Federal Democratic Republic of Ethiopia
Ethiopian Health Insurance Agency

EVALUATION OF COMMUNITY-BASED HEALTH INSURANCE PILOT SCHEMES IN ETHIOPIA: FINAL REPORT

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FOREWORD

Ethiopia is committed to achieving universal health coverage (UHC) – expanding high-quality health care services that are equitable and accessible to all. Because financial risk protection is a critical component of UHC, Ethiopia has begun establishing a comprehensive and sustainable risk protection system with health financing mechanisms adapted to our country's needs. The legal framework for the formal sector social health insurance (SHI) scheme has been put in place and final preparations are being made to fully implement the initiative. In the informal sector – which comprises over 85 percent of Ethiopians – community-based health insurance (CBHI) is being expanded. To coordinate and regulate health insurance in the country and lead implementation of SHI and CBHI, the Ethiopian government established the Ethiopian Health Insurance Agency (EHIA) in 2011. Although the agency is still relatively new, the attention given to it by the government has enabled it to open a headquarters in Addis Ababa and 20 branch offices throughout the country, and to hire a staff of more than 500.

The EHIA in collaboration with the regional governments of Amhara, Oromia, SNNP, and Tigray successfully implemented CBHI pilots in 13 districts. The agency now is working with the four regional governments to expand CBHI to an additional 185 districts.

The evaluation that is the subject of this report generated in-depth qualitative and quantitative evidence that is critical to making the policy decisions needed for scale-up of this high-priority national initiative and to addressing the challenges that were faced in pilot implementation. The EHIA has been mining the lessons generated by this evaluation, starting with the preliminary findings and continuing to this final report. Even in the draft phase, we used the evidence extensively to refine key CBHI design parameters for initial CBHI expansion and we will continue to use the latest information to scale up CBHI to the entire country. We encourage all our stakeholders to review the report and forward their practical comments on CBHI scale-up in the informal sector. We are glad to share the evidence with our peer countries in Africa and elsewhere so that they can collaborate in filling our gaps and can take lessons from our endeavor.

The successful completion of this exercise would not have been possible without the committed efforts and vital contributions of a wide range of stakeholders. Special thanks go to the United States Agency for International Development (USAID). I would also like to commend the staff of the Breakthrough International Consultancy firm for their professional work. This evaluation, similar to all other our interventions, materialized from the strong professional leadership, follow-up, and continued support of agency staff as well as the USAID Health Sector Financing Reform/Health Finance and Governance project country team and project backstopping provided by the Abt home office.

Mengistu Bekele (MD, MPH)
Acting Director General, Ethiopia Health Insurance Agency

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ACRONYMS

BOFED	Bureau of Finance and Economic Development
CSO	Civil Society Organization
CBHI	Community-Based Health Insurance
EFY	Ethiopian Fiscal Year
EHIA	Ethiopian Health Insurance Agency
FMOH	Federal Ministry of Health
FAMS	Financial Administration and Management System
FMHACA	Food, Medicines, Health Care Administration and Control Authority
FGD	Focus Group Discussion
GA	General Assembly
HC	Health Center
HH	Household
HSFR/HFG	Health Sector Finance Reform/Health Finance and Governance
ICT	Information, Communication and Technology
IPD	Inpatient Department
KHIIC	Kebele/Tabia Health Insurance Initiative Committee
KII	Key Informant Interview
M&E	Monitoring and Evaluation
OOP	Out-of-Pocket
OPD	Out-patient Department
PEI	Patient Exit Interview
PFSA	Pharmaceutical Fund and Supply Agency
RHB	Regional Health Bureau
SHI	Social Health Insurance
SNNP	Southern Nation and Nationalities Peoples
TA	Technical Assistance
Tabia	It is equivalent to Kebele in Tigray region
UHC	Universal Health Coverage
WHISC	Woreda Cabinet and Woreda Health Insurance Steering Committee
WHO	World Health Organization
WOFED	Woreda Finance and Economic Development
WorHO	Woreda Health Office
ZHD	Zonal Health Department

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The EHIA acknowledges in particular the financial and technical support of the United States Agency for International Development (USAID), which was made through the HSFR/HFG project, led by Abt Associates. Together, the agency team and HSFR/HFG selected the consulting firm that would do the day-to-day work, and they provided written and verbal feedback at critical junctures such as during development of the survey methodology, sampling techniques, and survey instruments and on different versions of the evaluation report.

The EHIA is extremely thankful for the professional work done by the Breakthrough International Consultancy (BIC) Plc., which conducted the qualitative and quantitative data collection and analysis, and drafted this report. We particularly appreciate the team for their high-quality work, patience, and flexibility in receiving and addressing extensive and at times uncoordinated comments from the agency and HSFR/HFG project.

The joint technical leadership, management support, and quality assurance provided by the EHIA and Abt Associates has been superb, as usual. The agency congratulates HSFR/HFG as well as its own experts who led and contributed at various stages of the data collection and analysis, and report writing.

Professional review, editing, and formatting by the Abt Associates home office was critical in giving the document its final shape, and contributed greatly to its readability.

EXECUTIVE SUMMARY

Background, Objectives, Scope, and Methodology

As part of its health care financing strategy in general and its health insurance strategy in particular, the Government of Ethiopia endorsed and launched community-based health insurance (CBHI) schemes in 13 pilot woredas in Amhara, Oromia, Southern Nations, Nationalities, and Peoples (SNNP), and Tigray regions in 2010/11 to provide risk protection mechanisms for those employed in the rural and the informal sectors. Three years on, the government has decided to scale up CBHI, with schemes in 161 woredas. This evaluation of the impact of the pilot schemes was intended to inform the scale-up process.

More specifically, the evaluation was to generate evidence on the impact of CBHI pilot schemes in terms of providing access to and utilization of health services; improving quality of health care; reducing financial risks for members and increasing resource mobilization in the health sector; and strengthening of community participation in the management of health services. The evaluation was also expected to provide policy recommendations for scaling up the schemes.

The evaluation used several complementary methods of data collection to generate evidence. Review of relevant documents on the design and status of CBHI schemes and lessons from other countries was done. Two quantitative surveys (a household survey and patient exit interviews [PEI]) were also conducted. Information was collected from 2,987 households (target: 200 in each pilot woreda and 100 in each control woreda) using a random sampling method at woreda and kebele/tabia levels and systematic sampling at the household level. PEIs were conducted with 462 patients at the facility level. Two qualitative data collection techniques (key informant interviews [KII] and focus group discussions [FGD]) also were used to generate information. To this end, 144 KIIs with CBHI stakeholders and 52 FGDs with CBHI members, non-CBHI members, and health providers were conducted. Administrative data from CBHI schemes and reports from the Health Sector Financing Reform/Health Finance and Governance (HSFR/HFG) project provided information for the analysis on resource mobilization and financial status of the pilot schemes. The evaluation used both descriptive and econometric analysis methods to generate the findings.

Findings

Design and Current Status

1. Overall there is no "one size fits all" strategy for implementing risk-pooling mechanism. Some countries have used top-down public financing (tax based) and social health insurance (SHI) without CBHI, while others have used CBHI as the main model of reaching the informal sector. As a result of these differences in design, country experiences show huge variation in the breadth, depth, and height of coverage achieved. Successful CBHI models show that there are important conditions for CBHI to grow and develop, including: (i) existence of a minimal level of (perceived) quality of care and gradual improvement of quality at the supply side; (ii) instituting adequate organizational practice and design including responsiveness to people's felt needs by the scheme management; (iii) government commitment and political will with clear action plans, national scope of implementation, existence of regulatory frameworks, and - last but not least - the unequivocal commitment to subsidize and finance the premium for the poorest in society; and (iv) the need for CBHI schemes to join forces to expand risk pooling and ensure financial sustainability.

2. Evidence from the experience of countries worldwide informed Ethiopia's CBHI design, which eschewed small-scale, voluntary membership and included mechanisms to finance the membership of the poor. The willingness and ability to pay of the pilot woreda population conducted by HSFR during the design phase as well as the assessment of readiness of facilities in the pilot woredas to provide health services informed the design parameters. Certain major features are unique to Ethiopia. Enrollment in a CBHI scheme is decided collectively at the kebele/tabia level as opposed to the household level. Associated kebeles/tabias form a larger woreda-wide scheme. Scheme management is integrated and works within the woreda administration office. A general subsidy from the federal government is provided for all scheme members and a targeted subsidy from the regional and woreda governments is provided for the very poor who cannot afford to pay the contribution. Scheme staff are employed through the government payroll. The federal government also provides resources to health facilities contracted to provide services to CBHI members, so that the providers maintain an acceptable quality of care. Although there is overall guidance from the federal level, scheme parameters are decided at the regional level based on the regional CBHI directives; as a result, there are minor variations in schemes in different regions in terms of registration and enrollment rates, membership caps, and service provider contracting.
3. The CBHI routine monitoring data from HSFR/HFG show that as of June 2013 the overall enrollment rate in pilot CBHI schemes is 48 percent of households (range: 25 percent in Deder to 100 percent - universal enrollment - in Yirgalem). Of the total eligible households, 7 percent registered as indigents (range: 1 percent in Deder to 15 percent in Tehuledere and Yirgalem). The average enrollment of the very poor is greater in Tigray and Amhara than in SNNP and Oromia. The per capita health service utilization rate of CBHI members was 0.7 outpatient visits in 2005 EFY (2012/13), more than twice the nationwide average of 0.3 visits. Ten of the 13 schemes are financially sound, while the other three (one in Amhara and two in SNNP) are having financial difficulties.

On Knowledge, Enrollment, and Affordability

4. Knowledge about CBHI: 95 percent of both members and non-members in pilot woredas are aware of the CBHI schemes. The main sources of information are a neighbor, a CBHI official, or a house-to-house sensitization program; these three represent 100 percent of information sources in Amhara, 96 percent in Oromia, 86 percent in SNNP, and 81 percent in Tigray. More than 96 percent of member households and 87 percent of non-member households know that it is not only those who are sick who should enroll in CBHI. This clearly shows the value of the intensive sensitization work done by government and especially by the HSFR/HFG project.
5. Reasons for enrollment: 37 percent of CBHI members joined primarily to reduce out-of-pocket (OOP) expenditure when seeking health care, 35 percent joined to more frequently seek care in order to improve their health status, and 18 percent joined because their premium is less than their OOP payments; only 4 percent said they joined because government paid their registration fees and premiums. Although the design of CBHI in Ethiopia states that the decision on whether to join the scheme is taken at the kebele/tabia level, there was no pressure by either the community or the kebele/tabia administration during the enrollment process. According to the household survey results, 84 percent of CBHI members feel that premiums are either easily or somewhat affordable and 83 percent feel that the registration fee is easily or somewhat affordable. The affordability of premiums and registration fee is therefore an issue for only 16 percent of registered members. All of the FGDs with CBHI members found that the payment is affordable if the services in the benefit package are indeed available. Though the schemes reported a low membership renewal rate, 97 percent of households enrolled as CBHI members and included in the evaluation survey indicated their intention to renew their membership when the current one expires. Eighty percent of non-members plan to join a scheme in the future.

