the level to which community feedback was taken into consideration in CBHI strategy

Source: Own survey data (2024)

In the above fig 5.11 the research result indicates that a significant portion of respondents, specifically 246 out of the total sample, believe that community feedback was not considered during the formulation of the Community-Based Health Insurance (CBHI) strategy. This 246 represents 65.1% of the entire sample, suggesting that most of the surveyed individuals feel that their input or the input of the community was not considered when developing the CBHI strategy. This lack of consideration for community feedback could have implications for the effectiveness and acceptance of the CBHI program, as it might not fully address the needs and preferences of the community it is intended to serve. The disparities and low involvement of community's feedback in CBHI policy formulation in Ethiopia has the same result with the research's conducted in different nations.

The extent to which community members participate in the processes of decision-making pertaining to community-based health insurance strategies varies depending on the setting. Although user associations are required by law to promote the interests of individuals and facilitate involvement in insurer decision-making in Colombia, many of them are weak or non-existent because of poor public awareness and scant insurer support (Bolivar-Vargas et al.,2022). Studies conducted in Kosovo show that the community is not very involved in the creation and formulation of policies, especially in Pristina (Kamberi and Baliqi, 2018). Despite high participant knowledge, Nigeria's Community Based Health Insurance (CBHI) programs confront obstacles like low enrolment (Odima et al.,2023). Community Health Committees (CHCs) in Kenya face challenges due to imprecise policy wording, poor communication, and insufficient financial support, which results in competing demands for resources and role conflicts (Karuga et al.,2023). The CHPS program in Ghana has a modest level of community involvement, with favourable opinions associated with proactive involvement in resource identification and outreach service coordination (Kweku et al.,2020).

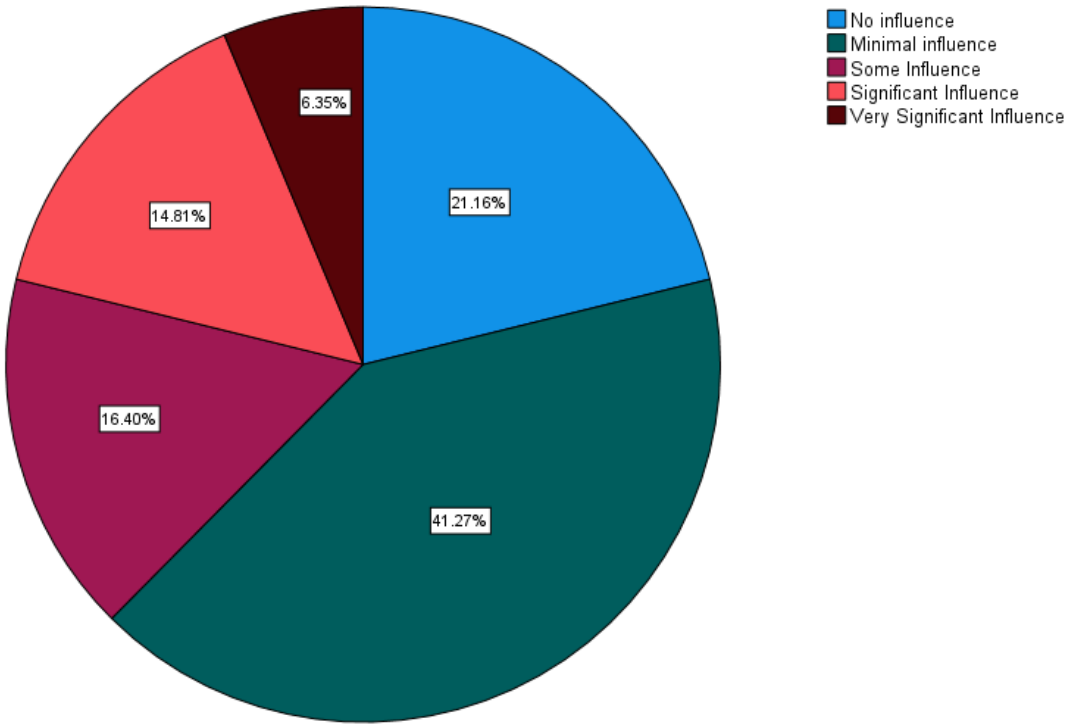

Fig5.12 Sample distribution on the level of community influence on shaping the key components of CBHI strategy

Source: Own survey data (2024)

The research result indicates that 218 respondents, which represent 57.7% of the sample, believe that the influence of community feedback on finalizing the Community-Based Health Insurance (CBHI) strategy is poor. This perception is attributed to power dynamics among the target population. In other words, most respondents feel that the involvement of community feedback in shaping the final CBHI strategy is insufficient, largely due to imbalances in power and influence within the community. These power dynamics may prevent certain groups or individuals from having their voices heard or their needs addressed adequately in the CBHI strategy formulation process. This could lead to a strategy that does not fully reflect or serve the interests of the entire community. This conclusion is supported by several studies carried out in different countries, and it is summarized in this interpretation for triangulation purposes.

The effectiveness of community-based health insurance (CBHI) schemes depends on community involvement in their finalization (Odima et al., 2023; Franz et al., 2018; Diop & Butera, 2005; Uzochukwu et al., 2015). Research indicates that substantial investments in community-based health care are necessary for CBHI schemes to be successful, highlighting the importance of long-term establishments with clear guidelines, ongoing support, and common goals. CBHI programs in Rwanda were founded on the principles of community solidarity and mutual aid, and actors were mobilized by high-level leadership to support the programs' national execution. Community support, power dynamics among community actors, and health personnel's views toward the program are some of the factors influencing the execution of the CBHI. Thus, completing successful CBHI plans requires including communities in decision-making processes, guaranteeing broad support, and clearly communicating policy requirements.

5.4. Degree of community involvement and participation in the CBHI strategy's development

Table 5.4 The relationship between Community engagement and Participation on implementation of CBHI

Correlations

		CBHI implementation	Comm. engagement & Part.
CBHI implementation	Pearson Correlation	1	.250**
	Sig. (2-tailed)		.001
	N	378	378
Comm. Engagement & Prat.	Pearson Correlation	.250**	1
	Sig. (2-tailed)	.001	
	N	378	378

**. Correlation is significant at the 0.01 level (2-tailed).

Source: Own survey data (2024)

The Pearson correlation coefficient between CBHI implementation and community engagement and participation is 0.25. This indicates a positive but weak correlation between the two variables. In practical terms, this means that as community engagement and participation in CBHI increase, the implementation of CBHI also tends to increase, but the relationship is not strong.

While there is a positive association, suggesting that higher levels of community engagement and participation are generally associated with better implementation of CBHI, the weak correlation implies that other factors might also play significant roles in the successful implementation of CBHI. Therefore, while fostering community engagement and participation is important, it should be part of a broader strategy that addresses various other aspects influencing CBHI implementation.

Whereas the sig. (2-tailed) is less than 0.05, which is significant. This implies that CBHI implementation is significantly correlated with community engagement and participation.

5.5. Analysing the third study hypothesis (H3)

The effectiveness and longevity of the CBHI plan in Oromia National Regional State depend on the level of community engagement and participation in its development.

This hypothesis looks at how the degree of community involvement and engagement affects the CBHI plan and strategy in the national regional state of Oromia.

The success and long-term viability of Oromia National Regional State's Community-Based Health Insurance (CBHI) program are greatly dependent on community involvement and engagement. Research from Southern Ethiopia (Zepre, 2023), Gudeya Bila (Asfaw et al., 2023), and Basona Worena District (Tefera & Ayele, 2022) emphasizes the importance of elements that affect household satisfaction and CBHI scheme enrolment, such as attending CBHI-related meetings, healthcare providers' respect, knowledge of CBHI, and illness experience. Furthermore, the research on Ethiopia's CBHI scale-up (Getahun et al., 2024) highlights how community involvement increases access to healthcare, mobilizes resources, and offers financial security. Consequently, increasing CBHI utilization is crucial for determining the effectiveness and sustainability of the strategy in the Oromia National Regional State. This can be achieved through active community involvement, awareness campaigns, and guaranteeing high-quality healthcare services.

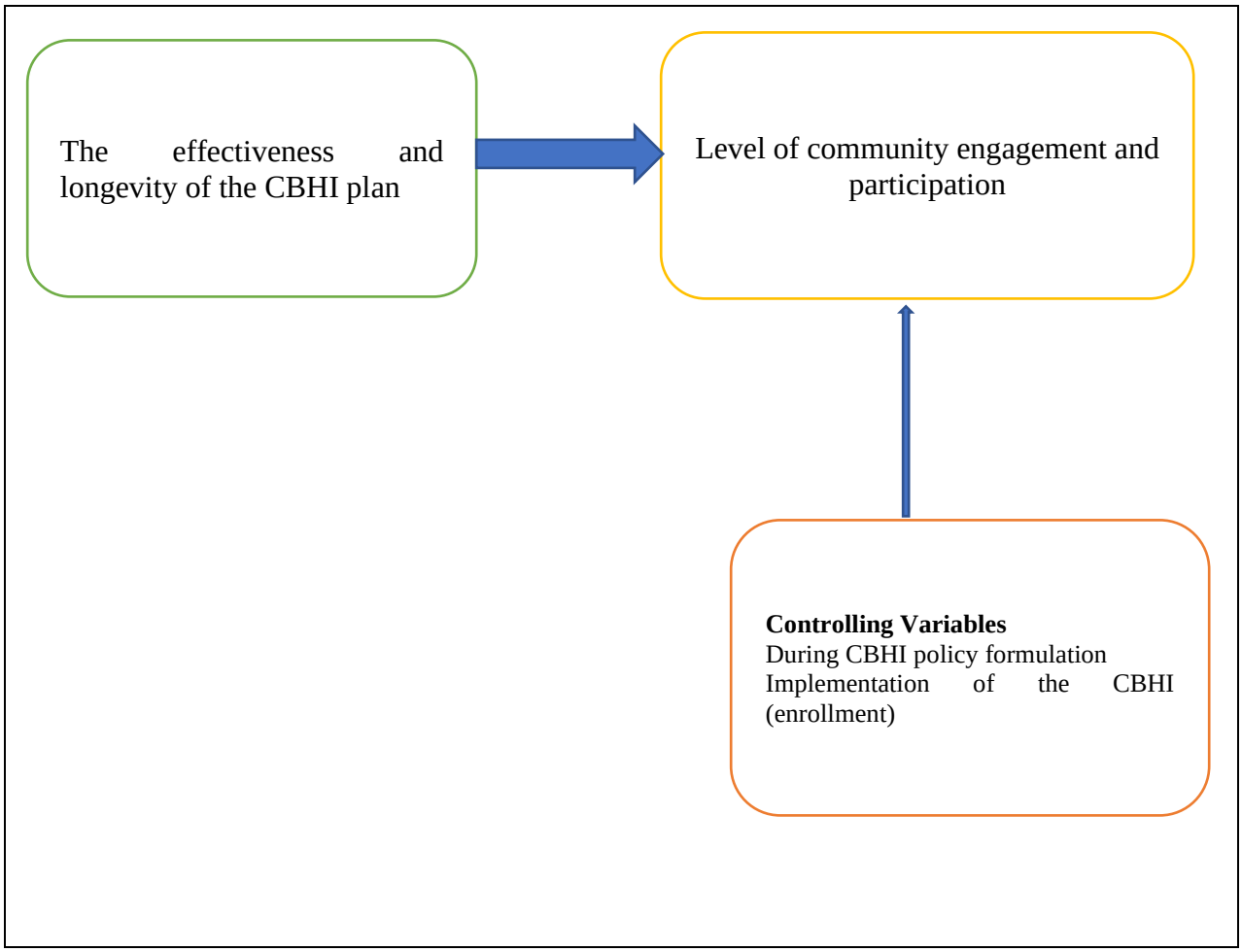

Figure5.13 Conceptual Model

Source: Author's own compilation based on research methods.

Table5.5 level of community-engagement and participation in the formulation of the CBHI strategy

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
The CBHI strategy development process effectively engaged community members.	378	1	5	2.51	1.143
Community participation and ownership are adequately ensured in CBHI schemes.	378	1	5	2.61	1.135
Community members were given meaningful opportunities to contribute to the CBHI strategy.	378	1	5	2.89	1.252
Enough efforts were made to raise awareness and educate community members about CBHI.	378	1	5	4.20	1.072
Community input played a crucial role in shaping the key elements of the CBHI strategy.	378	1	5	4.29	.908
Community leaders actively participated in the CBHI strategy formulation process.	378	1	5	4.33	.906
Community engagement significantly contributes to the success of the CBHI programs.	378	1	5	4.14	.978
I believe that the CBHI strategy genuinely represents the needs and preferences of our community regarding accessing health services.	378	1	5	4.17	.950

Community members were well-informed about the progress and decisions related to the CBHI strategy.	378	1	5	4.12	1.101
The CBHI strategy demonstrates a collaborative effort between community representatives and policymakers.	378	1	5	4.26	1.007
I believe that the CBHI strategy will contribute positively to the overall health and well-being of our community.	378	1	5	4.09	1.050
The CBHI strategy was developed in a way that encourages ongoing community involvement.	378	1	5	4.32	.975
The CBHI strategy demonstrates a commitment to addressing the unique challenges of our community.	378	1	5	4.34	.939
Community members were actively engaged in discussions about the long-term goals of the CBHI strategy.	378	1	5	4.23	1.065
The CBHI strategy development process fostered a sense of ownership and pride among community members.	378	1	5	4.07	1.010
Community perspectives were given equal importance to expert opinions in the CBHI strategy formulation.	378	1	5	4.32	1.006
The CBHI strategy reflects the collective aspirations of our community for better healthcare.	378	1	5	4.06	.982

Community engagement in the CBHI strategy was characterized by transparent communication.	378	1	5	4.05	.978
The CBHI strategy showcases a strong partnership between local institutions and the community.	378	1	5	4.36	.965
Valid N (listwise)	378				

Source: Own survey data (2024)

In Table 5.5 above, the beneficiaries were questioned about their level of community engagement and participation in the development of the CBHI plan. As a result, the data below represents beneficiary input regarding the community engagement and participation.

The weight assigned to each major element and the score assigned to each significant element inside the factor were the two elements considered to establish the point for each key component. An element would receive a perfect score of 5, which would indicate strong agreement; a score of 4 would indicate agreement; a score of 3 would indicate neutrality; a score of 2 would indicate disagreement; and a final score of 1 (strongly disagree) would result in one mark.

In the above table the first three items of questions were try to assess the community's engagement and participation during the invitation of the program in the west Showa zone and the respondent's response on this regard is negative. This implies that the level of community engagement and participation in west Showa zone at the time of scheme formulation was negative. However various strategies have been used to increase the awareness of the community.

As the interview data revealed that community engagement is male stone in the implementation of CBHI. Community is the primary stakeholders of CBHI and being participated in the scheme management and implementation (CBHI, senior expert in Oromia health Bureau).

Therefore, we can accept the hypothesis (H3) that the degree of community involvement and engagement in formulating the CBHI plan in the Oromia National Regional State determines its efficacy and lifespan.

The mean value (n) for the statement regarding the CBHI strategy development process effectively engaging community members is 2.51. This mean value indicates that most respondents disagree with the statement, suggesting that they do not believe the CBHI strategy development process effectively engaged community members. This implies that, during the initiation stage of the CBHI

policy, community members were not effectively involved or considered, according to the respondents. This lack of effective engagement might have contributed to a strategy that does not fully reflect the community's needs and perspectives.

This finding is supported by the following numerous studies conducted in various nations:

Programs for community-based health insurance have demonstrated differing degrees of success in including the community. Due to a lack of public knowledge, user associations in Colombia were found to be weak and inactive, which made it difficult for them to empower subscribers and improve the responsiveness of health insurance (Bolivar-Vargas et al.,2022). While increasing health insurance membership, particularly among the previously uninsured, improved technical quality of healthcare services did not significantly increase households' subjective judgments of healthcare quality in Ghana (Opoku et al.,2022). Ethiopia's community-based health insurance program successfully increased the use of outpatient services, promoting health equity and universal health coverage. However, because these services are freely available at public facilities, the program had no discernible effect on the use of healthcare services for mothers and children (McNeish et al.,2022). Maximizing the effectiveness of community-based health insurance programs requires the implementation of effective community engagement measures, such as enlisting the help of community leaders and establishing trust (Mussa et al.,2023).

Regarding community participation and ownership in the CBHI scheme, the data in Table 5.2 states that the CBHI scheme does not adequately ensure the ownership and participation of the target population.

The experience of different countries shows that the CBHI scheme is not adequately ensuring the ownership and participation of CBHI members. Various challenges have contributed to the low infectiveness of CBHI in ensuring the ownership and participation of the target population. There have been obstacles to ownership and participation in Community-Based Health Insurance (CBHI) programs in Bangladesh, Ethiopia, Senegal, Nigeria, and other nations. Stakeholders in Bangladesh emphasized the value of public-private partnerships, comprehensive benefit packages, and outside aid in boosting coverage and confidence (Shiekh et al., 2022). In a similar vein, low attendance in Ethiopia was ascribed to low awareness, budgetary limitations, and discontent with services (Tefera & Ayele, 2022). Research conducted in Senegal has underscored the importance of societal values, power dynamics, and sustainable governance systems in broadening the scope of CBHI (Mirach et al., 2023). According to Nigeria's experience, low uptake was caused by things

like regressive finance, low beneficiary involvement, and a lack of awareness of and trust in the programs (Mladovsky et al., 2015). It is essential to address these issues through specialized approaches, stakeholder involvement, and legislative changes to guarantee ownership and active participation in CBHI programs.

In terms of respondents' responses, community members were given meaningful opportunities to contribute to the CBHI strategy. As the data found in Table 5.2 shows, community members were not given meaningful opportunities to contribute to the CBHI strategy. This is due to power dynamics among the group of the CBHI target population. Power dynamics can influence whose voices are heard and whose input is valued, leading to certain groups within the community being marginalized or excluded from the decision-making process. As a result, the development and implementation of the CBHI strategy may not fully reflect the needs and preferences of the entire community, particularly those who are less influential or powerful.

In this regard, interviews were conducted with the provider affairs and quality assurance senior officers, and she stated that

'' In Ethiopia, community involvement in the formulation and execution of community-based health insurance (CBHI) initiatives has been a dynamic process. At first, government and non-governmental groups primarily designed the strategies, with little input from the community. Nonetheless, in recent years, initiatives to boost community involvement and engagement have been undertaken.

The implementation of the Community Conversation (CC) strategy by the Ethiopian government and its partners was a significant move. Community conversations (CCs) are facilitated dialogues designed to help members of the community identify their health needs, priorities, and possible solutions. The purpose of these discussions has been to get feedback on the creation and operation of health insurance programs, such as CBHI.

Notwithstanding these endeavours, obstacles persist in guaranteeing substantial community involvement in CBHI. These include the community's poor knowledge of insurance ideas, power dynamics that could prevent marginalized groups from participating, and the requirement for capacity building to allow for meaningful engagement. To overcome these obstacles and improve community involvement in CBHI initiatives in Ethiopia, sustained efforts are required'' (EHIS, provider affairs and quality assurance senior officer).

Vis-à-vis the question related to whether sufficient efforts were made to raise awareness and educate community members about CBHI, respondents' average responses of 4.20 suggest that respondents generally agree that significant efforts were made to raise awareness and educate the community about the CBHI scheme. From this finding, the following four points can be concluded:

Positive **Perception**: Most respondents believe that there were substantial efforts to inform and educate the community about CBHI.

Awareness **Campaigns**: This likely reflects the presence of effective awareness campaigns, informational sessions, or educational programs aimed at making the community knowledgeable about CBHI.

Community Engagement: Despite previous findings indicating challenges with community engagement and participation in strategy formulation, this result suggests that, at least in terms of awareness and education, the CBHI scheme performed well.

Impact on Implementation: Higher levels of awareness and education can lead to better understanding and potentially higher enrolment and participation rates in the CBHI scheme.

In summary, the respondents perceive that sufficient efforts were made to raise awareness and educate community members about CBHI, which is a positive aspect of the program's implementation. This suggests that while there may be areas needing improvement, such as community involvement in strategy formulation, the efforts to inform and educate the community have been successful.

''The government has promoted the establishment of community-managed health insurance programs. Community members are frequently involved in these schemes' decision-making procedures, which include deciding on benefit packages, setting premiums, and supervising fund administration. This strategy seeks to guarantee that the requirements and preferences of the community are considered while designing and implementing the plans'' (EHIS, provider affairs and quality assurance senior officer).

Significant efforts have been undertaken by the Ethiopian government to promote community enrolment in the Community-Based Health Insurance (CBHI) program and to increase public knowledge of it. To address low enrolment challenges such as low awareness, budgetary constraints, and dissatisfaction with health services, these measures include expanding the adoption of CBHI (Daraje, 2022). Despite efforts to incorporate communities, such as town hall meetings and community mobilization initiatives, the study discovered that the actual impact of

community participation on decision-making was little. Things like inadequate literacy and ignorance about health insurance were noted as obstacles to meaningful engagement. Furthermore, a commitment to expanding CBHI coverage is shown by the government's 2020 goal to reach 80% of districts and 80% of the population (Tahir et al., 2022). Research has indicated that effective pilot programs and robust political backing have facilitated community involvement, enhanced healthcare accessibility, and empowered women, all of which have led to heightened awareness and CBHI enrolment (Tefera and Ayele, 2022). Moreover, continuous efforts to improve awareness and enrolment in the CBHI scheme are highlighted by the government's focus on strengthening regional growth and resolving bottlenecks within implementing regions (Mulat et al., 2022).

Apropos, questions related to Community input played a crucial role in shaping the key elements of the CBHI strategy. Respondents believe that community input (community participation) played a crucial role in changing the CBHI strategy. Community input includes premium contributions, timely membership renewals, and CBHI enrolment. The research result indicates that respondents believe community input played a crucial role in shaping the key elements of the CBHI strategy. This implies that the contributions and feedback from community members were instrumental in influencing and modifying the strategy, ensuring it aligns better with the community's needs and preferences.

From this finding, the following four points can be concluded:

Significant Influence: Community participation had a substantial impact on the development and modification of the CBHI strategy.

Responsive Strategy: The CBHI strategy was likely adjusted based on the feedback and input from the community, making it more relevant and effective.

Community Involvement: This result highlights successful instances where the community was actively involved in the decision-making process, ensuring their voices were heard and considered.

Positive Outcome: The recognition of community input's importance suggests a collaborative approach toto strategy development, which can enhance the acceptance and success of the CBHI scheme.

In summary, the research result underscores the importance and effectiveness of community participation in shaping the CBHI strategy, demonstrating that when community members are actively involved, their input can lead to significant and beneficial changes in the strategy.

Community input has been pivotal in shaping key elements of Community-Based Health Insurance (CBHI) strategies. Research emphasizes the value of community involvement in removing obstacles to implementation (Sheikh et al., 2022). Community-Based Participatory Research (CBPR) approaches prioritize community voice in research and support community ownership and culturally cantered methodologies (Hicks et al., 2012). Through the effective integration of CBPA and CHIP, the River West Health Initiative was able to influence strategic planning processes by enabling residents to provide locally relevant health information (Sanders & Baisch 2008). Human resources, organizational design, and data management were the main areas of emphasis for management initiatives in Indian CBHI schemes, which emphasized the value of community participation in decision-making (Sinha et al., 2007, 2007). The viability and attractiveness of expanding CBHI programs were investigated, with a focus on community attitudes, acceptability, expansion enablers, and barriers (Kakama et al., 2020, 2020).

Concerning the involvement of community leaders in the CBHI the CBHI strategy formulation process, respondents agreed (n = 4.1) that the community leaders were participating in the CBHI strategy formulation. Community leaders are members of the CBHI the CBHI community who participated in the general the general counsel of the CBHI, CBHI, representing the target population; population; hence, hence, community leaders are the representatives of the target population who were involved in the CBHI decision--making process, including the CBHI strategy formulation process. The result of this data can be inferred from the following points:

Active Participation of Leaders: The mean value of 4.1 indicates a strong agreement among respondents that community leaders played an active role in the formulation of the CBHI strategy.

Leadership Influence: The involvement of community leaders implies that their influence and authority were leveraged in the strategy formulation, potentially guiding decisions and ensuring the strategy is in line with community needs and values.

Community Representation: The participation of community leaders likely provided a sense of representation for the community, as these leaders often act as intermediaries between the general population and policy makers policymakers.

Enhanced Legitimacy: The involvement of recognized leaders can enhance the legitimacy and acceptance of the CBHI strategy within the community, as decisions are seen to have been made with input from trusted and respected figures.

In summary, the research result indicates a positive perception among respondents regarding the involvement of community leaders in the CBHI strategy formulation process. This involvement likely contributed to a strategy that is more aligned with the community's needs and has greater support and legitimacy.

In the process of developing Community-Based Health Initiatives (CBHI), community leaders are essential (Hébert et al., 2015; Sprague et al., 2020). Studies reveal that incorporating Citizens Society Organizations (CSOs) into the process of developing strategies results in a higher influence on the strategies' content (Bajramović & Bezdrob, 2017).

Respondents responses to community engagement significantly contribute the success of the CBHI programs. As shown in the above table 5.2, the mean value for this question is 4.14, which implies that community engagement significantly contributes to the success of the CBHI programs in the west show zone. From this, one can infer that community engagement is one of the significant factors determining the success of the CBHI schemes in the west the west show zone. From this, we can infer that the involvement of community members in the CBHI programs might include activities such as decision-making processes, awareness campaigns, feedback mechanisms, and participatory planning.

The term "significantly contributes" implies that community engagement is not just beneficial but essential for the effectiveness and success of the CBHI programs. It indicates that without active

participation and support from the community, the programs might not achieve their intended outcomes.

For Community-Based Health Insurance (CBHI) initiatives to be successful, community involvement is essential. Research indicates that the main goals of community engagement initiatives are to mobilize difficult-to-reach populations, address disinformation, develop community ownership, and establish trust (Agrawal et al., 2023, 2023; Berrett-Abebe et al., 2023, 2023). Collaborating among institutions, professions, and stakeholders is essential for effective community involvement. It also highlights the value of deliberate leadership and places the community at the heart of efforts to promote health equity (Schlechter et al., 2021, 2021). Moreover, community-engaged dissemination and implementation research (CEDI) emphasizes how important it is to include stakeholders from a variety of backgrounds to incorporate local knowledge and, eventually, improve health disparities (Cory et al., 2021, 2021). The relevance of improved awareness and factors impacting engagement in community-based health education (CBHI) programs is underscored by primary healthcare professionals' favourable attitudes and increasing awareness towards CBHI (Miskeen & Al-Shahrani, 2023).

The respondents view of the of the CBHI strategy genuinely represents the needs and preferences of our community in accessing health services. services. Respondents agreed that the CBHI strategy genuinely represents the needs and preferences of our community in accessing health services. services. We can infer this result using the following points:

Alignment with Community Needs and Preferences: The CBHI strategy is perceived to be effectively addressing the specific health service needs and preferences of the community. This implies that the design and implementation of the CBHI program are considerate of local health priorities, cultural factors, and service expectations.

Positive Perception: The agreement among respondents indicates a positive perception of the CBHI strategy. It suggests that the program is seen as relevant, appropriate, and responsive to the community it serves.

Community Representation: The strategy is genuinely representative of the community's voice. This might mean that community members feel their opinions, feedback, and unique circumstances have been considered in the development and execution of the CBHI program.

Accessing Health Services: The focus on accessing health services points to the CBHI strategy's effectiveness in making healthcare more accessible, affordable, and tailored to the community's needs. This could include aspects such as the availability of services, financial protection, and service quality.

In summary, this result suggests that respondents believe the CBHI strategy in their community is effectively meeting their health service needs and preferences. It highlights the program's success in being community centred and suggests that stakeholders have done a good job aligning the CBHI strategy with local expectations and requirements.

There are various studies conducted in different countries that support this finding.

The community-based health insurance (CBHI) approach has been effective in mitigating healthcare disparities by encouraging low-cost, high-quality healthcare access, lowering out-of-pocket costs, and enhancing healthcare availability in low-income areas (Kakama et al., 2022). 2022). Stakeholders in Bangladesh stress the value of enlightening the public and motivating them to enrol in CBHI programs through outreach initiatives and community health worker visits (Sheikh et al., 2022, 2022). CBHI programs are highly enrolled in Rwanda, and despite budgetary constraints, local communities make substantial contributions to guarantee healthcare access (Sibomana, 2014). Furthermore, considerable others are eager to subscribe to CBHI for their older family members, indicating a desire to support the program within families, according to a study on elderly healthcare in rural communities (Kakama, 2020Kakama, 2020). All of these results point to the fact that CBHI policies, by enhancing healthcare access, protecting finances, and winning over community members, are in line with the requirements and preferences of the community.

The statement "Respondents agreed that community members were well-informed about the progress and decisions related to the CBHI strategy" indicates that the individuals surveyed believe there is effective communication and transparency regarding the Community-Based Health

Insurance (CBHI) strategy. The agreement among respondents suggests that the channels and methods used to communicate information about the CBHI strategy are effective. This includes how progress updates, decisions, and changes are conveyed to the community. The statement implies a high level of transparency in the CBHI program. Community members are kept informed about the decisions being made, which fosters trust and confidence in the program.

The research result indicating that respondents agree that agree that various stakeholders, including community representatives and policymakers, were involved in the CBHI strategy formulation suggests a collaborative and inclusive approach. This implies that

Stakeholder Involvement: The agreement among respondents signifies that the formulation of the Community-Based Health Insurance (CBHI) strategy included contributions from a diverse group of stakeholders. This likely means that various voices, perspectives, and interests were considered during the development process.

Community Representatives: The involvement of community representatives implies that those directly impacted by the CBHI strategy had a say in its creation. This inclusion helps ensure that the strategy aligns with the community's actual needs and preferences, making it more relevant and effective.

Policymakers: The participation of policymakers indicates that the strategy was also shaped by those with the authority to implement and regulate it. Their involvement ensures that the strategy is feasible within the existing legal and regulatory framework and that it has the necessary support for execution.

Collaborative Effort: The agreement among respondents highlights the collaborative nature of the strategy formulation process. This collaboration likely involved joint meetings, consultations, workshops, or other forms of participatory planning where different stakeholders could voice their opinions and contribute to the strategy.

Ethiopia's Community-Based Health Insurance (CBHI) program is an example of how community leaders and legislators work together (Mulat et al., 2022, 2022). Ethiopia's adoption of the CBHI program benefited from international efforts to promote universal health care and domestic

resource mobilization, garnering significant political backing, and involving a range of stakeholders (Tefera & Ayele, 2022). The Community-Based Health Initiative (CBHI) program attracted interest from members of the community, particularly those with chronic illnesses, despite initial obstacles such as low participation rates caused by less awareness and financial constraints (Geta et al., 2023, 2023). Research shows that the CBHI considerably increased access to contemporary health services and decreased utilization disparities across various socioeconomic factors, highlighting the necessity of greater community involvement, awareness, and cooperative government-society design for successful implementation (Tahir et al., 2022, 2022; Jembere, 2018).

The research result indicating that respondents agreed with the contribution of community-based health insurance to the overall health and well-being of the community suggests that the participants recognize the positive impact of CBHI on their lives. Respondents likely perceive that CBHI has enhanced their access to essential healthcare services. This could mean more people can visit healthcare facilities, receive treatments, and access medications without significant financial barriers. The agreement could reflect improvements in health outcomes among the community members. With better access to healthcare, individuals may experience fewer health complications, lower mortality rates, and overall better health conditions. Beside this, the positive response suggests a level of trust and satisfaction with the CBHI scheme. This trust can encourage more community members to enrol and participate in the program, further enhancing its effectiveness. The sense of shared benefit from CBHI can strengthen community bonds as members recognize that the scheme contributes to collective well-being and supports each other in times of health crises.

Overall, the respondents' agreement indicates a perception that CBHI has significantly contributed to the community's health and well-being, highlighting its role in improving healthcare accessibility, financial protection, and overall health outcomes.

Ethiopia's Community-Based Health Insurance (CBHI) program has improved people's health and well-being. According to studies, being a member of the CBHI increases the use of health services, lowers out-of-pocket costs, and lowers catastrophic health expenditures, which benefits the community at large as well as insured households (Daraje, 2022; Lakew et al., 2023, 2023;

Alemyehu et al., 2023, 2023). Members' quality of life has been effectively improved by CBHI; insured people have a higher quality of life than their uninsured counter parts (Get et (Get et al., 2023). Furthermore, CBHI has played a significant role in mitigating differences in the consumption of contemporary health services by households, thereby enhancing healthcare service accessibility and promoting equity within communities (Kassa, 2023). Overall, the data point to the CBHI strategy's critical role in advancing financial protection, advancing universal health care, and improving community health and well-being in Ethiopia.