6. The evaluation looked at the determinants of enrollment in CBHI and found the major factors to be household size; age, education, and sex of the head of household; and size of cultivated land (not only owned land). Larger families and those with older household heads are more likely to enroll than those with the opposite characteristics. Household heads who are literate are also more likely to enroll in to the scheme than those with no education. Household heads who completed primary education are more likely to join a scheme than those with no education. Households headed by a female are more likely to join than are male-headed households. There is no significant difference in the enrollment rate in Amhara, Oromia, and Tigray regions, while the rate in SNNP is lower than in Amhara (the reference region for this comparison).

7. Of the 1,287 CBHI member households interviewed for the household survey, 1,169 (91 percent) paid their own registration. The remaining 9 percent were enrolled either through the local government subsidy (5 percent) or, in Tigray, through their own contribution that was deducted from their "safety net" payment (4 percent). Amhara and Tigray seem to perform better in financing the poor. The assessment explored how far the targeted subsidy for CBHI was reaching the very poor and documented that 60 percent and 83 percent of the households benefitting from the targeted subsidy came from the lowest and second-lowest expenditure quintiles, respectively; only 5 percent of the targeted subsidy might have reached the richest two quintiles. This clearly shows that the selection of beneficiaries for the targeted subsidy is by and large fair though stopping the leakage should be tackled promptly.

8. The survey also asked non-members their reasons for not being enrolled in the CBHI scheme. For 49 percent of the respondents, the registration fees and the premium are either not affordable (39 percent) or the payment schedule is not appropriate for them (10 percent); another 17 percent did not have adequate knowledge of and information about CBHI, and yet another 12 percent wanted to see the CBHI scheme in operation before they would join. The affordability of premiums and registration fee is therefore an issue for 39 percent of non-members. This percentage, added to the 16 percent of non-members taking the "wait and see" approach, shows that there is need to further explore how the fiscal space can be expanded to ensure the full coverage of indigents by CBHI and to ensure the financial viability of the schemes.

On Health Service Utilization by CBHI Members and Non-members:

9. Most health centers in the pilot woredas are contracted by the CBHI scheme to provide services to scheme members. Even some health centers that had gaps in their readiness to provide quality care were contracted based on the demand from the community. In some regions physical access overrides woreda boundaries (Amhara and SNNP) and/or readiness of health facilities. All pilot woredas have also signed service contracts with their referral hospitals. Amhara, Oromia, and Tigray (not SNNP) also entered contracts to ensure the possibility of referrals within the region.

10. Almost all health facilities visited by the evaluation team asserted that they provide all of the services that are expected at their level. All KII respondents said that the introduction of CBHI has increased health service utilization, for the following reasons: better financial protection for members when seeking care, the sensitization program when schemes were established, and continued health promotion efforts of the facilities, health extension workers, and the Health Development Army. FDGs with CBHI members in all pilot woredas confirmed that they visit health facilities immediately when they feel sick, which was not the case before. Of those reporting illness in the reference period, 1,049 individuals (71.7 percent) reported that they visited health facilities. Overall, 72.3 percent of CBHI members visited health facilities, similar to the aforementioned per capita visit rate of 0.7. Eighty-two percent reported using their membership card when utilizing health care. The econometric analysis documented that the likelihood of CBHI members visiting a health facility when feeling sick in the pilot woreda was 26.3 percentage points higher than that of non-members. This is clear evidence that scaling up CBHI is likely to increase utilization and intensity of care in Ethiopia.

11. The establishment of CBHI schemes provided health professionals a degree of freedom to prescribe the appropriate diagnostic tests and drugs without worrying about the CBHI member's ability to pay. This, according to the providers, is a great relief and key to improvement in service quality. By increasing utilization, CBHI is also generating more resources for contracted health facilities, resources that they can invest in improving quality of care. The additional in-cash and in-kind resources provided to contracted health facilities by the woreda, regional, and federal governments also are contributing to quality. Both CBHI members and non-members PEI respondents said they have witnessed improvements since the establishment of CBHI. In all measures of perceived quality of care, a greater percentage of CBHI members than non-members feel that there is improvement; about 90 percent of these respondents reported to have either been satisfied or very satisfied with cleanness of the facility, courteousness of health professionals, and waiting time.
12. There are major challenges in the quality of services provided. First, contracted providers differ in their readiness in terms such as pharmacy services, laboratory facilities, reception, and outpatient services. Second, health facilities, especially hospitals, are frequently short of drugs and patients must buy items from outside (private) retailers. Health facilities attribute the shortages mainly to shortages at Pharmaceutical Fund and Supply Agency (PFSA) hubs. The practice of moral hazard by pharmacists at contracted health facilities was reported to exacerbate the shortages.[1] Third, there are frequent breakdowns of medical equipment, due mainly to lack of preventive maintenance but also to health worker negligence and mishandling. Fourth, there are complaints about availability and capacity of staff. Finally, no pilot woreda has systematic, regular, and standard mechanisms for collecting and properly addressing complaints.
13. When contracted services are not available, members have to pay out of pocket for drugs, and for diagnostic and other health services in non-contracted health facilities. This affects CBHI members more than it does the general public. Those who have no money, in part because they spent it on their CBHI fee and premium, are not able to access care. Second, whereas CBHI members should be reimbursed by the scheme for full or partial payments, they often are not - their expenditures might be disallowed by scheme bylaws, the pharmacist at the contracted health facility fails to stamp the back of the member's prescription, or the reception might not record/register it in the patient's file. Even when private drug retailers provide a member with prescribed drugs, the members might need to travel to the woreda town, sometimes repeatedly, to process the reimbursement.
14. There are reported cases of moral hazard and inappropriate practice both by providers and CBHI members. CBHI members have become assertive in demanding their rights and sometimes making unreasonable demands, including jumping the queue; demanding a prescription for a particular type of drug; returning to the facility for another consultation or treatment before finishing the prescribed drug regimen, demanding unnecessary diagnostics and prescriptions; requesting drugs for their children without bringing them to the facility; and demanding immediate referral. Types of moral hazard and other inappropriate provider practices reported include lack of courtesy and mistreating patients, such as displaying partiality toward some patients; overprescribing services including drugs and diagnostics; unnecessarily referring patients to private wings and private clinics; and making claims for reimbursement without backing them up with necessary evidence.

[1] This was suggested in one referral hospital in Amhara and in one of the pilot woredas in Tigray

On Financial Risk Protection

15. The analysis of PEI responses clearly shows that very few CBHI members incurred OOP expenses during their visit. Of the 184 members interviewed, only 2.1 percent paid for consultations, 1.6 percent for diagnostics, and 2.7 percent for drugs. Of the 259 non-members surveyed in the pilot and control woredas, 88 percent paid for consultations, 38 percent for diagnostics, and 90 percent for drugs. The average per person payment for members was half of the average paid by non-members. The findings of the household survey also showed that both the incidence and amount of OOP payment were slightly higher for non-members for all three types of services mentioned above. The evaluation estimated the extent to which households face the risk of being impoverished (i.e., falling below a defined poverty line) by OOP health expenditure using the non-food consumption expenditure. It used two alternative thresholds: 25 percent and 15 percent (i.e., if a household's OOP expenditure on health is equal to or greater than either 25 percent or 15 percent of its non-food expenditures). The findings showed that the risk of being impoverished by OOP health expenditure is 7 percent for CBHI members and 19 percent for non-members at the 15 percent threshold and is 3 percent for members and 9 percent for non-members at the 25 percent threshold. This shows that CBHI members have a lesser risk of being impoverished as a result of OOP payments than non-members. We also attempted to estimate the head count, poverty gap, and normalized poverty gap for members and non-members by adopting Soumitra Ghosh's model (Ghosh 2010). The estimate shows that an additional 1 percent of CBHI member households and 5 percent of non-members dropped below the threshold poverty as result of OOP payments. The poverty gap was Birr 58 for members and Birr 143 for non-members. A regression analysis, based on a dichotomous choice (logistical regression) model, controlling for other factors, also showed that being a member is negatively related to impoverishment due to OOP payments. The evidence in Ethiopia therefore shows OOP payments in general have an impoverishing impact on households, but the impact on CBHI members is much less than on non-members. The analysis thus provides evidence that scaling up CBHI schemes will have a beneficial pay-off by reducing the incident and severity of poverty for CBHI members.

On Mobilizing Additional Resources to Health Providers

16. The CBHI schemes have been able to collect a total of Birr 22.7 million in premium payments. Amhara and Oromia regions have mobilized more than the other two regions. Revenue collected was greater in the first year of CBHI than in subsequent years, evidence of a decline in new and renewing membership. Inadequate contribution/premium collection from the community affects the total available resources. However, resources available to the schemes in the form of targeted subsidy are not affected because the woreda and regional governments are paying these premiums. Hence the lower the level of enrollment rate, the lower is the collection from the community and thus the total available resources. Actual premium collected compared with potential contribution/premium calculated based on number of eligible households shows that there are serious challenges in enrollment and collection of premiums in the pilot woredas. This has to be rectified in the scale-up phase because the effectiveness and continued relevance of CBHI scheme as one of the paths to universal health coverage (UHC) depends on CBHI collecting a reasonable share from the community.

17. CBHI schemes reimbursed about Birr 16.9 million to contracted health centers and hospitals for services rendered. Key informants and FGDs with health facility staff confirmed that CBHI has increased the utilization of services and retained revenues in health facilities, particularly health centers. More than 90 percent of service utilization by members takes place in, and more than 90 percent of reimbursement is made to, health centers in Amhara, SNNP, and Tigray. In Oromia, hospitals account for only about 5 percent of CBHI member utilization but they took in about 31 percent of the total reimbursement paid out. Overall CBHI schemes seem to provide the correct utilization pattern (using lower-level facilities more) and payment trends also follow this pattern. The reasons for a large proportion of payment going to hospitals in Oromia needs to be further explored to reduce the undesirable impact on scheme financial status.

18. According to the CBHI design, there are three types of government subsidies to the schemes: targeted and general subsidies, and financing the scheme management costs (salaries, office space, and operational costs). The regional and woreda governments finance premiums of indigents using different arrangements. In Tigray, the regional government finances 70 percent of indigents' premium contribution and the woreda finance 30 percent. In Amhara, the split is 90/10. In SNNP and Oromia, woredas finance all the costs of indigents. Woreda governments also finance the salaries and operational costs of all schemes. The federal government subsidizes 25 percent of the CBHI premiums, for both paying and non-paying members. Through the end of June 2013, the total amount of subsidy paid to the 13 pilot woredas was Birr 16.5 million: Birr 9.7 million from the general subsidy and Birr 6.8 million from the targeted subsidy. The total subsidy constituted about 42 percent of the total revenue generated by schemes. Of this, the general subsidy accounts for 25 percent and the targeted subsidy for 17 percent. Members' contribution/premium accounts for 58 percent of total revenue collected by the schemes. Of the total revenue generated from all pilot schemes, 35.3 percent was from Amhara, 27.3 percent in Oromia, 24.2 percent in Tigray, and 13.1 percent in SNNP. However, there is still a very strong government commitment to CBHI. If the pilot arrangement continues during scale-up, the financial implication for the government at all levels will be enormous. While government commitment and financing is one ingredient of a successful CBHI scheme, too much subsidy also raises questions about the relevance and added value of CBHI as against different tax-financed health services and SHI. Scale-up should therefore balance effective premium mobilization and government financing.

19. Overall, Ethiopia's CBHI schemes were able to finance the health service costs using financial resources generated from contributions. The reimbursement made to the health facilities stands at about 75 percent of contributions from paying and non-paying members (without any subsidy). However, CBHI schemes in three woredas (Fogera, Yirgalem, and Damot Woyde) would not have been able to finance their health service costs without the subsidy (owe more money from health facilities). When the targeted subsidy was included, all woredas except Yirgalem had a positive balance and a claims ratio of 57.4 percent. When the general subsidy was included in this total (contribution and targeted subsidy), all woredas remained in good financial situation and the claims ratio became 43.2 percent. When we look at regional performance, schemes in Amhara, Tigray, and Oromia are financially healthy while those in the SNNP are the ones whose financial status is flagging, jeopardizing sustainability.

20. The resource mobilization potential of CBHI schemes during scale-up has been explored based on three sets of assumptions.[2] Thus, the total amount of resources that can be mobilized from community in the form of premiums in pilot and scale-up woredas in all four regions will be approximately Birr 345 million per year. The projected total annual reimbursable for health facilities in all four regions will be Birr 316.5 million per year. The fiscal implications for the total government subsidy at all levels of the scale-up range from Birr 93,875 million per year under the pilot case (see Table ES1) to close Birr 400 million if all estimated households living below poverty line are to be covered through the targeted subsidy. The average financial burden for a woreda is Birr 121,963.07 per year (first scenario) to Birr 221,925.76 per year (third scenario). If the government considers scaling up the schemes in non-pastoralist areas (first scenario), the fiscal implications will increase to Birr 817.9 million per year, of which 616.7 million per year will be from the Federal Ministry of Health (FMOH) as a general subsidy.

Table ES1: Projected Annual Financial Implications of CBHI Scale-up to Federal, Regional, and Woreda Governments ('000 Birr)

	161 expansion woredas			All non-pastoralist woredas		
	10%	Pilot	29%	10%	Pilot	29%
Total Budget	148,346	146,466	203,087	817,962	836,801	1,196,815
Federal Budget	93,875	93,875	93,875	616,680	616,680	616,680
Regional Budget	32,090	31,212	68,241	118,883	140,501	342,423
Average woreda budget (161 woredas)				Total woredas' subsidy budget, all non-pastoralist woredas		
Total	121.96	117.74	221.93	82,398	79,260	237,712

[2] The first set of assumptions are the policy decisions already made by each regional government for scaling up, particularly with regard to the number of expansion woredas, premiums and registration fees, scheme organization, indigents' coverage rate, and government subsidy structures. The second set of assumptions are related to the performance of schemes, that is, that service utilization rates and reimbursements for health facilities will be similar to the averages of regional pilot woredas. The third set of assumptions relates to the number of indigents to be financed. There are three scenarios: regional averages of pilot performance in each region; 10% of eligible households in woredas; and full coverage of people (29% of CBHI eligible population) who are expected to be below poverty line were considered. The projection is made only for a year and thus does not take inflation into account.

Policy and Programmatic Implications of Findings on Scale-up

Overall Policy Recommendation

The plan to scale up CBHI to other woredas is timely. Given the evidence generated in this evaluation, CBHI scale-up as a path to UHC needs to be pursued with commitment of governments at all levels. However, internationally acknowledged CBHI pillars should guide the scale-up to UHC (promoting equitable access by removing financial barriers, especially direct payments; making prepayments mechanisms compulsory; creating larger risk pools for financial sustainability, and governments covering the premiums of very poor). There is a need for a comprehensive CBHI scale-up strategy whose development considers different design parameters and implementation arrangements, such as urban vs rural. It is recommended that implementation be phased.

Explore the Relevance of CBHI to Pastoralist Context

The way of life in pastoralist communities differs from that of urban and rural contexts. The service delivery mechanism remains weak and the FMOH is working to strengthen these systems. CBHI has been piloted only in rural and to a limited context in urban settings. Its relevance to the pastoralist context should be explored during the scale-up.

Legislation and Operational Frameworks

As learned from the CBHI pilot, there is a need to provide a legal basis for CBHI scale-up and this requires either the development of a CBHI legislative framework or revisiting the health insurance proclamation. This legislative framework should clearly define the CBHI scale-up roles and mandates of the FMOH/Ethiopian Health Insurance Agency (EHIA) vis-a-vis regional health bureaus and woreda administrations and/or health offices. It must also provide a legal basis for networking of CBHI schemes to create larger risk pools for the purposes of reinsurance and future integration of CBHI into SHI as a vehicle for UHC. Finally, CBHI bylaws and the CBHI Financial and Administrative Management System (FAMS) need to be reviewed and modified.

Strengthen Institutional Arrangements

If CBHI is to be a vehicle for moving toward UHC, it requires strong and functional institutional arrangements. This requires reexamining the structure of the EHIA and its branch offices, as well as regional and woreda government structures and their relationship in CBHI implementation. It is also necessary to review and establish kebele/tabia-level structures for CBHI. These structures could be new or an incentive and sanction mechanism to get kebele/tabia executives to play a role in CBHI enrollment, and collection and depositing of premiums. There also must be strengthening strategies to recruit and retain the CBHI team: clarifying the structure of the team, revising the salary scale, defining the career structure, and creating an enabling working environment by allocating an adequate operational budget.

Revisit CBHI Parameters

The disease burden, utilization pattern, and ability of the households to pay for the premiums differ between rural and urban areas. There is therefore a need to adjust CBHI parameters to fit the urban and rural contexts. In revising the parameters, it is recommended that (i) premium levels be revised according to willingness and ability to pay analysis in each area, include introducing a stratified (sliding) premium schedule especially in urban woredas; (ii) co-payment per outpatient visit be introduced, especially in urban areas; (iii) the feasibility of including ambulance services in the benefit package be considered; and (iv) the provider payment mechanism be reviewed.

Strengthen Scheme and Provider Interface

The long-term sustainability of the CBHI schemes will depend greatly on their healthy and transparent working arrangement with providers. During scale-up, it will be necessary to invest time and resources on sensitizing health facility personnel to an extent greater than has been done in the pilots. There is also a need to strengthen health facility audits to control for moral hazard on the part of providers. Establishing/strengthening scheme and provider consultation forums will help to avoid misunderstanding and to clarify working arrangements and issues around claims management and processing of reimbursements. SNNP's facility-community forum might be considered for replication as it gives providers and CBHI members a venue in which to raise complaints and agree on solutions. In urban areas, there is a need to consider contracting private health facilities that are nearby, popular with residents, meet accreditation/certification requirements, and are willing to negotiate on fees to control costs.

Strengthen CBHI Management and Coordination

The financial sustainability of schemes will depend largely on the strength of CBHI management. The scaling-up process should consider strengthening several aspects of the management systems. There is a need to review the operational guidelines developed during the pilots to fix current weaknesses. Revising renewal mechanisms and enforcing the scheme bylaws on membership renewal and collection of premiums is a priority. The sensitization strategy needs to be strengthened; this includes developing sensitization tools, documenting pilot successes, and incorporating lessons learned could help increase enrollments. There is also a need to strengthen CBHI coordination structures and make them functional. Applying strategies that the government is using in other aspects of health service delivery, it is suggested that kebele/tabia/community sensitization and follow-up be linked with the Health Extension Program and the Health Development Army. Enhancing the involvement of zone and woreda health offices in the management of the CBHI and providing better orientation to zonal, woreda, and kebele/tabia officials could help strengthen leadership and commitment at all levels. Best practices from the enrollment-leading woredas of Yirgalem and Tehuledere - making enrollment part of the overall woreda cabinet evaluation criteria included in the checklist - should be considered for replication.

Strengthen Monitoring and Evaluation System

Timely generation and use of evidence on what works and what doesn't is critical for good scheme management and for policy decision making. There is a need to review and strengthen the CBHI monitoring and evaluation (M&E) and management information system by taking actions that include defining key data analysis and use requirements; defining responsibilities at the federal, regional, zonal, and woreda levels; strengthening record keeping at scheme and kebele/tabia levels; and strengthening periodic reporting and performance reviews. There is also a need to improve the information system to ensure that data on health service utilization by CBHI beneficiaries are properly documented and shared with the schemes. The routine M&E system should include regular supportive supervision by government authorities at all levels.

Enhance Financial Sustainability of Schemes

As noted above, the financial sustainability of some of the pilot CBHI schemes is in jeopardy. There is a need to increase enrollment for better risk pooling at the scheme level. Premium collection mechanisms should be strengthened and premium levels made congruent with benefit packages and service utilization. There is also a need to establish larger risk pools to have reinsurance and risk pooling among schemes. To do this, zonal and regional CBHI risk pools with clear resource contribution and expenditure assignment criteria should be established. This could gradually evolve into a national CBHI risk pool.