Respondents responses to the CBHI strategy were developed in a way that encourages ongoing community involvement. The respondents (n = 4.32) believed that the current CBHI strategy promotes ongoing community engagement and involvement in the CBHI scheme activities. This implies that the CBHI scheme includes mechanisms that encourage participation, feedback, and collaboration from community members. Respondents feel that the CBHI strategy not only engages them but also involves them in various activities and decision-making processes. This could include regular meetings, community forums, or participatory planning sessions where members can voice their opinions and contribute to the development and improvement of the CBHI scheme. Ongoing community engagement and involvement are crucial for the sustainability of the CBHI scheme. The respondents' belief in this aspect suggests that the strategy effectively fosters a sense of ownership and responsibility among community members, which is essential for the long-term success of the program. The positive response implies that the current CBHI strategy likely promotes trust and transparency. When community members are regularly engaged and involved, they are more likely to trust the scheme and perceive it as transparent and accountable. The strategy likely includes educational and awareness programs that inform community members about the benefits, procedures, and importance of the CBHI scheme. This knowledge empowers them to participate actively and make informed decisions.

In summary, the respondents' belief that the current CBHI strategy promotes ongoing community engagement and involvement highlights the scheme's effectiveness in integrating community participation. This involvement is critical for fostering trust, ensuring transparency, and enhancing the overall sustainability and success of the CBHI program.

Ethiopia's Community-Based Health Insurance (CBHI) program aims to encourage continuous community engagement (Kaso et al., 2022, 2022; Tefera & Ayele, 2022). The CBHI program seeks to empower women, increase community involvement, and resource mobilization, enhance health service accessibility, and offer financial security (Mulat et al., 2022, 2022). Membership renewal rates, which reflect active community participation, are highly influenced by variables like favourable attitudes toward the program, perceived quality of health services, and familiarity with the CBHI scheme (Geta et al., 2023, 2023). The CBHI initiative has attracted a lot of attention from community members, particularly those with chronic illnesses, demonstrating continued community engagement despite early hurdles such as such as limited awareness and financial constraints (Tahir et al., 2022). The scheme's success depends on ongoing community involvement, raising public awareness, and taking economic factors into account in order to guarantee sustained participation and accomplish universal health care.

The research result indicating that the mean (n) value is 4.34 implies that respondents believe the CBHI strategy demonstrates a commitment to addressing the unique challenges of their community. This high mean value on a Likert scale (typically ranging from 1 to 5) suggests strong agreement among respondents, and it has several key implications:

Effectiveness in Problem-Solving: Respondents perceive that the CBHI scheme effectively addresses the specific and unique challenges faced by their community. This means the scheme is seen as relevant and impactful in tackling local health issues.

Tailored Approach: The high mean value indicates that the CBHI strategy is likely customized to meet the needs of the community rather than adopting a one-size-fits-all approach. This tailored approach ensures that the interventions and solutions provided by the CBHI scheme are suitable for the community's context.

Community-Specific Solutions: The respondents' agreement suggests that the CBHI scheme includes solutions designed to solve problems unique to their community. These solutions could involve addressing prevalent diseases, improving access to healthcare facilities, providing affordable healthcare, or tackling socioeconomic barriers to health.

Commitment and responsiveness: The mean value of 4.34 reflects a perception of the CBHI strategy as committed and responsive to the community's needs. This commitment can build trust and confidence among community members in the scheme's ability to support them.

Holistic Impact: The respondents' belief that the CBHI scheme is solving their unique challenges indicates a holistic impact on their overall health and well-being. The scheme is likely to be likely to be seen as a comprehensive approach that considers various aspects of healthcare and addresses multiple factors affecting the community.

Positive Perception: The positive perception among respondents suggests satisfaction with the CBHI scheme's performance. This satisfaction can lead to higher enrolment rates, continued participation, and greater community support for the scheme.

Continuous Improvement: The high level of high level of agreement implies that the CBHI strategy may include mechanisms for continuous assessment and improvement, ensuring it remains effective in addressing evolving community challenges.

In summary, the mean value of 4.34 implies a strong belief among respondents that the CBHI strategy is successfully addressing their community's unique challenges. This suggests that the scheme is effective, relevant, and responsive to the specific needs of the community, fostering trust, satisfaction, and ongoing support.

The Community-Based Health Insurance (CBHI) plan shows a devoted approach to tackling the difficulties encountered by communities (Sanjib, 2020). By combining their resources, CBHI programs seek to safeguard low-income populations financially against unforeseen medical costs in the future (Haldar et al., 2021, 2021). Although CBHI can aid in reaching underprivileged groups, government-built health infrastructure cannot be replaced by it (Aggarwal, 2011). The tactic is pooling assets to pay for medical costs, especially for individuals who are not eligible for regular health insurance benefits, including workers in the unorganized sector (Sniezek, 2012). It is clear from examining package prices and contrasting them with hospital expenditures that CBHI plans would not always provide sufficient coverage, which could result in operating losses for healthcare facilities (Hayes et al., 2021). Notwithstanding obstacles, CBHI continues to be an essential instrument for improving community health needs and access to healthcare services.

Regarding the question, community members were actively engaged in discussions about the long-term goals of the CBHI strategy. The research result indicates that respondents perceive Community-Based Health Insurance (CBHI) members as being actively engaged in discussions regarding the primary issues of CBHI, such as its goals and strategies. CBHI members are not merely passive recipients of health insurance services but are actively participating in the dialogue. This involvement suggests a level of engagement and ownership among members concerning the CBHI program. The members are likely to be well-informed about the goals and strategies of the CBHI program. Active involvement in discussions typically necessitates a good understanding of the topics being discussed.

The findings suggest a collaborative approach to managing and evolving the CBHI program. Members' input is considered valuable in shaping the program's direction and addressing its main concerns. The active involvement of members could indicate a sense of empowerment within the community. It suggests that the CBHI program is not only providing health insurance but also fostering a participatory environment where members can voice their opinions and influence decisions. According to Vértesy & Namomsa (2023) Women frequently were unable to obtain healthcare on their own because they did not have access to social security, health insurance, or financial independence. For Ethiopian women and their families, things are starting to change as the result of CBHI intention.

Active discussions among members could lead to continuous improvement of the CBHI program. By addressing concerns and strategizing collectively, the program can better meet the needs of its members and adapt to changing circumstances. Overall, this research result highlights the importance of member engagement for the effectiveness and sustainability of the CBHI program.

Discussions concerning the long-term objectives of the Community-Based Health Insurance (CBHI) approach were actively taking place among Ethiopian community members (Yonas et al., 2022; Mulat et al., 2022). The CBHI program sought to lower out-of-pocket costs, guarantee access to necessary medical care, and raise funds (Tahir et al., 2022). Despite early obstacles, including low knowledge, misunderstandings, financial limitations, and discontent with health services impeding enrolment (Shigute et al., 2020), the program attracted a lot of interest from the community, particularly from those with chronic illnesses and those who believed their family's

health status was compromised (Mirach et al., 2023). For the CBHI to be implemented and decision-making to be successful, stakeholders stressed the significance of progressively raising risk pooling, enhancing operational staff training and health information systems, engaging a variety of stakeholders, and improving service quality.

In terms of respondents views, does the CBHI strategy foster a sense of ownership and pride among community members? The research result that respondents agree that current Community-Based Health Insurance (CBHI) nurtures a feeling of ownership and trust among the members of their community indicates several significant implications. The majority of the CBHI members have trust in CBHI, which has a positive impact on the sustainability of the scheme. CBHI members feel a sense of ownership over the program. This feeling likely arises from their active involvement in discussions and decision-making processes, contributing to a perception that the program belongs to them and serves their interests.

The program has successfully built trust among its members. Trust is crucial for the success of any community-based initiative, as it encourages participation, adherence to guidelines, and mutual support among members. The nurturing of ownership and trust strengthens community bonds. When members feel they have a stake in the program and trust in its operations, it fosters a stronger, more cohesive community. A sense of ownership and trust is vital for the sustainability of the CBHI program. Engaged and trusting members are more likely to continue participating, contributing to the program's long-term success and stability.

The feelings of ownership and trust can create a positive feedback loop. As members see their input valued and the program working effectively, their trust grows, leading to even greater engagement and a stronger sense of ownership. When members feel ownership and trust in the CBHI, they are more likely to actively participate, follow through with commitments, and advocate for the program within their community. This can lead to improved outcomes, such as better health coverage and more effective use of resources.

Overall, these findings suggest that the CBHI program has successfully created an environment where members feel invested and confident in the program, which is essential for its ongoing success and effectiveness.

In Ethiopia, the implementation of the Community-Based Health Insurance (CBHI) program has positively impacted community members' sense of pride and ownership. Research demonstrates that financial protection and the use of necessary health care are improved when the community is involved in the development and monitoring of health services, for example, through CBHI schemes (Tefera and Ayele, 2022; Kaso et al., 2022). Households' interests and attitudes have also improved because of the CBHI's successful implementation; a large majority of them have good opinions about the program (Jembere, 2018). Furthermore, positive attitudes regarding the program, a sense of ownership and commitment among participants, and a thorough understanding of the CBHI program all have a substantial impact on membership renewal rates (Tiruneh et al., 2020). All things considered, CBHI has been extremely important in helping Ethiopian communities develop a sense of pride and ownership.

The research result indicating that respondents agree that community perspectives were given equal importance to expert opinions on the Community-Based Health Insurance (CBHI) strategy formulation in Ethiopia has several important implications:

Inclusivity in Decision-Making: The equal consideration of community perspectives and expert opinions suggests an inclusive decision-making process. This inclusivity ensures that the needs and views of the community are represented alongside technical and professional insights.

Community Empowerment: Giving equal importance to community perspectives empowers the community. It recognizes the value of local knowledge and experiences and encourages active participation and engagement from community members.

Balanced Approach: The strategy formulation for CBHI is balanced, integrating both grassroots insights and expert knowledge. This balance can lead to more practical, acceptable, and effective strategies that address real community needs while being informed by professional expertise.

Increased Trust and Buy-In: When community perspectives are valued equally with expert opinions, it can increase trust in the program and its leadership. Community members are more likely to support and participate in a program they feel they have a voice in shaping.

Enhanced Relevance and Effectiveness: Strategies developed with input from both the community and experts are likely to be more relevant and effective. Community members can provide insights into local challenges and practical solutions, while experts contribute technical knowledge and evidence-based practices.

Sustainable Development: This approach supports sustainable development by fostering a sense of ownership and commitment among community members. When people see their perspectives influencing policy and strategy, they are more likely to remain engaged and supportive over the long term.

Overall, the finding underscores the importance of collaborative and participatory approaches in the formulation of CBHI strategies, leading to programs that are more attuned to the needs and realities of the communities they serve.

Various studies are conducted worldwide regarding community perspectives as well as expert opinions on health insurance. Along with expert ideas, community perspectives were deemed essential in developing Bangladesh's Community-Based Health Insurance (CBHI) policy. Stakeholders stressed the value of enlisting the help of influential members of the community and going door-to-door to inform and persuade people to sign up for CBHI programs (Sheikh et al., 2022). Similar to this, in the context of measuring community wellbeing, professionals, public officials, and people displayed differing priorities in terms of community wellbeing characteristics, highlighting the necessity of acknowledging various weighting schemes based on various points of view (Wijayanto et al., 2014). These results demonstrate how important it is to include expert and community viewpoints during the policy-making process in order to ensure a more thorough and inclusive approach to tackling issues related to healthcare and community wellness.

In terms of CBHI strategy, it reflects the collective aspirations of our community for better healthcare. Respondents believed that the collective aspirations of the community were included in the CBHI strategy. From this, one can infer that the insured services covered by CBHI fulfil the community’s desire for better health care. The research result indicating that respondents believe the CBHI strategy reflects the collective aspirations of the community for better healthcare suggests several key points:

1. **Community-Centred Strategy:** The CBHI strategy is designed with a strong focus on the community's needs and desires. This alignment ensures that the program is relevant and responsive to the specific health concerns and goals of the community members.
2. **Reflecting Collective Aspirations:** The strategy incorporates the collective aspirations of the community, meaning that the shared hopes and goals for improved healthcare are considered in its formulation. This collective approach helps to unify the community around common objectives.
3. **Enhanced Support and Engagement:** When community members see their collective aspirations reflected in the CBHI strategy, it can enhance their support and engagement with the program. They are more likely to participate actively and contribute to the program's success when they feel their goals and needs are being addressed.
4. **Improved Health Outcomes:** By aligning the CBHI strategy with the community's aspirations, the program is more likely to achieve positive health outcomes. Strategies that are grounded in the real aspirations of the community can better address specific health issues and improve overall health standards.
5. **Building Trust and Ownership:** Including the collective aspirations of the community in the CBHI strategy helps to build trust and a sense of ownership among members. This can lead to greater community cohesion and commitment to the program's long-term goals.
6. **Responsive and Adaptive Strategy:** A strategy that reflects collective aspirations is more likely to be adaptive and responsive to changing community needs. This dynamic approach ensures that the program can evolve and remain effective over time.

Overall, these findings highlight the importance of developing CBHI strategies that are closely aligned with the community's collective aspirations for better healthcare. This alignment not only ensures the relevance and effectiveness of the program but also fosters greater community support, engagement, and trust.

Ethiopia's Community-Based Health Insurance (CBHI) plan is in line with the community's overall goals for better access to healthcare and financial security. CBHI has had a strong positive influence on lowering inequities in the use of contemporary health services, shielding households from unaffordable medical costs, and improving the use of health services. Research shows that

rural households are very eager to pay for CBHI programs, highlighting the need for accessible and reasonably priced healthcare in the area (Geta et al., 2023; Kaso et al., 2022; Kassa, 2023).

The research result that respondents agreed with a mean value of 4.05 indicates community engagement in the CBHI strategy was characterized by transparent communication, which suggests several important points:

Transparency in Communication: The high mean value underscores that the communication processes within the CBHI strategy were open and transparent. This likely means that information was freely shared, decision-making processes were clear, and there was an ongoing dialogue between the community and the program administrators.

Trust and Credibility: Transparent communication fosters trust and credibility. When community members feel that they are kept informed and that communication is honest and open, they are more likely to trust the program and its administrators.

Effective Engagement: Transparent communication is a cornerstone of effective community engagement. It ensures that community members are well-informed about the strategy, their roles, and the outcomes of their contributions, which can lead to more active and meaningful participation.

Informed Decision-Making: Transparent communication allows community members to make informed decisions regarding their involvement and contributions to the CBHI strategy. This can enhance the overall effectiveness and relevance of the program.

Positive Perception: The respondents' agreement with the statement suggests a positive perception of the engagement process. This positive perception is crucial for the continued success and sustainability of the CBHI program, as it encourages ongoing support and participation from the community.

In summary, the mean value of 4.05, indicating agreement that community engagement in the CBHI strategy was characterized by transparent communication, reflects a strong endorsement of

the openness and clarity in how the strategy was communicated. This transparency is essential for building trust, fostering effective participation, and ensuring the success of the CBHI program.

Transparent communication was a defining feature of community engagement in Ethiopia's Community-Based Health Insurance (CBHI) strategy (Adebisi et al., 2021). The study emphasized how crucial it is for the research community to be involved in planning, sharing evidence, regulating procedures, and distributing findings in health research (Carvalho & Capurro, 2016). The study also underlined how important community involvement is to guaranteeing community ownership of research results (Chantler et al., 2018). Open communication and transparency have been found to be essential components of successful community involvement programs because they foster shared accountability and constructive dialogue about health issues among community members (Schlechter et al., 2021). Effective community involvement was found to be hampered by a lack of openness and a distance from the local populace, which emphasizes the significance of open and transparent communication channels when interacting with communities (Solomon et al., 2021).

Regarding the respondent's view, the CBHI strategy showcases a strong partnership between local institutions and the community. They believed that there is a partnership between the CBHI and local institutions like Ambo Hospital (both general and referral hospitals), Gedo Hospital, and Bako Hospital to provide health services to the CBHI members. Besides this, there is collaboration with Kenema Public Pharmacy when there are no medicines within the government hospital and patients buy the prescribed medicines from the agreed pharmacy.

The research result that respondents believe the CBHI strategy showcases a strong partnership between local institutions and the community highlights several key points:

Enhanced Healthcare Access: The involvement of multiple hospitals and a public pharmacy suggests that the CBHI strategy has successfully expanded access to healthcare services. Members can receive care from various institutions, ensuring more comprehensive coverage and the availability of medical services.

Integrated Health Services: The collaboration with hospitals and pharmacies indicates an integrated approach to healthcare delivery. This integration ensures that when government

hospitals lack certain medicines, patients can still obtain their prescribed medications from agreed-upon pharmacies, minimizing disruptions in their treatment.

Community and Institutional Support: The belief in a strong partnership reflects positively on the CBHI program's ability to garner support from both the community and local healthcare institutions. This support is crucial for the program's sustainability and effectiveness.

Improved Service Delivery: The partnerships likely contribute to improved service delivery for CBHI members. By working with established healthcare providers, the program can leverage existing infrastructure and expertise to better serve its members.

Building Trust and Credibility: Effective partnerships with reputable local institutions help build trust and credibility for the CBHI program. When members see that their health needs are being met through a collaborative network of providers, their confidence in the program increases.

Resource Optimization: Collaboration with local hospitals and pharmacies helps optimize resources. It ensures that members have access to necessary treatments and medications even when specific resources are unavailable at one location, demonstrating a practical and flexible approach to healthcare provision.

In summary, respondents' views on the CBHI strategy showcasing a strong partnership between local institutions and the community indicate that the program has effectively established collaborative relationships to enhance healthcare access and service delivery for its members. This collaboration not only improves the quality of care but also strengthens community trust and support for the CBHI program.

Ethiopia's Community-Based Health Insurance (CBHI) program is an example of strong collaboration between community members and local organizations (Geta et al., 2023; Mulat et al., 2022; Kassa, 2023; Daraje, 2022; Alemayehu et al., 2023). With strong political backing and the use of early pilots to guide scaling up, the CBHI implementation boosted international efforts towards universal health coverage and domestic resource mobilization. This tactic encouraged community involvement, enhanced accessibility to healthcare, offered financial security, and gave women more influence. Furthermore, among enrolled households, CBHI dramatically decreased

catastrophic health expenses, demonstrating its efficacy in health service consumption and financial protection. In addition to improving health outcomes, community and local institution participation in the CBHI scheme adds to the program's success and sustainability in Ethiopia.

5.6. Traditional community-support institution and CBHI implementation

5.6.1. Analysis of hypothesis number five (H5)

This section aims to examine the six hypotheses, which state that:

In the west show zone, incorporating traditional community support structures and local healthcare practices into the CBHI strategy results in higher program adoption and sustainability.

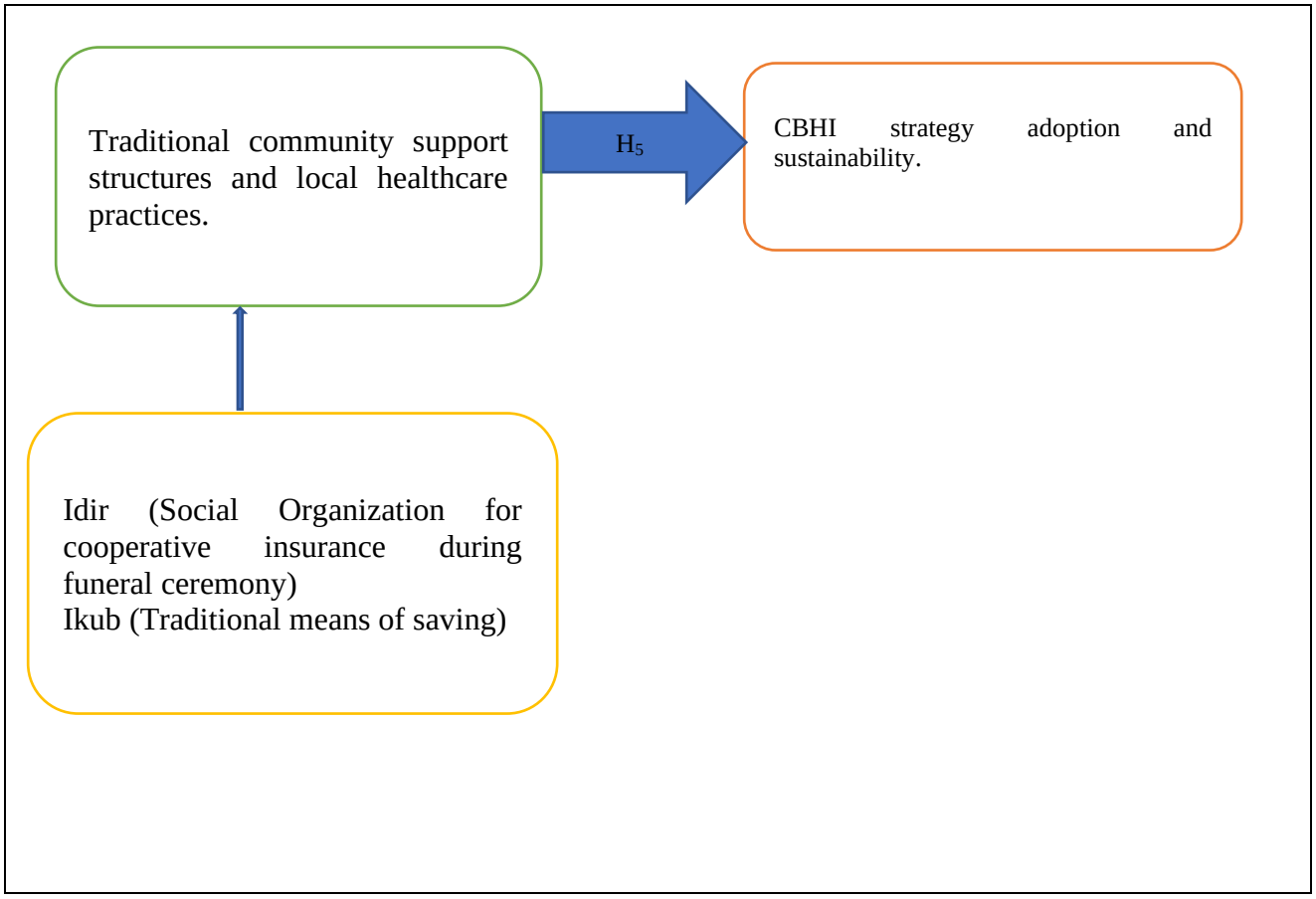

Fig 5.14 Conceptual Model

Source: Author's own compilation based on research methods.

This hypothesis investigates whether incorporating local healthcare (nearby health centres and health posts) and traditional community support systems like Ikub and Idir into the CBHI strategy leads to increased program uptake and sustainability in the West Showa zone. Table 5.6 revealed that the traditional community support system is significantly affecting the adoption and sustainability of the CBHI strategy. The respondent's average response to the elements of the role of traditional community support systems and local healthcare practices in CBHI implementation (Table 5.6) is positive. Therefore, we must accept the above hypothesis (H5).

Table 5.6 The Pearson correlation between CBHI implementation and traditional community support systems

Correlations

		CBHI Implementation	Traditional community support systems
CBHI implementation	Pearson Correlation	1	.026**
	Sig. (2-tailed)		.001
	N	378	378
Traditional community support systems	Pearson Correlation	.026**	1
	Sig. (2-tailed)	.001	
	N	378	378

**. Correlation is significant at the 0.01 level (2-tailed).

Source: Own survey data (2024)

The Pearson correlation between CBHI implementation and traditional community support systems is 0.026, which is positive and significantly correlated. Therefore, CBHI implementation and traditional community support are positively correlated. The more traditional community support institutions engaged the more significant effect it has on CBHI sustainability.

The sig. (2-tailed) value is less than 0.05, implying that CBHI implementation is significantly correlated with traditional community support systems.

Traditional community-support systems in Ethiopia are diverse and deeply rooted in the social and cultural fabric of the country. These systems often provide mutual aid, social cohesion, and various forms of support to community members. Here are some prominent traditional community-support systems in Ethiopia: Edir (a community-based mutual aid association primarily formed to provide

financial and social support during times of bereavement), Ikub (a traditional rotating savings and credit association where members contribute a fixed amount of money regularly), and Mahber (a religious or social association that organizes regular gatherings for spiritual, social, or economic purposes).

The relationship between the implementation of a community-based health insurance (CBHI) system and traditional community support systems can be understood in several dimensions:

Mutual Reinforcement: Traditional community support systems can reinforce CBHI implementation by providing a foundation of trust and solidarity. These systems, which are often based on established social networks and mutual aid practices, can encourage community members to participate in and support the CBHI program.

Enhanced Engagement and Participation: Traditional community support systems can facilitate greater engagement and participation in the CBHI. These systems often involve local leaders and respected figures who can advocate for the CBHI, helping to educate the community and build trust in the program.

Resource Mobilization: Traditional community support systems can aid in resource mobilization for the CBHI. They can help pool financial resources, mobilize volunteers, and provide infrastructure or logistical support, making it easier to implement and sustain the CBHI.

Cultural Compatibility: By integrating with traditional community support systems, the CBHI can be more culturally compatible and acceptable. Traditional systems are often deeply rooted in the community's culture and practices and aligning the CBHI with these systems can facilitate smoother implementation and higher acceptance.

Sustainability: The involvement of traditional community support systems can enhance the sustainability of the CBHI. These systems can provide ongoing support, both financially and socially, helping to maintain the CBHI over the long term. The trust and social cohesion inherent in traditional systems can lead to greater commitment and adherence to the CBHI.

Trust and Credibility: Traditional community support systems can lend credibility to the CBHI. When community members see familiar and trusted systems involved in the CBHI, they are more likely to trust the program and view it as legitimate and beneficial.

Communication and Information Dissemination: Traditional community support systems can play a crucial role in communication and information dissemination. They can help spread

awareness about the CBHI, its benefits, and how to enrol, ensuring that the information reaches all community members, including those who might be harder to reach through formal channels.

In summary, the relationship between CBHI implementation and traditional community support systems is synergistic. Traditional support systems can enhance the effectiveness, acceptance, and sustainability of the CBHI by leveraging their established networks, trust, and cultural alignment with the community.

Table 5.7 The role of traditional community support systems and local healthcare practices on CBHI implementation

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
The involvement of respected community elders in endorsing health care programs positively impacts community members' willingness to participate.	378	4	1	5	4.09	.985	.971
The accessibility of healthcare programs within the community positively influences community members' acceptance of such programs.	378	4	1	5	4.03	1.064	1.132

The level of integration of local healthcare practices into modern healthcare programs impacts the community's perception of the programs' relevance.	378	4	1	5	4.13	1.002	1.004
The current healthcare programs gain acceptance among community members because they prioritize community input and feedback.	378	4	1	5	4.03	1.090	1.187
The presence of effective communication channels between healthcare providers and community members facilitates program acceptance.	378	4	1	5	4.05	1.038	1.077
Traditional rituals and ceremonies that incorporate healthcare messages contribute to the community's openness to healthcare programs in my area.	378	4	1	5	4.08	.994	.988

Traditional community leaders' endorsement of healthcare programs fosters a sense of trust and credibility among community members.	378	4	1	5	4.05	1.028	1.056
The availability of healthcare information in local languages increases the likelihood of program acceptance by the community.	378	4	1	5	4.29	.904	.818
The involvement of women and mothers in healthcare decisions positively influences the community's acceptance of healthcare initiatives.	378	4	1	5	4.20	.917	.842
The presence of community-based healthcare workers enhances the community's understanding and acceptance of healthcare programs.	378	4	1	5	4.09	1.022	1.044
Valid N (listwise)	378						

Source: own survey data (2024)

The beneficiaries were asked about the impact of local healthcare practices and conventional community support networks on CBHI implementation in Table 5.7 above. Therefore, the

information below shows what the beneficiaries think about the effect of traditional community support systems and local healthcare practices on CBHI implementation. The two factors taken into consideration to determine the point for each key component were the weight assigned to each major element and the score assigned to each significant element inside the factor. A perfect score of five would denote strong agreement; a score of four would denote agreement; a score of three would denote neutrality; a score of two would denote disagreement; and a final score of one would yield one mark (strongly disagree).

In terms of the involvement of respected community elders in endorsing health care programs, it positively impacts community members' willingness to participate. Respondents agree that the involvement of community elders had a positive impact on the decision to enrol in the CBHI. This implies that CBHI has high acceptance rates when endorsed by elders in the community. Community elders often hold significant influence and are trusted figures within their communities. Their endorsement and involvement in the CBHI program likely increase trust and credibility, encouraging more community members to enrol. The involvement of elders helps ensure that the CBHI program is culturally relevant and acceptable to the community. Elders can bridge the gap between traditional practices and modern initiatives, facilitating smoother integration and acceptance. Elders serve as role models for the community. Their participation can inspire and motivate others to follow suit, leading to higher enrolment rates. When respected elders support and participate in the program, it signals to others that the CBHI is beneficial and trustworthy.

The desire of community members to participate in health care programs in Ethiopia is positively impacted when respected community elders are involved in the endorsement process. Research indicates that when community leaders support community-based health insurance (CBHI) programs, these initiatives are highly accepted (Demeke, 2023; Kasim et al., 2019). Elders are also essential in meeting the social and emotional needs of the community, which improves everyone's general wellbeing and encourages participation in health initiatives (Kedir et al., 2022). Moreover, programs such as Iddir-based health insurance systems, which make use of community self-help organizations, have demonstrated a significant degree of participation, particularly from individuals with greater wealth, education, and family sizes (Kassahun et al., 2018). Thus, community members' willingness to participate in healthcare services and enrol in health insurance plans can be greatly influenced by the involvement of esteemed seniors in health care activities.

In terms of accessibility, healthcare programs within the community positively influence CBHI programs. The data found in the above table 5.6 indicates that respondents perceive the Community-Based Health Insurance (CBHI) programs positively within their community. They believe that these programs are successful in gaining acceptance and are effective in making healthcare services more accessible. This suggests that the CBHI programs are likely meeting community needs and reducing barriers to healthcare, such as cost and availability, thereby improving overall health service utilization and potentially health outcomes.

Community-Based Health Insurance (CBHI) programs benefit from the availability of healthcare services in the local area (James et al., 2008; Chen and Wu, 2022; Simiene et al., 2021). Research indicates that increasing the geographic reach of healthcare facilities improves healthcare service equity, which is advantageous for CBHI initiatives (Donfouet & Mahieu, 2012). Furthermore, studies show that CBHI programs have improved members' access to healthcare services, highlighting the significance of these initiatives in enhancing healthcare access for the intended population (Yu et al., 2018). CBHI members have greater rates of healthcare-seeking behaviour than non-members, demonstrating the substantial influence of the organization on healthcare-seeking behaviour for pediatric illnesses. For this reason, improving community access to healthcare services is essential to the efficacy and success of CBHI initiatives.

The level of integration of local healthcare practices into modern healthcare programs impacts the community's perception of the programs' relevance. The research result suggests that the respondents believe that integrating local healthcare practices within modern healthcare programs has positively influenced their perception of community-based health insurance (CBHI). This indicates that blending familiar, culturally relevant healthcare approaches with modern medical practices has enhanced acceptance and trust in CBHI programs. The integration likely resonates better with community values and practices, making the CBHI programs more relatable and effective in encouraging participation and utilization.

The degree to which contemporary healthcare programs include indigenous medical practices influences how relevant community-based health insurance (CBHI) is viewed in Ethiopia. Research indicates that CBHI programs have improved the perception of the quality of healthcare services, decreased catastrophic health spending, and increased the use of healthcare services (Bayked et al., 2023; Geta et al., 2023). Nonetheless, differences in healthcare use continue to exist across many sociodemographic variables, suggesting that the CBHI scheme has to be specifically

improved in order to address these differences (Bayked et al., 2023; Musa et al., 2023). Although beneficiary satisfaction with CBHI in Ethiopia is moderate, there are signs that improving population coverage and healthcare quality is necessary to effectively achieve universal health coverage (Geta et al., 2023). Therefore, the community's opinion of the CBHI scheme's relevance and its overall influence on healthcare services in Ethiopia can be improved by skilfully incorporating traditional medical practices with contemporary healthcare initiatives.

Regarding the types of communication channels between health care providers and users, the research result indicates that respondents believe the existing communication channels between healthcare providers and users are effective. This effectiveness in communication plays a significant role in facilitating the acceptance of Community-Based Health Insurance (CBHI) programs. Clear, efficient communication likely helps in disseminating information, addressing concerns, and building trust, thereby encouraging more people to participate in and benefit from CBHI programs.

Studies show that using efficient channels of communication between health care providers and the community impacts the adoption of health care programs in Ethiopia.

In Ethiopia, health program adoption is greatly influenced by the availability of efficient channels of communication between healthcare personnel and the community (Wolka et al., 2022). Research on Mobile Health and Nutrition Teams (MHNTs) in Ethiopia emphasizes the significance of government ownership and community involvement as sustainability drivers (Tsegaye et al., 2022; Abamecha et al., 2021). Furthermore, the perceived quality, utility, and accessibility of health education resources are factors that impact their use during pandemics such as COVID-19, underscoring the importance of communication tools in healthcare environments (Debele et al., 2022). As demonstrated by the school-engaged SBCC strategy for malaria prevention, putting techniques that improve communication into practice, such as behaviour change communication interventions, can have a substantial influence on program acceptability and viability. Thus, promoting efficient channels of communication between communities and healthcare practitioners is crucial to guaranteeing program acceptability and success in Ethiopia.

Like other health care programs, CBHI schemes are influenced by the efficient channels of communication between employees of health care and the user.