Enhance Protection of Poor Households through Targeted Subsidy

The evaluation found different levels of commitment to financing indigents among regions. There is a need to enhance commitment of certain regional governments for this. In this connection, there is a need not only to increase resource allocation to cover the very poor - in all regions but especially in regions where coverage is currently lower - but also to improve the identification process to reduce leakage. If the fiscal space allows, all the households living below poverty line should be considered eligible for targeting. The flat 10 percent target should be adopted based on the conditions of woredas, for instance, highest percentage for food-insecure and lesser percentage for food-secure woredas.

Meet financial and Technical Resource Requirements for Scale-up

Regions and the FMOH need to be aware of the financial and technical resources needed to scale up CBHI and they should take appropriate measures to mobilize the additional resources. Regions need to mobilize about Birr 48.3 million and the FMOH about Birr 126 million per year. There is also a need to support the schemes with per diem, fuel, vehicle, and other travel-related expenses. When viewed from the perspective of movement toward UHC, these fiscal implications are not huge. Considerable technical input also is required to establish and manage the schemes.

Remove Overall Health Systems Constraints

The ultimate goal of health insurance is to improve health status through increased access to quality health services. CBHI schemes can only be successful if members have access to good quality care, which depends on the performance of the overall health system. The findings of this evaluation imply that government should continue investment in removing health system constraints. There is also a need to improve the availability of drugs and medical supplies by closely working with PFSA. Finally, it is clear that CBHI increases health services utilization by beneficiaries; thus, there is a need to design mechanisms to address complaints by and create incentives for health workers in reference to the additional work burden that increased utilization will mean for them.

SECTION 1. INTRODUCTION

1. INTRODUCTION

1.1 Background

Prior to 1998, the per capita expenditure for health in Ethiopia was very low: in the years from 1980 into the mid-1990s, it fluctuated between US$1.00 and US$1.20, which was far below the sub-Saharan African per capita average of US$6.70 (FMOH, 1998). The resource allocation was also skewed in favor of hospitals and urban areas. The user fees charged in health facilities did not reflect the cost of health care and all revenue collected was remitted to the government treasury. There was no or little insurance coverage in the country. 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 sustainability of quality health care services. It also aimed at enhancing community participation and ownership of health services.

The Health Care Financing strategy, implemented over the past 15 years, is meeting its objectives. It has provided greater autonomy to health care facilities and mobilized revenue for facilities, including primary care facilities, by reforms such as establishing facility boards, retaining user fees, outsourcing non-clinical services, opening private wings in public hospitals as an income-generating and -retaining mechanism for medical professionals and health facilities, and introducing a third-party payer for fee waived patients.

As these supply-side reforms took root in the regions, the government also initiated demand-side financing reforms. The Federal Ministry of Health (FMOH) developed a two-pronged health insurance strategy of social health insurance (SHI) and community-based health insurance (CBHI) schemes. These demand-side initiatives are designed to pool risks and protect households from out-of-pocket (OOP) expenditures when receiving health facility services. The SHI scheme will provide financial coverage for the formal sector while CBHI targets those employed in the rural and the informal sectors. CBHI implementation began in Ethiopian fiscal year (EFY) 2003 (2010/11) as pilot schemes in 13 woredas of Amhara, Oromia, Southern Nations Nationalities and Peoples (SNNP), and Tigray regional states. The large Oromia Region has four pilot woredas, and the other three regions each have three pilot woredas. Each region has also identified a control woreda to ensure proper impact evaluation. Table 1.1 presents the list of pilot and control woredas by region.

Table 1.1: List of Pilot and Control Woredas

Amhara	Oromia	SNNP	Tigray
A. Pilot Woreda			
South Achefer	Gimbichu	Yirgalem town	Kilte Awlaelo
Fogera	Kuyu	Damboya	Ahferom
Tehuledere	Deder	Damot Woyde	Tahitay Adiabo
	Limmu Kossa		
B. Control Woreda			
Dembia	Merti	Wonago	Raya Azebo

After three years of piloting, the government decided to expand CBHI schemes to 161 woredas of the country. So that the scale-up process would benefit from the experiences of the pilot schemes, it was decided to evaluate the impact of CBHI in the pilot woredas with respect to the intended objectives. The United States Agency for International Development (USAID)-financed Health Sector Financing Reform/Health Finance and Governance (HSFR/HFG) Project engaged Breakthrough International Consultancy (BIC) to carry out the evaluation.

1.2 Objectives and Deliverables of the Study

As clearly indicated in the terms of reference, the overall objective of the study was to evaluate the impact of the CBHI pilot schemes on equitable access to sustainable quality health care, increased financial protection, and effective social inclusion among the communities in which the pilot programs have been implemented. The specific objectives of the study included evaluating the extent to which CBHI has impacted on, and document the lessons learned, with respect to the following:

- Improving financial access to health care services;
- Improving quality of health care services;
- Increase resource mobilization in the health sector; and
- Strengthening of community participation in the management of health services.

Furthermore, based on the findings, study was also expected to provide recommendations that will inform policymakers on optimal actions and options for scale-up of the schemes to the national level.

This report synthesizes CBHI evaluation reports on each of the four regions with the CBHI pilot schemes. The regional reports reported on qualitative and secondary information sources. The household survey and the patient exit interview (PEI) results were analyzed nationally. Any finding specific to any regions for any issue is highlighted on the relevant sections of this report.

1.3 Study Methodology

1.3.1 Methods

The evaluation used a variety of complementary methods of data collection for generating evidence for the study (see Box 1.1). In addition to the review of relevant documents, the evaluation is based on two quantitative surveys (a household survey and PEI) and two qualitative data collection techniques (key informant interviews (KII) and focus group discussions (FGD)). The combination of data collection methods provided a wealth of information in order to assess not only the process of CBHI design and implementation, but also factors contributing to enrollment in CBHI schemes and the impact of CBHI schemes on access to health services and financial protection. The analysis of the effect of CBHI on resource mobilization and financial sustainability was based on administrative data from CBHI schemes and reports from the health sector reform project.

Box 1.1 Reports and evidences that help generate the evidence for this Report

This report was informed by a number of evidences generated during the evaluation process. These evidences include:

- Design and progress reports from HSFR/HFG project
- Four regional reports written to provide input to this evaluation based on qualitative information (KIIs and FGDs) and secondary data at facility and woreda levels
- Analysis of the patient exit interview
- Analysis of the household survey data

1.3.2 Sampling Design

Sampling for household survey: A household survey was conducted using the questionnaire attached as Annex B. The objective of the household survey was to generate data and evidence on the impact of CBHI on improving financial access and health service seeking behavior of members.

The sampling design was a combination of purposive, simple random and systematic sampling. We have four regional states where each region has three pilot woredas and one control woreda (Oromia has four pilot woredas). After getting the list of Kebeles/ Tabias in pilot and control woredas, most logistically inaccessible Kebeles/ Tabias were excluded from sample selection for cost reasons. Five Kebeles/ Tabias were selected randomly (lottery method) with the presence of each woreda administration and CBHI management team (see sample minutes of one woreda as Annex C). Once the five Kebeles/ Tabias in each woreda were selected, the survey was carried out in two gots/ kushets/development committees in each kebele/tabia.3 Gots are selected randomly (lottery method) with the presence of kebele/tabia leaders (see sample got selection minutes, Annex D). The survey team selected a given number of households from each kebele/tabia with some reserves using systematic sampling (see Box 1.2 for details). Of the total planned 3,000 households, data were collected and analyzed from 2,987 households (99 percent).

Box 1.2: Sampling Procedure for Household Survey in Pilot Woredas

- Five kebeles/Tabias from each woreda were selected randomly (through a lottery method).
- In each kebele/Tabia, two gots/kushets were selected randomly in consultation with the kebele/Tabia administration.
- A fresh list of households was taken for each of the 10 selected gots/kushets, from which sample households were randomly selected.
- Systematic sampling was used to select the 10 CBHI member and the 10 non-CBHI member household (n^{th} household) in each got
- A reserve list was prepared for replacement if and when some of the selected households are not available. The size of the replacement was in total 10 percent of the households.

Table 1.3: Distribution of Planned and Surveyed Households by Woreda

Woreda	# of HHs planned for survey	# of HHs surveyed
South Achefer	200	200
Fogera	200	200
Tehuledere	200	200
Dembia (control woreda)	100	100
Kilte Awlaelo,	200	200
Ahferom	200	200
Tahitay Adiabo	200	200
Raya (control woreda)	100	100
Gimbichu	200	200
Kuyu	200	200
Deder	200	200
Limmu Kossa	200	198
Merti (control woreda)	100	100

3 Gots and kushets are sub-kebele entities.

Woreda	# of HHs planned for survey	# of HHs surveyed
Yirgalem City	200	197
Damboya	200	195
Damot Woyde	200	200
Wonago (control woreda)	100	97
Total	3000	2,987 (99%)

Source: HH survey
Note: HH=household

Patient exit interviews: The PEI was intended to generate information from members and non-members of CBHI on their perceptions of the impact of CBHI on improving access to health care services, quality of care, and what lessons can be learned for scale-up of the scheme. Three facilities were randomly selected (two health centers and one hospital) from all contracted health facilities in each pilot woreda. At least 30 patients (eight outpatients from each hospital and 10 outpatients from each health center plus two inpatients from hospitals) were selected for the interview (see Table 1.4). PEI was conducted using the tool attached as Annex H. Of the total planned 510 PEI, the total collected was 462 (91 percent). The shortfall is the result of inadequate availability of patients during the data collection process at the facility level.

Table 1.4: Distribution of Planned and Actual Patients Exit Interviews

Woreda	Planned PEIs	Actual PEIs conducted	Percent
South Achefer	30	24	80%
Fogera	30	25	83%
Tehuledere	30	27	90%
Dembia (Control woreda)	30	20	67%
Kilte Awlaelo	30	28	93%
Ahferom	30	28	93%
Tahitay Adiabo	30	27	90%
Raya (Control woreda)	30	30	100%
Gimbichu	30	30	100%
Kuyu	30	27	90%
Deder	30	30	100%
Limmu Kossa	30	30	100%
Merti (Control woreda)	30	29	97%
Yirgalem city	30	21	70%
Damboya	30	28	93%
Damot Woyde	30	31	103%
Wonago (control woreda)	30	27	90%
Total	510	462	91%

Source: PEI survey

Key informant interviews: As part of the qualitative survey, KIIs were carried out using a guide developed for this purpose and attached as Annex F. The KIIs were intended to gather information from people who have better understanding of health care financing in general and CBHI implementation in particular on key issues such as management and governance, regulatory framework, sensitization, capacity building, and CBHI parameters (premium, benefit packages, general and targeted subsidies, etc.) with the purpose of drawing lessons for scale-up of the schemes. The interviews were conducted with government authorities and HSFR/HFG project managers at federal, regional, and woreda levels. Table 1.5 shows the distribution of KII by region. All the planned KIIs were carried out.