Traditional rituals and ceremonies that incorporate healthcare messages contribute to the community’s openness to healthcare programs in Ethiopia. The research result suggests that

traditional rituals and ceremonies incorporating healthcare messages significantly contribute to the community's openness to healthcare programs, including Community-Based Health Insurance (CBHI). Respondents agreed that receiving information and awareness about CBHI from trusted figures such as religious leaders, local administrators, and CBHI officials has effectively increased their understanding and acceptance of these programs. This approach leverages established social structures and trusted community leaders to enhance communication and trust, thereby fostering greater engagement and participation in healthcare initiatives.

In Ethiopia, traditional rituals and ceremonies like coffee ceremonies held after childbirth and gatherings for community discussions during coffee ceremonies are very important in spreading health-related information and raising community involvement in healthcare initiatives (Limperg et al., 2021; de Fouw et al., 1999). These cultural traditions facilitate the acceptance and adoption of healthcare services, such as screening for cardiovascular disease and cervical cancer, in addition to acting as platforms for the dissemination of health-related information (Kedir et al., 2022; Aragaw et al., 2020). Furthermore, the community's deeply ingrained knowledge and behaviours are reflected in traditional medicine, which is extensively practiced in Ethiopia, and this influences the community's attitudes regarding healthcare treatments (Levene et al., 2016). Comprehending and integrating these customary beliefs and practices into healthcare initiatives helps cultivate community trust, acceptance, and involvement, ultimately leading to enhanced healthcare results in Ethiopia.

The research result indicates that the endorsement of healthcare programs by traditional community leaders fosters a significant sense of trust and credibility among community members. With a mean value of 4.05, it suggests that the community leaders' support of Community-Based Health Insurance (CBHI) schemes have a strong positive impact on the community's trust and perception of these programs. This endorsement likely helps legitimize the CBHI schemes, encouraging greater acceptance and participation from community members.

There are various studies conducted in Ethiopia that support this conclusion.

In Ethiopia, traditional community leaders are vital in supporting healthcare initiatives and building community members' credibility and trust. Studies conducted in rural Ethiopia demonstrate the value of the Health Development Army (HDA) and Health Extension Workers (HEWs) as reliable health communicators who successfully disseminate maternal health information (Akafu et al., 2023). Furthermore, community trust and involvement are increased

when diverse actors, such as health extension workers, religious leaders, and community members, are involved in the promotion of mother and child health services (Asfaw et al., 2019). Additionally, trust levels are strongly impacted by household heads' endorsement of community-based health insurance schemes and members' positive opinions toward the scheme, highlighting the significance of trust-building elements in healthcare programs (Mamo et al., 2019; Akafu et al., 2023). Overall, the support of traditional community leaders enhances credibility and confidence, which in turn increases the efficacy of Ethiopia's healthcare programs.

The data found in the above table 5.6 revealed that the availability of healthcare information in the local language, mainly Afaan Oromo, has a significant positive impact on the acceptance of community-based health insurance (CBHI) within the community. Respondents agreed that being able to access healthcare services and information in their mother tongue enhances their understanding and trust in the CBHI scheme, thereby increasing its acceptance and effectiveness within the community. This highlights the importance of culturally and linguistically appropriate communication in promoting public health initiatives.

The community's adoption of the program in Ethiopia is greatly influenced by the accessibility of healthcare information in their native tongues. Research indicates that the utilization of the Health Extension Program (HEP) as a service delivery platform facilitated the effective execution and expansion of evidence-based interventions (EBIs) across the country, hence enhancing the viability and coverage of healthcare initiatives (Tadele et al., 2023). In addition, the electronic Community Health Information System (eCHIS) program emphasized the significance of community-wide activities to integrate health structures and promote community health, with a focus on improving the quality of healthcare data and service supply (Hailemariam et al., 2023). Additionally, it was discovered that healthcare providers used printed Information, Education, and Communication (IEC) materials rather frequently, highlighting the significance of offering health education through a variety of learning resources (Drown et al., 2024). As a result, in Ethiopia, providing healthcare information in the native tongue improves community participation and program acceptance.

Apropos respondents' responses on the involvement of women and mothers in healthcare decisions positively influence the community's acceptance of healthcare initiatives. The data found in the above table 5.6 show that respondents believe the engagement of mothers and women in healthcare decisions has a positive impact on the acceptance of Community-Based Health

Insurance (CBHI) schemes by the community. This involvement likely empowers women, who often play key roles in family health and decision-making, thereby fostering greater trust and participation in the CBHI schemes. Their active participation helps ensure that the healthcare needs and preferences of families are better understood and addressed, contributing to the overall success and acceptance of the program.

Women and mothers' involvement in healthcare decision-making has a substantial impact on the community's acceptance of healthcare programs. Women play an important role in determining decisions on reproductive health, immunization programs, and maternal healthcare, which influences community acceptability of these activities (Meier et al., 2023; Jaya et al., 2019; Batura et al., 2022).

In Ethiopia, women's participation in healthcare decision-making has a substantial impact on the acceptability of healthcare efforts by the community. Studies show that women's autonomy in maternity healthcare decision-making has a favourable impact on service utilization (Kebede et al., 2023; Getu et al., 2023). Furthermore, including women in decision-making processes for maternal health services improves the continuum of care, enabling continued access to treatments from early pregnancy to postpartum (Ayele et al., 2022). Gender-based norms, power dynamics, and social support all play important roles in mouldings women's decisions about childbirth and postnatal care services, eventually influencing community attitudes and acceptance of healthcare initiatives (Kassahun & Zewdie, 2022). Gender intersectionality, specifically men's involvement in supporting women's healthcare decisions, is emphasized as critical for increasing access to and use of reproductive, maternity, and child health services in Ethiopia (Tiruneh et al., 2021).

The research result indicates that the presence of community-based healthcare workers, such as health extension workers, positively impacts the community's understanding and acceptance of Community-Based Health Insurance (CBHI). Respondents agreed that these health workers play a crucial role in raising awareness and promoting the benefits of CBHI, thereby enhancing its acceptance. Their direct engagement with the community helps in effectively disseminating information, addressing concerns, and building trust in the CBHI schemes. Healthcare professionals who work in the community are essential to the public health system. They serve as vital conduits between formal healthcare institutions and communities, advancing community-clinical ties, culturally competent care, and health fairness (Mashauri, 2023; Rodriguez et al., 2023).

The acceptability of health insurance among informal workers is significantly influenced by community-based healthcare providers. Research indicates that elements like professionalism, secrecy, and trust affect how well-liked community health workers (CHWs) are when they perform home visits to provide maternity and child health services (Ahmed et al., 2018). Enrolment rates are also greatly impacted by the knowledge and attitudes of informal workers toward community-based health insurance (Bantie et al., 2020). Additionally, it has been discovered that the introduction of Community-Based Health Insurance (CBHI) programs increases the number of insured informal workers who use healthcare services from medically qualified providers, underscoring the beneficial effects of such programs on the acceptance and use of health insurance (Mussa et al., 2023). All things considered, the existence and efficacy of CHWs can improve the populations of informal workers' acceptance and use of health insurance. Community-based healthcare workers influence health insurance uptake through a variety of approaches. According to studies, CHWs have a considerable impact on the consumption of maternal health services because they are aware of warning signals, get sufficient training, and have vital maternal care skills (Eric et al., 2023). Furthermore, CHWs help to raise awareness and enrolment in community-based health insurance schemes by providing frequent supervision, transportation, refresher training, and motivation, all of which have been linked to improved maternal healthcare uptake (Boyer et al., 2021). Geographic distance, individual risk choices, wealth, education, and community participation all have an impact on health insurance adoption, emphasizing CHWs' diverse role in promoting access to important healthcare services and financial risk protection (Ntube et al., 2023; Bantie et al., 2020; Bayked et al., 2021).

Table 5.8 The correlations between DV and IV

Correlations

		CBHI implementation	Financial Hard ship	Community health outcome
CBHI implementation	Pearson Correlation	1	.221**	.246**
	Sig. (2-tailed)		.000	.000
	N	378	378	378
Financial Hard ship	Pearson Correlation	.221**	1	.582**
	Sig. (2-tailed)	.000		.000
	N	378	378	378
Community health outcome	Pearson Correlation	.246**	.582**	1
	Sig. (2-tailed)	.000	.000	
	N	378	378	378

** Correlation is significant at the 0.01 level (2-tailed).

Source: Own survey data (2024)

5.7.Analysing the initial study hypothesis (H1)

This sub-section of this chapter examines the first research hypothesis, which asserts that:

CBHI programs in Ethiopia cover outpatient and inpatient care, critical drugs, maternity and child health services, and specific diagnostic tests. However, specialized and high-cost medical procedures have limited coverage, requiring beneficiaries to seek additional financial assistance.

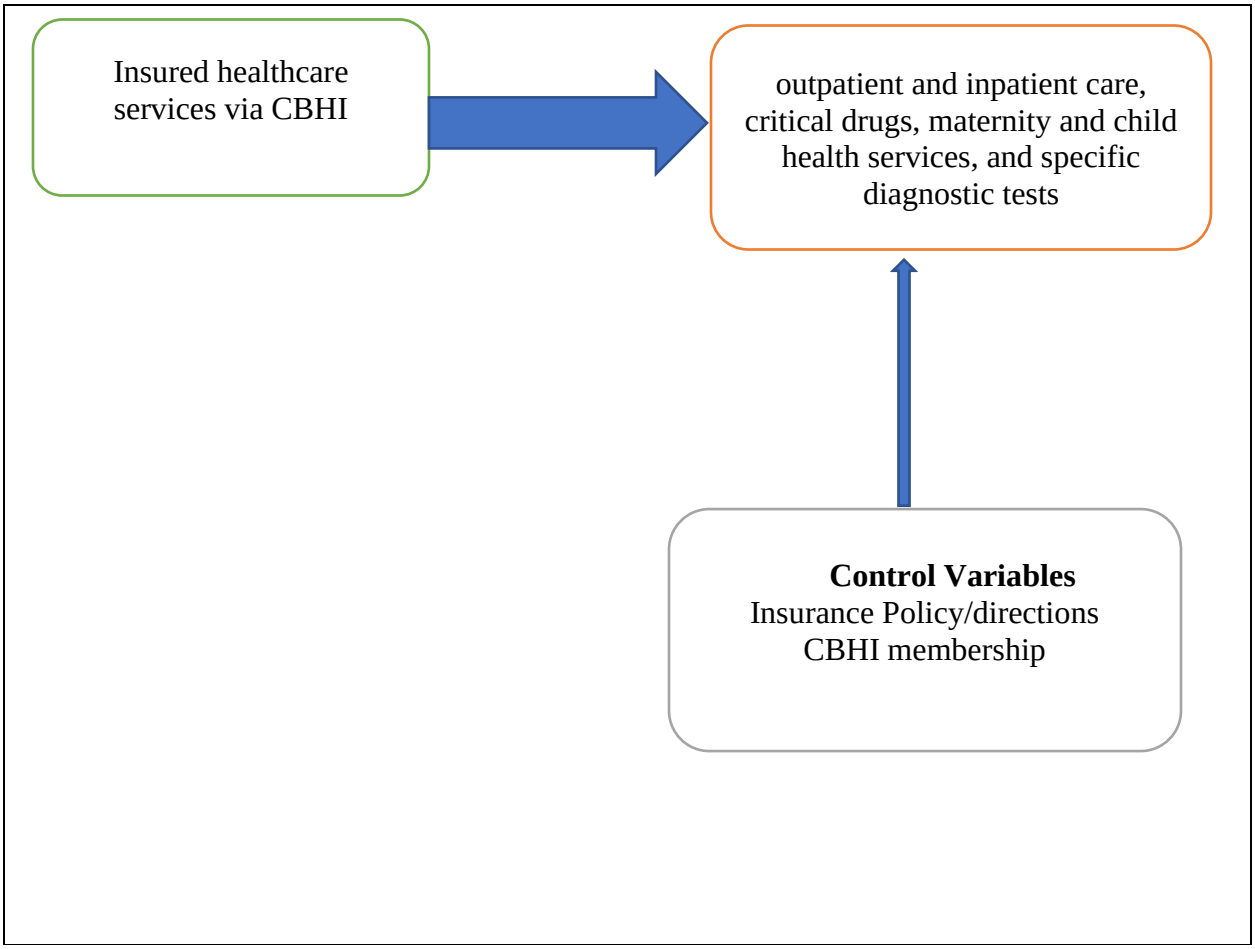

Fig5.15 Conceptual Model 1

Source: compiled by the authors using the research methodology

As figure 5.15shows, this hypothesis examines major variables related to healthcare services provided for CBHI members, which could have a direct and significant effect on the satisfaction

of the community with the sachem's coverage. Thus, the first hypothesis examines whether the insured healthcare services are comprehensive or not.

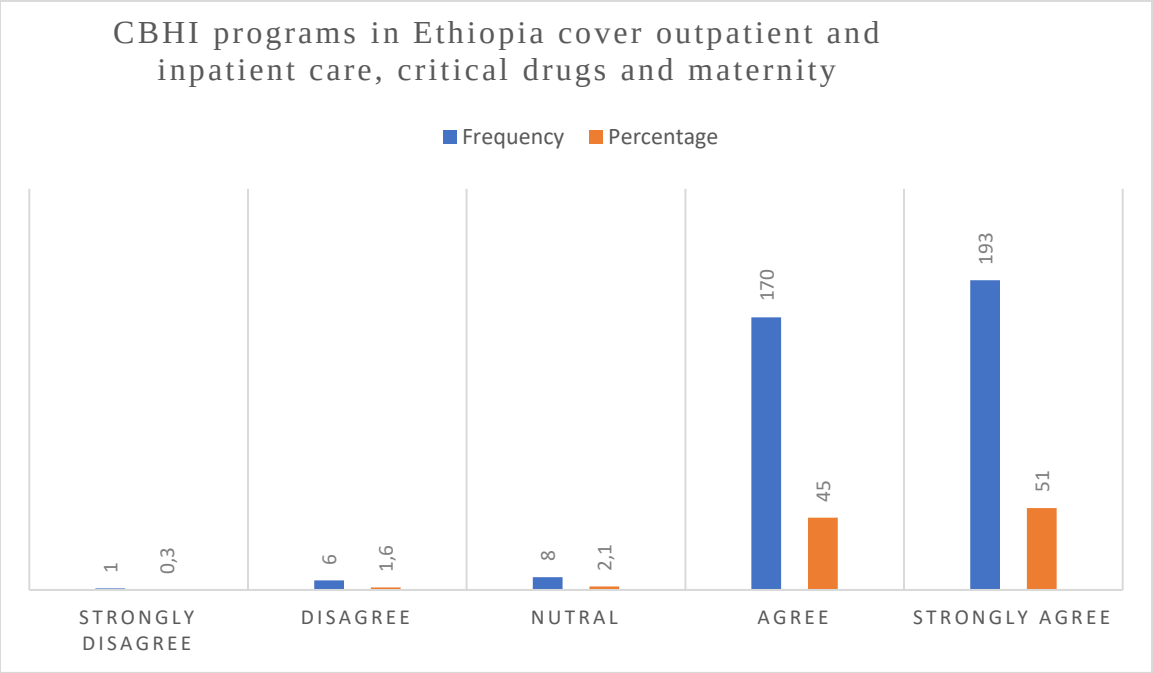

Fig5.16 Insured healthcare services covered by CBHI

Source: Own survey data (2024)

The result indicates that the majority (96%) of respondents believe that Community-Based Health Insurance (CBHI) programs in Ethiopia provide coverage for essential healthcare services such as outpatient and inpatient care, critical medications, maternity and child health services, and specific diagnostic tests. However, the coverage is not comprehensive when it comes to more costly and specialized medical procedures. Those serves are

1. Expensive and Specialized Medical Procedures:
2. Complex surgeries
3. Specialized treatments (e.g., cancer treatment, kidney dialysis)
4. Advanced diagnostic tests (e.g., MRIs, CT scans)

5. High-Cost Medications:
6. Drugs for chronic or life-threatening conditions that are expensive and require long-term use.
7. Specialized Consultations and Treatments:
8. Care is provided by specialist doctors, particularly in private hospitals.
9. Specialized therapies, such as physiotherapy or rehabilitation services.
10. Cosmetic and non-essential treatments:
11. Procedures deemed non-essential, such as cosmetic surgeries,
12. Private Healthcare Services:
13. Services provided in private health facilities are often not covered or are partially covered.
14. International Treatment:
15. Treatments sought outside of Ethiopia are generally not covered.
16. The exclusions highlight areas where CBHI coverage is limited, and beneficiaries may need to pay out-of-pocket or seek alternative funding for these services.

This gap means that beneficiaries who require such services often need to seek alternative financial support, as the CBHI program does not fully cover these more expensive treatments. This could highlight a potential area for improvement in the CBHI programs to better meet the healthcare needs of beneficiaries, especially for critical and specialized treatments. Accordingly, the first research hypothesis (H1) was accepted.

Table 5.9 Correlation Coefficient and Interpretation

Pearson Correlation Coefficient of absolute magnitude of the observed	Interpretation
+/- 0.00-0.10	Positive/Negative Negligible correlation
+/- 0.10-0.39	Positive/Negative Weak correlation
+/- 0.40-0.69	Positive/Negative Moderate Correlation
+/- 0.70-0.89	Positive/Negative Strong Correlation
+/-90-1.00	Positive/Negative Very strong Correlation

Source: Schober et al., (2018)

Based on the above table 5.9, we can interpret the data found in the above table 5.8.

The Pearson correlation between CBHI implementation and protecting the CBHI user from financial hardship is 0.221, which implies a positive and weak correlation. The more people enrolled in CBHI, the more they are protected from catastrophic health care costs at the time they seek health services.

When we come to its sig. (2-tailed), as we can see in the above table 5.8, since the value is less than 0.05, it is significant. CBHI implementation and protecting the CBHI user from financial hardship are significantly correlated.

The Pearson correlation between CBHI implementation and community-health outcomes is 0.246; this implies that there is a positive correlation between them, but they have a negative correlation.

When we see the sig. (2-tailed) value in the above table 5.8, it is less than 0.05, which means the correlation is significant. Implementation of CBHI and community-health outcomes is significantly correlated.

One Way MONOVA Analysis

Table 5.10 Descriptive Statistics

	Implementation	Mean	Std. Deviation	N
Financial Hard ship	1.46	3.8571	.	1
	1.54	3.6429	.10102	2
	1.77	3.7143	.	1
	2.31	3.1429	.	1
	2.54	4.7143	.00000	2
	2.62	3.8571	.	1
	3.15	4.7143	.00000	2
	3.23	4.5714	.00000	2
	3.31	4.8571	.00000	2
	3.38	3.6429	1.65985	4
	3.46	3.3810	1.57359	3
	3.54	3.7714	1.31940	5
	3.62	4.3929	.47201	4
	3.69	3.9107	1.02715	8
	3.77	4.3482	.75226	16
	3.85	4.4762	.71344	18
	3.92	3.9929	.93904	20
	4.00	4.4089	.31187	29
	4.08	4.3247	.39739	44
	4.15	4.3547	.53673	29
	4.23	4.0045	.92474	32
	4.31	4.3401	.38986	21
	4.38	4.4041	.73621	35
	4.46	4.4929	.31256	20
	4.54	4.4762	.34300	18
	4.62	4.5714	.44416	19

	4.69	4.6939	.17357	7
	4.77	4.5238	.11121	12
	4.85	4.7857	.08248	4
	4.92	4.6190	.14754	6
	5.00	4.7429	.17561	10
	Total	4.3348	.65293	378
Community health	1.46	3.5385	.	1
outcome	1.54	3.6154	.10879	2
	1.77	3.6923	.	1
	2.31	4.0769	.	1
	2.54	4.5385	.00000	2
	2.62	4.0000	.	1
	3.15	4.3077	.00000	2
	3.23	4.3846	.00000	2
	3.31	4.3077	.00000	2
	3.38	3.5000	1.29709	4
	3.46	3.2308	1.70103	3
	3.54	3.8308	1.03832	5
	3.62	4.0192	.19231	4
	3.69	4.0769	.40076	8
	3.77	4.0769	.73514	16
	3.85	4.3120	.39881	18
	3.92	4.0038	.85055	20
	4.00	4.2467	.25043	29
	4.08	4.1993	.29552	44
	4.15	4.2626	.24283	29
	4.23	4.0144	.82767	32
	4.31	4.0293	.66461	21
	4.38	4.3209	.55171	35

	4.46	4.3923	.34210	20
	4.54	4.4060	.22820	18
	4.62	4.3401	.20723	19
	4.69	4.3846	.28782	7
	4.77	4.5385	.10372	12
	4.85	4.7692	.08882	4
	4.92	4.4103	.14322	6
	5.00	4.5538	.13950	10
	Total	4.2163	.54178	378

Source: Own survey data (2024)

Box's Test of Equality of Covariance Matrices[a]

Box's M	431.068
F	6.399
df1	60
df2	4760.662
Sig.	.000

Tests the null hypothesis that the observed covariance matrices of the dependent variables are equal across groups.

a. Design: Intercept + Implementation

Based on the above result:

The covariance matrices of financial hardship and community health outcomes are equal across the group.

As we can see from the sig. values of Box's test of equality of covariance matrices, it is significant, so we will reject the null hypothesis, which states that:

- The implementation of CBHI is not significantly protecting the community from financial hardship at the time of seeking health services.
- The implementation of CBHI is not significantly improving the community's health outcomes.

Table 5.11 Multivariate Tests[a]

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	Pillai's Trace	.958	3914.875[b]	2.000	346.000	.000	.958
	Wilks' Lambda	.042	3914.875[b]	2.000	346.000	.000	.958
	Hotelling's Trace	22.629	3914.875[b]	2.000	346.000	.000	.958
	Roy's Largest Root	22.629	3914.875[b]	2.000	346.000	.000	.958
CBHI Implementation	Pillai's Trace	.232	1.515	60.000	694.000	.009	.116
	Wilks' Lambda	.777	1.550[b]	60.000	692.000	.006	.118
	Hotelling's Trace	.276	1.585	60.000	690.000	.004	.121
	Roy's Largest Root	.226	2.615[c]	30.000	347.000	.000	.184

a. Design: Intercept + Implementation

b. Exact statistic

c. The statistic is an upper bound on F that yields a lower bound on the significance level.

The multivariate tests of CBHI implementation The Wilks-Lambda test is used to test whether CBHI implementation is significant in reducing financial hardship for the community at the time

of seeking health services or not. As well, whether CBHI is significantly improving the community's health outcome or not.

As the value of the Wilks-Lamda test is 0.006, it is significant since it is less than 0.05, so we will reject the null hypothesis and accept the following hypothesis:

- The implementation of CBHI is significantly protecting the community from financial hardship when seeking health services.
- The implementation of CBHI is significantly improving the community's health outcomes.

Table 5.12 Levene's Test of Equality of Error Variances[a]

		Levene Statistic	df1	df2	Sig.
Financial hardship	Based on Mean	3.072	26	347	.000
	Based on Median	1.797	26	347	.011
	Based on Median and with adjusted df	1.797	26	154.165	.016
	Based on trimmed mean	2.648	26	347	.000
Community health outcome	Based on Mean	3.614	26	347	.000
	Based on Median	1.906	26	347	.006
	Based on Median and with adjusted df	1.906	26	124.955	.010
	Based on trimmed mean	2.966	26	347	.000

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.

a. Design: Intercept + Implementation

- Since the values of financial hardship based on the mean are significant, we will reject the null hypothesis that the error variance of the dependent variable is equal across groups.
- If the value of the community health outcome based on the mean is significant, we will reject the null hypothesis.

Table 5.13 Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	FH	24.892[a]	30	.830	2.120	.001	.155
	CHO	17.331[b]	30	.578	2.148	.001	.157
Intercept	FH	1943.955	1	1943.955	4966.207	.000	.935
	CHO	1846.332	1	1846.332	6864.698	.000	.952
Implementation	FH	24.892	30	.830	2.120	.001	.155
	CHO	17.331	30	.578	2.148	.001	.157
Error	FH	135.828	347	.391			
	CHO	93.329	347	.269			
Total	FH	7263.673	378				
	CHO	6830.503	378				
Corrected Total	FH	160.720	377				
	CHO	110.661	377				

a. R Squared = .155 (Adjusted R Squared = .082)

b. R Squared = .157 (Adjusted R Squared = .084)

- The implementation of CBHI is significantly protecting the community from financial hardship when seeking health services.
- The implementation of CBHI is significantly improving the community's health outcomes.

5.8. Analysing the fourth study hypothesis (H4)

This section aims to examine the fourth research hypothesis, which states that

The West Shewa Zone of Ethiopia will benefit from improved healthcare access and financial protection through the implementation of community-based health insurance (CBHI), but obstacles will need to be overcome, including inadequate funding, inadequate infrastructure, low enrolment and participation rates, and a lack of knowledge among the target population about the benefits of health insurance.

As shown in Tables 5.11 and 5.13, the Wilks-Lamda test value of 0.006 indicates significance as it is less than 0.05. Therefore, the null hypothesis is rejected, and the above hypothesis is accepted. The implementation of CBHI is significantly protecting the community from financial hardship when seeking health services. The implementation of CBHI is significantly improving the community's health outcomes. However, challenges such as inconsistent quality of healthcare services under CBHI coverage, inadequate infrastructure and healthcare facilities, the complex and time-consuming process of claims reimbursement within CBHI systems, and a limited healthcare provider network hindering access to quality services under CBHI are affecting the implementation of the implementation of the CBHI scheme in the West Show Zone (Table 5.2).

5.9. Summary and Partial Conclusion

Community-based health insurance (CBHI) has balanced gender participation, with almost equal membership among males and families. CBHI is playing a vital role in improving healthcare access for marginalized groups, particularly women, in developing countries like Ethiopia, where traditional healthcare services are challenging to access. The implementation of CBHI programs has significantly enhanced women's access to healthcare services and financial protection, contributing to improved health outcomes for women in underserved communities.

Among the 378 CBHI members surveyed, 52.12% were males and 47.88% were females. Family membership and participation in CBHI are almost equal to those of males. CBHI has helped improve access to healthcare services for marginalized groups, especially women, in developing countries like Ethiopia. Beneficiaries report inconsistent quality of healthcare services under CBHI, causing dissatisfaction. Mean score for service quality is 4.06, indicating strong agreement on inconsistency. Inadequate infrastructure negatively impacts CBHI effectiveness, with a mean score of 4.15. Claim reimbursement process perceived as moderately complex and time-consuming. Lack of awareness about CBHI options significantly hinders enrolment, with a mean score of 4.35. Community involvement in CBHI policy formulation is uneven, affecting program effectiveness. Disparities in community engagement lead to inadequate representation of needs in CBHI policies. Majority feel community perspectives are poorly considered in CBHI strategy formulation. Effective community engagement is crucial for the success of CBHI programs. Studies support the need for improved outreach and educational efforts regarding CBHI.

57.7% of respondents believe community feedback influence on CBHI strategy is poor. Power dynamics within the community hinder adequate representation in strategy formulation. Positive but weak correlation (0.25) between community engagement and CBHI implementation. Increased community participation is associated with better CBHI implementation, but other factors are also significant. Community engagement is vital for the effectiveness and sustainability of CBHI in Oromia. Active involvement and awareness campaigns are essential for increasing CBHI utilization. Community engagement and participation in CBHI development are perceived negatively. Respondents disagree that the CBHI strategy effectively engages community members (mean score 2.51). Significant efforts made to raise awareness about CBHI, with a mean score of 4.20. Community members' involvement is crucial for the success of CBHI programs. Community participation significantly impacts the development and modification of the CBHI strategy.

Community involvement leads to significant changes in the CBHI strategy. Collaborative approach enhances acceptance and success of the CBHI scheme. Leadership influence is leveraged in strategy formulation, aligning it with community needs. Involvement of community leaders enhances legitimacy and acceptance of the CBHI strategy. The strategy effectively addresses community health service needs and preferences. Policymaker participation ensures the CBHI strategy is feasible within legal frameworks. Ongoing community involvement is encouraged in the CBHI strategy. Respondents believe the strategy promotes trust and transparency among community members. High mean value (4.34) indicates commitment to addressing community challenges. The CBHI strategy is perceived as committed and responsive to community needs. Positive perception of CBHI performance can lead to higher enrolment and community support. The CBHI strategy reflects community aspirations for better healthcare.

Community-centered approach ensures relevance and responsiveness to health concerns. Enhanced support and engagement from community members when their aspirations are reflected. Improved health outcomes are likely when strategies align with community needs. Strong partnership between CBHI and local institutions enhances healthcare access. Collaboration with local healthcare providers ensures comprehensive service delivery. Traditional community support systems positively affect CBHI adoption and sustainability. Positive correlation between CBHI implementation and protection from financial hardship. Significant correlation between CBHI implementation and community health outcomes. Implementation of CBHI significantly protects against financial hardship and improves health outcomes. CBHI implementation improves

healthcare access and financial protection but faces challenges. Inconsistent service quality, inadequate infrastructure, and low enrolment hinder CBHI effectiveness. The 2019 Mini Ethiopian Demographic and Health Survey highlighted the importance of community-based health insurance in enhancing reproductive-age women's access to healthcare in Ethiopia. Women's access to healthcare services and financial protection has significantly increased with the implementation of CBHI programs. The study analysed the impact of community-based health insurance (CBHI) on financial hardship and community health outcomes. The results showed that CBHI implementation significantly reduced financial hardship and improved community health outcomes. Tests like Box's test and Wilks lambda were used to assess the significance of the results. Levene's test indicated significant differences in error variances across groups for financial hardship and community health outcomes. The study confirmed that CBHI implementation is beneficial but faces challenges like inadequate funding, infrastructure, and low enrolment rates. Despite improvements in financial protection and health outcomes, challenges like inconsistent healthcare quality and limited provider networks hinder CBHI effectiveness.

Chapter Six: CBHI Implementation and Challenges from CBHI Employees' Perspectives

6.1. Introduction

This chapter presents the feedback of employees of CBHI at the federal, regional, and district levels. This includes the background of the respondents, The relationship between administrative capacity, level of education, and work experience Challenges of CBHI Implementation, Influence of stakeholders on the success of CBHI strategy implementation in the study area, The effect of administrative capacity and manpower on CBHI implementation in the West Showa zone, the effect of resource allocation on CBHI implementation in the West Showa zone, and the relationship between administrative capacity, level of education, and work experience. Randomly selected 50 participants were selected for providing their responses, and interviews were also conducted with higher officials of CBHI.

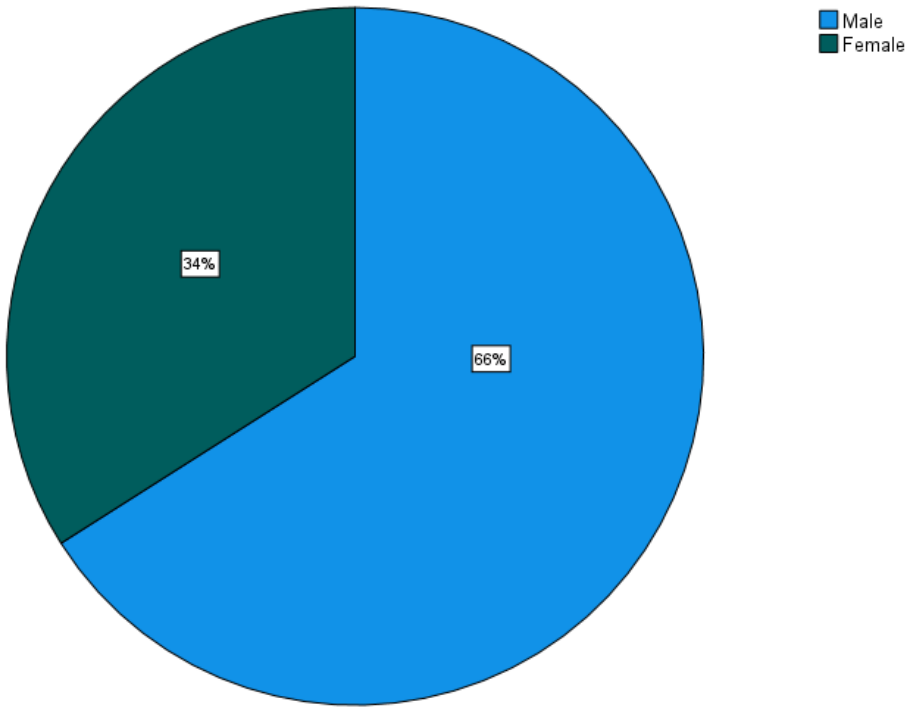

Fig 6.1 Sample distribution based on Gender

Source: Own survey data (2024)

Thirty of the total responses were men, making up 66% of the sample, while the remaining twenty were female CBHI employees, making up 34% of the sample. This suggests that male CBHI employees made up most of the respondents.

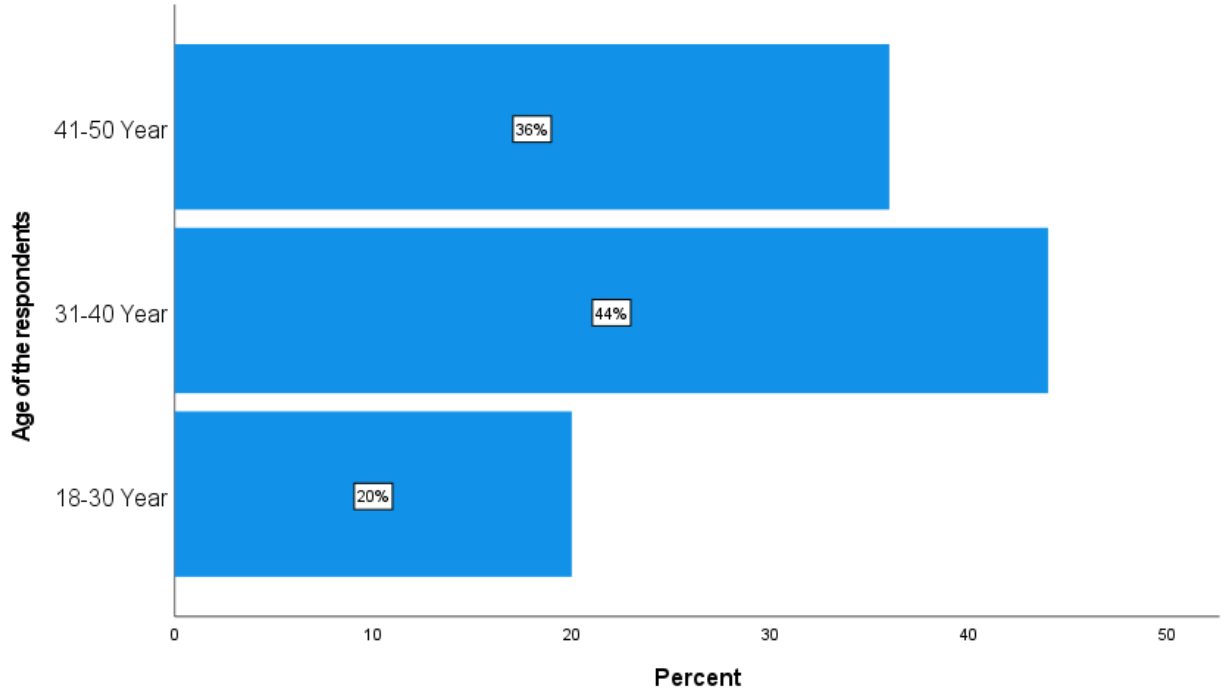

Fig 6.2 Age of the respondents

Source: Own survey data (2024)

The age distribution of the respondents shows that 10 individuals, or 20% of the sample, were between 18 and 30 years old. A larger group of 22 respondents, making up 44% of the sample, fell within the 31–40 age range. Finally, 18 respondents, accounting for 36% of the sample, were aged between 41 and 50 years old.

This distribution implies that most of the respondents (64%) are in the younger to middle-aged workforce, particularly those between 31 and 50 years old. The significant representation of younger individuals suggests that the CBHI workforce is largely composed of people in their prime working years, which could indicate a dynamic and active workforce capable of implementing and managing the program effectively.

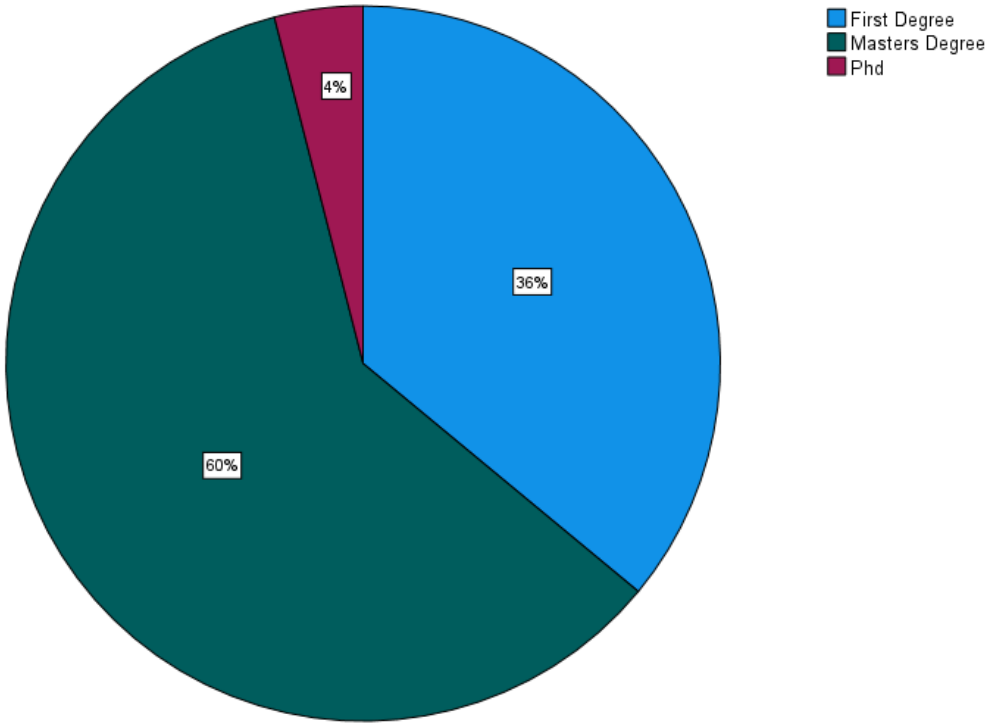

Fig 6.3 Sample distribution by Level of Education

Source: Own survey data (2024)

In terms of educational level, the data shows that 18 respondents, or 36% of the sample, hold a first degree (bachelor's degree). A larger portion of the 30 respondents, or 60% of the sample, have a master's degree. Additionally, 2 respondents, accounting for 4% of the sample, are PhD holders. This suggests that most of the respondents (64%) have an advanced level of education (a master's degree or higher). The high level of education among the respondents likely contributes positively to their productivity and the overall effectiveness of the Community-Based Health Insurance (CBHI) program. The presence of a well-educated workforce may enhance the implementation, management, and success of the CBHI scheme, as these individuals are likely equipped with the knowledge and skills necessary to address complex challenges and improve service delivery.

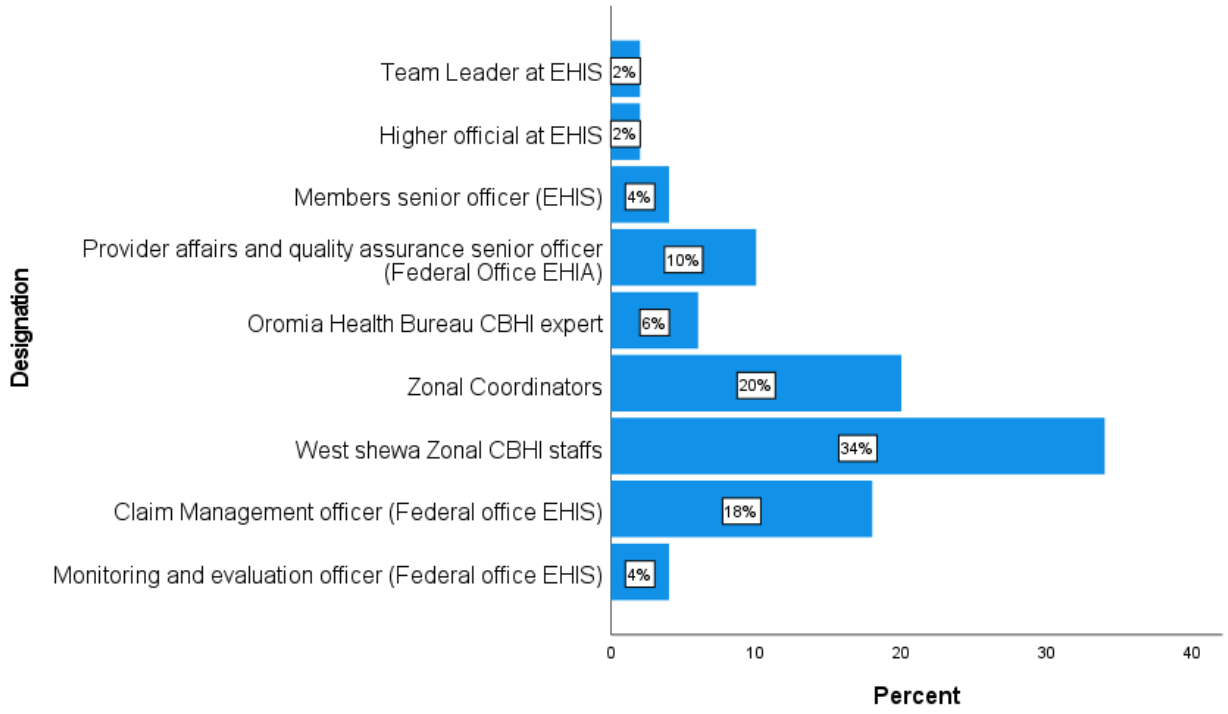

Fig 6.4 Sample distribution by Work positions

Source: Own survey data (2024)

The research included respondents from various key positions within the Community-Based Health Insurance (CBHI) framework, such as team leaders, senior officers in membership and provider affairs, quality assurance officers, officials from the Oromia Health Bureau and West Shewa Zone CBHI, as well as claim management and monitoring evaluation officers.

This broad representation suggests that the research engaged the main stakeholders of CBHI, including the Ethiopian Health Insurance Service, the Oromia Health Bureau, and the West Shewa Health Bureau. By involving employees from different departments and levels of the CBHI structure, the study was able to gather diverse perspectives and insights on the implementation and challenges of CBHI in Ethiopia. This inclusivity enhances the comprehensiveness of the feedback and views collected, thereby improving the reliability and validity of the research data. The involvement of various stakeholders and departments ensures that the findings are more representative and reflective of the actual conditions and experiences within the CBHI program.

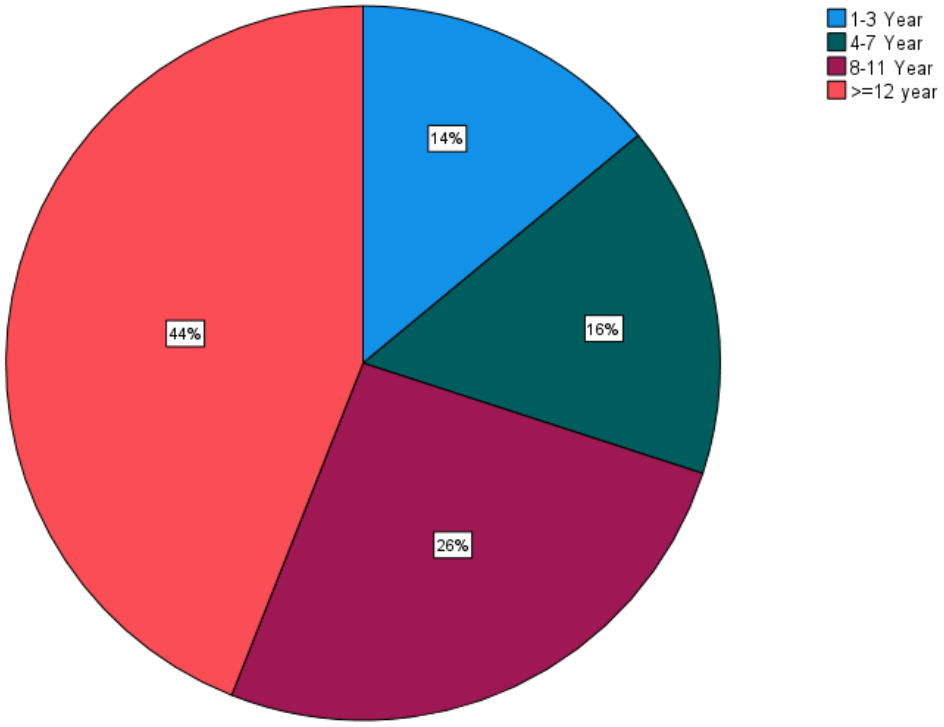

Fig. 6.5: Sample distribution by work experience

Source: Own survey data (2024)

The work experience distribution among the respondents indicates that 7 individuals, or 14% of the sample, have 1-3 years of service. Eight respondents, accounting for 16%, have worked for 4–7 years. A larger group of 13 respondents, representing 26% of the sample, have 8–11 years of experience, while 22 respondents, or 44%, have more than 12 years of experience.

This distribution suggests that all respondents have relevant work experience, with a significant majority (70%) having over eight years of experience. This high level of experience among the respondents implies that they are likely well-versed in their roles and knowledgeable about the Community-Based Health Insurance (CBHI) system. Their extensive experience can contribute to more informed and credible feedback, enhancing the depth and accuracy of the study's findings on the implementation and challenges of CBHI in Ethiopia.

6.2. **Challenges related to CBHI implementation in the West Showa Zone**

Table 6.1: Challenges of CBHI Implementation

Descriptive Statistics

	N	Min	Max	Mean	Std. Deviation
Limited financial resources are a major challenge.	50	1	5	4.02	1.317
Inadequate healthcare infrastructure poses challenge.	50	1	5	4.28	1.031
A lack of awareness about HI Benefits hinders CBHI enrolment.	50	1	5	4.40	.990
Socioeconomic disparities affect the enrolment rates.	50	1	5	4.10	1.147
Inconsistent administrative capacity across districts.	50	1	5	4.20	1.161
Difficulties in recruiting and training local healthcare workers.	50	1	5	4.12	1.304
Challenges in reaching remote and underserved areas.	50	1	5	4.00	1.443
Inadequate coordination among stakeholders.	50	1	5	4.16	1.113
Challenges in building trust and credibility.	50	1	5	2.46	1.417
Difficulties in negotiating agreements with providers.	50	1	5	4.34	1.099
Political and bureaucratic processes challenges.	50	1	5	4.48	.931
External factors (e.g., economic instability).	50	1	5	4.28	1.051
Financial sustainability challenge.	50	1	5	4.06	1.252
Complex claims reimbursement process.	50	1	5	4.28	1.031
Valid N (listwise)	50				

Source: Own survey data (2024)

In Table 6.1, CBHI personnel were asked to share their feedback on the challenges facing CBHI implementation. As a result, the data shown below represents employees' feedback on the difficulties confronting CBHI. The point for each key component was determined by considering two factors: the weight assigned to each major element and the score provided to each significant element within the factor. A perfect score of 5 indicates strong agreement, a score of 4 indicates agreement, a score of 3 indicates neutrality, a score of 2 indicates disagreement, and a final score of 1 (strongly disagree) yields one mark.

The respondents' views on the impact of inadequate financial resources on the implementation of Community-Based Health Insurance (CBHI) were measured, and the mean response value was

4.02, as indicated in Table 6.1. This mean value suggests that, on average, respondents strongly agree or agree that inadequate financial resources are significantly affecting the implementation of CBHI in the West Showa zone.

The high mean score reflects a consensus among employees that the lack of enough financial resources is a critical issue hindering the effective operation and expansion of the CBHI program. This finding highlights the importance of addressing financial constraints to improve the program's effectiveness and ensure that it meets the healthcare needs of the community.

There have been various studies conducted that support the conclusion of this finding.

In Ethiopia, insufficient financial resources are limiting the adoption of community-based health insurance (CBHI) (Daraje, 2022; Namomsa, 2023; Zepre, 2023; Zepre, 2023). The current trend in developing countries, including Ethiopia, demonstrates that people frequently rely on out-of-pocket expenditures for healthcare, resulting in financial vulnerability and limiting access to critical services (Zarepour et al., 2023). According to studies, difficulties include limited government healthcare funding, a large reliance on out-of-pocket expenses, and poor resource utilization (Moyehodie et al., 2022). Furthermore, the implementation of a mandatory Social Health Insurance (SHI) program faces opposition due to public employees' refusal to pay the planned premium. These financial constraints influence CBHI enrolment rates, with differences reported between regions based on wealth status and other individual and community-level characteristics. Addressing these financial hurdles is critical to the successful implementation and sustainability of CBHI in Ethiopia.

Limited financial resources do constitute a substantial impediment to the implementation of community-based health insurance (CBHI) methods (Sheikh et al., 2022). The CBHI programs are intended to reduce out-of-pocket costs and enhance healthcare access; however, budgetary constraints limit their usefulness (Adsul et al., 2022). In resource-constrained environments, such as Bangladesh, financial hurdles such as insufficient external support and competing financial priorities at the family level hamper the expansion of CBHI programs (Kakama et al., 2020). Furthermore, the success of CBHI implementation is dependent on reasonable premiums and extensive benefit packages, which can be difficult to maintain without adequate financial resources (Barriga et al., 2023). Overcoming these financial barriers is critical for the effective growth of CBHI schemes and reaching universal health care goals in countries with limited resources (Manyazewal et al., 2016).

The respondents' feedback indicates that inadequate healthcare infrastructure is a significant challenge to the implementation of Community-Based Health Insurance (CBHI). They agreed that the lack of enough healthcare infrastructure not only hinders the effective implementation of CBHI but also negatively impacts the quality of healthcare services provided.

The researcher's observation supports this view, noting a serious shortage of medicines, which forces patients to purchase drugs from private vendors. This situation exacerbates the challenges faced by CBHI, as it underscores the gap in infrastructure and resource availability that affects the program's ability to deliver comprehensive and quality healthcare services. Addressing these infrastructure issues is crucial for improving CBHI effectiveness and ensuring that beneficiaries receive the necessary care.

Inadequate healthcare infrastructure poses a substantial barrier to the implementation of the Community-Based Health Insurance (CBHI) plan. The lack of enough staff, infrastructure, and resources impedes the proper operation of healthcare services, lowering the quality of care given under CBHI regulations (Sheikh et al., 2022).

Inadequate healthcare infrastructure reduces Community-Based Health Insurance (CBHI) membership. Lower CBHI enrolment rates are attributed to factors such as poor quality of care, the unavailability of laboratory services, and a perceived lack of respectful treatment (Desalegn et al., 2023; Daraje, 2022). Furthermore, the lack of basic logistics and supplies in healthcare facilities serves as a barrier to CBHI enrollment (Gashaw et al., 2022). According to studies, trust in the CBHI system, perceived quality of service, and premium affordability are all important factors in determining membership rates (Habte et al., 2022). Furthermore, strengthening community education, improving healthcare service quality, and guaranteeing transparent management are proposed measures for overcoming hurdles to CBHI enrolment caused by insufficient healthcare infrastructure (Abdilwohab et al., 2021).

Inadequate healthcare infrastructure (mainly lack of available medicines) is among the supply-side challenges affecting CBHI effectiveness and leading to low CBHI membership enrolment.

The respondents agreed that a lack of awareness about the benefits of health insurance is a significant factor hindering enrolment in the Community-Based Health Insurance (CBHI) program. This suggests that community members who are not enrolled in CBHI may lack sufficient knowledge about the program's advantages, which affects their willingness to participate.

Despite efforts to raise awareness through various channels, there remains a knowledge gap among potential enrolees. This indicates that more effective strategies may be needed to educate and inform the community about the benefits of CBHI to increase participation and ensure that more individuals can benefit from the program. Addressing this awareness gap is crucial for improving enrolment rates and the overall success of the CBHI initiative.

There are studies conducted in Ethiopia regarding the effect of a lack of awareness on CBHI enrolment.

In fact, the effectiveness of community-based health insurance (CBHI) in Ethiopia is hampered by a lack of knowledge about the advantages of health insurance. Research indicates that low awareness levels are a factor in both high dropout rates and low enrolment (Daraje, 2022). Furthermore, community members' comprehension and impression of the program, particularly those who have chronic illnesses, are critical to the success of CBHI in Ethiopia (Mussa et al., 2023). The CBHI scheme's awareness, trustworthiness, and benefit knowledge has been found to be important elements that favourably impact membership renewal rates (Gashaw et al., 2022). Therefore, to improve the acceptance and sustainability of CBHI in Ethiopia, addressing the lack of awareness through focused awareness campaigns and educational activities is crucial.

The respondents agreed that socioeconomic disparities significantly impact enrolment rates in Community-Based Health Insurance (CBHI) programs. Specifically, income levels and education levels among community members are key contributing factors.

1. **Income Levels:** Individuals with lower incomes may struggle to afford the premiums or contributions required for CBHI enrolment, reducing their participation in the program.

2. **Education Levels:** Lower levels of education may lead to a lack of understanding about the benefits of CBHI and its importance, affecting individuals' willingness to enrol.

These socioeconomic factors create barriers to enrolment, highlighting the need for targeted strategies to address these disparities and make CBHI more accessible to all segments of the community. This could involve offering financial assistance, improving educational outreach, and designing programs that cater to diverse socioeconomic backgrounds.

Socioeconomic factors influence the accessibility and affordability of Community-Based Health Insurance (CBHI) programs in various communities. According to studies, willingness to subscribe to CBHI is strongly connected with age, education level, occupation, religion, marital

status, place of residence, and monthly income (Archibong et al., 2023). Furthermore, socioeconomic position influences enrolment in CBHI schemes, with the wealthy being more likely to pay for CBHI than the poor, and actual enrolment is closely related to socioeconomic rank (Chirwa et al., 2021). Gender discrepancies also exist, with female-headed families making lesser contributions to CBHI expenditure than male-headed ones (Asante et al., 2016). These findings underline the importance of personalized approaches to CBHI design, including flexible payment plans, subsidized premiums for the poor, and the elimination of co-pays, to improve equality and promote enrolment among vulnerable populations.

The mean value of 4.20 for the question regarding the effect of inconsistent administrative capacity on CBHI implementation indicates a strong agreement among respondents that varying levels of administrative capacity across different regions contribute to disparities in CBHI implementation. This high mean score suggests that respondents believe the inconsistency in administrative resources, skills, and processes between regions significantly affects how well CBHI is implemented. Regions with stronger administrative capacity are likely to manage and deliver CBHI services more effectively, while those with weaker administrative support face greater challenges. Addressing these inconsistencies and strengthening administrative capacity uniformly across regions could help reduce disparities and improve the overall effectiveness of the CBHI program.

Inconsistent administrative capacity impedes the effective implementation of community-based health insurance (CBHI) strategies (Sheikh et al., 2022; Hussien et al., 2022; Tefera & Ayele, 2022). Implementation challenges include poor population coverage, adverse selection, and a lack of external assistance (Vroom et al., 2022). Furthermore, a study in Ethiopia found that CBHI schemes have negative growth ratios due to governance methods, healthcare quality, and community awareness issues (Kühler, 2019). Furthermore, a lack of administrative capacity within the health system, as witnessed in Romania, hampers the practical implementation of EU-driven changes, reducing the efficacy of CBHI policies. Addressing these capacity concerns requires specific methods, professional administrative support, and political will to improve the successful implementation and viability of CBHI programs in low- and middle-income nations.

The respondents agreed that the Community-Based Health Insurance (CBHI) strategy encounters difficulties in both recruiting and training local healthcare workers. This feedback highlights two main challenges:

1. **Recruitment:** CBHI is struggling to attract and hire new healthcare workers, which can impact the program's ability to expand and provide services effectively.

2. **Training:** There are challenges in providing adequate training for existing and new healthcare workers, which affects their preparedness and ability to deliver quality care within the CBHI framework.

These difficulties in staffing and training can hinder the successful implementation of CBHI and the quality of services provided. Addressing these issues may require developing more robust recruitment strategies and investing in comprehensive training programs to ensure that healthcare workers are well-equipped to support the goals of the CBHI program.

Lack of budget and existing CBHI procedures responsible for recruiting new employees and providing training and development (CBHI zonal experts).

Ethiopia's Community-Based Health Insurance (CBHI) approach confronts issues in recruiting and educating local healthcare workers. These problems include the perception that paying clients receive preferential care over insurance enrolees, which leads to a preference for private health facilities (Kang and Kang, 2023). Furthermore, the practice of health professional licensing is poorly administered in Ethiopia, with many professionals working without a license, lowering the quality of healthcare (Mekonen and Tedla, 2022). Furthermore, training and supervision methods for health extension workers (HEWs) in noncommunicable disease (NCD) service delivery are insufficient, with discrepancies in training quality and supervision practices that have a detrimental impact on service delivery and employee motivation (Tesema et al., 2022). Addressing these difficulties through better licensing standards, fair treatment of insurance enrolees, and greater training and supervision for healthcare personnel is critical to the CBHI strategy's success in Ethiopia.

The respondents agreed that the Community-Based Health Insurance (CBHI) strategy faces significant challenges in reaching remote and underserved areas. The difficulties in implementation in these regions are attributed to several factors:

1. **Political Situation:** Unstable or unfavourable political conditions can obstruct the effective deployment of CBHI services, impacting outreach and operations.

2. **Poor Infrastructure:** Inadequate infrastructure, such as a lack of roads, transportation, and healthcare facilities, hampers the ability to deliver CBHI services to remote areas.

These factors contribute to the limited implementation of CBHI in these regions, affecting the program's reach and effectiveness. Addressing these challenges might involve improving infrastructure, developing strategies to navigate political issues, and creating targeted outreach programs to enhance the accessibility of CBHI services in remote and underserved areas.

The Community-Based Health Insurance (CBHI) plan in Ethiopia has unique problems reaching remote and neglected communities. Challenges include perceived preferential treatment for paying clients, drug shortages resulting in stockouts, high patient flow causing overload in public health facilities, unnecessary price increases by private pharmacies, and confusion over annual renewal payments without service utilization (Mekonen and Tedla, 2022). Furthermore, Ethiopia's low total CBHI enrolment coverage, which is concentrated in large regions, makes it difficult to reach outlying communities (Mulat et al., 2022). Furthermore, inadequate ICT infrastructure, a lack of computer skills, budget constraints, and management styles impede the use of ICT in the healthcare system, limiting CBHI access to underserved regions (Daraje, 2022). Addressing these obstacles is critical to expanding CBHI access in Ethiopia's distant and underserved communities.

The mean value of 2.46 for the question regarding the CBHI strategy's challenges in building trust and credibility suggests that respondents generally do not perceive a significant issue with trust and credibility within the communities.

This relatively low mean value indicates that the Community-Based Health Insurance (CBHI) strategy is not losing trust or credibility among its members. On the contrary, it implies that CBHI has successfully established and maintained trust and credibility within the communities it serves. The positive perception of trust and credibility is beneficial for the sustainability of the CBHI scheme, as it indicates that members are likely to continue their participation and support, contributing to the long-term success and stability of the program.

Various mechanisms, like community leaders, religious leaders, and other influencers within the community, improving the quality of health care services, addressing client satisfaction, reducing waiting time for healthcare services, conducting regular promotional and educational campaigns, providing good benefit packages, and establishing public-private partnerships, were used to build the trust and credibility of CBHI schemes with the insured communities (Woreda CBHI officials).

There are various studies that support the conclusion of these findings:

There are several efficient ways to establish credibility and confidence in communities during the community-based health insurance (CBHI) rollout. These include raising the standard of

healthcare, attending to client satisfaction, making sure that providers are viewed favourably, cutting down on wait times, holding frequent awareness and education campaigns, engaging community leaders, offering complete benefit packages, and creating public-private partnerships (Akafu et al., 2023; Sheikh et al., 2022; Gashaw et al., 2022). Building and sustaining trust in communities also requires providing training, raising awareness of CBHI concepts, and guaranteeing confidence in the CBHI program (Odima et al., 2022). Enhancing confidence and credibility can be achieved through utilizing community involvement, eliminating implementation challenges, and methodically including key stakeholders. These actions will ultimately result in the successful implementation of the CBHI and greater population coverage (Tefera & Ayele, 2022).

The respondents indicated that the Community-Based Health Insurance (CBHI) strategy encounters difficulties in negotiating agreements with healthcare providers, including hospitals, health centres, health posts, and public pharmacies. The data suggests that these difficulties are affecting the effectiveness of the CBHI scheme.

Key challenges identified include:

1. **Stock Out of Medicines:** Providers experiencing shortages of essential medications can impact the ability of the CBHI to deliver comprehensive and reliable services to its members.

2. **Claim Settlement Issues:** Problems with settling claims for services rendered can create friction between CBHI and healthcare providers, potentially affecting the willingness of providers to participate in the scheme.

These challenges in negotiating and maintaining agreements with healthcare providers can hinder the overall implementation and effectiveness of the CBHI program. Addressing these issues may involve improving the supply chain for medicines and streamlining the claims process to ensure smoother operations and better cooperation with healthcare providers.

Negotiating contracts with healthcare providers presents difficulties for Ethiopia's community-based health insurance programs, which affects their capacity to pay for services and maintain their financial stability (Getahun et al., 2023). These schemes' financial reports show that it is difficult to keep claims costs and revenue in balance, which results in negative net incomes and significant losses (Hussien et al., 2022). The schemes' inability to pay service providers' claims on

time also makes it more difficult for them to be financially viable (Namomsa, 2023). These difficulties underline the necessity of interventions to deal with problems like moral hazard, adverse selection, and medication stockouts to improve the bargaining process with healthcare providers and guarantee the sustainability of the schemes (Terefe et al., 2022). For Ethiopia's community-based health insurance schemes to operate effectively, these agreements must be improved (Tefera & Ayele, 2022).

The respondents agreed that political and bureaucratic processes significantly affect the implementation of the Community-Based Health Insurance (CBHI) program. The data from Table 6.1 highlights two main issues:

1. **Lack of Political Commitment:** Insufficient support and commitment from middle-level officials can impede the effective implementation of CBHI. This lack of engagement may result in inadequate policy support and resource allocation, impacting the program's success.

2. **Bureaucratic Processes:** The complexity and time-consuming nature of the bureaucratic processes involved in claims reimbursement within CBHI systems create inefficiencies. These cumbersome procedures can delay payments and frustrate both service providers and beneficiaries, affecting overall program performance.

These challenges suggest that addressing political and bureaucratic barriers is crucial for improving the efficiency and effectiveness of the CBHI program. Ensuring stronger political support and streamlining bureaucratic processes could enhance implementation and service delivery.

However, political and administrative procedures have an impact on the Community-Based Health Insurance (CBHI) program's implementation in Ethiopia. The CBHI agenda has benefited greatly from political support, and the scheme's early experiments provided valuable insights for its expansion (Tefera & Ayele, 2022). Strong political support and community engagement made possible by CBHI have been credited with helping to negotiate obstacles, including subpar care (Mulat et al., 2022). successfully. Furthermore, the perception of receiving preferential treatment for paying clients over insurance beneficiaries has brought attention to problems with the service delivery process, highlighting the need for measures aimed at raising awareness and improving public health facilities (Shigute et al., 2020).

Political concerns offer hurdles to Ethiopia's Community-Based Health Insurance (CBHI) plan. The successful implementation and extension of CBHI are dependent on political support, as evidenced by the scheme's strong governmental backing in Ethiopia (Tefera and Ayele, 2022). However, difficulties such as perceived preferential treatment for paying clients in healthcare facilities have been recognized as potential deterrents to CBHI enrolment (Mulat et al., 2022). Furthermore, inadequate government spending in the health sector and inefficient resource utilization impede the effective operation of health insurance programs such as CBHI in Ethiopia (Daraje, 2022). Overcoming these political hurdles is critical to the long-term viability and effectiveness of CBHI in Ethiopia, and it will necessitate enhanced policy frameworks and stakeholder engagement (Mekonen & Tedla, 2022).

Bureaucratic processes provide substantial barriers to the successful implementation of Community-Based Health Insurance (CBHI) in Ethiopia. These challenges include limited awareness and misconceptions about the program, financial constraints preventing premium payments, dissatisfaction with health services, perceived preferential treatment for paying patients, drug shortages resulting in stockouts, high patient flow causing overload in public health facilities, and confusion about annual renewal payments without service utilization (Tefera & Ayele, 2022; Mekonen & Tedla, 2022; Namomsa, 2023). Furthermore, insufficient ICT infrastructure, a lack of computer skills, financial constraints, management style challenges, and the absence of enabling legislation all limit the efficient implementation of CBHI in Ethiopia (Mulat et al., 2022; Lott et al., 2021). These bureaucratic roadblocks must be overcome to improve the success and sustainability of the CBHI plan in the country.

The respondents agreed that external factors, such as economic instability, have a significant impact on the sustainability of Community-Based Health Insurance (CBHI) programs. Specifically, they pointed out that the current high levels of inflation are driving up the costs of health infrastructure. This economic pressure is leading to shortages in the availability of medicines, which directly affects the ability of CBHI programs to provide adequate healthcare services.

The increase in costs due to inflation can strain the financial resources of CBHI programs, making it more difficult to maintain a steady supply of essential medicines and other healthcare resources. This situation can compromise the quality and reliability of the services provided under CBHI,

posing a challenge to the long-term sustainability of the program. Addressing these economic challenges is crucial for ensuring the continued effectiveness and viability of CBHI schemes.

The respondent's response towards financial sustainability is a major challenge faced by some CBHI programs in Ethiopia. The mean value of 4.06 implies that the respondents agreed that financial sustainability is a major challenge faced by some CBHI programs in Ethiopia. Low CBHI enrolment, low membership renewal, and low general and target subsidies from the government.

There is financial fragmentation among the CBHI schemes, which is a challenge for CBHI implementation and efficient use of the finances. This is since the fact that the collected membership premium is handled at the district level by the provident and quality assurance officer of EHIS.