Table 1.5: Distribution of Key Informant Interviews by Region

Key Informant interviews	Planned					Accomplished				
	Amhara	Tigray	SNNP	Oromia	Total	Amhara	Tigray	SNNP	Oromia	Total
Head of woreda	3	3	3	4	13	3	3	3	4	13
Regional level (RHB, BOFED; HSFR/HFG)	3	3	3	3	12	3	3	3	3	12
Heads at woreda level (WorHO; WOFED or two CBHI board members), CBHI management team)	16	16	16	20	68	16	16	16	20	68
Facility levels	12	12	12	15	51	12	12	12	15	51
Total KIIs	**31**	**31**	**31**	**39**	**144**	**31**	**31**	**31**	**39**	**144**

Source: Regional reports

Note: RHB=regional health bureau, BOFED=bureau of finance and economic development, WorHO=woreda health office, WOFED= woreda office of finance and economic development

Focus group discussions: FGDs were carried out with three types of groups to gather qualitative information in each pilot woreda. These target groups were members of CBHI schemes (one in each pilot woreda), non-members of CBHI schemes (one in each pilot woredas), and the staff of the contracted facilities (one in each health center). The objective was to obtain the perceptions of the FGD participants on the benefits of CBHI and its perceived positive and negative impacts for members and facility staff. All the planned FDGs were carried out. The FGD guide used is presented in Annex G. Table 1.6 shows the distribution of FGDs carried out by region.

Table 1.6: Regional Distribution of FDGs Planned and Carried Out

FGDs	Amhara	Tigray	SNNP	Oromia	Sum
Members of CBHI	3	3	3	4	13
Non-members of CBHI	3	3	3	4	13
Health center staff	6	6	6	8	26
Total	**12**	**12**	**12**	**16**	**52**

Source: Regional reports

1.4 Data Collection Instruments

The evaluation used structured questionnaires both for household and patient exit interviews, while guidelines for key informant interviews (KIIs) and focus group discussions (FGDs). The household questionnaire gathered information on households and individuals socio-economic and demographic characteristics including household expenditure for consumable goods, health care and their participation in the CBHI program. The patient exit interview questionnaire on the other hand collected information on patient's demographic characteristics, health services utilization and perceived quality of health care services.

1.5 Recruitment and Deployment of Enumerators and Supervisors

Data collectors were recruited based on their experience in household data collection in general and in CBHI in particular. The household survey data collection was conducted independently for research by the Ethiopian Economics Association (EEA) and was carried out in three rounds. The data collectors recruited and trained for this evaluation survey knew the pilot woredas, and had experience on how to work with schemes and the population. The plan was to recruit and deploy a total of 51 enumerators (household survey and PEI) and eight supervisors. In the end, 55 enumerators and 17 supervisors were recruited and deployed, 8 percent and 113 percent more than the respective targets. The number and distribution of enumerators and supervisors deployed are presented in Table 1.7.

Table 1.7: Number and Distribution of Deployed Enumerators and Supervisors by Region

	Amhara	Tigray	SNNP	Oromia	Total
Data Collectors					
PEI	2	2	2	3	9
HH survey	11	11	11	13	46
Total	13	13	13	16	55
Supervisors	4	4	4	5	17
Total	**17**	**17**	**17**	**21**	**72**

All the enumerators and supervisors deployed for the household survey were trained for one and half days (December 20 and 21, 2013). PEI enumerators were trained for half a day.

1.6 Models Specification

The evaluation used the basic model of regression that was used to estimate the impact of CBHI in the prepayment scheme in Rwanda (Schneider and Diop 2001), the country that managed to achieve almost universal coverage of its population with these schemes. The Rwanda model was used because its scheme design elements, such as government commitment by issuing policies and strategies and legalizing schemes, scheme establishment at the district level, and government's commitment to subsidize the poor, are similar to what Ethiopia used.

Accordingly four models were used to investigate the impact of CBHI schemes in the pilot woredas based on a set of explanatory variables. These are:

a. The probability to buy health insurance for specific population groups in the pilot woredas;

b. The probability of using basic health care services by the insured and non-insured households;

c. The intensity of using basic health care services by the insured and non-insured households; and

d. The impoverishing effect of OOP health expenditures per episode of illness for all sick individuals and for those who sought professional care.

1.6.1 Demand for Health Insurance

The logit regression model was used to estimate the probability of CBHI enrollment for households in pilot woredas to determine the factors that affect enrollment and also assess if the poorest among the poor is covered by a CBHI scheme. The model estimated households' CBHI enrollment probability, and the extent to which this decision is influenced by specific socio-demographic and economic characteristics. The hypothesis tested was that the CBHI member and non-member households do not differ in their socio-economic characteristics. In a logit regression, the dependent variable "demand for insurance" Di, will equal 1 if individuals buy insurance, or zero otherwise. Formally, the logit model can be written as a linear function of the explanatory variables:

$$L_i = b_1 + b_2 X_{2i} + \ldots + b_k X_{ki} \quad (1)$$

$$P_i \text{ (D for CBHI membership)} = 1/(1+1/e^{L_i}) \quad (2)$$

The second equation shows that the conditional probability to register into CBHI Pi is a non-linear function of the explanatory variables Xi, which represents a series of attributes that are assumed to have caused a household to buy health insurance membership in the pilot woredas. Learning from the experiences of other countries, the explanatory variables used in determining the estimates in the model were health status (as proxies by illness), household size, age and sex of the family head, education of the family head, total livestock unit, land size covered by crops, per capita expenditure, and regional dummies. These variables are by and large relevant to the characteristics of the population in the four regions.

We estimated the unknown coefficients bi which are the weights to each of the households' socio-demographic and economic characteristics in the probability that Di = 1 for given Xi. Insurance was only an option for those households who live in pilot districts and the regression was performed with household survey data from pilot woredas only. The household head is the unit of analysis.

1.6.2 Access to the Modern Health Care System

Outpatients' health care utilization was measured for those individuals who reported sickness during the four weeks preceding the interview in the household survey, and has responded to the curative care questionnaire.

The probability of CBHI in increasing health care utilization was examined at three different levels: outpatient, inpatient, and maternal and child health care. However, the observations for inpatient and maternal and child health services were too limited to warrant a regression analysis. The evaluation team suggests that the impact of CBHI on maternal and child health be undertaken during the scaling-up process. For the outpatient health care utilization, we examined the effect of CBHI membership on the probability of a person visiting health facilities when he or she feels ill and on the intensity/frequency of health care utilization (number of visits to a health facility).

To examine the probability of CBHI members using health care facilities when they feel ill relative to non-members, we estimated equation 3 using logit regression. The specification of the equation is presented below.

$$Y_i = CBHI_i g + X_i d + e_i \quad (3)$$

Where, Y_i indicates the probability of using health care for individual i (individual visiting health facilities when they feel ill), $CBHI_i$ is a dummy variable indicating whether individual i is enrolled in

the scheme, X consists of controlling variables such as size of livestock, cultivated land size, sex of head of household, distance to health facility, age of head household, household size, education of head of household, per capita total expenditure, expenditure/wealth quintile, and region. These variables are theoretically and contextually relevant to influence decision to seek care in the Ethiopian context.

To examine whether CBHI members are more likely to frequently visit health facilities when they feel ill relative to non-members, we estimated equation 4. Since the dependent variable is a count data for which the value zero cannot occur, we can only use either zero-truncated negative binomial or zero-truncated Poisson regression. Exploring the data revealed that there is evidence for over dispersion and in this case the proper model is zero-truncated negative binomial regression (Cameron and Trivedi 2009). The specification of the equation is presented below.

$$y_i = CBHI_i a + X_i b + e_i, \quad (4)$$

Where, y_i indicates the intensity/frequency of health care utilization for individual i, $CBHI_i$ is a dummy variable indicating whether individual i is enrolled in the scheme, X consists of controlling variables such as size of livestock, cultivated land size, sex of head of household, distance to health facility, age of head of household, household size, education of head of household, per capita total expenditure, expenditure, wealth as measured by tropical livestock unit and land size, economic quintile, and region.

1.6.3 Financial impact of household OOP health expenditures

The methodology employed to measure catastrophic payments for health care has been discussed by Wagstaff, Adam and Eddy van Doorslaer (2003). An OOP payment for health care is considered catastrophic when the payment exceeds some threshold (Z cat), defined as a fraction of total household consumption or non-food consumption. If T represents OOP payments for health care, x represents total household expenditure and f(x) stands for food expenditure, then a household is said to have incurred catastrophic payments when T/x or T/[x-f(x)] exceeds a specified threshold. One of the approaches used to measure catastrophic payments for health care involves analyzing the incidence of catastrophic payments, that is, the percentage of households that spend more on health care than the threshold, which can be measured by the headcount and 'catastrophic overshoot.' Table 1.8 shows the definition of catastrophic and their associated thresholds.

Table 1.8: Definition of Catastrophic Spending and Its Thresholds

Indicator	Definition	Source of information
Incidence of catastrophic health expenditure due to OOP payments	Percentage of population whose health expenditures exceeds 10% of total expenditures	Estimations using household expenditure surveys
	Percentage of population whose health expenditures exceeds 40% of non-food expenditures	Estimations using household expenditure surveys
Incidence of impoverishment due to OOP payments	Percentage of population whose health expenditures put them below the poverty line	Estimations using household expenditure surveys
Mean positive overshoot of catastrophic payments	Average amount by which OOP spending exceeds threshold, for those with catastrophic payments	Estimations using household expenditure surveys
Poverty gap due to OOP payments	Average amount by which expenditures fall below the poverty line, for those impoverished by OOP payment	Estimations using household expenditure surveys

Source: Evans et al. (2013)

In estimating the financial protection impact of CBHI, we tried to measure impoverishment using three dependent variables and two thresholds. The dependent variables were total expenditure, food expenditure and non-food expenditure. The thresholds used as catastrophic was 104 percent for total spending, 40 percent for food and 15 and 25 percent for non-food spending.