Financial sustainability is a serious concern for several community-based health insurance (CBHI) systems in Ethiopia. The financial stability of CBHI programs is hampered by low government expenditures in the health sector, a reliance on out-of-pocket expenses, inefficient resource utilization, and unpredictable donor support (Daraje, 2022; Mulat et al., 2022). Furthermore, the deployment of information and communication technology (ICT) in the healthcare system is hampered by budget constraints, inadequate infrastructure, and a lack of enabling regulations, all of which have an impact on the financial viability of Ethiopian health initiatives (Tefera and Ayele, 2022). Despite attempting to provide financial security and improve health-seeking behaviour, CBHI schemes encounter obstacles such as perceived preferential treatment for paying customers, drug shortages, and high patient flow, which jeopardize their financial viability (Namomsa, 2023). Efforts to resolve these difficulties are critical to ensuring the long-term financial viability of CBHI projects in Ethiopia.

6.3. **The role of stakeholders in CBHI implementation**

Table 6.2: Influence of stakeholders on the success of CBHI strategy implementation in the study area

Descriptive Statistics

	N	Min	Max	Mean	Std. Deviation
There is Strong Gov-Ngo collaboration.	50	2	5	4.66	.688
Multiple stakeholder's involvement improves CBHI design.	50	1	5	4.40	.808
Collaboration expands CBHI coverage.	50	2	5	4.40	.670
Gov-Ngo-community engagement drives success	50	2	5	4.54	.646
Shared Responsibility for CBHI goals.	50	3	5	4.40	.571
Coordination mitigates implementation challenges.	50	3	5	4.52	.646
Gov-Ngo collobration ensures fair resource allocation.	50	2	5	4.66	.593
Diverse expertise enhances healthcare quality.	50	2	5	4.08	.944
Improved community engagement through coordination.	50	3	5	4.46	.613
Collaborative decision-making adapts CBHI to local context	50	3	5	4.20	.700
CBHI responsiviness to envolving health care needs.	50	2	5	4.04	.925
Stakeholders coordination enhances accountability	50	1	5	4.32	.819
Identification/utilization of local resources for sustainability.	50	1	5	4.16	.889
Stakeholder involvement boosts Community awareness.	50	2	5	4.12	.799
Government-Ngo collaboration improves enrollement rates.	50	3	5	4.38	.697
Capacity-bulding opportunities through collaboration.	50	3	5	4.32	.653
Allignment of CBHI with broader health policies.	50	2	5	4.20	.881
Valid N (listwise)	50				

Source: Own survey data (2024)

In Table 6.2, CBHI personnel were asked to share their feedback on the influence of stakeholders on the success of CBHI strategy implementation in the study area. As a result, the data shown below represents employee feedback on the impact of stakeholders on CBHI implementation. The point for each key component was determined by considering two factors: the weight assigned to each major element and the score provided to each significant element within the factor. A perfect

score of 5 indicates strong agreement, a score of 4 indicates agreement, a score of 3 indicates neutrality, a score of 2 indicates disagreement, and a final score of 1 (strongly disagree) yields one mark.

The respondents indicated that the Community-Based Health Insurance (CBHI) program in Ethiopia has established strong collaboration with a range of stakeholders, including both government agencies and non-governmental organizations (NGOs). The data from Table 6.2 highlights these key partnerships:

1. **Government Agencies:** CBHI collaborates closely with several government entities, such as the Federal Ministry of Health, Regional Health Bureaus, District Health Bureaus, Regional and Zonal Administrations, and financial institutions. These collaborations are essential for the implementation, oversight, and expansion of the CBHI scheme, as they provide the necessary institutional support and resources.
2. **Non-Governmental Organizations (NGOs):** The program also partners with NGOs like Abt Global, which operates via USAID-funded projects. According to Ethiopia Abt Global (2024), the organization's main role involves the implementation and scaling up of the CBHI program, as well as supporting the institutionalization of the scheme. This partnership helps enhance the program's capacity to reach more communities and improve its operational efficiency.

Strong collaboration with these stakeholders is crucial for the success and sustainability of the CBHI program. Government agencies provide essential policy and infrastructural support, while NGOs contribute through expertise, funding, and programmatic support, ensuring that CBHI can effectively serve its target populations.

The respondents agreed that the involvement of multiple stakeholders fosters a more comprehensive and holistic approach to the implementation of the Community-Based Health Insurance (CBHI) strategy within the West Showa Zone. This consensus implies that the participation of various stakeholders such as government agencies, NGOs, community leaders, and financial institutions is beneficial for the CBHI program.

The engagement of these diverse stakeholders contributes to a well-rounded implementation strategy by integrating different perspectives, resources, and expertise. This collaborative approach helps address the complex challenges of CBHI implementation more effectively, ensuring that the program is better equipped to meet the healthcare needs of the community. The involvement of multiple stakeholders is thus seen as a key factor in the successful and sustainable implementation of CBHI schemes in the West Showa Zone.

Multiple stakeholders' involvement has a substantial impact on Ethiopia's Community-Based Health Insurance (CBHI) implementation. Research indicates that households, as key stakeholders in CBHI initiatives, have a significant impact on enrolment rates and satisfaction levels (Zarepour et al., 2023; Zepre et al., 2023). Stakeholder engagement is crucial because it can influence program execution, as can the willingness of formal sector employees to pay premiums and their opinions toward it (Alemayehu et al., 2023). Additionally, the availability of prescribed medication, faith in leadership, and a thorough understanding of the CBHI scheme are supportive elements that have a beneficial impact on stakeholder satisfaction and program sustainability (Degefa et al., 2023). It is imperative to involve multiple stakeholders, such as the government, health facilities, and the community, to guarantee the efficacy and fiscal safeguards offered by CBHI initiatives in Ethiopia (Daraje, 2022).

6.4. **Analysis of research hypothesis number five (H5)**

The purpose of this section is to investigate the fifth research hypothesis, which claims that:

The successful implementation of the CBHI plan in the West Showa Zone is largely dependent on the cooperation and coordination of several stakeholders, including local authorities, non-governmental organizations, and government agencies.

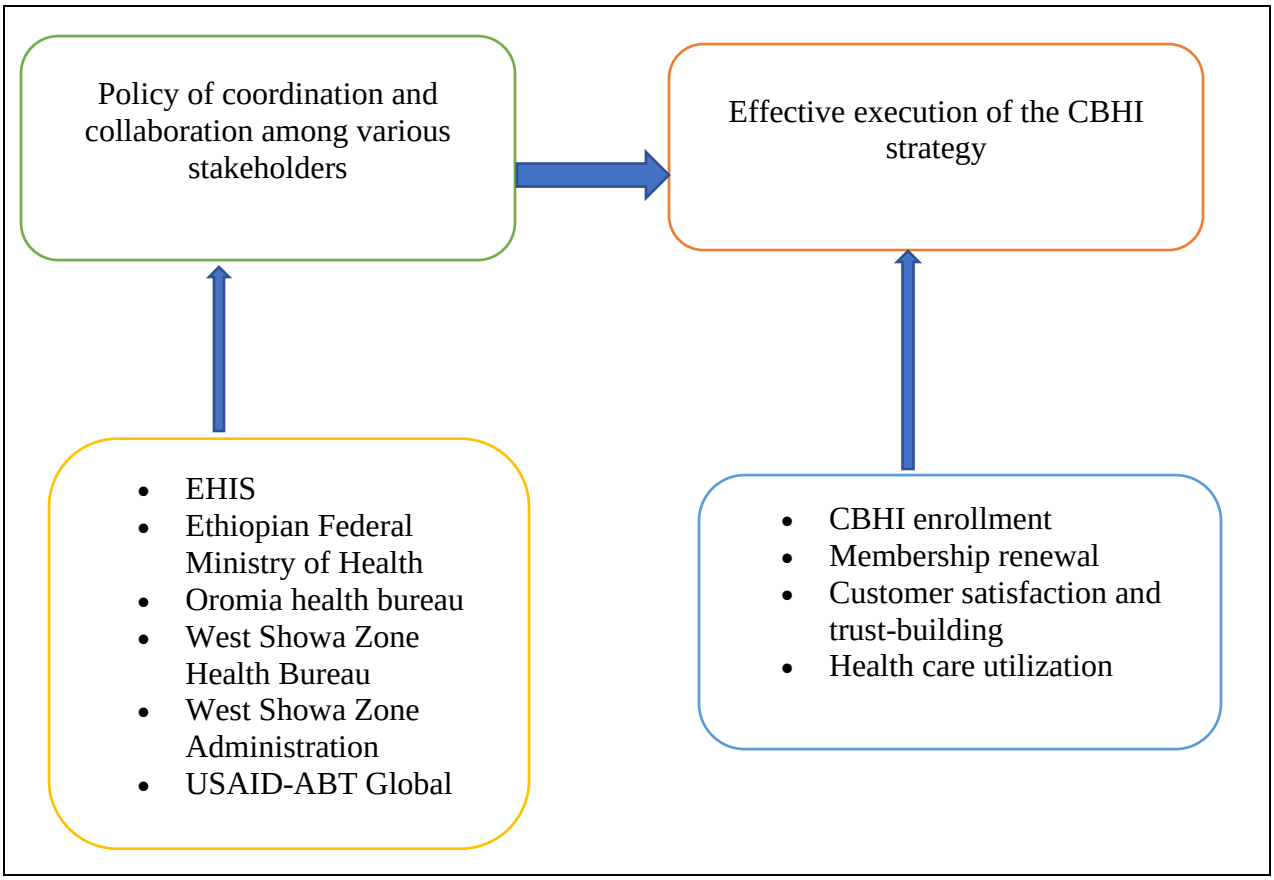

Fig. 6.6: Conceptual Model on Coordination and Collaboration among Various Stakeholders Vis-à-vis Effective execution of the CBHI strategy

Source: The author's own compilation based on research methods.

This hypothesis aims to examine the impact of coordination and collaboration among various stakeholders on the effective execution of the CBHI strategy. The data found in the above table revealed that effective execution of CBHI depends on collaboration among different CBHI stakeholders. Hence, the proposed hypothesis 5 was accepted.

Respondents agreed that the collaboration among different stakeholders positively influences the coverage and reach of the Community-Based Health Insurance (CBHI) program within communities in the West Showa Zone. This feedback suggests that the collective efforts of stakeholders such as government agencies, NGOs, community organizations, and financial institutions are contributing to the expansion and effectiveness of CBHI.

The positive impact of this collaboration is likely seen in the broader reach of the program, making CBHI more accessible to a larger portion of the population. By working together, these stakeholders can pool resources, share expertise, and coordinate efforts to overcome challenges, thereby enhancing the program's ability to serve the healthcare needs of the community. This collaborative approach is crucial for the continued growth and success of CBHI in the region.

Collaboration among stakeholders is critical to the success of community-based health insurance (CBHI) programs. Studies emphasize the importance of incorporating a diverse range of players in program implementation, including local communities, government bodies, and organizations (Nugrahaini, 2022; Darwis et al., 2019; Agbanu, 2010). Effective collaboration improves program performance by increasing skills, healthcare quality, and stakeholder trust (Hanida et al., 2017). Furthermore, successful CBHI initiatives rely on strong stakeholder connections, shared decision-making, and frequent communication to achieve improved results and sustainability (Awotunde et al., 2020).

The results indicate that active engagement and effective communication channels between government agencies, non-governmental organizations (NGOs), and community leaders significantly contribute to the successful implementation of the Community-Based Health Insurance (CBHI) strategy in the West Showa Zone.

This active engagement ensures that all key stakeholders are aligned and working collaboratively towards common goals, which enhances coordination and efficiency in implementing the CBHI strategy. Effective communication allows for the timely sharing of information, the addressing of issues, and the dissemination of knowledge, all of which are crucial for overcoming challenges and adapting the program to meet the needs of the community.

The strong interaction among these stakeholders fosters a more integrated and responsive approach to CBHI implementation, ensuring that the program is well-supported and better positioned to achieve its objectives of improving healthcare access and coverage in the West Showa Zone.

The Community-Based Health Insurance (CBHI) model in Ethiopia is only successful when government agencies, non-governmental organizations (NGOs), and community leaders actively engage and communicate with one another (Hailemariam et al., 2023; Tefera & Ayele, 2022).

These partnerships aid in dispelling myths, raising awareness of the CBHI program, and raising enrolment rates all around. Involving community leaders also guarantees improved community mobilization and support for the program, which improves trust and participation (Tiruneh et al., 2022). In addition, the involvement of multiple stakeholders' aids in the recognition of obstacles, such as budgetary limitations and discontent with medical care. It permits the creation of focused approaches to surmount these difficulties, ultimately supporting the successful execution and long-term viability of the CBHI initiative in Ethiopia.

The respondents agreed that the collaborative efforts between different stakeholders have created a favourable environment for sharing responsibility in achieving the goals of the Community-Based Health Insurance (CBHI) program in West Showa Zone. This indicates that the involvement of various stakeholders, such as government agencies, NGOs, community leaders, and healthcare providers, has led to a collective sense of ownership and accountability for the success of the CBHI scheme.

By working together, these stakeholders can distribute tasks and responsibilities effectively, ensuring that all aspects of the CBHI program are addressed. This shared responsibility enhances the program's implementation by ensuring that no single entity bears the entire burden, and it encourages a more cooperative and coordinated approach to overcoming challenges and meeting the program's objectives. This collaborative environment is essential for the long-term sustainability and effectiveness of the CBHI scheme in the region.

Working together is essential to creating a sense of shared accountability for accomplishing the objectives of Ethiopia's Community-Based Health Insurance (CBHI) program. Many stakeholders cooperating toward a single goal have been credited with the successful implementation and scale-up of CBHI (Tefera and Ayele, 2022; Mulat et al., 2022). Involving various stakeholders is crucial for resource mobilization and maintaining the sustainable development of CBHI, as it involves healthcare professionals, policymakers, and the commercial sector (Tahir et al., 2022). Participation in the program has also been demonstrated to raise health facilities' accountability since it emphasizes the shared duty of providing high-quality healthcare services. Health facilities are obligated to provide quality services using the premiums collected from registered households

(Simieneh et al., 2021). All things considered, cooperative efforts foster a positive atmosphere that increases CBHI's effectiveness and influence in Ethiopia.

Respondents agreed that stakeholder coordination significantly facilitates the identification and mitigation of challenges encountered during the implementation of the Community-Based Health Insurance (CBHI) strategy in the West Showa Zone. This consensus highlights the importance of effective collaboration among stakeholders such as government agencies, NGOs, community leaders, and healthcare providers in addressing issues that arise during the program's execution.

The coordination among these various entities helps in:

1. **Identifying Challenges:** Collaborative efforts enable stakeholders to share insights and data, leading to a clearer understanding of the problems affecting CBHI implementation.
2. **Mitigating Issues:** With a coordinated approach, stakeholders can develop and implement solutions more efficiently, addressing challenges in a timely and effective manner.

This effective stakeholder coordination is crucial for the smooth operation and success of the CBHI program, as it ensures that challenges are addressed comprehensively and collaboratively, enhancing the overall impact and sustainability of the scheme.

Stakeholder coordination facilitates the identification and mitigation of challenges faced during the implementation of the CBHI strategy in the West Showa Zone. In this regard, respondents agreed that the coordination among the stakeholders is supporting the sorting of the challenges facing them and working on solving those challenges.

To detect and mitigate difficulties throughout the implementation of Community-Based Health Insurance (CBHI) in Ethiopia, collaboration among stakeholders is essential. Mekonen and Tedla, 2022). Research has indicated that a number of issues are common to Ethiopian health insurance programs, including the perception of preferential care for paying patients, a lack of medications, a high patient volume in public health facilities, and uncertainty around annual renewal payments (Hordofa et al., 2019). Similar problems, such as a lack of shared plans, insufficient organizational structures, and a lack of ongoing capacity-building mechanisms, arise when interested stakeholders in adult literacy initiatives fail to coordinate with one another (Nigussie, 2021). To solve these

problems and guarantee the successful implementation of health insurance and literacy initiatives in Ethiopia, effective cooperation among stakeholders is important.

The respondents indicated that the diverse expertise of different stakeholders significantly enhances the overall quality of healthcare services provided to CBHI members. According to the data in Table 6.2, various types of expertise such as healthcare, health policy, and other specialized knowledge contributed by stakeholders are improving the quality of services within the CBHI program.

Here's how the diverse expertise impacts the CBHI program:

1. **Healthcare Expertise:** Professionals with medical and healthcare expertise ensure that the services provided are of high quality, meet clinical standards, and address the health needs of the insured community.
2. **Health Policy Expertise:** Experts in health policy contribute to designing effective policies and strategies that enhance the program's structure, governance, and operational efficiency.
3. **Specialized Knowledge:** Other forms of expertise, such as financial, administrative, and logistical knowledge, help in managing resources effectively, optimizing processes, and ensuring that the program runs smoothly.

The collaboration among stakeholders with varied expertise leads to a more holistic approach to healthcare service delivery, ultimately improving the quality of care and ensuring that CBHI members receive better health services.

Diverse stakeholders' knowledge is critical to the success of community-based health insurance (CBHI) programs in Ethiopia. Stakeholders such as legislators, healthcare providers, and the commercial sector help the program succeed by mobilizing resources, improving service quality, and increasing community engagement (Tefera & Ayele, 2022).

The financial viability of CBHI schemes is strongly dependent on stakeholder participation to address concerns like adverse selection, delays in claim settlement, and low premium rates (Hussien et al., 2022). As a result, a collaborative effort from a wide range of stakeholders is required to ensure the efficacy and sustainability of CBHI projects in Ethiopia.

Respondents agreed that effective stakeholder coordination plays a crucial role in enhancing community engagement and participation in the Community-Based Health Insurance (CBHI) program. According to the feedback:

1. **Improved Community Engagement:** Effective coordination among stakeholders helps in mobilizing community members, raising awareness about CBHI, and fostering active participation. When stakeholders work together seamlessly, they can create more impactful outreach efforts and educational programs.
2. **Enhanced Participation:** Coordinated efforts ensure that community members are more involved in the CBHI program, leading to higher levels of enrolment and engagement. The alignment of efforts among various stakeholders facilitates better communication and support, which encourages community involvement.
3. **Current State:** The coordination among stakeholders is reported to be better in most parts of Ethiopia, contributing positively to the levels of community engagement and participation.

Overall, effective stakeholder coordination helps create a supportive environment that encourages greater involvement from the community, which is essential for the success and sustainability of the CBHI program.

Effective community participation is greatly enhanced by stakeholder collaboration. A cooperative strategy to address community issues and guarantee active participation in research activities can be formed by involving a variety of stakeholders, including people in the community, healthcare experts, and local government representatives (Siew, 2023; Silberberg & Martinez-Bianchi, 2019). Key components of stakeholder engagement include dedication, respect, and power sharing (Poger et al., 2021). Community involvement can be further strengthened by including stakeholders through innovative educational approaches and bidirectional learning (Chabukswar et al., 2022). Including a variety of stakeholders can also result in better trial design, execution, and dissemination plans, including payers, pharmacists, patient partners, and guidelines experts (Barger et al., 2019). In general, good stakeholder coordination increases community ownership, rapport, and trust, all of which improve community involvement in research projects.

CBHI officials agreed that the collaborative decision-making processes among stakeholders have significantly contributed to the adaptability of the CBHI strategy to the local contexts in the West Showa Zone. This means that:

1. **Local Context Adaptation:** Joint decision-making allows for incorporating local knowledge and insights, ensuring that the CBHI strategy is tailored to address the specific needs and conditions of the West Showa Zone. This adaptability helps make the program more relevant and effective in the local context.
2. **Stakeholder Involvement:** The involvement of various stakeholders in the decision-making process brings diverse perspectives and expertise, which enhances the ability to adapt and respond to local challenges and opportunities.
3. **Enhanced Effectiveness:** By adapting the CBHI strategy to fit the local context through collaborative efforts, the program is better positioned to meet the needs of the community, improve service delivery, and achieve its goals more effectively.

Overall, collaborative decision-making processes play a crucial role in ensuring that the CBHI strategy remains flexible and responsive to the specific conditions of the West Showa Zone, leading to more successful and impactful implementation.

Stakeholder collaboration in decision-making is essential to improving the Community-Based Health Insurance (CBHI) strategy's capacity to adapt to Ethiopian local circumstances. It has been discovered that including stakeholders in the implementation of healthcare initiatives can help with identifying obstacles, selecting implementation tactics, and resolving implementation-related issues (Tiruneh et al., 2022). Facilitators for effective data-driven decision-making (DDM) techniques were identified as including external change agents, internal change leaders, and encouraging team-based reflection (Baynes et al., 2022). Strong governmental backing, community mobilization, and early pilot programs that provided guidance for the scaling-up process were also credited with the CBHI's successful expansion in Ethiopia, underscoring the significance of stakeholder participation in policy implementation (Tefera & Ayele, 2022). In order to successfully execute healthcare initiatives in Ethiopia and to ensure that they are tailored to local circumstances, collaborative decision-making processes are important.

Respondents (mean value = 4.04) concurred that stakeholder collaboration plays a crucial role in ensuring that the CBHI program effectively addresses the changing healthcare needs of the local population in the West Showa Zone. This suggests that:

1. **Adaptability to Healthcare Needs:** The collaborative efforts among stakeholders help the CBHI program remain responsive to evolving healthcare requirements, ensuring that the services provided meet the current and emerging needs of the community.
2. **Positive Impact:** The high level of agreement indicates that stakeholders' collaboration positively contributes to the effectiveness of the CBHI scheme, enhancing its ability to serve the healthcare needs of the insured population.
3. **Ongoing Adjustment:** The active involvement of various stakeholders allows for continuous assessment and adjustment of the program, ensuring it remains relevant and effective in addressing the healthcare needs of the community.

In summary, collaboration among stakeholders is essential for the CBHI program to adapt and respond effectively to the healthcare needs of the community, thereby contributing to the overall success and sustainability of the scheme.

The consensus among respondents was that well-organized coordination among stakeholders can significantly enhance the transparency and accountability of the Community-Based Health Insurance (CBHI) program. This implies that:

1. **Improved Transparency:** Effective stakeholder coordination ensures that processes and decisions related to the CBHI program are clear and visible to all parties involved, including the community. This transparency helps build trust and ensures that stakeholders are aware of how resources are allocated and used.
2. **Enhanced Accountability:** Coordination among stakeholders facilitates better oversight and accountability mechanisms. When roles and responsibilities are clearly defined and communication is effective, stakeholders can hold each other accountable for their contributions and performance, ensuring that the CBHI program operates as intended.

3. **Strengthened Trust:** By improving transparency and accountability, stakeholder coordination helps build trust among the community and stakeholders, which is crucial for the successful implementation and sustainability of the CBHI program.

Overall, organized and collaborative efforts among stakeholders are essential for ensuring that the CBHI program remains transparent and accountable, thereby enhancing its effectiveness and credibility within the community.

The respondents indicated that collaboration with community elders, religious institutions, and the target community significantly supports the sustainability of the CBHI program in the area. Specifically:

1. **Awareness Creation:** Collaboration with community elders and religious institutions helps in creating awareness about the benefits of CBHI, which encourages more community members to enrol in the scheme.
2. **Increased Engagement and Participation:** The involvement of these stakeholders enhances community engagement and participation by leveraging their influence and trust within the community. This leads to higher enrolment rates and active involvement in the CBHI program.
3. **Resource Mobilization:** Engaging local stakeholders helps in mobilizing resources and convincing members of the community to participate in CBHI. Their support and endorsement can facilitate resource acquisition and program sustainability.

Overall, the collaborative efforts of local stakeholders play a crucial role in promoting CBHI enrolment, increasing community engagement, and mobilizing resources, all of which contribute to the program's long-term sustainability and effectiveness.

IDIR is a group of people whose goal is to provide social and economic insurance for its members in the event of death, accident, or property loss, among other things (Emana, 2009).

Respondents noted that effective collaboration between government entities, such as the Ethiopian Health Insurance Service (EHIS), and non-governmental organizations (NGOs) like USAID has a

positive impact on the enrolment rates and membership retention of the CBHI program. Specifically:

1. **Increased Enrolment Rates:** The partnership between EHIS and NGOs helps to promote the CBHI program more effectively, leading to higher enrolment rates. The support from NGOs can enhance outreach efforts and provide additional resources for expanding coverage.
2. **Improved Membership Retention:** Effective collaboration ensures that the CBHI program is better managed and supported, which can lead to higher satisfaction among members and improved retention rates. The combined efforts of the government and NGOs contribute to maintaining the quality of services and addressing any issues that might affect membership continuity.
3. **Coverage for Non-Paying Members:** The government plays a crucial role in covering non-paying members of the CBHI, ensuring that even those who cannot afford to contribute are still included in the program. This support helps in maintaining a broader membership base and ensuring that the program reaches underserved populations.

Overall, the collaboration between government and NGOs enhances the effectiveness of the CBHI program, leading to better enrolment and retention outcomes by leveraging the strengths and resources of both sectors.

The Community-Based Health Insurance (CBHI) program in Ethiopia has seen a notable increase in enrolment and membership retention because of effective cooperation between government and non-governmental organizations. Enrolment in participating districts has reached 50%, indicating that the government's efforts to increase CBHI coverage are yielding encouraging results (Daraje, 2022). According to studies, enrolling in the CBHI program lowers catastrophic health costs by 79.4% and boosts universal health coverage by 24.8% (Mussa et al., 2023). Additionally, research has shown that CBHI participation is linked to higher use of health services, protection from financial risk, and lower out-of-pocket medical expenses. These findings demonstrate the program's beneficial effects on households' financial stability and healthcare-seeking behaviour (Bayked et al., 2023). This emphasizes how crucial it is for government and non-government organizations to work together to advance the efficacy and sustainability of CBHI in Ethiopia.

Respondents agreed that collaborative efforts with various NGOs are creating valuable opportunities for capacity building and knowledge sharing among stakeholders involved in the CBHI program. Specifically:

1. **Capacity Building:** Collaboration with NGOs facilitates training and development programs that enhance the skills and capabilities of stakeholders involved in the CBHI program. This improves the overall effectiveness and efficiency of program implementation.
2. **Knowledge Sharing:** NGOs often bring expertise and best practices that are shared with local stakeholders, including government agencies and community organizations. This exchange of knowledge helps in improving strategies, addressing challenges, and implementing innovative solutions.
3. **Enhanced Stakeholder Competence:** The joint efforts in capacity building and knowledge transfer contribute to a more competent and well-informed group of stakeholders, which positively impacts the management and sustainability of the CBHI program.

Overall, the collaboration with NGOs in capacity building and knowledge sharing strengthens the ability of stakeholders to effectively contribute to the CBHI program, leading to improved outcomes and more successful implementation.

As the interview data reveal, USAID-funded projects, Abt Global Works, and UNICEF (Supporting on Social Programs, or PSP) play a crucial role in offering support, technical help, and training to local stakeholders, such as administrators, healthcare professionals, and members of the community. These issues have been addressed by collaborative efforts inside quality improvement collaboratives, which have improved teamwork skills, encouraged system-level changes, and fostered collaboration through learning sessions, experience sharing, and peer support. Moreover, data quality and utilization have improved because of a health information systems capacity-building and mentorship program, highlighting the need to enlist professionals from other fields to improve the health information system (West Showa Zone CBHI expert).

There are several advantages to cooperation among participants in Ethiopia's Community-Based Health Insurance (CBHI) scheme. First off, these kinds of partnerships have the potential to strengthen women's empowerment, increase community involvement, enhance access to healthcare, and offer financial security (Belay et al., 2022). Second, the quality and application of health data can be improved through a cooperative capacity-building and mentorship program involving professionals from diverse sectors, resulting in data-driven decision-making in the healthcare industry (Friman et al., 2023). As demonstrated by a collaborative academic and non-academic partnership case study from Sweden (Mulat et al., 2022), collaborative capacity-building techniques can also facilitate the transfer of knowledge, encourage innovation, and aid in the shift to sustainable mobility. In general, cooperative efforts in knowledge-sharing and capacity-building can improve the sustainability, resource mobilization, and service delivery of healthcare initiatives such as the CBHI in Ethiopia.

Respondents agreed that stakeholder coordination plays a crucial role in ensuring that the CBHI program is aligned with broader health policies and goals. Specifically:

1. **Alignment with Health Policies:** Effective cooperation among stakeholders ensures that the CBHI program is in harmony with broader health policies, such as achieving universal health coverage (UHC). This alignment helps the program contribute to national and global health objectives.
2. **Increasing Healthcare Utilization:** By working together, stakeholders can ensure that the CBHI program encourages greater utilization of healthcare services within the community. This helps in improving overall health outcomes and reducing preventable diseases.
3. **Reducing Out-of-Pocket Payments:** Coordinated efforts contribute to minimizing out-of-pocket expenses for individuals by providing comprehensive coverage and reducing financial barriers to accessing healthcare services.
4. **Enhancing Quality and Equity:** Collaboration helps in improving the quality and equity of healthcare services provided by the CBHI program, ensuring that all members, regardless of their socioeconomic status, receive appropriate care.
5. **Meeting Sustainable Development Goals (SDGs):** Coordinated stakeholder efforts align the CBHI program with the Sustainable Development Goals, particularly those related to health and well-being, ensuring that the program supports long-term global health objectives.

Overall, stakeholder coordination ensures that the CBHI program effectively supports and integrates with broader health policies and goals, contributing to improved healthcare outcomes and sustainability.

Stakeholder coordination is critical for connecting Community-Based Health Insurance (CBHI) initiatives with Ethiopia's broader health policies and goals. Stakeholder cooperation ensures the successful deployment and long-term viability of CBHI schemes (Tahir et al., 2022). It contributes to addressing issues such as perceived preferential treatment for paying clients, medicine shortages, and quality of care concerns (Mekonen & Tedla, 2022; Shigute et al., 2020). Furthermore, stakeholder participation increases awareness, enrolment, and sustainability of CBHI initiatives, resulting in better health outcomes and financial protection for households (Daraje, 2022). The government's role as a strong coordinator of foreign aid in the health sector highlights the need for stakeholder alignment in meeting national health goals (Teshome & Hoebink, 2018). Effective coordination promotes stakeholder synergy, allowing for more efficient resource usage and the attainment of Ethiopia's health policy goals.

Generally, the following results of the coordination and cooperation among CBHI stakeholders are being observed: it encourages a more thorough and holistic approach to the implementation of the CBHI strategy, influences the program's coverage and reach within communities in West Showa Zone, significantly contributes to the strategy's implementation success in West Showa Zone, fosters a sense of shared responsibility for achieving the program's goals, makes it easier to identify and mitigate difficulties encountered during the strategy's implementation, ensures a more equitable distribution of resources to support CBHI implementation, improves the overall quality of healthcare services offered through the CBHI program, and is improving community engagement and participation in the CBHI program. Contribute to the CBHI strategy's adaptability to local contexts, guarantee that the program is responsive to the population's changing healthcare needs, improve the program's accountability and transparency, make it easier to find and use local resources to support the program's sustainability, raise community understanding and awareness of the CBHI program, have a positive impact on the program's enrolments rates and membership retention, and provide opportunities for capacity-building and knowledge-sharing among various stakeholders.

6.5. The effect of administrative capacity and manpower on CBHI implementation in the West Showa Zone

Table 6.3: The effect of administrative capacity and manpower on CBHI implementation in the West Showa Zone

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
There is a lack of administrative capacity among Woreda CBHI employees.	50	3	5	4.40	.606
There is a lack of manpower to carry out membership renewal, cash reimbursement, and other activities of CBHI.	50	2	5	4.32	.653
The differences in administrative capacity among districts within the West Shewa Zone significantly impact the success of CBHI implementation.	50	1	5	4.36	.985
The level of administrative expertise in each district affects the efficiency of CBHI enrolments processes.	50	1	5	4.26	1.046
Variations in the number of trained personnel in different districts contribute to differences in CBHI service quality.	50	2	5	4.34	.798
Districts with stronger administrative capacity are better equipped to adapt CBHI programs to local community needs.	50	2	5	4.36	.851

The effectiveness of CBHI awareness campaigns varies based on the administrative capacity of each district.	50	4	5	4.50	.505
Valid N (listwise)	50				

Source: Own survey data (2024)

Employees of CBHI were asked to provide input on the impact of administrative capability and manpower on CBHI implementation in the western zone (Table 6.3). Consequently, the information below displays employee opinions regarding the degree of CBHI implementation capability.

Two criteria were taken into consideration to determine the point value for each key component: the weight assigned to each major element and the score given to each significant element within the factor. Strong agreement is indicated by a perfect score of 5, disagreement is shown by a score of 2, neutrality is indicated by a score of 3, and strong disagreement is indicated by a final score of 1 (strongly disagree), which carries one mark.

Respondents agreed that there is a significant lack of administrative capacity among Woreda (district) employees and a shortage of CBHI staff, especially in rural areas. Specifically:

Administrative Capacity Issues: The mean value of 4.40 indicates a strong agreement that there is a deficiency in administrative capacity among district employees. This suggests that administrative structures and processes may be insufficiently developed or supported.

Shortage of Manpower: The mean value of 4.32 reflects agreement that there is a shortage of personnel, particularly in rural areas. This shortage of staff exacerbates the administrative burden on existing employees and affects the efficiency of CBHI program implementation.

Training and Development Needs: The lack of administrative capacity and manpower highlights the need for more comprehensive training and development programs to build the skills and capabilities of employees. This will help address administrative challenges and improve program management.