The poverty headcount and the poverty gap were estimated to measure the extent to which households have become poorer by making OOP payments for health care. While the poverty headcount measures the number of households living below the poverty line as a percentage of total households, the poverty gap captures the depth of poverty or the amount by which poor households fall short of reaching the poverty line. In so doing we estimated the average prepayment, post-payment, and normalized poverty gap for CBHI and non-CBHI households' using 5-10% consumption expenditure used by Soumitra Ghosh, 2010 to our context to the level that it can become significant and see if membership to CBHI has an impact in reducing the impoverishing effect of OOP payments.

We also used a logit regression model to explore if there is a link between the CBHI membership and OOP caused impoverishment. The explanatory variables used to estimate this include membership in CBHI, household size, sex and age of household head, education, total livestock unit as a proxy for wealth, land size covered by crops, per capital expenditure, and dummy for regional variation.

1.7 Organization of the Report

This first chapter has presented the background, objectives, methodology, sampling, and data collection instruments of the CBHI evaluation. Chapter 2 reviews evidence on the impact of CBHI in other countries in terms of increased utilization of health services and financial protection measures. Chapter 3 documents the design and implementation of CBHI in Ethiopia and the current status of the pilot schemes. Chapter 4 presents the major characteristics of household survey and PEI respondents. Chapter 5 presents the findings of the evaluation as per the terms of reference. Chapter 6 outlines the lessons learned and policy implication of the findings.

[4] These thresholds are internally accepted as can be seen from the SPAAN et al. 2012.

SECTION 2.
LITERATURE REVIEW: OTHER COUNTRY EXPERIENCES ON CBHI

2. LITERATURE REVIEW: COUNTRY EXPERIENCES ON CBHI

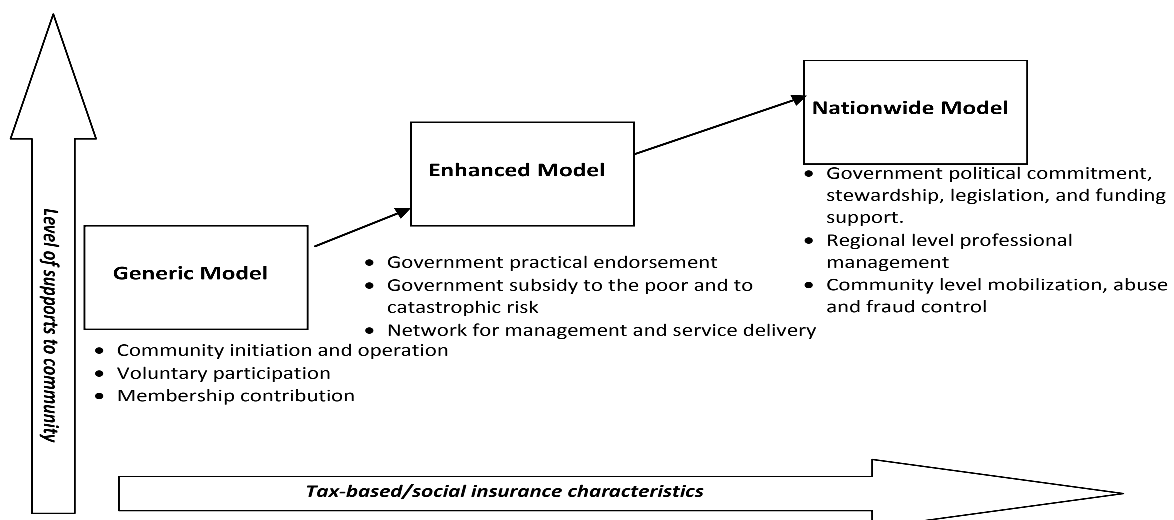
2.1 Theoretical/Conceptual Framework of CBHI

CBHI is a risk-pooling approach that tries to spread health costs across households with different health profiles to prevent catastrophic expenditures that come with unexpected health events or chronic diseases, and enables cross-subsidies from rich to poor populations. In theory CBHI schemes have five characteristics:

- Dynamic risk pooling, where the schemes are organized by and for individuals who share common characteristics (geographical, occupational, ethnic, religious, gender, etc.);
- Solidarity, where risk sharing is as inclusive as possible within a given community and membership premiums are independent of individual health risks;
- Participatory decision making and management;
- Nonprofit character; and
- Voluntary affiliation (Soors et al. 2010).

There is no "one size fits all" strategy for implementing universal health coverage (UHC) in developing countries. Colombia, Mexico, and the Republic of Korea used top-down public (tax-based) financing and SHI without CBHI; Rwanda used CBHI as the main model for reaching the informal sector. Wang and Pielemeier (2012) argued that a bottom-up approach may better fit low-income counties and accelerate progress toward UHC. They provided a three-model framework for the development of CBHI schemes in low-income countries as a way to achieve UHC. The characteristic of these models, their potential, and their limitations are presented in Figure 2.1 below and Annex A.2.

Figure 2.1: CBHI Development Framework



Adapted from: Hong Wang and Nancy Pielemeier (2012)

2.2 Empirical Evidence on the Impact of CBHI

In recent years, interest in using CBHI as a vehicle for moving toward UHC has grown. Studies done in many countries provide evidence on the determinants of enrollment in CBHI and the impact of CBHI membership on health service utilization and financial protection. Recent publications on the experience of CBHI and UHC around the world include Acharya et al. (2013), Giedion et al. (2013), Lagomarsino et al. (2012), and Spaan et al. (2012), and Lu et al. (2012) studied the impact of CBHI in Rwanda. This section relies heavily on these studies to summarize the major findings of CBHI impact and provide a better understanding and perspective of the successes and challenge of CBHI schemes in other countries.

The studies reviewed by Acharya (2013) found differences in the determinants of insurance uptake but there are some shared findings, including the following:

- The sex of the head of the household seems not to matter, although there are some cases in which female-headed households are more likely to join;
- There is no clear pattern in other demographic variables, although families with young children and families headed by the elderly seem more likely to join;
- Better-educated households are consistently more likely to join, particularly if household member(s) have secondary or higher education degrees;
- Participation in an insurance program is also consistently correlated with per capita expenditure: richer households are more likely to join;
- Initial conditions, such as chronic illnesses, seem not to influence the decision to join either way; and
- Residence in rural areas and distance from health facilities do not seem to deter households from joining insurance programs. Isaac Odeyemi (2014) summarized the positive and negative factors that affect CBHI uptake rates in Africa (see Annex B).

Assessments have been conducted on the impact of CBHI on access to health services. According to Gideon et al. (2012), 25 of the 29 studies that analyzed the impact of CBHI schemes on universal health coverage (UHC) found favorable and statistically significant impacts on household access (see Table 2.1).

Table 2.1: Reviewed papers on CBHI impact on access to care

Author/ Reviewer	# papers reviewed	# of papers with access indicators	Impact findings			Existence of heterogeneous impact
			Overall positive	Varies across services	Greater impact on worse-off	
Giedion et al. (2012)	41	29	25	14	15	23
Achaya (2013)	14	14	9			

This provides international evidence that financial protection schemes like CBHI do improve access to and utilization of services. Several papers also suggest that financial protection schemes affect the type of care used, moving people from use of self-medication or alternative medicine to formal care. And in some cases, schemes have an impact on the type of provider chosen rather than on utilization levels (Gideon et al. 2012).

Yip, W. and W.C.Hsiao (2008) documented that the Rural Mutual Health Care scheme in the western and central regions of China has increased the probability of an outpatient visit by 70 percent and reduced the probability of self-medication by similar percentages, which, according to the authors, suggests that enrollees substitute self-medication for formal health care in the absence of the scheme.

There is also evidence that suggests that financial protection schemes that focus on price subsidies sometimes improve access to and utilization of health services through mechanisms that go beyond affordability. In Colombia, for instance, uptake of some services such as prenatal care and immunization increased after people enrolled in CBHI schemes although these services were free for everyone irrespective of a person's insurance membership status. The evaluation of Rwanda's CBHI also documented that at the individual level, mutuelles (CBHI schemes) improved utilization among the general population, children under five, and women delivering a child. At the provincial level, the study found a positive effect of mutuelle coverage on child and maternal care.

Twenty-three of the 29 studies in the Gideon et al. (2012) review found differences in how CBHI affected access and utilization across different population groups (demographic and socio-economic), regions, countries, and/or the particular design of the scheme. Nevertheless, the evidence indicates that, overall, UHC schemes improve access and utilization of services.

The positive results of the CBHI schemes in promoting medical care utilization suggests that CBHI can be an effective tool for achieving UHC, together with other policy instruments (Lu et al. 2012). Shimelis Abebe (2010) also concluded that CBHI membership has a potential to increase health care utilization by about 15 percent following an illness episode. The effect is slightly higher for poor households than for the non-poor.

Many studies have also assessed the impact of CBHI on financial protection. According to Giedion et al. (2012), SHI and CBHI schemes frequently reduce OOP expenditures, and sometimes prevent catastrophic expenditures and impoverishment. Furthermore, the worse-off seem to reap greater benefits from SHI and CBHI schemes in terms of lowering their OOP expenditures and improving their financial protection.

Table 2.2: Reviewed papers on impact CBHI on protecting impoverishment

Author	# papers reviewed	Impact findings				
		Overall positive impact	Positive impact on reducing catastrophic health expenditure	Impact on protecting impoverish ment	Positive impact on other financial protection indicators	Greater impact among the worse-off
Giedion et al. (2012)	41	15	14	15	2	7

2.3 Success Factors for CBHI Schemes

Soors et al. (2010) reviewed the design and implementation of 16 African and six Asian countries' CBHI experiences and concluded that there is great heterogeneity in institutional designs and organizational models for implementing CBHI on both continents. They also documented the huge variation in coverage achieved, in terms of breadth, depth, and height. Except in Rwanda and Ghana, CBHI in sub-Saharan Africa remains a relatively marginal, although growing phenomenon that currently occupies only a minor role in the wider endeavor of achieving UHC. Coverage at the country level rarely exceeds a few percent. They also note that most schemes still are – again with the notable exceptions of Rwanda and Ghana – the result of scattered local project initiatives heavily dependent on support from external organizations. They concluded that the important conditions for CBHI to develop and grow are:

- The existence of a minimal level of (perceived) quality of care in health facilities. Development of CBHI must go hand in hand with gradually improving quality on the supply side, with the necessary institutional and regulatory environment to steer and control provider behavior.

- The need for adequate organizational structure and practice. The design of the schemes should include responsiveness to people's felt needs, financially soundness, and rationality.
- The need for political will, clear action plans, national scope of implementation beyond pilot project settings, existence of regulatory frameworks, and – last but not least – the unequivocal acceptance of the need of subsidies to finance partly or totally the premium for the poorest in society.
- The need for CBHI schemes to join forces as has been shown in Mali and is in progress in several African countries. Otherwise, they can make affiliation mandatory, as did Ghana and Rwanda. Failing to join forces – as experienced in Senegal – raises a question about the feasibility of voluntary solidarity.
- Affordability is important but may not be enough to positively influence health status. Improving affordability is a necessary condition, but careful consideration should be given to other dimensions of access. There is thus a need to design complementary interventions for other access parameters as financial protection measures are implemented. The impact of the CBHI schemes is often greater on the poor than on the non-poor implying that they could be used as a vehicle to improve welfare of the poor.
- The CBHI needs to be an integral part of a national health financing strategy; this strategy should ensure that small and independent CBHI schemes must gradually evolve through the three stages, from basic model, to enhanced model, and eventually to a nationwide model, along the way addressing the inherent limitations of CBHI (Wang and Pielemeier 2012).

SECTION 3. CBHI EVALUATION FINDINGS

3. ETHIOPIAN CBHI PILOT SCHEMES: DESIGN AND CURRENT STATUS

3.1 Scheme Design and Parameters

3.1.1 Influence of International Experience on Ethiopia's CBHI Design

The design of the Ethiopian CBHI pilot learned from the experiences of other countries, especially those that are believed to have been successful. The best practices around avoiding small-scale, voluntary membership and ensuring the membership of the very poor were considered and incorporated in the design the schemes design. The feasibility study that provided the evidence on the willingness and ability to pay of the pilot woreda population as well as the readiness of facilities in the pilot woredas informed the design parameters (HSFR 2009). The major features of the Ethiopian CBHI pilot scheme include:

- The decision to join the CBHI scheme is made collectively at the kebele/tabia level with the direct participation of the kebele/tabia population. However, actual enrollment to scheme happens when the household decide to pay contribution.
- CBHI will have sections in each kebele/tabia. The association of these kebele/tabia sections will form the woreda-level CBHI scheme.
- Woreda CBHIs are integrated and work within the woreda administration office, and will be responsible for pooling and administrating CBHI funds, contracting with and processing reimbursements for health service providers. To ensure schemes are accountable to their members, woreda-level boards will be established that will comprise members of the CBHI.
- The bylaws, endorsed by each CBHI scheme, provide the legal status supported by the federal health insurance strategy and regional CBHI directives.
- General and targeted subsidies are an integral part of the design of the pilot scheme. A general subsidy is provided to all members of the CBHI by the federal government, while a targeted subsidy from the regional and woreda governments is provided to the very poor who cannot afford to pay the contribution.
- The federal government has also provided resources for investing in CBHI contracted facilities to make sure that the service providers have some acceptable quality of care when services to members of the CBHI starts.

The design of the CBHI pilot, as described above, was informed not only by reviewing best practices around the world, but also by study tours to Ghana, Mexico, Rwanda, and Senegal that exposed the design team to the different perspectives of what works and what does not and an understanding of the comparative CBHI models. This enabled the design team to develop different policy options for consideration by the top management of the FMOH. The decision to introduce CBHI pilots in 12 woredas (later expanded to 13) as well as the different parameters was taken by FMOH. This initially was supported by the development and endorsement as well as proclamation of the Ethiopian Health Insurance Strategy. The CBHI Directive developed at the federal level served as "Prototype Directive" for the regions to adapt and endorse their own directives and guidelines. This helped the

establishment of the pilot CBHI schemes in the 13 woredas. The design also included the definition of the four control districts to help see the counterfactual during the evaluation of the pilot schemes.

3.1.2 Major Parameters of Ethiopian CBHI Pilot Schemes

As noted above the federal ministry of health (FMOH) provided the necessary guidance on defining the CBHI major parameters based on the findings of the regional feasibility studies and the respective regional context. The major CBHI parameters and their regional adaptations are presented in Table 3.1.

Table 3.1: Main Parameters of the Ethiopian CBHI scheme

No	Major Parameters	Federal Guidelines	Regional Adaptations			
			Amhara	SNNP	Oromia	Tigray
1	Membership	Decision to enroll in scheme to be taken by kebele/tabia collectively	Membership determined collectively at kebele/tabia level based on majority vote	Membership determined collectively at kebele/tabia level	Membership determined collectively at kebele/tabia level based on majority vote	Membership determined collectively at kebele/tabia level based on majority vote
			Membership also based on household level		Membership limited to 5 HH members	All core family members (father, mother, and children under 18); households who wish to enroll children over 18 years of age pay Birr 30 per child.
2	Registration fee and premiums	Registration fee set by regions	Fee of Birr 3 per HH	Fee of Birr 5 per HH	Fee of Birr 5 per HH	Fee of Birr 5 per HH
		Premium set by regions	Premium payment of 144 per family per year	Premium payment of 10.50 per month per HH= Birr 126 per year	Premium payment of Birr 180/ core family members and Birr 36 /additional noncore family member	Birr 132 per household per year plus In addition Birr 30 per person/ year for dependents more than18 years of age.
3	Financing the very poor (indigents)	Regions and woredas pay registration fee and premiums of the very poor. Payment of this contribution covered 30% by the woreda and 70% by region.	90% of targeted subsidy from the region and 10% from the woreda. Beneficiaries selected with participation of the community.	No clear guideline by the region. Payment of contribution covered 100% by woreda. Beneficiaries selected with participation of the community.	No clear guideline by the region. Payment of contribution will be covered 100% by the woreda. Beneficiaries will be selected with participation of the community to ensure fairness and transparency.	70% of targeted subsidy from region and 30% from the woreda. A maximum of 10% of the eligible household will be selected.
4	General subsidy	Federal government finances 25% of enrollment contributions per year	Federal government finances 25% of overall enrollment contributions per year	Federal government finances 25% of overall enrollment contributions per year	Federal government finances 25% of overall enrollment contributions per year	Federal government finances 25% of overall enrollment contributions per year
5	Provider payment mechanism	Fee-for-service	Fee-for-service	Fee-for-service	Fee-for-service	Fee-for-service.

No	Major Parameters	Federal Guidelines	Regional Adaptations			
			Amhara	SNNP	Oromia	Tigray
6	Housing of CBHI scheme		Woreda administration	Woreda administration	Woreda administration	Woreda administration
7	Benefit package	All services available in health centers and hospitals, excluding tooth implantation and eyeglasses	All services available in health centers and hospitals, excluding tooth implantation and eyeglasses	All services available in health centers and hospitals, excluding tooth implantation and eyeglasses	All services available in health centers and hospitals, excluding tooth implantation and eyeglasses	All services available in health centers and hospitals, excluding tooth implantation and eyeglasses.
8	Governance and management		Woreda CBHI board oversees the initiative. The scheme staff is employed by woreda administration.	Woreda CBHI board oversees the initiative. The scheme staff is employed by woreda administration.	Woreda CBHI board oversees the initiative. The scheme staff is employed by woreda administration.	Woreda CBHI board oversees the initiative. The WorHO assigns the curative core process owner as a coordinator in addition to his duties in the health office. Other CBHI executive staffs are employed by the woreda administration.

Before launching the pilot, extensive training and sensitization was given to policymakers, planners, regional and woreda officials, kebele/tabia officials, CBHI executive staffs, community workers, community members, and other CBHI stakeholders. Below are listed some of the stakeholders who were trained/sensitized before or immediately after the establishment of the schemes:

- Woreda cabinet and woreda health insurance steering committee (WHISC) members in the pilot woredas.
- Kebele/tabia cabinet and kebele/tabia health insurance initiative committee (KHIIC) members (two each from each pilot kebele/tabia), supervisors of health extension workers, WorHO representatives, health facility staff, and amateur artists. Woreda cabinet and WHISC members were part of the team of trainers.
- Kebele/tabia- and got-level executive staff, who received training on the CBHI financial administration and management system (FAMS).
- Community sensitization and awareness creation activities were conducted in collaboration with implementing partners both at woreda and kebele/tabia levels, using local amateur artists. Additional awareness creation activities were also conducted, including kebele/tabia-level consultation with community members; production and distribution of posters and leaflets in local languages; and organization of a one-day orientation workshop for zonal cabinet members in some pilot regions.

In addition, health providers in the four regions were trained on selected topics including basics of health insurance; the rationale for the CBHI program; legal framework documents; the roles and responsibilities of health facilities; and contents of contract agreements to be signed between health facilities and schemes. Advocacy events were organized for health workers, newly hired health extension workers, development agents, schoolteachers, CBHI executive staff, woreda sector offices, newly assigned woreda cabinet members, kebele/tabia leaders/managers, and influential community members.

3.2 Establishment and Functioning of CBHI Schemes

3.2.1 Endorsement of bylaws

Stakeholders including RHBs, woreda cabinet and WHISCs members, kebele/tabia cabinet and KHIIC members, and HSFR/HFG project staff organized kebele/tabia-level CBHI consultative meetings in the four pilot regions to get kebele/tabias' decisions on whether they wanted to join the CBHI schemes and if so to enable them select their representatives for the CBHI General Assembly organized at the woreda level. After a thorough discussion, the community in each pilot kebele/tabia and woreda unanimously decided to join the scheme and designated his or her delegates for the General Assembly. Each General Assembly endorsed the CBHI bylaws decided on the amount of the registration fee and annual premium, and fixed the timetable for the collection of premiums. It also established a Board of Directors, and officially established the scheme.

3.2.2 CBHI operational templates preparation

CBHI identification cards, voucher pads, and other supporting documents and materials were printed by the HSFR project at central level and distributed to the pilot regions/woredas. The HSFR/HFG project facilitated the production of CBHI seals and distributed them to each pilot woreda. It also prepared a detailed list of equipment and furniture to be purchased for each CBHI scheme office (housed in the respective woreda administration offices).

3.2.3 Bank accounts

Schemes bank accounts were opened with Omo Micro-finance for SNNP and with commercial bank of Ethiopia for schemes in other three pilot regions.

3.2.4 Contracts with health facility

Each region adapted for its own use a prototype agreement that had been developed centrally and each scheme entered into contracts with health facilities.