Administrative Burden: The shortage of staff and insufficient administrative capacity can lead to increased workloads and administrative burdens for existing employees, potentially impacting the quality of service delivery and the overall effectiveness of the CBHI program.

In summary, addressing these issues through targeted training, capacity building, and recruitment efforts is crucial for enhancing the administrative efficiency and effectiveness of the CBHI program.

As the interview data reveal, there are various factors causing disparities in administrative capacities among the CBHI employees of the West Show Zone: inadequate management, restricted decision-making authority, poor intergovernmental connections, financial capabilities, and insufficient financial and human resources, all of which impede the effective implementation of decentralization projects (District CBHI Coordinator).

There are various studies conducted in Ethiopia concerning the capacity of employees for CBHI implementation, and their results support the conclusion of the above findings.

According to Negash et al. (2019), the lack of competence among Woreda community-based health insurance (CBHI) staff is mostly due to weak management, strategic planning, and financial capacities. Furthermore, Agegnehu's (2014) study identifies issues such as a shortage of health staff (midwifery, lab technician, and pharmacy technician), insufficient funding for duty service and per diem payments, and drug shortages. These problems degrade the quality of health care and contribute to the overall capacity deficit in the Woreda CBHI system. Addressing these difficulties through capacity-building activities, financial support, and strategic planning enhancements is critical to increasing the effectiveness and sustainability of Woreda's community-based health insurance programs.

Respondents agreed that differences in administrative capacity among CBHI employees impact the success of the scheme's implementation, leading to performance variations across districts. Specifically:

Impact on Implementation Success: Variations in administrative capacity among CBHI employees affect the overall success of the scheme. Areas with stronger administrative capacity tend to have more effective implementation and better outcomes compared to those with weaker administrative support.

Performance Variation: The differences in administrative capacity result in inconsistent performance across districts. This means that some districts may experience more successful implementation and service delivery, while others may struggle due to insufficient administrative support.

Need for Standardization: To address these disparities, it may be necessary to standardize administrative practices and support systems across districts. This could involve enhancing training, increasing resources, and improving overall administrative infrastructure.

Equity in Implementation: Ensuring that all districts have adequate administrative capacity is crucial for achieving uniform success in the CBHI program. This will help reduce performance gaps and ensure that the benefits of the program are distributed more equitably.

Overall, addressing the differences in administrative capacity is essential for improving the effectiveness and consistency of CBHI program implementation across all districts.

The interview response with a higher official of EHIS revealed that differences in administrative capacity resulted from effective management capacity, technical support, and collaboration with formal health financing networks, which are crucial for enhancing the sustainability and outreach of community-based health insurance schemes.

Ethiopian Community-Based Health Insurance (CBHI) implementation varies depending on administrative capacity. Ethiopia's pooled coverage of CBHI enrolments was found to be 45 percent, which is less than the 85 percent national target set for 2020 (Tahir et al., 2022). CBHI coverage is influenced by variables such as living in a rural area, the gender of the household head, educational attainment, wealth index, and availability of financial resources (Alemayehu et al., 2023). Furthermore, there are regional differences in the readiness to pay for CBHI; the Oromia region is less eager to pay than the Amhara region (Gizaw and Weldeslassie, 2021). These differences emphasize how crucial it is to deal with administrative issues, raise awareness, and improve financial accessibility to guarantee the fair and efficient implementation of CBHI throughout Ethiopia's many areas.

The feedback from respondents, with a mean value of 4.26, indicates a strong agreement that the level of administrative expertise in each district significantly impacts the efficiency of the CBHI enrolments processes. Specifically:

Impact on Enrolment Efficiency: The high mean value suggests that differences in administrative expertise are a key factor affecting the efficiency of the CBHI enrolments process. Districts with higher levels of administrative expertise are likely to have smoother and more efficient enrolments procedures.

Variation in Enrolment Performance: The variation in administrative expertise across districts leads to differing enrolments performance. Districts with more experienced and skilled

administrators are better equipped to handle enrolments processes effectively, while those with less expertise may face challenges that hinder their performance.

Implications for Program Success: The efficiency of enrolments is crucial for the overall success of the CBHI program. Inconsistent administrative expertise can result in uneven coverage, with some districts achieving higher enrolments rates than others, which could undermine the program's effectiveness.

Need for Capacity Building: To address these disparities, there may be a need for targeted capacity-building initiatives aimed at improving the administrative expertise in districts that are lagging. This could involve additional training, mentorship, and resource allocation to ensure that all districts can manage the enrolments process efficiently.

In summary, the level of administrative expertise plays a critical role in the efficiency of CBHI enrolments processes, leading to variations in performance across districts. Addressing these differences is essential for ensuring consistent and effective enrolments throughout the program.

To optimize resources, boost productivity, and ultimately expand the number of individuals with health insurance coverage, it is imperative to have knowledgeable administrators who understand the complexities of health systems and insurance programs. Since CBHI is volunteer-run, we must raise awareness and persuade the community to sign up. In this instance, the degree of administrative expertise required to create an efficient CBHI performance among the various districts of the West Showa Zone must possess the qualities of communication skill, emotional intelligence, commitment, organizational skill, problem-solving abilities, technology proficiency, and customer service skill (West Showa Zone CBHI expert).

Respondents reached a consensus that variations in the number of trained personnel across different districts contribute to differences in the quality of CBHI services. Specifically:

Impact on Service Quality: The availability of trained personnel directly influences the quality of services provided by the CBHI scheme. Districts with more trained staff are better equipped to deliver high-quality services, while those with fewer trained personnel may struggle to meet service expectations.

Variation Across Districts: The differences in the number of trained personnel across districts lead to inconsistencies in the quality of CBHI services. This results in some districts offering better services than others, depending on the availability and expertise of their staff.

Implications for Program Effectiveness: The quality of service is a critical factor in the success of the CBHI program. If certain districts provide lower-quality services due to a lack of trained personnel, it could undermine the program's overall effectiveness and credibility.

Need for Uniform Training and Resources: To address these disparities, it may be necessary to implement uniform training programs and allocate resources more equitably across districts. Ensuring that all districts have access to sufficient trained personnel will help improve the consistency and quality of CBHI services.

In summary, the number of trained personnel in each district is a key determinant of the quality of CBHI services. Addressing the disparities in staff training and availability is essential for enhancing service quality and ensuring the success of the CBHI program across all districts.

Variations in the number of trained personnel across different districts greatly impact the quality of Ethiopia's community-based health insurance services. Research indicates that several elements are significant predictors of users' satisfaction, including the availability of laboratory services (Getaneh et al., 2023), prompt care at medical institutions (Geta et al., 2023), and referral services (Baykedet al., 2023).

Respondents have reached a consensus that there is a positive relationship between administrative capacity and the ability to adapt CBHI programs to meet local community needs. Specifically:

Positive Relationship: The stronger the administrative capacity in a district or region, the better it is able to adapt and localize CBHI programs to suit the specific needs of the community. This suggests that effective administration is key to tailoring the program to address local health challenges and preferences.

Adapting to Community Needs: Districts with robust administrative systems are more likely to successfully implement CBHI programs that are responsive to the unique demands and circumstances of their local communities. This adaptability is crucial for ensuring that the program is relevant and effective in different contexts.

Implications for Program Success: The ability to align CBHI programs with local community needs is essential for the program's success and sustainability. When programs are well-adapted to local conditions, they are more likely to be accepted and utilized by the community, leading to higher enrolments and satisfaction rates.

Need for Capacity Building: Strengthening administrative capacity in districts where it is lacking could enhance the ability of those districts to adapt CBHI programs to better serve their communities. This might involve training, resource allocation, and the development of localized administrative strategies.

In summary, a strong administrative capacity is crucial for adapting CBHI programs to meet local community needs effectively. Enhancing administrative capabilities will improve the program's relevance and success across diverse communities.

In Ethiopia, districts possessing more robust administrative capabilities are in a better position to customize Community-Based Health Insurance (CBHI) schemes to fulfil the specific needs of the local populace. Several variables, including resource mobilization, community involvement, and governmental backing, are necessary for the successful implementation of CBHI (Mulat et al., 2022). Studies show that being a part of CBHI improves health facilities' responsibility by guaranteeing the delivery of high-quality services, which is essential for enrolments and retention (Tefera et al., 2021). Furthermore, it has been demonstrated that CBHI dramatically lowers catastrophic health costs for enrolled households, enhancing access to healthcare services and offering financial security (Kassa, 2023). District-level preparedness is crucial for the sustainable implementation of new health services, such as the Community-Based New-born Care program, which calls for thorough planning and evaluation of the health system's capacity to accept the service (Daraje, 2022).

The data from Table 6.3 indicates that administrative capacity has a significant impact on the effectiveness of CBHI awareness campaigns. Specifically:

Key Determinants: The effectiveness of awareness campaigns is closely linked to administrative capacity, which includes factors such as the number of experts, availability of manpower, and sufficient budget. These resources are essential for planning, executing, and sustaining effective awareness campaigns.

Impact on Awareness and Knowledge: When administrative capacity is strong, awareness campaigns are more effective in increasing community knowledge and understanding of CBHI. This, in turn, can lead to higher enrolments rates and better participation in the CBHI program.

Challenges in Low-Capacity Areas: In districts with lower administrative capacity, awareness campaigns may be less effective. Limited manpower, insufficient expertise, and budget constraints can hinder the ability to reach and educate the community effectively about the benefits of CBHI.

Implications for Program Success: The success of CBHI programs depends not only on their design but also on their ability to communicate their benefits to the community. Strong administrative capacity is therefore crucial for ensuring that awareness campaigns are impactful and lead to increased community engagement.

Need for Resource Allocation: To improve the effectiveness of CBHI awareness campaigns, it may be necessary to allocate more resources to districts with weaker administrative capacity. This could involve training additional personnel, increasing budget allocations, and providing the necessary tools and materials for successful campaign execution.

In summary, administrative capacity is a critical factor in determining the effectiveness of CBHI awareness campaigns. Enhancing administrative resources will likely lead to more successful efforts to raise community awareness and boost enrollment in the program.

Data from the interview reveals that tailored techniques have been used to implement CBHI awareness campaigns in the West Showa zone. And we notice that the best way to maximize CBHI adoption and sustainability in our districts is to collaborate with local leaders like the Health Development Army and Women's Development Army, customize awareness campaigns to suit community needs and issues, and make use of already-existing community institutions (West Showa Zone CBHI expert).

Community-Based Health Insurance (CBHI) awareness programs in Ethiopia are greatly influenced by the administrative capabilities of Ethiopian districts (Mirach et al., 2023; Kaso et al., 2022; Tefra and Ayele, 2022). Strong district-level management capabilities can improve CBHI program implementation and outreach, guaranteeing increased household knowledge and participation (Liu et al., 2022). The performance of CBHI awareness programs is influenced by district-level decentralization, which in turn affects important characteristics of local government responsiveness, accountability, and transparency (Tefera & Ayele, 2022). Successful district-level management strategies, such as teaching and mentoring, can hasten the positive developments in healthcare programs such as CBHI, ultimately enhancing the general efficacy of awareness campaigns and boosting community involvement.

6.6. **The effect of resource allocation on CBHI implementation in west Showa zone**

Table 6.4 The effect of resource Allocation on CBHI implementation in west Showa zone

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Differences in resources allocation among districts in the west Showa zone contribute to varying challenges during CBHI implementation.	50	2	5	4.30	.763
The availability of adequate funding influences the success of CBHI enrolments and service delivery efforts.	50	1	5	4.48	.789
Resource constraints in certain districts hinder the implementation of CBHI outreach and education initiatives.	50	2	5	4.46	.646
Equitable allocation of resources among districts is essential for consistent CBHI implementation outcomes.	50	2	5	4.54	.613
Resource availability aligned with population needs is crucial for the success of CBHI service delivery.	50	3	5	4.52	.544
Valid N (listwise)	50				

Source: Own survey data (2024)

Regarding the impact of resource allocation on CBHI implementation in the west show zone, Table 6.4 surveyed CBHI employees for their opinions. As a result, employee opinions regarding the impact of resources on CBHI are displayed in the information below. To calculate the point value for each major component, two factors were considered: the score provided to each significant element inside the factor and the weight applied to each major element. A final score of 1 (strongly

disagree), which carries one mark, indicates significant disagreement. A perfect score of 5 indicates strong agreement. A score of 2 indicates disagreement. A score of 3 indicates neutrality. Respondents have agreed that resource allocation disparities among districts are significantly impacting the implementation of CBHI programs. Specifically:

1. **Impact on Implementation:** Differences in resource allocation are leading to variations in how CBHI programs are implemented across different districts. Districts with more resources are better equipped to effectively implement the program, while those with fewer resources may struggle with aspects such as enrolments, service provision, and resource mobilization.

2. **Variation in Membership enrolment:** Districts receiving more resources tend to have higher membership enrolment rates. Adequate funding allows these districts to conduct more effective awareness campaigns, streamline the enrolment process, and provide better services, making the CBHI program more attractive to potential members.

3. **Differences in Service Provision:** Resource-rich districts are likely to offer better quality and more comprehensive health services under the CBHI scheme. In contrast, districts with limited resources may face challenges in maintaining service quality, which could lead to dissatisfaction among members and lower retention rates.

4. **Resource Mobilization:** Districts with more resources can more effectively mobilize additional resources from within the community and external partners. This capability helps to sustain and expand the CBHI program, while districts with less resource allocation may find it difficult to achieve the same level of success.

5. **Implications for Equity:** The disparities in resource allocation raise concerns about equity within the CBHI program. To ensure that all communities benefit equally from the program, it may be necessary to review and adjust resource allocation practices, ensuring that districts with greater needs receive sufficient support.

In summary, differences in resource allocation among districts are creating significant variations in CBHI implementation, affecting membership enrolment, service provision, and resource mobilization. Addressing these disparities is crucial for ensuring a more equitable and effective CBHI program across all districts.

The availability of resources affects how well Community-Based Health Insurance (CBHI) initiatives are implemented in the West Shewa Zone. According to research, several important variables influence CBHI enrolment, including knowledge, courteous treatment, laboratory services, when premium payments are due, education level, and financial standing Lin et al., 2023; Desalegn et al.,2023). In addition, the availability of resources such as technological assistance, social and emotional support, and stakeholder and user involvement is critical to building trust, motivation, and sustainability at various stages of implementation (Mekuria & Chaka, 2019).

The respondents' feedback, with a mean value of 4.48, indicates a strong consensus that the allocation of adequate funding significantly influences both CBHI enrolment and the quality of service delivery.

1. **Impact of Adequate Funding:**

- **Quality of Service Delivery:** Districts that receive sufficient funds are better positioned to deliver higher quality services under the CBHI scheme. This includes being able to provide essential healthcare services, maintain a steady supply of medicines, and support efficient healthcare infrastructure.

- **CBHI enrolment:** Adequate funding enables more effective outreach and education initiatives, which in turn drive higher enrolment rates in the CBHI program. Well-funded districts can implement comprehensive awareness campaigns, streamline the enrolment process, and ensure that members renew their participation, leading to sustained and potentially growing membership.

2. **Challenges in Resource-Constrained Districts:**

- **Hindered Implementation:** In districts where resources are limited, the implementation of CBHI outreach and education initiatives is negatively impacted. This can result in lower enrolment rates, challenges in membership renewal, and poorer service delivery quality.

- **Variation Across Districts:** The variation in CBHI performance across different districts is influenced by the level of resource allocation. Districts with better funding see higher enrolment and better service delivery, while those with less funding struggle to achieve similar results.

3. **Factors Contributing to Variation:**

- **enrolment and Membership Renewal:** Districts that receive more funding tend to have higher enrolment rates and better membership renewal rates, as they can provide better services and effectively communicate the benefits of the CBHI program.
- **Administrative Capacity:** The ability of district administrators to efficiently manage and utilize allocated funds also plays a role in the success of the CBHI program. Districts with stronger administrative capacity are more likely to make effective use of their resources, further enhancing service delivery and enrolment efforts.

In summary, the allocation of adequate funds is a critical factor that influences the success of CBHI enrolment and service delivery efforts. Resource constraints in certain districts are creating significant challenges, leading to variations in program performance, which are further exacerbated by differences in enrolment rates, membership renewal, and administrative capacity. Addressing these disparities in funding and resource allocation is essential for improving the overall effectiveness of the CBHI program.

Financial resources are critical to the success of community-based health insurance (CBHI) in Ethiopia. According to studies, CBHI membership boosts health service consumption and financial protection, while decreasing out-of-pocket payments and catastrophic health expenses (Musa et al.,2023). Furthermore, enrolment in CBHI improves health-seeking behaviour among vulnerable households, boosting usage of healthcare services, particularly outpatient treatment (Alemayehu et al.,2023). Furthermore, households engaged in CBHI benefit from increased wellbeing, including lower per-capita health spending and higher consumption of necessary goods and services (Daraje, 2022). Despite these encouraging outcomes, problems remain, such as the need for expanded national coverage to attain universal health coverage for the entire population (Asfaw et al.,2022). Thus, substantial financial resources are required to maintain and enhance the benefits of CBHI in Ethiopia.

Resource constraints in some Ethiopian areas make it difficult to undertake community-based health insurance (CBHI) outreach and education activities (Daraje, 2022; Mussa et al.,2023; Namomsa,2023). These constraints include limited government spending in the health sector, a high reliance on out-of-pocket expenses, inefficient resource utilization, and unreliable donor funding (Belayneh, 2023). Furthermore, obstacles such as inadequate ICT infrastructure, a lack of

computer skills, budget constraints, and insufficient policies impede the successful implementation of CBHI programs (Bayked, 2023). Despite efforts to increase CBHI coverage, enrolment rates are influenced by age, education level, land ownership, involvement in safety net programs, and awareness of CBHI. Addressing resource restrictions through increased finance, capacity training, and policy support is critical to increasing the efficacy and reach of CBHI projects in Ethiopia.

Respondents have strongly agreed, with a mean value of 4.54, that the equitable allocation of resources among districts is crucial for achieving consistent outcomes in the implementation of the CBHI program.

1. **Importance of Equitable Resource Allocation:**

- **Consistency in Implementation:** Equitable distribution of resources ensures that all districts, regardless of their current capacity or financial standing, have the necessary tools and support to implement the CBHI program effectively. This leads to more uniform outcomes across different regions, reducing disparities in service quality and enrolment rates.

- **Enhanced Program Effectiveness:** When resources are allocated equitably, it allows for a more balanced approach to service delivery, outreach, and education initiatives. This ensures that communities in all districts can access similar levels of healthcare services and benefits, thereby improving the overall effectiveness of the CBHI program.

2. **Addressing Disparities:**

- **Mitigating Variations:** The current disparities in resource allocation have led to inconsistent CBHI implementation outcomes, with some districts performing better than others. Equitable resource distribution is seen as a solution to these variations, enabling districts with fewer resources to catch up and perform on par with better-resourced areas.

- **Improving Equity:** Equitable allocation of resources not only improves the quality of services provided but also ensures that all members of the community, regardless of their location, have equal access to the benefits of the CBHI program. This promotes a fairer and more just healthcare system across the regions.

3. **Impact on Overall Program Success:**

- **Sustaining Membership:** Equitable resources help in sustaining high enrolment and renewal rates by ensuring that all districts can offer a similar quality of service, thus maintaining trust and satisfaction among CBHI members.
- **Strengthening Administrative Capacity:** By distributing resources more evenly, districts with weaker administrative capacities can be supported to improve, leading to a more consistent and reliable administration of the CBHI program across all regions.

In summary, respondents believe that equitable allocation of resources among districts is vital for ensuring consistent and effective implementation of the CBHI program. By addressing current disparities, this approach would lead to more uniform outcomes, improving service delivery, enrolment rates, and overall program success across all regions.

Equitable resource allocation across districts is critical for achieving consistent Community-Based Health Insurance (CBHI) implementation outcomes in Ethiopia (Daraje, 2023). Decision-making mechanisms for equitable infrastructure resource allocation are critical for addressing infrastructure imbalance and social injustice in the country (Desalegn and Solomon, 20230. The CBHI plan in Ethiopia has had a good impact, including more community engagement, improved access to health care, and financial protection (Mulat et al.,2022) However, overall CBHI enrolment in Ethiopia remains low at 45%, falling short of the national target of 80% (Tahir et al.,2022). CBHI enrolment is influenced by factors such as premium affordability, understanding of the scheme, perceived service quality, trust in the scheme, and the existence of a person with a chronic disease in the household (Habte, et al.,2022). To improve CBHI implementation outcomes, resolving resource allocation inequities among districts is critical for establishing equitable healthcare access and financial protection for all populations.

The data in Table 6.4 highlights the significance of aligning resource mobilization with population needs for the success of the CBHI scheme in providing services to insured members.

1. **Alignment with Population Needs:**

- **Importance of Resource Mobilization:** Mobilizing resources in a way that is aligned with the specific needs of the population is crucial for the success of the CBHI scheme. When resources

are directed toward areas of greatest need, the program can more effectively meet the healthcare demands of the insured community, leading to better outcomes and higher satisfaction among members.

- **Tailored Services:** Aligning resources with population needs ensures that the services provided are relevant and responsive to the local context. This approach helps in addressing the unique healthcare challenges faced by different communities, thereby enhancing the effectiveness of the CBHI program.

2. **Local Resource Mobilization:**

- **Community Involvement:** The CBHI program promotes the mobilization of resources from local communities, which not only supports the financial sustainability of the scheme but also encourages community ownership and participation. When communities are involved in resource mobilization, they are more likely to engage with and support the program.

- **Revenue Generation:** Local resource mobilization is one of the key strategies for generating revenue for healthcare financing in Ethiopia. By tapping into local resources, the CBHI program can supplement government funding and donor support, making the scheme more resilient and less dependent on external sources of finance.

3. **Impact on Service Provision:**

- **Enhanced Service Delivery:** Aligning resource mobilization with population needs helps ensure that the CBHI scheme can provide essential healthcare services effectively. This alignment allows the program to allocate funds and resources where they are most needed, improving the quality and availability of services for insured members.

- **Sustainability:** By focusing on local resource mobilization, the CBHI program can build a more sustainable financial model. This approach reduces the reliance on external funding and helps create a more self-sufficient healthcare system that is better equipped to meet the ongoing needs of the population.

In summary, the alignment of resource mobilization with population needs is identified as a critical factor for the success of the CBHI scheme in Ethiopia. This strategy ensures that resources are

used efficiently and effectively to meet the healthcare needs of insured members, promoting sustainability and improving the overall quality of service delivery within the program.

Resource availability in line with population needs is critical to the success of community-based health insurance (CBHI) service delivery. Studies have identified factors that influence CBHI membership renewal rates, such as affordability, knowledge, and perceived quality of health services (Kaso et al.,2022; Kim & Kang, 2022). Furthermore, the use of Micro Health Insurance (MHI) programs in low- and middle-income countries is influenced by factors such as awareness raising, distance from healthcare facilities, and access concerns (Durovich & Roberts, 2018). Residence, education level, family size, chronic sickness presence, and household attitude are all factors that influence CBHI scheme utilization in Ethiopia (Cheema et al., 2020). These findings highlight the significance of matching available resources to the individual demands of the population to maintain the sustainability and efficacy of CBHI service delivery.

6.7. **Summary and partial conclusion**

Differences in resource allocation among districts in the West Shewa Zone affect CBHI implementation challenges. Adequate funding influences CBHI enrolment and service delivery success. Resource constraints hinder CBHI outreach and education in certain districts. Equitable resource allocation is crucial for consistent CBHI outcomes. Resource availability aligned with population needs is vital for CBHI service success. Employee opinions show resource allocation impacts CBHI implementation. Financial resources are essential for CBHI success in Ethiopia. Resource constraints in some areas hinder CBHI outreach and education. Equitable resource allocation is necessary for consistent CBHI effectiveness. Aligning resources with population needs is critical for CBHI service success. Matching available resources to population demands is crucial for CBHI sustainability.

Building trust and credibility in Community-Based Health Insurance (CBHI) schemes in Ethiopia is crucial for their success and sustainability. Strategies to establish trust include engaging community leaders, improving healthcare quality, addressing client satisfaction, and creating public-private partnerships. Challenges in negotiating agreements with healthcare providers impact the financial stability of CBHI programs in Ethiopia. Political and bureaucratic processes affect the implementation of CBHI, requiring strong support and community engagement. External factors like economic instability can hinder the sustainability of CBHI programs. Financial sustainability is a major challenge for CBHI schemes in Ethiopia due to low enrolment,

membership renewal, and government subsidies. Overcoming bureaucratic barriers and improving financial management are essential for the success of CBHI initiatives in Ethiopia. Multiple stakeholders' involvement, including households, impacts CBHI positively by influencing enrolment rates and satisfaction levels. Engaging various stakeholders, such as the government and community, is crucial for the success and sustainability of CBHI initiatives in Ethiopia.

Stakeholder collaboration in decision-making helps adapt the CBHI strategy to local needs. Involving stakeholders' aids in identifying obstacles, selecting tactics, and resolving issues. Effective data-driven decision-making involves external agents, internal leaders, and team reflection. Government support, community mobilization, and pilot programs contribute to CBHI success. Collaboration ensures CBHI adapts to changing healthcare needs and enhances transparency. Involving local resources and stakeholders supports CBHI sustainability and community engagement. Collaboration between government and NGOs boosts CBHI enrolment and membership retention. Capacity-building and knowledge-sharing among stakeholders improve CBHI effectiveness. Cooperation aligns CBHI with broader health policies and goals for better health outcomes. Stakeholder coordination enhances program implementation, coverage, and quality of healthcare services. Collaboration fosters shared responsibility, problem-solving, resource distribution, and community engagement. It ensures adaptability, responsiveness to changing needs, transparency, resource utilization, and awareness. Positive impacts include increased enrolment, membership retention, and opportunities for capacity-building. Overall, stakeholder collaboration is crucial for the success, sustainability, and effectiveness of CBHI initiatives in Ethiopia.

Lack of administrative capacity and manpower in Woreda affects CBHI implementation. Disparities in administrative capacity hinder decentralization projects in West Showa Zone. Studies in Ethiopia highlight issues like lack of competence and funding in CBHI staff. Differences in administrative capacity impact CBHI implementation success and enrolment. Administrative expertise is crucial for efficient CBHI performance and service quality. Trained personnel availability affects CBHI service quality and user satisfaction. Strong administrative capacity helps in adapting CBHI programs to local community needs. Districts with robust administrative capabilities can customize CBHI schemes effectively. Administrative capacity influences the effectiveness of CBHI awareness campaigns. Collaborating with local leaders and customizing campaigns enhance CBHI adoption. District-level management capabilities improve CBHI

program implementation and outreach. Successful district-level strategies accelerate positive developments in healthcare programs. Decentralization affects local government responsiveness, accountability, and transparency in CBHI awareness programs.

Differences in resource allocation affect CBHI implementation, leading to variations in membership, services, and funding among districts. Adequate funding influences CBHI enrolment and service quality, while resource constraints hinder outreach and education efforts. Financial resources are crucial for CBHI success in Ethiopia, improving health service consumption and reducing out-of-pocket expenses. Equitable resource allocation is vital for consistent CBHI outcomes and addressing infrastructure imbalances and social injustices. Mobilizing local resources aligned with population needs is key for CBHI service success and revenue generation in healthcare financing. Factors like affordability, knowledge, and quality influence CBHI membership renewal rates and scheme utilization in Ethiopia. Matching available resources to population demands is essential for sustaining and enhancing CBHI service delivery effectiveness.

Chapter Seven: Conclusion and Policy Implications

7.1. Conclusion

A study conducted among 378 respondents found nearly equal representation of male and female participants in a Community-Based Health Insurance (CBHI) program. Thanks to CBHI, women and underprivileged groups have better access to healthcare in underdeveloped nations like Ethiopia. In nations like Ethiopia and India, Community-Based Health Insurance (CBHI) is essential to improving women's access to healthcare and financial security. Women's participation in health insurance programs is influenced by various factors, including the gender of the household head, the size of the family, and location. Research indicates that engaging in community-based health initiatives can assist women in overcoming obstacles to obtaining health insurance, underscoring the significance of CBHI in guaranteeing women's financial stability and the availability of high-quality healthcare services for universal health coverage.

enrolment in Community-Based Health Insurance (CBHI) is significantly influenced by age, with older people having greater participation rates. The likelihood of enrolment in CBHI is higher among older people, especially those over 60, especially if they are exposed to media. This suggests that age should be taken into consideration when developing measures to improve CBHI coverage. The CBHI is more likely to be enrolled by younger couples and those between the ages of 30 and 49, which highlights the importance of considering age demographics when developing and implementing CBHI programs.

Given that most respondents have finished their elementary and secondary education, formal education is crucial for CBHI enrolment and knowledge levels. Research from Ethiopia and Indonesia bolsters the idea that involvement in CBHI initiatives is correlated with education and awareness. Research conducted in Ethiopia and Indonesia has shown that education has a major impact on the effectiveness and acceptance of CBHI initiatives. The success of these programs is ultimately attributed to higher education levels, which also boost enrolment and utilization of health services and improve awareness of CBHI.

Since 2013, the Ethiopian government has expanded Community-Based Health Insurance (CBHI) to provide healthcare services to low-income and rural communities. The majority of CBHI members pay fees, which helps to ensure the scheme's long-term viability while also providing improved health results and financial security. CBHI members, both paying and non-paying, benefit from lower catastrophic health expenses and improved health outcomes, which help to

achieve universal health care. Disparities in healthcare access between paying and non-paying members must be addressed to promote equitable health outcomes for all CBHI members. CBHI is critical in lowering catastrophic health-care costs and supporting universal health coverage, particularly among households with chronic diseases. Testimonials from non-paying CBHI members emphasize the scheme's value in providing healthcare services and financial security, despite problems such as a lack of drugs.

According to the beneficiaries of CBHI the major challenges facing the scheme were slow claim reimbursement stpes this includes Claim submission, claim review and adjudication, payment processing reconcelation and reporting and dispute resolution and high patient volume reduce the effectiveness of Community-Based Health Insurance (CBHI) initiatives. Delays in reimbursement can put a financial pressure on healthcare facilities, jeopardizing their long-term survival and patient access to important health services. Lack of awareness of CBHI choices impedes enrolment, resulting in poor participation rates and financial hardship for patients. CBHI programs' limited healthcare provider networks can make it difficult to receive high-quality services and specialized care. CBHI programs struggle to meet different healthcare demands due to restricted coverage, inadequate health systems, and a lack of financial sustainability. Insufficient grasp of insurance principles and procedures contributes to limited community participation in CBHI systems. Overall, CBHI has challenges such as inconsistent healthcare service quality, inadequate infrastructure, difficult reimbursement systems, a lack of understanding of CBHI alternatives, and restricted healthcare provider networks.

Due to a top-down approach, there are differences in the community's involvement in creating CBHI. Research from Nigeria and Colombia highlights issues such as low engagement rates and insufficient community involvement. Because of low awareness, the poor's exclusion, and the limited effectiveness of user associations, research indicates that different levels of the community are involved in creating CBHIs. Gaining public awareness of the advantages of CBHI is essential to enhancing community involvement. Health, income, education, and knowledge of CBHI benefits are some of the elements that affect community involvement in CBHI initiatives. Improving public awareness and inclusivity are crucial for boosting community involvement in CBHI design.

The decisions made throughout the development of Community-Based Health Insurance (CBHI) programs are not widely known in the community. Respondents' opinions were divided regarding

the consideration of community perspectives in the creation of CBHI strategies, with 42.32% indicating inadequate consideration. Ethiopia's CBHI program lacks grassroots initiation, in contrast to Thailand's policy, which was created with active community input. Research from several nations reveals difficulties with CBHI programs, including membership losses because of poor service, knowledge gaps, and cost concerns. Issues with sustainability and financial viability also impede CBHI programs in Ethiopia.

Low community involvement in policymaking in Ethiopia and other countries is reflected in the 65.1% of respondents who believed that community feedback was not considered during the formation of the CBHI plan. Research from several nations supports the belief held by 57.7% of respondents that low community feedback affects the finalization of CBHI policies because of power dynamics within the population. Successful CBHI programs necessitate significant community investments, unambiguous guidelines, continuous support, and community participation in decision-making processes to achieve widespread acceptance and efficient dissemination of policy needs

The Pearson correlation coefficient between CBHI implementation and community engagement and participation is 0.25, indicating a positive and significant association between the two variables. increased community engagement and participation in CBHI leads to increased implementation rates. Whereas the sig. (2-tailed) is less than 0.05, it is significant. CBHI implementation has a substantial correlation with community engagement and participation.

Community engagement is critical for the success and long-term viability of Community-Based Health Insurance (CBHI) in Oromia, as community participation in planning influences program effectiveness. The term "community" in the context of Community-Based Health Insurance (CBHI) refers to a group of individuals who share shared traits, interests, or social connections, or who reside in a geographic area.

Continuous awareness and education enable CBHI members to actively participate in conversations concerning long-term objectives and tactics. Ethiopian community members actively discuss CBHI's long-term goals, which include lowering expenses, ensuring access to care, and raising funding. CBHI in Ethiopia generates a sense of ownership and pride among its members, which benefits sustainability and community health. To achieve inclusion and efficacy, community perspectives, as well as professional ideas, must be considered while developing CBHI strategies. The CBHI approach reflects community ambitions for better healthcare and fulfils

requests for enhanced health services. Ethiopia's CBHI plan is in line with community aspirations for improved healthcare access and financial security, as well as eliminating disparities and improving health-care utilization. Transparent communication is essential for community engagement within CBHI strategies, ensuring shared accountability and healthy dialogue. Strong collaborations between local institutions and the community, such as hospitals and pharmacies, contribute to the success and sustainability of CBHI programs in Ethiopia.

Incorporating traditional community support systems and local healthcare practices into the CBHI plan for the West Showa zone increases program adoption and sustainability. The hypothesis investigates the favourable relationship between CBHI implementation and conventional community support systems (Traditional social networks, customs, and organizations that are in place within a community to support, help, and care for its individuals are referred to as conventional community support systems. These systems are essential for promoting social cohesiveness and resilience and are frequently based on historical customs, cultural norms, and beliefs), demonstrating that their engagement has a major impact on CBHI sustainability. The Pearson correlation coefficient of 0.26 reveals that there is a positive and substantial association between CBHI deployment and traditional community support networks in this study.

The initial study hypothesis in Ethiopia's CBHI programs includes outpatient/inpatient care, vital medications, maternity/child health services, and specialized testing, but excludes costly procedures. A survey found that 96% of basic therapies were covered, but there was limited coverage for costlier specialist operations, prompting beneficiaries to seek additional funding. The correlation coefficient study demonstrated a favourable and statistically significant relationship between CBHI implementation and financial hardship protection. enrolment in CBHI provides increased protection against catastrophic healthcare expenses, with a positive significant link identified between CBHI implementation and community health outcomes.

The covariance matrices of financial stress and community health outcomes are equal across the group, as shown by Box's test. The implementation of CBHI considerably shields the community from financial stress and improves health outcomes, as evidenced by Wilks Lambda test results. Levene's test reveals considerable disparities in error variances between financial stress and community health outcomes. Between-Subjects Effects tests demonstrate that CBHI implementation provides considerable financial and health advantages to the community. The research hypothesis on the benefits of CBHI in the West Shewa Zone is supported, despite

constraints such as insufficient financing and infrastructure. Implementing CBHI presents challenges such as uneven healthcare quality, complex claims reimbursement, and restricted healthcare provider networks. The Wilks Lambda test results support rejecting the null hypothesis and accepting the hypothesis that CBHI improves financial protection and health outcomes.

The survey's sample group for the CBHI employees was well-educated, as evidenced by the fact that 60% of respondents had a master's degree, followed by those with a first degree (36%) and a PhD (4%). The involvement of various stakeholders from several CBHI departments, including team leaders, officers from health bureaus, and claim management officers, improved the study's feedback comprehensiveness and data quality. The study's dependability in evaluating the obstacles and implementation of CBHI in Ethiopia was bolstered by the respondents' substantial work experience, with 70% of them possessing over eight years of expertise.

Employees stated that the main issues facing the CBHI were influence of political, bureaucratic processes, external factors such as unstable economies, bureaucratic obstacles, low awareness, limited funding, and problems with ICT infrastructure. Significant reductions in government funding to CBHI's general and target subsidies have been brought about by the decline in foreign aid from outside partners. Furthermore, Ethiopia's outstanding foreign debt has grown and is influencing how much money is allocated to various areas of the economy, including the health sector. Now, Ethiopia pays more toward its foreign debt each year than it does on health spending. The IMF estimates that 25% of the nation's overall budget, or $286.61 billion, is used to pay down its foreign debt. This suggests that the government may cut back on or possibly stop funding the CBHI, which would influence the program's ability to remain financially viable.

Regarding stakeholder influence, CBHI staff members reported that they worked closely with governmental and non-governmental organizations such as Abt Global to develop and expand CBHI. The involvement of multiple stakeholders in the West Showa Zone improves the implementation of the CBHI plan in a holistic manner, which has a substantial impact on enrolment rates and satisfaction levels. Stakeholder engagement influences program implementation and sustainability. This encompasses both formal sector personnel and families. Thus, involving a diverse range of stakeholders is crucial for the effectiveness of CBHI activities in Ethiopia.

Collaboration among stakeholders improves the CBHI strategy's flexibility to adjust to Ethiopia's unique demands. Team-based reflection, internal leaders, and external change agents are all necessary for effective data-driven decision-making in the healthcare industry. Pilot projects,

community organizing, and government assistance all contribute to CBHI's effective growth in Ethiopia. Working together with stakeholders guarantees that CBHI programs enhance transparency and adapt to changing healthcare requirements. Involving religious organizations and community leaders increases CBHI awareness and resource mobilization. Collaboration between NGOs and the government raises CBHI membership retention and enrolment rates in Ethiopia. Enrolment in the CBHI lowers medical expenses, promotes universal health coverage, and strengthens financial security. The CBHI program's capacity building and knowledge exchange are improved through cooperative efforts with NGOs. Partnerships in CBHI programs enhance community involvement, empower women, and provide access to healthcare. Coordination amongst stakeholders helps CBHI projects fit in with Ethiopia's larger health objectives and policies. In CBHI programs, stakeholder participation enhances awareness, enrolment, sustainability, and health outcomes. Effective stakeholder cooperation is essential for achieving Ethiopia's health policy objectives, maximizing resource efficiency, and successfully implementing CBHI. In CBHI efforts, stakeholder collaboration results in more community involvement and engagement, better healthcare quality, and comprehensive execution.

CBHI implementation is hampered by lack of administrative competence due to inadequate training and development initiatives. Problems with staffing levels, finances, and poor management have an impact on the quality and enrolment of CBHI. District-level enrolment efficiency and the success of CBHI implementation are impacted by differences in administrative capabilities. Having strong administrative capabilities is essential for tailoring CBHI programs to Ethiopian communities' specific requirements. The quality of CBHI services and user satisfaction are highly impacted by the availability of skilled personnel. The success of community knowledge and CBHI awareness programs is influenced by administrative competence. Customizing awareness efforts and working with local leaders are essential for the effective acceptance and sustainability of CBHI. Capabilities for district-level administration are essential to enhancing outreach and program execution for the CBHI in Ethiopia. District decentralization, which increases the responsiveness and transparency of local administration, impacts the success of CBHI awareness efforts. District-level mentoring and teaching initiatives can boost community involvement and awareness campaigns in healthcare initiatives like CBHI, hastening their favourable outcomes.

Employee perceptions regarding the influence of resources on the CBHI implementation reveal disparities in resource allocation among districts, impacting membership enrolment, services, and resource mobilization. Enrolment in CBHI is influenced by several factors, including knowledge, financial status, and treatment. This highlights the need for resources like technology and stakeholder involvement for sustainability and trust. Enough money has a favourable impact on CBHI enrolment and service quality, but in some districts, resource limitations hampered outreach and education programs. To improve household well-being, financial protection, and the use of health services, financial resources are essential for the success of CBHI in Ethiopia.

7.2. The New Scientific Results

1. Community-based health insurance enhances healthcare access for women and other marginalized groups in the community. By enhancing their general health and well-being, marginalized groups can become more empowered and able to engage more fully in society, thanks to access to healthcare.
2. A community leader's endorsement boosts trust in community-based health insurance programs. Within the Oromoo nation, Abba Gadaa and Hadhaa Siqee are frequently regarded as reliable individuals. Positive incentives for people to participate in CBHI are being created by the involvement of these local leaders. Their support gives CBHI programs legitimacy and increases the likelihood that people will see them as dependable and advantageous. These leaders have been working with the local CBHI offices to shape the attitudes and actions of the community by promoting the CBHI, and their endorsement has changed the target communities' opinions and boosted enrolment. Leaders are encouraging community members to take part in CBHI activities by planning gatherings that highlight the significance and advantages of these initiatives, such as seminars and meetings. To make CBHI programs more palatable and useful in the community, leaders assist in customizing them to fit with regional cultural norms and values.
3. Community-based health insurance implementation significantly protects the community from financial hardship and impowers social cohesion by encouraging mutual support and solidarity. In general, by lowering the burden of out-of-pocket payments, improving healthcare cost predictability and management, and encouraging better health outcomes through timely treatment and preventative care, CBHI strengthens communities' financial resilience against

health-related spending. It can protect individual families while bolstering the community's general social and economic fabric.

4. Community-based health insurance implementation improves community health outcomes significantly, as households are investing in education, nutrition, and housing, leading to better socio-economic development. The community's standard of living is being raised by CBHI by enhancing healthcare access, reducing OOP (out-of-pocket spending), and increasing healthcare-seeking behaviour. Psychologically, they are not concerned about the expense of healthcare and are instead allocating their budget to other investments.
5. According to the results, CBHI staff members recognized several significant obstacles influencing the program's execution. These difficulties include poor stakeholder coordination, the negative consequences of political and bureaucratic procedures, and outside variables including unstable economies, red tape, low community awareness, a lack of money, and shortcomings in ICT infrastructure. Implementation gaps are caused by a lack of coordination amongst different groups, including local administrations, healthcare providers, and government agencies. This problem frequently leads to ineffective resource use, delays in decision-making, and inefficiencies in service delivery. The program's efficiency and adaptability may be impacted by slowed processes caused by political dynamics and bureaucratic red tape. For example, too complicated administrative processes could prevent timely approvals or cause needless delays in the distribution of funds. Meanwhile, the primary outside variables such as the program's financial viability may be jeopardized by an unstable economy since members may find it difficult to pay premiums during recessions. Program engagement and enrollment rates are negatively impacted when the target group is unaware of the advantages of CBHI. The operational efficiency of the program is jeopardized by inadequate or antiquated ICT systems that make it difficult to handle data, track enrollment, and process claims. Insufficient funding limits the program's capacity to expand operations, provide comprehensive services, or make investments in necessary infrastructure and technologies. The study indicates that the difficulties are being gradually resolved as the CBHI system exhibits the ability to learn and grow. The program is gradually improving its coordination mechanisms, resolving bureaucratic inefficiencies, fortifying its infrastructure, and engaging the community by recognizing its flaws. By taking care of these problems, CBHI

programs may be better implemented, provide better services, and accomplish their goals of making healthcare more accessible and protecting the target population financially.

6. The decline in foreign aid from international partners has led to substantial reductions in government funding for both general and targeted subsidies of the community-based health insurance program. Furthermore, Ethiopia's escalating foreign debt burden significantly impacts the allocation of resources to various sectors of the economy, including the health sector. Currently, Ethiopia's annual foreign debt repayments exceed its healthcare expenditures. According to International Monetary Fund (IMF) estimates, the country allocates $286.61 billion, equivalent to 25% of its total budget, toward servicing its foreign debt. This financial strain raises concerns that the government may reduce or even discontinue its funding for CBHI, thereby undermining the sustainability of the program. Given that CBHI operates on a non-profit model, its continued functionality relies heavily on external financial support from the government or international partners. Without such resources, the program faces significant challenges in maintaining its operations and achieving its intended goals. The reduction in external aid diminishes the fiscal space available for government programs, particularly those like CBHI which depends on subsidies to provide affordable healthcare to vulnerable populations. The high proportion of the national budget allocated to foreign debt repayment reduces the funding available for critical sectors, including health. This fiscal constraint creates a ripple effect, limiting government support for social programs. CBHI is a solidarity-based health financing model designed to provide equitable access to healthcare. Unlike for-profit models, it lacks mechanisms to generate revenue independently. As such, it is heavily reliant on subsidies and external funding to remain viable. Without these resources, the program risks collapse, potentially leaving beneficiaries without access to affordable healthcare services.

Addressing these financial challenges requires exploring alternative funding mechanisms, such as diversifying revenue sources, improving efficiency, or advocating for renewed support from international partners.

7.3. **Recommendations**

To minimize the inequities in coverage and contribution rates, new procedures should be designed by organizing the CBHI scheme at the regional level (cross-subsidization) rather than the district level, that is, from the district level CBHI to the regional level scheme to create a larger risk pool.

Two important policy windows international initiatives toward universal health coverage and domestic resource mobilization were utilized in the implementation of the CBHI. In order to do this, CBHI authorities should focus on boosting risk pooling to improve financial sustainability. It is essential to prioritize the availability of medications and the quality of health services, as well as to include multiple stakeholders, train operational staff, and maintain a strong health information system.

To improve the quality of the health service provided to the insured, the SHIS has to establish a monitoring and evaluation method and identify the best method of maximizing health system performance based on the ensured service provided under CBHI, contractual deals with the hospitals that provide these services, and methods of payment for these hospitals.

To improve the lack of administrative competence, SHIS should work on training and development for its employees through Comprehensive Training Programs (CTP) and create and carry out recurring training courses for CBHI administrators on important subjects such as customer service, data analysis, financial management, and health insurance management. Courses for certification assist educational establishments in providing health insurance administration certification programs.

In order to improve delays in reimbursement, SHIS should work on enhancing administrative efficiency by establishing standard procedures, training administrative staff, introducing automated systems, designing robust information systems by establishing integrated health information systems (IHIS) among providers, insurers, and members, strengthening financial management (efficient fund allocation, regular audits, and prompt payments to providers), and simplifying the claim submission process and procedures.

Encouraging equitable health outcomes for all CBHI members requires addressing disparities in healthcare access between paying and non-paying members. The following policy can improve the disparities in health care services between indigent and non-indigent members of the CBHI: Subsides and financial support through state subsidies and cross-subsidization (introduce cross-subsidization into the CBHI program so that the premiums of wealthier members help to partially pay for the coverage of members who are less fortunate), ensure equitable resource allocation through inclusive benefit packages and targeted funding, Developing and implementing strong outreach and enrolment programs can be done through active enrolment drives and community engagement to promote CBHI participation among indigent populations and address any barriers

to accessing health services. develop quality assurance monitoring through uniform quality standards and regular monitoring; integrate health care services via a holistic care approach that integrates CBHI with other social services programs, addressing not just health care but also related social determinants of health; and, in partnership with NGOs and policy, create regulations that uphold the rights of impoverished individuals to fair access to healthcare and require their inclusion in CBHI programs; and introduce legislation mandating that healthcare providers treat all CBHI members equally, irrespective of their ability to pay.

Generally, governments and CBHI programs can endeavour to lessen healthcare access inequities by putting these policy ideas into practice, guaranteeing that both paying and impoverished members receive fair and excellent healthcare services.

7.4. The Practical Applicability of the Research Results

The research results presented in the study on Community-Based Health Insurance (CBHI) have several practical applications that can significantly impact local healthcare systems and community engagement. Here are some key points regarding their applicability:

Community Engagement: The study emphasizes the importance of community input in shaping the key elements of CBHI. This suggests that involving local communities in the design and implementation of health insurance programs can lead to better outcomes and increased acceptance of these initiatives.

Impact on Healthcare Practices: The research highlights how local healthcare practices and conventional methods influence the effectiveness of CBHI. Understanding these dynamics can help policymakers tailor health insurance programs to better meet the needs of the community, thereby improving overall health outcomes.

Methodological Insights: The comprehensive overview of the research methodology employed in the study provides valuable insights into how data collection and analysis can be structured. This can serve as a guide for future research in similar contexts, ensuring that studies are robust and yield actionable results.

Resource Allocation: The findings regarding the impact of resource allocation on CBHI implementation indicate that effective management of resources is crucial for accommodating diverse healthcare needs. This insight can help organizations and governments optimize their resource distribution to enhance the efficacy of health insurance programs.

Challenges and Solutions: The research identifies various challenges faced during the implementation of CBHI, such as administrative issues and community participation willingness. Addressing these challenges through targeted strategies can improve the success rate of CBHI programs in Ethiopia and similar regions.

Policy Recommendations: The study's conclusions can inform policymakers about the necessary adjustments needed in the CBHI framework to ensure it aligns with the healthcare needs of local communities. This can lead to more effective health policies that promote better health outcomes

In summary, the practical applicability of the research results lies in their potential to enhance community engagement, optimize resource allocation, and inform policy decisions, ultimately leading to improved health outcomes in the regions where CBHI is implemented.

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Appendix

Appendix A: Survey Questioner for CBHI beneficiaries

National University of Public Service

Doctorial School of Public Administration Sciences

Questions for the Beneficiaries of CBHI

The title of the Dissertation is Community-Based Health Insurance Implementation and Challenges in Ethiopia: Case of West Showa Zone Oromiya National Regional State.

You are asked to take part in a study on the involvement of Community-Based Health Insurance Implementation and Challenges in Ethiopia. This questionnaire is part of a Ph.D. research study at Hungary's National University of Public Service's Doctoral School of Public Administration Science. The goal of this in-depth study is to determine the extent to which CBHI strategy implemented in Oromia national regional state and what the challenges of CBHI implementation are. This Questioner has **six** parts and takes about 15 minutes to complete. Your correct answers will help the study's success. You may rest assured that your information will be kept private and only utilized for the research topic. I confirm that respondent anonymity is completely guaranteed and that your participation in the study is completely voluntary.

Thank you Very Much in advance

Questioner

I. Background of the respondents

1. Gender
   A. Male B. Female
2. Age
   A. 18-30 Year
   B. 31-40 Year
   C. 41-50 Year
   D. 51-60 Year
   E. >=61 Year
3. Level of education
   A. Basic Education C. High school
   B. Grade 1-8 D. Diploma E. Degree F. Do not write and read

4. Marital Status
   A. Single C. Widowed
   B. Married D. Divorced
5. Family size
   A. 1-3 children's C. 8-11 Children's
   B. 4-7 children's D. >=12 children's
6. Income level per year
   A. 1000-3000birr C. 6100-9000 birr
   B. 3100-6000birr D. 9100-12,100 E. >12,100 birr
7. What is your village/District?
   A. Ambo C. Chaliya
   B. Bako Tibe
8. What is your type of membership
   A. Premium paying
   B. Non-paying member (Indigent-member)
9. When you become member of this insurance
   A. Since 2018 G.c C. Since 2020 G.c
   B. Since 2019 G.c D. Since 2021 G.c E. Other_____

II. Questions related to CBHI Implementation

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where 1 indicates "Strongly Disagree," 2 indicates " Disagree", 3 indicates "Neutral" 4 indicates " Agree" and 5 indicates "Strongly Agree."

Items	5	4	3	2	1
1. The policies governing CBHI in the West Shewa Zone are clear and well-defined.					
2. The process of enrolling members into CBHI is efficient and accessible to all residents.					
3. The benefit packages offered by CBHI are comprehensive and meet the healthcare needs of residents.					
4. The payment mechanisms for CBHI are convenient and easy to understand					
5. There is sufficient awareness and education about CBHI among residents in the West Shewa Zone.					
6. I am satisfied with the communication channels used to inform residents about CBHI					
7. Do you think the benefits offered by CBHI are sufficient to meet the healthcare needs of residents?					
8. I am satisfied with the accessibility of information about CBHI enrollment and benefits.					
9. Do you think the enrollment process for CBHI is inclusive and accessible to vulnerable populations (e.g., low-income families, and elderly individuals)?					

10. I am satisfied with the level of trust and transparency in managing community-based health insurance funds.					
11. The community awareness campaigns about CBHI are effective.					
12. Do you believe that CBHI has the potential to be sustainable in the long term in the West Shewa Zone?					
13. The overall progress of CBHI implementation is good in the West Shewa Zone?					

III. Challenges facing CBHI implementation

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where 1 indicates "Strongly Disagree," 2 indicates " Disagree", 3 indicates "Neutral," 4 indicates " Agree" and 5 indicates "Strongly Agree."

Items	**5**	**4**	**3**	**2**	**1**
1. Quality of healthcare services under CBHI coverage can be inconsistent, and leading to member dissatisfaction.					
2. Inadequate infrastructure and healthcare facilities in certain regions impact the effectiveness of CBHI.					
3. The process of claims reimbursement within CBHI systems can be complex and time-consuming.					
4. Lack of awareness about CBHI options hinders enrollment among community members.					
5. Limited healthcare provider network is hindering access to quality services under CBHI.					
6. CBHI programs struggle to accommodate the diverse healthcare needs of the community.					
7. Limited understanding of insurance concepts and procedures has made it difficult for community to engage with CBHI.					

IV. Questions Related to level of community-engagement and participation in the formulation of the CBHI strategy

1. To what extent do you believe that community members were involved in the formulation of the CBHI strategy?
   A. Very Low C. Medium
   B. Low D. High E. Very high
2. How informed do you feel about the decisions made during the formulation of the CBHI strategy?
   A. Very Informed C. Somewhat Informed
   B. Moderately Informed D. Slightly Informed E. Not Informed at All
3. In your opinion, are community perspectives adequately considered in the CBHI strategy formulation?
   A. Not at All C. Somewhat
   B. Slightly D. Moderately E. Completely
4. To what extent do you think community feedback was considered when finalizing the CBHI strategy?
   A. None C. Some
   B. A little D. Quite a bit E. A lot
5. How much influence do you believe community members had on shaping the key components of the CBHI strategy?
   A. No Influence C. Some Influence
   B. Minimal Influence D. Significant Influence E. Very Significant Influence

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where 1 indicates "Strongly Disagree", 2 indicates " Disagree", 3 indicates "Neutral," 4 indicates " Agree" and 5 indicates "Strongly Agree."

Items	5	4	3	2	1
1. The CBHI strategy development process effectively engaged community members.					
2. Community participation and ownership are adequately ensured in CBHI schemes.					
3. Community members were given meaningful opportunities to contribute to the CBHI strategy.					
4. Sufficient efforts were made to raise awareness and educate community members about CBHI.					
5. Community input played a crucial role in shaping the key elements of the CBHI strategy.					
6. Community leaders actively participated in the CBHI strategy formulation process.					
7. Community engagement significantly contributes to the success of the CBHI programs.					
8. I believe that the CBHI strategy genuinely represents the needs and preferences of our community in accessing health service.					

9. Community members were well-informed about the progress and decisions related to the CBHI strategy.					
10. The CBHI strategy demonstrates a collaborative effort between community representatives and policy makers.					
11. I believe the CBHI strategy will contribute positively to our community's health and well-being.					
12. The CBHI strategy was developed in a way that encourages ongoing community involvement.					
13. The CBHI strategy demonstrates a commitment to addressing the unique challenges of our community.					
14. Community members were actively engaged in discussions about the long-term goals of the CBHI strategy.					
15. The CBHI strategy development process fostered a sense of ownership and pride among community members.					
16. Community perspectives were given equal importance to expert opinions in the CBHI strategy formulation.					
17. The CBHI strategy reflects the collective aspirations of our community for better healthcare.					
18. Community engagement in the CBHI strategy was characterized by transparent communication.					
19. The CBHI strategy showcases a strong partnership between local institution and the community.					

V. Questions related to how traditional community support systems and local healthcare practices influencing the program acceptance by the community in the study area.

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where 1 indicates "Strongly Disagree," 2 indicates " Disagree", 3 indicates "Neutral," 4 indicates " Agree" and 5 indicates "Strongly Agree."

Items	5	4	3	2	1
1. The involvement of respected community elders in endorsing health care programs positively impacts community member's willingness to participate.					
2. The accessibility of healthcare programs within the community positively influences community member's acceptance of such programs.					
3. The level of integration of local healthcare practices in modern healthcare programs impacts the community's perception of the program's relevance.					
4. The current healthcare programs are gain acceptance among community members because it prioritizes community input and feedback.					
5. The presence of effective communication channels between healthcare providers and community members facilitates program acceptance.					
6. Traditional rituals and ceremonies that incorporate healthcare messages contribute to the community's openness to healthcare programs in my areas.					

7. Traditional community leaders' endorsement of healthcare programs fosters a sense of trust and credibility among community members.					
8. The availability of healthcare information in local languages increases the likelihood of program acceptance by the community.					
9. The involvement of women and mothers in healthcare decisions positively influences the community's acceptance of healthcare initiatives.					
10. The presence of community-based healthcare workers enhances the community's understanding and acceptance of healthcare programs.					

VI. Contents of CBHI

1. CBHI programs in Ethiopia cover outpatient and inpatient care, critical drugs, maternity. However, specialized and high-cost medical procedures have limited coverage, requiring beneficiaries to seek additional financial assistance.
   A. Strongly Disagree C. Neutral
   B. Disagree D. Agree E. Strongly Agree

VII. Impact of CBHI on the Protection of members from financial hardship

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where 1 indicates "Strongly Disagree", 2 indicates " Disagree", 3 indicates "Neutral," 4 indicates " Agree" and 5 indicates "Strongly Agree."

Items	5	4	3	2	1
1. As a member of CBHI I am able to afford healthcare services without experiencing financial hardship.					
2. I am satisfied with the level of financial risk pooling in the healthcare system.					
3. As CBHI member I feel financially secure in case of a major illness or medical emergency.					
4. I feel that my current health insurance provides adequate coverage for my healthcare needs.					
5. After being enrolled in CBHI I am not concerned about the financial impact of healthcare expenses on my household budget.					
6. Improvements in financial protection would encourage more people to seek healthcare services in the West Shewa Zone.					

VIII. The impact of CBHI on community's health outcome

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where 1 indicates "Strongly Disagree", 2 indicates " Disagree", 3 indicates "Neutral," 4 indicates " Agree" and 5 indicates "Strongly Agree."

Items	5	4	3	2	1
1. CBHI has increased access to preventive healthcare services (e.g., vaccinations, screenings) for residents.					
2. CBHI has reduced the financial burden of healthcare expenses on residents, leading to better health-seeking behavior.					
3. Residents covered by CBHI are more likely to seek early treatment for health issues, leading to improved health outcomes.					
4. CBHI has contributed to a decrease in the prevalence of communicable diseases (e.g., malaria, tuberculosis) through improved access to treatment.					
5. The availability of health insurance has improved the overall health status of residents in the community.					
6. CBHI has led to a decrease in the number of residents experiencing catastrophic health expenditures.					
7. I believe that there is better availability of healthcare services (e.g., clinics, hospitals) in our community since the introduction of CBHI?					
8. I believe that CBHI has helped to improve the overall health awareness and health literacy of residents.					
9. I am satisfied with the quality of healthcare services available to you through CBHI.					
10. I Have noticed positive changes in the utilization of healthcare services (e.g., frequency of doctor visits, hospital admissions) among CBHI members.					
11. CBHI has impact on reducing the burden of non-communicable diseases (e.g., diabetes, hypertension) in your community.					
12. I believe that CBHI has contributed to decrease the prevalence of preventable diseases (e.g., vaccine-preventable diseases) in your community.					
13. CBHI is effective in promoting a healthy lifestyle and preventive care among residents.					

Yuunvarsiitii Paablik Sarvisii Haangaarii

Gaaffii Fayyadamtoota Inshuraansii Fayyaa Hawaasa

Mata dureen qorannoo koo Raawwii Inshuraansii Fayyaa Hawaasa Bu'uureffatee fi Rakkoolee isaa mudachaa jiru Zoonii Showaa Lixaa keessati. Qo'annoo hirmaannaa Raawwii Inshuraansii Fayyaa Hawaasa Bu'uura godhatee fi Qormaata Itoophiyaa irratti gaggeeffamu irratti akka hirmaattan isin gaafanna. Gaaffiin Kun qaama barnoota Ph.D. qorannoo Yuunivarsiitii Biyyaalessaa Paablik Sarvisii Haangaarii Muummee Doktarummaa Saayinsii Bulchiinsa Mootummaa keessatti. Galmi qorannoo gadi fageenyaa kanaa tarsiimoon Inshuraansii Fayyaa Hawaasa mootummaa naannoo biyyoolessaa Oromiyaa keessatti hangam hojiirra oolaa turee fi qormaanni raawwii Inshuraansii Fayyaa Hawaasa maal akka ta'e adda baasuudha. Gaaffiin Kun kutaalee ja'a kan qabu yoo ta'u, xumuruuf gara daqiiqaa 15 fudhata. Deebiin sirrii ta'e kennitanii milkaa'ina qorannichaaf gargaara. Odeeffannoon keessan dhuunfaatti kan eegamuu fi mata duree qorannoo qofaaf akka itti fayyadamu siniif mirkaneesuu barbadaa.

Hirmaannaan keessan qorannicha keessatti guutummaatti fedhii keessanii akka ta’e nan mirkaneessa.

Baay'ee Galatoomaa!

Gaafataa

I. Gaaffilee odeeffannoo waliigalaa waa’ee fayyadamtootaa Insuransii Fayyaa

Hawaasa wajjin walqabatan

1. Saala: A. Dhiira B. Dubartii
2. Umurii A. Waggaa 18-30 B. Waggaa 31-40 C. Waggaa 41-50 D. Waggaa 51-60 E. >=waggaa 61
3. Sadarkaa barnootaa
   A. Barnoota Bu’uuraa C. Mana barumsaa sadarkaa lammaffaa
   B. Kutaa 1-8 D. Dippiloomaa E. Digirii F. Dubbisuufi barressu kan hin dandenyee
4. Haala Gaa’elaa A. Qofa B. Kan fuudhe C. Dubartii abbaan manaa irraa du’e D. Kan wal hiikan E. Kan haati warraa irraa duute
5. Baay’ina maatii A. 1-3 C. 8-11 B. 4-7 D. Kan biroo_____.
6. Sadarkaa galii (Waggatti) A. Birrii 1000-3000 C. Birrii 6100-9000 B. 3100-6000birrii D. Birrii 9100-12,100 E. Birrii>12,100 F. Harka Qalleeyyi
7. Gandi Kaam jiratuu _____.
8. Insuransii Fayyaa Hawaasa kessatti gartuu Miseensaa kami dha
   A. Kan busiii mallqaaa kaffaluu
   B. Kan Bilisaa Yaalamu (Harka Qalleeyyi)
9. Yoomii kaasse miseensaa Insuransii Fayyaa Hawaasa tatani?
   A. Bara 2018 irraa eeglee C. Bara 2020 eeglee
   Bara 2019 irraa eeglee D. Bara 2021 eeglee E._____

I. Gaaffiiwwan Raawwii Insuransii Fayyaa Hawaasa waliin walqabatan

Qajeelfama: Deebiin keessan yoo “Cimsee Walii Hin Galu" ta’e 1 filadhaa, yoo Walii hingalu ta’e 2 filadhaa; yoomoo "Giddugaleessa," ta’e 3 filadhaa; yoo Walii Gala jeetanii 4 filadhaa; "Cimsee Walii Gala" dha yoo ta’e debiin keessan 5 filadhachuu dhaan Malattoo √ barressudhaan deebii keessan kenna.

Gaaffii	**5**	**4**	**3**	**2**	**1**
1. Adeemsi Insuransii Fayyaa Hawaasa hubachuu fi fayyadamuuf Ifaa dha.					

2. Adeemsa Galmee keesatti waa'ee faayidaa fi uwwisaa saganataa inshuransii					
3. Qabiyeen faayidaa Inshuraansii fayyaa hawaasa irratti hundaa'een kennamu hunda galeessa kan ta'ee fi fedhii eegumsa fayyaa jiraattotaa					
4. Malli kaffaltii Inshuraansii fayyaa hawaasa mijataa fi hubachuuf salphaadha					
5. Jiraattota Zoonii Shewa Lixaa biratti waa'ee Inshuraansii fayyaa hawaasa hubannoo fi barumsi gahaan jira.					
6. Karaalee qunnamtii jiraattota waa'ee inshuraansii fayyaa Hawaasa irratti hundaa'e beeksisuuf itti fayyadamanitti gammadeera.					
7. Faayidaan inshuraansii fayyaa hawaasa fedhii eegumsa fayyaa jiraattotaa guutuuf gahaadha jettanii yaaddu?					
8. Odeeffannoon waa'ee galmee fi faayidaa inshuraansii fayyaa hawaasa dhaqqabamaa ta'uu isaatii nan amanaa.					
9. Adeemsi galmee inshuraansii fayyaa hunda hammatee fi hawasaa midhamoo ta'aniif (fkn, maatii galii xiqqaa qaban, fi maanguddootaf)					
10. Iftoomina maallaqa busii miseensootaa inshuraansii fayyaa hawaasa itti fayyadamuu/taajajila oolu irratti Amantaa guutu qaba.					
11. Duulli hubannoo hawaasaa waa'ee inshuraansii fayyaa guddisuu irrati fudhatamaa jiru bu'a qabeessa.					
12. Zoonii shawa lixaa keessatti inshuraansii fayyaa hawaasa yeroo dheeraaf itti fufiinsa qabaachuu danda'a jettanii amantuu?					
13. Adeemsi waliigalaa raawwii inshuraansii fayyaa hawaasa zoonii shewa lixaa keessatti gaarii dha?					

II. **Hojiirra Oolmaa Inshuraansii Fayyaa Hawaasa fi Rakkolee isa mudachaa jiru**

Qajeelfama: Deebiin keessan yoo "Cimsee Walii Hin Galu" ta'e 1 filadhaa, yoo Walii hingalu ta'e 2 filadhaa; yoomoo "Giddugaleessa," ta'e 3 filadhaa; yoo Walii Gala jeetanii 4 filadhaa; "Cimsee Walii Gala" dha yoo ta'e debiin keessan 5 filadhachuu dhaan Malattoo √ barressudhaan deebii keessan kenna.

Gaaffii	**5**	**4**	**3**	**2**	**1**
1. Tajaajilii fayyaa IFH jalatii kennamuu qulqullinnaa itti fuffinsaa qabchuu dhabuun isaa missensoonii akka hin gammanee tasisa.					

2. Bu'uuraaleen misoomaa fi dhaabbileen eegumsa fayyaa naannoolee murtaa'an keessatti gahaa ta'uu dhabuun bu'a qabeessummaa inshuraansii fayyaa hawaasa irratti dhiibbaa qaba.					
3. Adeemsi qarshii ofii gafachuu irratti (qorichaa qarshii ofiitin bitanii booda) Inshuraansii Fayyaa Hawaasa keessatti walxaxaa fi yeroo kan fudhatu dha.					
4. Waa'ee filannoowwan Inshuraansii Fayyaa Hawaasa hubannoo dhabuun miseensota hawaasaa biratti galmee gufachiisa.					
5. Waliiti dhufenyii dhiyeessitoota eegumsa fayyaa gahaa tauu dhisusati miseensoonii IFH tajaajila qulqullina qabu akka hin arganne gufachiisaa jira.					
6. Sagantaawwan sirni Inshuraansii Fayyaa Hawaasa fedhii kunuunsa fayyaa hawaasaa guutu irratti hanqina qaba.					
7. Hawaasni yaad-rimee fi hojimaata inshuraansii fayyaa irratti hubaannoo xiqqo qabachuun isaa hirmaannaa hawwasaa gaddi					

III. Gaaffiiwwan Sadarkaa hirmaannaa hawaasaa fi hirmaannaa tarsiimoo inshuraansii fayyaa hawaasa basuu waliin walqabatan.

1. Tarsiimoo inshuraansii fayyaa hawaasa basuu keessatti miseensonni hawaasaa hangam hirmaatan jettanii amantu?

   A. Baayyee Gadi aanaa C. Giddugaleessa

   B. Gadi aanaa D. Ol aanaa E. Baayyee ol aanaa

2. Murtoowwan yeroo tarsiimoon Inshuraansii Fayyaa Hawaasa bocuu irratti murtaa'an ilaalchisee odeeffannoo hangami qabduu?

   A. Odeeffannoo baayyee kan qabu C. Odeeffannoo hamma tokko kan qabu

   B. Odeeffannoo giddugaleessaa D. Odeeffannoo xiqqoo E. Tasumaa odeeffannoo hin qabne

3. Akka yaada keessaniitti, tarsiimoo Inshuraansii Fayyaa Hawaasa basuu keessatti ilaalchi (Yaadni) hawaasaa haala gahaa ta'een ilaalamaa/mee jiraa?

A. Tasumaa miti B. Xiqqoo C. Hamma tokko D. Giddugaleessa E. Guutummaatti

4. Tarsiimoo Inshuraansii Fayyaa Hawaasa yeroo xumuramu yaadni hawaasaa hangam tilmaama keessa galeera jettanii yaaddu?

A. Tokkollee hin jiru B. Xiqqoo C. Tokko tokko D. Baay'ee Xiqqoo E. Baay'ee

5. Miseensonni hawaasaa qaamolee ijoo tarsiimoo Inshuraansii Fayyaa Hawaasa basu irratti dhiibbaa hangamii qaban jettanii amantu?

A. Dhiibbaa hin Qabanii C. Dhiibbaa tokko tokko

B. Dhiibbaa xiqqaa D. Dhiibbaa guddaa E. Dhiibbaa baay'ee guddaa

Qajeelfama: Deebiin keessan yoo "Cimsee Walii Hin Galu" ta'e 1 filadhaa, yoo Walii hingalu ta'e 2 filadhaa; yoomoo "Giddugaleessa," ta'e 3 filadhaa; yoo Walii Gala jeetanii 4 filadhaa; "Cimsee Walii Gala" dha yoo ta'e debiin keessan 5 filadhachuu dhaan Malattoo √ barressudhaan deebii keessan kenna.

Gaaffii	**5**	**4**	**3**	**2**	**1**
1. Adeemsi qophii tarsiimoo Inshuraansii Fayyaa Hawaasa miseensota hawaasaa bu'a qabeessa ta'een hirmaachiseera.					
2. Hirmaannaan hawaasaa fi abbummaan Taajajila Inshuraansii Fayyaa Hawaasa keessatti haala gahaa ta'een mirkanaa'era.					
3. Miseensonni hawaasaa tarsiimoo taajajila inshuraansii fayyaa Hawaasa keessatti gumaacha akka godhan carraan gaari kennameefii jira.					
4. Waa'ee Taajajila Inshuraansii Fayyaa Hawaasa hubannoo uumuu fi miseensota hawaasaa barsiisuuf tattaaffiin gahaan taasifameera.					
5. Galteen hawaasaa qaamolee ijoo tarsiimoo Inshuraansii Fayyaa Hawaasa bocuu keessatti gahee murteessaa taphateera.					

6. Galteen hawaasaa qaamolee (bakka bu'oota hawaasa) ijoo tarsiimoo inshuraansii fayyaa hawaasa basuu keessatti gahee murteessaa taphateera.					
7. Hirmaannaan hawaasaa milkaa'ina sagantaalee inshuraansii fayyaa hawaasa keessatti gumaacha guddaa qaba.					
8. Tarsiimoon inshuraansii fayyaa hawaasa fedhii fi filannoo hawaasa keenyaa tajaajila fayyaa argachuu keessatti qabu sirriti bakka bu'a jedheen amana.					
9. Miseensonni hawaasaa waa'ee adeemsaa fi murtii tarsiimoo inshuraansii fayyaa hawaasa waliin walqabatee jiru odeeffannoo gaarii qabu turan.					
10. Tarsiimoon inshuraansii fayyaa hawaasa tattaaffii walta'iinsaa bakka bu'oota hawaasaa fi qaamolee imaammata baasan gidduutti taasifamu agarsiisa.					
11. Tarsiimoon inshuraansii fayyaa fayyaa fi nageenya hawaasa keenyaaf gumaacha gaarii qaba jedheen amana.					
12. Tarsiimoon inshuraansii fayyaa hawaasa haala hirmaannaa hawaasaa itti fufiinsa qabu jajjabeessuun kan qophaa'e dha.					
13. Tarsiimoon inshuraansii fayyaa hawaasa qormaata addaa hawaasa keenyaa furuuf kutannoo qabaachuu agarsiisa.					
14. Miseensonni hawaasaa waa'ee galmoota yeroo dheeraa tarsiimoo IFH irratti marii irratti dammaqinaan bobba'aniiru.					
15. Adeemsi qophii tarsiimoo inshuraansii fayyaa hawaasa miseensota hawaasaa biratti miira abbummaa fi amanamummaa guddiseera.					

16. Tarsiimoo inshuraansii fayyaa hawaasa bocuu (baasuu) keessatti ilaalchi hawaasaa yaada ogeeyyii wajjin walqixa bakki kennameerafi.					
17. Tarsiimoon inshuraansii fayyaa hawaasa hawwii waloo hawaasni keenya kunuunsa fayyaa fooyya'aa argachuuf qabu kan calaqqisiisudha.					
18. Tarsiimoo inshuraansii fayyaa hawaasa keessatti hirmaannaan hawaasaa qunnamtii iftoomina qabuun kan amala qabu ture.					
19. Tarsiimoon inshuraansii fayyaa hawaasa walta'iinsa cimaa dhaabbilee naannoo fi hawaasa gidduu jiru agarsiisa.					

IV. Gaaffiiwwan Sirni deeggarsa hawaasaa aadaa fi gochoonni eegumsa fayyaa naannoo fudhatama sagantichaa hawaasa naannoo qorannichaa irratti dhiibbaa akkamii geessisan wal qabatee dhiyaate.

Qajeelfama: Deebiin keessan yoo "Cimsee Walii Hin Galu" ta'e 1 filadhaa, yoo Walii hingalu ta'e 2 filadhaa; yoomoo "Giddugaleessa," ta'e 3 filadhaa; yoo Walii Gala jeetanii 4 filadhaa; "Cimsee Walii Gala" dha yoo ta'e debiin keessan 5 filadhachuu dhaan Malattoo √ barressudhaan deebii keessan kenna.

Gaaffii	5	4	3	2	1
1. Sagantaa eegumsa fayyaa raggaasisuu keessatti hirmaannaan bakkaa bu'oota hawwasaa (jaarsoliin hawaasaa kessatti kabaja qabani) fedhii miseensonni hawaasaa hirmaachuuf qaban irratti dhiibbaa gaarii qaba.					
2. Dhaqqabummaan sagantaalee eegumsa fayyaa hawaasa keessatti miseensi hawaasaa sagantaalee akkasii fudhachuu irratti dhiibbaa gaarii qaba.					

3. Sadarkaan gochaalee eegumsa fayyaa naannoo sagantaalee eegumsa fayyaa ammayyaa keessatti walitti makamuun ilaalcha hawaasni barbaachisummaa sagantaalee irratti qabu irratti dhiibbaa qaba.					
4. Sagantaaleen eegumsa fayyaa amma jiran galtee fi yaada hawaasaa dursa waan kennaniif miseensota hawaasa biratti fudhatama argachaa jiru.					
5. Dhiyeessitoota eegumsa fayyaa fi miseensota hawaasaa gidduutti karaaleen qunnamtii bu'a qabeessa ta'an jiraachuun isaanii fudhatama sagantichaaf haala mijeessa.					
6. Sirnoonni aadaa fi sirnoonni ergaa eegumsa fayyaa of keessaa qaban hawaasni sagantaalee eegumsa fayyaa naannoo kootti banaa akka ta'uuf gumaachu.					
7. Hoggantoonni hawaasaa aadaa sagantaalee eegumsa fayyaa raggaasisuun miseensota hawaasaa biratti miira amantaa fi amanamummaa ni guddisa.					
8. Odeeffannoon eegumsa fayyaa afaanota hawaasnii hubachuu danda'aun argamuun carraa fudhatama sagantichaa (IFH) hawaasa biratti ni dabala.					
9. Murtii eegumsa fayyaa keessatti hirmaannaan dubartootaa fi haadholiin hawaasni jalqabbii eegumsa fayyaa fudhachuu irratti bu'a gaarii qaba.					
10. Hojjetoonni eegumsa fayyaa hawaasa bu'uura godhatan jiraachuun isaanii hubannoo fi fudhatama hawaasni sagantaalee eegumsa fayyaa irratti qabu ni guddisa.					

VI. <u>Qabiyyee inshuraansii fayyaa hawaasa</u>

1. Sagantaan inshuraansii fayyaa hawaasa Itoophiyaa keessatti kunuunsa dhukkubsattoota ciisanii yaalaa aragachaa jiranifi fi kan dedebi'anii yaalamanii, qoricha murteessaa, fi da'umsa kan hammatudha.

   A. Cimsee Walii Hin Galu C. Giddugaleessa
   B. Walii Hin Galu D. Waliigalaa E. Bayyee Waliigalaa

VII. <u>Gahee inshuraansiin fayyaa hawaasa basii hin maleef akka miseensonii hin saxilamnee gochuu irratti qabuu</u>

Qajeelfama: Deebiin keessan yoo "Cimsee Walii Hin Galu" ta'e 1 filadhaa, yoo Walii hingalu ta'e 2 filadhaa; yoomoo "Giddugaleessa," ta'e 3 filadhaa; yoo Walii Gala jeetanii 4 filadhaa; "Cimsee Walii Gala" dha yoo ta'e debiin keessan 5 filadhachuu dhaan Malattoo √ barressudhaan deebii keessan kenna.

Gaaffii	**5**	**4**	**3**	**2**	**1**
1. Akka miseensa inshuraansii fayyaa hawaasa tokkoti, osoo rakkoon maallaqaa hin mudatin tajaajila eegumsa fayyaa argachuu nan danda'a.					
2. Sadarkaa sasabii maallaqaa yeroo balaaf oolu sirna eegumsa fayyaa keessatti walitti qabuun gammadeen jira.					
3. Akka miseensa inshuraansii fayyaa hawaasa tokkoti yoo dhukkubni guddaan ykn balaan yaalaa hatattamaa mudate rakkon maallaqaa nan yaadessu.					
4. Inshuraansii fayyaa koo ammaa fedhii kunuunsa fayyaa kootiif uwwisa gahaa akka kennu natti dhaga'ama.					
5. Inshuraansii fayyaa hawaasa keessatti Erga miseensa ta'ee booda dhiibbaa maallaqaa baasii kunuunsa fayyaa baajata mana koo irratti qabu hin yaadda'u					
6. IFH ummataa basii hin maleef akka hin saaxilmnee guchuun isaa namoonni baay'een tajaajila eegumsa fayyaa akka barbaadan ni jajjabeessa					

VIII. <u>Gahee inshuraansiin fayyaa hawaasa bu'aa fayyaa hawaasaa irratti qabu</u>

Qajeelfama: Deebiin keessan yoo "Cimsee Walii Hin Galu" ta'e 1 filadhaa, yoo Walii hingalu ta'e 2 filadhaa; yoomoo "Giddugaleessa," ta'e 3 filadhaa; yoo Walii Gala jeetanii 4 filadhaa; "Cimsee Walii Gala" dha yoo ta'e debiin keessan 5 filadhachuu dhaan Malattoo √ barressudhaan deebii keessan kenna.

Gaaffii	**5**	**4**	**3**	**2**	**1**
1. Inshuraansii fayyaa hawaasa jiraattotaaf tajaajila eegumsa fayyaa ittisaa (fkn, talaallii, fi qorannoo) argachuu akka dabalu taasiseera.					
2. Inshuraansii fayyaa hawaasa ba'aa maallaqaa baasii kunuunsa fayyaa jiraattota irraa hir'isuun hawasaa fayyaa bulessa ta'e uumera.					
3. Jiraattonni inshuraansii fayyaa hawaasa miseensaa tahan dhimmoota fayyaatiin dafanii yaala aragachuu isaaniitiin bu'aa fayyaa fooyya'aa ta'e argamsiisa.					
4. Inshuraansii fayyaa hawaasa carraa wal'aansaa fooyya'aa ta'een tamsa'ina dhukkuboota daddarboo (fkn, busaa, tiruu) hir'isuuf gumaacheera.					
5. Inshuraansii fayyaa jiraachuun isaa haala fayyaa waliigalaa jiraattota hawaasaa fooyyessee jira.					
6. Inshuraansii fayyaa hawaasa irratti hundaa'e lakkoofsi jiraattota baasii fayyaa balaa guddaa mudatan akka hir'atu taasiseera.					
7. Erga inshuraansii fayyaa Hawaasa jalqabee as hawaasa keenya keessatti tajaajilli eegumsa fayyaa (fkn, kilinika, fi hospitaalota) fooyya'aan akka jiru nan amana.					
8. Inshuraansii fayyaa hawaasa hubannoo fayyaa waliigalaa fi dubbisuu fi barreessuu fayyaa jiraattotaa fooyyessuuf gargaareera jedheen amana.					

9. Qulqullina tajaajila eegumsa fayyaa karaa inshuraansii fayyaa hawaasa bu'uura godhateen isiniif dhiyaatutti quufa qaba.					
10. Itti fayyadama tajaajila eegumsa fayyaa (irra deddeebiin yaalamuu fi hospitaala seenuu) miseensota inshuraansii fayyaa hawaasa biratti jijjiirama gaarii hubadheera.					
11. Inshuraansii fayyaa hawaasa nannoo kooti ba'aa dhukkuboota daddarboo hin taane (fkn, dhukkuba sukkaaraa, dhiibbaa dhiigaa) hir'isuu irratti dhiibbaa qaba.					
12. Inshuraansii fayyaa hawaasa nannoo kooti tamsa'ina dhukkuboota ittifamuu danda'an (fkn dhukkuboota talaalliin ittifamuu danda'an) hir'isuuf gumaacheera jedheen amana.					
13. Inshuraansii fayyaa hawaasa jiraattota biratti jireenya fayya qabeessaa fi kunuunsa ittisaa guddisuu keessatti bu'a qabeessa.					

Appendix B: Survey Questioner for CBHI employees

The title of the Dissertation is Community-Based Health Insurance Implementation and Challenges in Ethiopia: Case of West Showa Zone Oromiya National Regional State.

You are asked to take part in a study on the involvement of Community-Based Health Insurance Implementation and Challenges in Ethiopia. This questionnaire is part of a Ph.D. research study at Hungary's National University of Public Service's Doctoral School of Public Administration Science. The goal of this in-depth study is to determine the extent to which CBHI strategy implemented in Oromia national regional state and what are the challenges facing CBHI implementation. This questioner has four parts and takes about 15 minutes to complete. Your correct answers will help the study's success. You may rest assured that your information will be kept private and only utilized for the research topic. I confirm that respondent anonymity is completely guaranteed and that your participation in the study is completely voluntary.

Thank you Very Much in advance

Questioner

I. Background of the respondents

1. Gender

   A) Male B) Female
2. Age

   A) 18-30 Year B. 31-40 Year C. 41-50 Year D.51-60 years E. >=61 years
3. Level of education

   A) Diploma C) Master's Degree

   B) First Degree D) PhD E) other_____
4. Designation

   A. Monitoring and evaluation officer (Federal office EHIS)
   B. Claim Management officer (Federal office EHIS)
   C. Zonal CBHI Expert
   D. Zonal Coordinator
   E. Oromia Health Bureau CBHI expert
   F. Provider affairs and quality assurance senior officer (Federal Office EHIA)
   G. Members senior officer (EHIS)
   H. Higher official at EHIS
   I. Team Leader at EHIS

5. Work Experience

   A. 1-3 Years B. 4-7 Years C. 8-11 Years D. >=12 Years

II. Challenges of CBHI Implementation

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where 1 indicates "Strongly Disagree," 2 indicates " Disagree", 3 indicates "Neutral," 4 indicates " Agree" and 5 indicates "Strongly Agree."

Items	5	4	3	2	1
1. Limited financial resources are a major challenge in the implementation of the CBHI strategy.					
2. Inadequate healthcare infrastructure poses a significant challenge to CBHI Implementation.					
3. A lack of awareness about the benefits of health insurance hinders CBHI enrollment.					
4. Socioeconomic disparities affect the enrollment rates of CBHI programs in different communities.					
5. Inconsistent administrative capacity across districts affects the implementation of the CBHI strategy.					

6. The CBHI strategy faces difficulties in recruiting and training local healthcare workers.					
7. The CBHI strategy encounters challenges in reaching remote and underserved areas.					
8. The CBHI strategy faces challenges in building trust and credibility within communities.					
9. The CBHI strategy faces difficulties in negotiating agreements with healthcare providers.					
10. Challenges related to political and bureaucratic processes affect CBHI implementation.					
11. External factors, such as economic instability, can affect the sustainability of CBHI programs.					
12. Financial sustainability is a major challenge faced by some CBHI programs in Ethiopia.					
13. Complex claims reimbursement process is a common challenge with CBHI systems.					

III. Questions related to Influence of stakeholders on the success of CBHI strategy implementation in the study area

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where 1 indicates "Strongly Disagree," 2 indicates " Disagree", 3 indicates "Neutral," 4 indicates " Agree" and 5 indicates "Strongly Agree."

Items	5	4	3	2	1
1. We have strong collaboration between government agencies, non-governmental organizations.					
2. The involvement of multiple stakeholders fosters a more comprehensive and holistic approach to CBHI strategy implementation within West Showa Zone.					
3. The collaboration among different stakeholders positively influences the coverage and reach of the CBHI program within communities in West Showa Zone.					
4. The active engagement and communication between government agencies, non-governmental organizations, and community leaders significantly contribute to the success of the CBHI strategy implementation in West Showa Zone.					
5. Collaborative efforts create a sense of shared responsibility for achieving the goals of the CBHI program in West Showa Zone.					
6. Stakeholder coordination facilitates the identification and mitigation of challenges faced during the implementation of the CBHI strategy in West Showa Zone.					
7. Collaboration between government and non-government entities ensures a more equitable distribution of resources to support CBHI implementation in West Showa Zone.					

8. The diverse expertise brought by different stakeholders enhances the overall quality of healthcare services provided through the CBHI program in West Showa Zone.					
9. Effective stakeholder coordination leads to improve community engagement and participation in the CBHI program in your area.					
10. Collaborative decision-making processes between stakeholders contribute to the adaptability of the CBHI strategy to local contexts in your area.					
11. Stakeholder collaboration ensures that the CBHI program is responsive to the evolving healthcare needs of the population in your area.					
12. A well-coordinated approach among stakeholders enhances the accountability and transparency of the CBHI program in your area.					
13. Collaboration facilitates the identification and utilization of local resources to support the sustainability of the CBHI program in your area.					
14. Stakeholder involvement enhances the understating and awareness of the CBHI program the local population in your area.					
15. Effective collaboration between government and non-government entities positively affects the enrolment rates and membership retention of the CBHI program in your area.					
16. Collaborative efforts create opportunities for capacity-building and knowledge sharing among different stakeholders involved in the CBHI program in your area.					
17. Coordination between stakeholders ensures that the CBHI program is aligned with the broader health policies and goals in your area.					

IV. Questions related to the effect of Administrative capacity/ Manpower and resource on CBHI implementation in west how zone.

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where 1 indicates "Strongly Disagree," 2 indicates " Disagree", 3 indicates "Neutral," 4 indicates " Agree" and 5 indicates "Strongly Agree."

Items (Administrative capacity and manpower)	**5**	**4**	**3**	**2**	**1**
1. There is lack of administrative capacity among Woreda CBHI employees.					
2. There is lack of enough manpower in order to carry out membership renewal, cash reimbursement and other activities of CBHI.					
3. The differences in administrative capacity among districts within the west shewa zone significantly impact the success of CBHI implementation.					
4. The level of administrative expertise in each district affects the efficiency of CBHI enrollment processes.					
5. Variations in the number of trained personnel in different districts contribute to differences in CBHI service quality.					
6. Districts with stronger administrative capacity are better equipped to adapt CBHI programs to local community needs.					
7. The effectiveness of CBHI awareness campaigns varies based on the administrative capacity of each district.					

Items (Resource Allocation)	5	4	3	2	1
1. Differences in resources allocation among districts in the west showa zone contribute to varying challenges during CBHI implementation.					
2. The availability of adequate funding influences the success of CBHI enrollment and service delivery efforts.					
3. Resource constraints in certain districts hinder the implementation of CBHI outreach and education initiatives.					
4. Equitable allocation of resources among districts is essential for consistent CBHI implementation outcomes.					
5. Resource availability aligned with population needs is crucial for the success of CBHI service delivery.					

Appendix C: Interviews: Interview questions for CBHI officials

The title of the Dissertation is Community-Based Health Insurance Implementation and Challenges in Ethiopia: Case of West Showa Zone Oromiya National Regional State.

You are asked to take part in a study on the involvement of Community-Based Health Insurance Implementation and Challenges in Ethiopia. This questionnaire is part of a Ph.D. research study at Hungary's National University of Public Service's Doctoral School of Public Administration Science. The goal of this in-depth study is to determine the extent to which CBHI strategy implemented in Oromia national regional state and what the challenges of implementations are. This Interview has 6 questions and takes about 10 minutes to complete. Your correct answers will help the study's success. You may rest assured that your information will be kept private and only utilized for the research topic. I confirm that respondent anonymity is completely guaranteed and that your participation in the study is completely voluntary.

- How is the CBHI strategy formulated and implemented in Oromia national regional state and what are the challenges of implementations?
- What is the status of community-based health insurance (CBHI) implementation in different parts of west showa zone Oromiya National regional state?
- What are the major challenges faced by CBHI programs in Ethiopia, including issues related to governance, financing, administration, and accountability?
- How does the regulatory and policy framework in Ethiopia facilitate or hinder the growth and functioning of CBHI schemes?
- What are the key factors influencing the adoption and enrollment rates of CBHI schemes among various socioeconomic groups in West Showa Zone?

- What is the effect of CBHI on healthcare access, utilization, and financial protection for vulnerable populations in west showa zone?

Appendix D. Consent Letter

YUUNIVARSIITII AMBOO

Ambo University
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College of Business and Economics
ቢዝነስና ኢኮኖሚክስ ኮሌጅ
Department of Public Administration and Development Management
የሕዝብ አስተዳደርና ልማት ሥራ አመራር ት/ት ክፍል

Ref. No: AU/PADM/0010/2016

Date: 12/04/2016

To: West Shawa Zone Health Bureau

Subject: Requesting Cooperation

Mr. Gutema Nemomsa Dereje is an academic staff of Ambo University, department of Public Administration and Development Management and currently Pursuing his PhD degree in Hungary, Budapest at National University of Public Service. As part of the program he is going to gather data for his PhD dissertation with a title, Implementation and Challenges of CBHI in Ethiopia, the Case of West Shawa Zone. The study is already underway and it is believed to benefit the country in general and your zonal office in particular. In this view, the department kindly requests you to cooperate with the candidate so that he will get access to relevant data in your office.

With Best Regards
Head, Department of Public Administration & Development Management
የህዝብ አስተዳደርና ልማት ሥራ አመራር ት/ክፍል ኃላፊ
Department of PADM

Ambo University Department of Public Administration & Development Management

16/04/2016

P.O.Box 19 AMBO ETHIOPIA E-mail: padm.department@ambou.ed.edu.et Telephone: 251118766169

BIIROO FAYYAA OROMIYAA
OROMIA HEALTH BUREAU

Guyyaa Date ቀን 6/5/2016
Lakk Ref.no ቁጥር BORHUSTC/14/1164

Wajjira Fayyaa Godina Shawwaa Lixaatiif
B/J

Dhimmi: Xalayya Deggersa Kennuu Ilaala.

Akkuma beekamu Biiroon Keenya Ogeyyii, dhabbile akkasumas namoota qorannoo fi Gamaggama jalqabaa fi Xumuraa (baseline and Endline Assessment) geggessuuf propozaala dhiyeffatan propoozaala isaanii madaaluun akkasumas iddoo biraatti ilaalchisani fudhatama argatan (approved) dhiyeffatan, propoozaala isaanii ilaaluudhaan waraqaa deggersaa ni kenna. Haaluma kanaan **Obbo Guutamaa Namoomsaa**, barsiisaa yuunivarsiitii Amboo kan ta'an, qorannoo mata duree **"Implemetation and challenge of CBHI in Ethiopia, the case of West Shawa zone'** jedhurratti godina keessan aanaalee Ambo, Bako Tibbe fi Calliyaa keessaatti qorannoo hojjechuudhaaf propoozaala isaani koree "Health Research Ethical Review Committee" Biiroo keenyatti dhiyeffatani jiru. Haaluma kanaan koreen "Health Research Ethical Review Committee" Biiroo keenya piropoozaali kana ilaaluun mirkanesse qorannoon Kun akka geggeeffamuu murtesse jira.

Kanaafuu, hojii qorannoo kana irratti deggersa barbaachisa akka gootaniifii gaafachaa qorannoon kun qacceffamee eerga xumuramee booda firii isaa koppii tokko **BFO** tiif akka galii godhan galagalcha xalayaa kanaan isaan beeksifna. Kanuma Yaada keessa galchuun **Obbo Guutamaa Namoomsaa** wayitti qorannoon kun qaaceffame xumuramu firii isaa koppii tokko BFO tiif galii gochuuf mallattoo kootiin ni mirkanessa.

Biiroo Fayyaa Oromiyaatti Daayireektooreetii Hooggansa BIT/Fayyaa Hawaasaa, Qorannoo fi Tajaajiila Baankii Dhiigaa
Oromia Health Bureau PHEM Research & Blood Bank Service Director

Nagaa Wajjin,
Dr Burhaanuu Qonaa (Bsc. MPH)
Qindeessaa Garee Qorannoo fi Qo'annoo Fayyaa Hawwasaa

G/G

Maqaa: **Obbo Guutamaa Namoomsaa**
Mallattoo _____
Bilbila;
B/J

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Oromia health bureau | t.me/ORHBCommunication | Seerbet (Caloalii) Finfinnee

Appendix E. List of Publications by the researcher

Articles

1. Namomsa, G. (2019). Assessing the practice and challenges of Community Based Health Insurance in Ethiopia: Case of Oromia National Regional State District of Gimbichu. Journal Homepage: -www. journalijar. com.

2. Daraje, G. N. (2022). The Enrollment of Households in Community-Based Health Insurance (CBHI) in Ethiopia: The Case of the Aletu District. *Hungarian J. Afr. Stud.*, *16*, 47.

3. Daraje, G. N. (2021). Challenges and Achievement of Public Sector Reform Using the Kaizen Philosophy: The Case of Ambo University= Wyzwania i Osiągnięcia Reformy Sektora Publicznego z Wykorzystaniem Filozofii Kaizen: Przypadek Uniwersytetu w Ambo. *INTERCATHEDRA: SCIENTIFIC QUARTERLY-FACULTY OF ECONOMICS AND SOCIAL SCIENCES POZNAŃ UNIVERSITY OF LIFE SCIENCES*, *48*(3), 123-131.

4. Daraje, G. N. (2023). Evaluation of Achievement and Challenges of health care reform using Community-based health insurance in Ethiopia. Verejná Správa a Spoločnosť, 24(2). https://doi.org/10.33542/VSS2023-2-1.

5. Vértesy, L., & Namomsa, G. (2023). The Role of Community-Based Health Insurance in Empowerment of Women‟s Health and Economic Rights in Ethiopia. *Jogelméleti Szemle*, (3), 33-48.

6. Namomsa Daraje, G. (2023). Disability and response to COVID-19. On social protection in Sub-Saharan African countries–The case of Ethiopia.

7. Daraje Gutama Namomsa (2023). Evaluation of Achievement and Challenges of health care reform using Community-based health insurance in Ethiopia VEREJNA SPRAVA A SPOLOCNOST 24: 2 pp. 25-36., 12 p. (2023)

8. Namomsa Daraje, G. (2023). DIGITALIZING COMMUNITY-BASED HEALTH INSURANCE IN ETHIOPIA.

9. Chali, B. D., Lakatos, V., & Daraje, G. N. (2024). Enhancing Well-Being Through Cooperative: Strengthening Social Capital for Public Welfare in Ethiopia. Acta Academiae Beregsasiensis. Economics, (6), 207-222. https://doi.org/10.58423/2786-6742/2024-6-207-222

10. Daraje, G. N., & Phyu0000, A. K. GADAA SYSTEM: INDIGENOUS POLITICAL AND ADMINISTRATION SYSTEM OF OROMO PEOPLE IN ETHIOPIA. https://doi.org/10.47833/2025.1.ART.005

Appendix F. List of Scientific lectures by the researcher

1. **Assessing the Current type of University-Industry Linkage in the Higher Education Institution of Ethiopia: Case of Ambo University**. *ICABEP2021 International Conference on Accounting, Business, Economics and Politics* 3rd joint conference organized by the collaboration of the Faculty of Administrative Sciences and Economics, Tishk International University, College of Administration and Economics, Salahaddin University-Erbil, and University of Szczecin, Poland.
2. **"Children's rights vs. Parental Responsibility"** International Doctoral Conference. 11 October 2021, Budapest/Miskolc.
3. **The Impact of Community Based Health Insurance (CBHI) on health status and the Financial Risk Protection (FRP) case of Ethiopian rural areas**. In the Service of the Nation Conference 2021, A Haza Szolgálatában 2021 Konferencia ‖ Budapest ‖ 9, November 2021 ‖ 2021 November 19.
4. **The Role of EU on Supporting Health Projects in Ethiopia. In:** Kiss, R. (2022). European Union Policies International Thematic Conference-October 21, 2022. Budapest, Hungary-Book of Abstracts. European Union Policies International Thematic Conference Doctorates' Council of Ludovika – University of Public Service ‖ October 21, 2022
5. **Challenges and Achievements of health care reform using Community-Based Health Insurance in Ethiopia** in: Kiss, R. (2022). Critical Rethinking of Public Administration: April 08, 2022. Budapest, Hungary: Book of Abstracts.
6. **Indigenous Political and Administration system of Oromo people in Ethiopia: Conference lecture** (2023) XVIII. Debrecen PhD Conference, 9.6.2023, Debrecen, Hungary, Country: Hungary.
7. **Role of Community-based Health Insurance on Health and Economic Empowerment of Women's rural parts of Ethiopia: Conference lecture** (2023) XVIII. Debrecen PhD Conference, 9.6.2023, Debrecen, Magyarország, Country: Hungary.
8. **Investigating Language Barriers in Public Healthcare Services: A Case Study of International Students in Budapest, Hungary in**: Hristina, Rucheva Tasev (eds.) International Virtual Academic Conference - Book of Abstracts: Education and Social Sciences; Business and Economics Thessaloniki, Greece: International Academic Institute (2023) 8 p. pp. 6-6., 1 p.
9. **The significance of CBHI on health and economic empowerment of women in Ethiopia. In:** Kiss, R. (2023). Critical Rethinking of Public Administration: April 21, 2023, Budapest, Hungary–Book of Abstracts.

10. **The state and issues of Urban Governance in Ethiopia in**: Bátori, Annamária; Mezei, József (eds.) In the Service of the Nation Conference - 2024 - Book of Abstracts Bp, Hungary: Doktoranduszok Országos Szövetsége (DOSZ) (2024) 77 p. pp. 68-68., 1 p.