3.2.5 Monitoring and evaluation system

The RHB in each CBHI pilot regions selected one control woreda, based on socio-economic and other factors. Analytical framework and data collection and reporting formats were developed to analyze routine monitoring data collected from pilot woredas and produce regional CBHI performance reports.

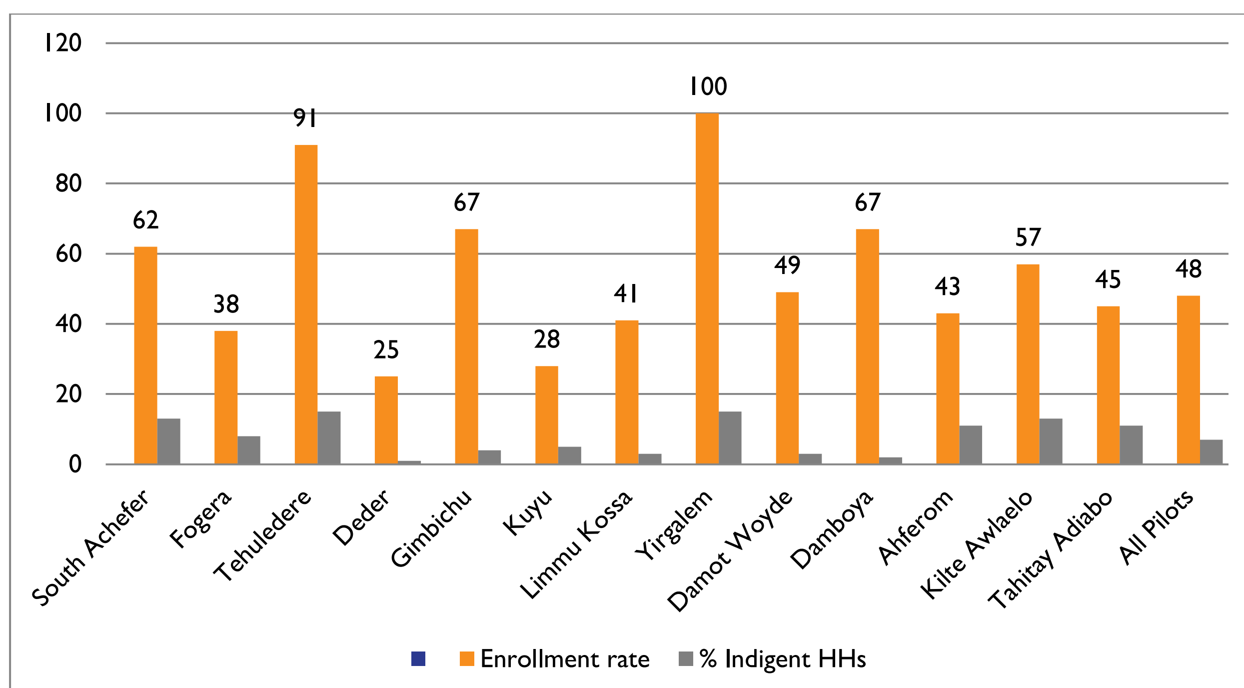
In all of these preparatory stages as well as in the day-to-day implementation of CBHI schemes to date, the technical and financial support role played by HSFR/HFG project was essential – the project has been at the forefront of CBHI conceptualization, design, piloting, and pilot expansion.

3.3 Current Status of CBHI Pilots

3.3.1 Enrollment

According to the data from the HSFR/HFG project information system, the overall enrollment in the pilot schemes is 48 percent, with wide variation by woreda. Enrollment ranges from a low of 25 percent in Deder to 100 percent (universal enrollment) in Yirgalem5 (see Figure 3.1). The overall percentage of households registered as indigents is 7 percent, and ranges from 1 percent in Deder to 15 percent in Tehuledere and Yirgalem.

Figure 3.1: Enrollment Rate (%) and % of Indigent HHs Registered as Members, June 2013

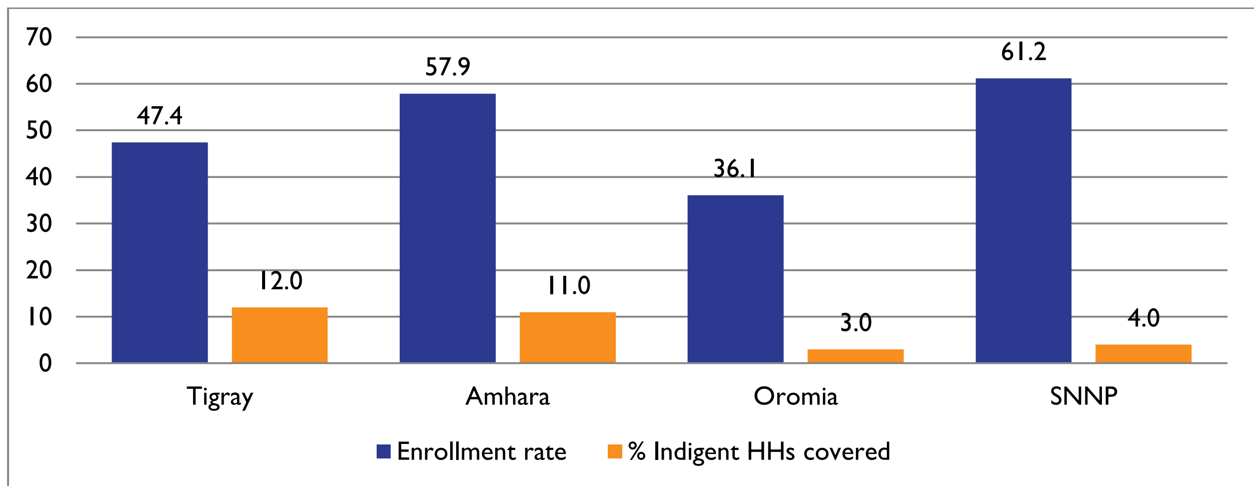


Source: HSFR/HFG

[5] The data collected from pilot woredas during the assessment differs somewhat from the information obtained from HSFR/HFG. In Yirgalem, for instance, the enrollment rate based on woreda data included civil servants, pensioners, and drop-outs; the data had not been updated for lack of an ICT (information communication technology) person since EFY 2005 (2012/13).

Looked at from the regional perspective, households enrollment rate ranges from 61 percent in SNNP to 36 percent in Oromia (see Figure 3.2).

Figure 3.2 Regional Enrollment Rate and % of HHs Registered as Indigents, June 2013

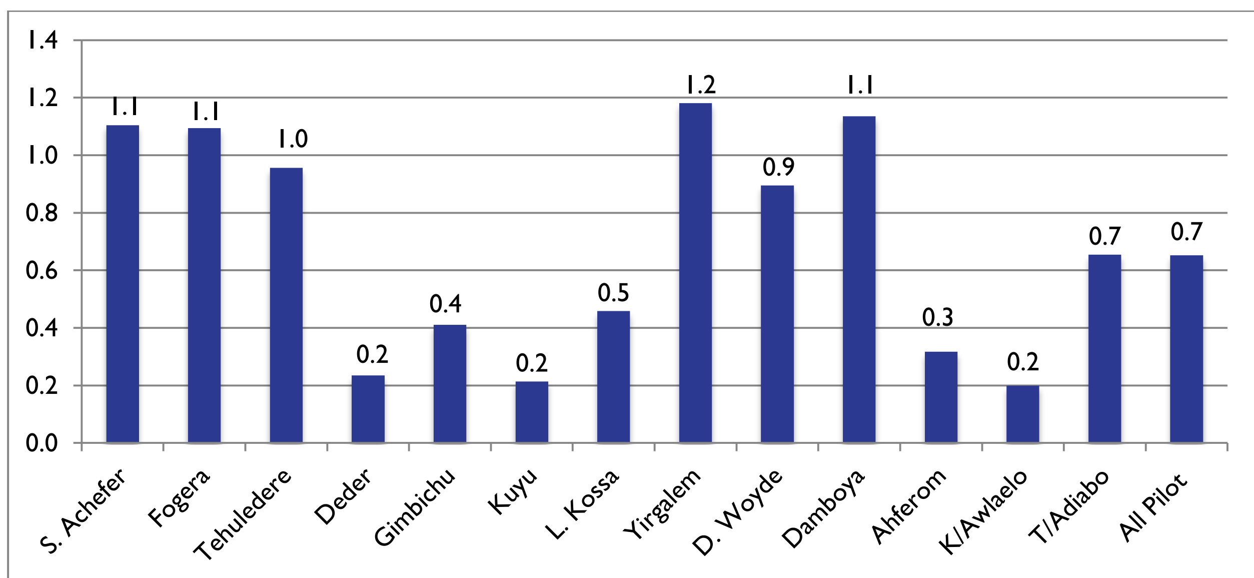


Source: HSFR/HFG Project

3.3.2 Health Service Utilization of CBHI Members

The per capita health service utilization rate for CBHI members was 0.7 outpatient visits in EFY 2005 (2012/13). This is more than double compared with the national per capita utilization rate of 0.3 visits. The rates in Amhara and SNNP pilot woredas again exceeded those in Oromia and Tigray (see Figure 3.3).

Figure 3.3: Per Capita Health Service Utilization Rate for Year 2012/13



Source: HSFR/HFG

3.3.3 Scheme Finances

The financial condition of the schemes when taking into consideration all financial resources i.e., contribution from paying members, general subsidy and targeted subsidy; the financial condition of all schemes (13) is so far positive. When contribution collected from paying members was taken into account alone, the three schemes namely Fogera, Yirgalem and Damboya can't cover their expenditures for health care services. Yirgalem, for instance, has a current negative balance and outstanding liabilities of more than six months. As can be expected, those schemes with higher utilization per capita also are financially weaker.

Table 3.2: Financial Status of CBHI Schemes, June 2013 (Birr)

		Premiums collected	Reimbursements to health facilities	Balance
Amhara	S. Achefer	2,881,681.32	2,080,113.95	801,567
	Fogera	1,670,205.00	2,451,874.50	-781,670
	Tehuledere	3,339,650.00	3,033,377.99	306,272
	Total	7,891,536	7,565,366.44	326,170
Oromia	Deder	1,293,318.00	647,954.00	645,364
	Gimbichu	2,901,874.00	633,014.00	2,268,860
	Kuyu	607,019.00	202,990.00	404,029
	L. Kossa	1,610,987.00	1,404,014.00	206,973
	Total	6,413,198	2,887,972.00	3,525,226
SNNP	Yirgalem	406,050.70	635,705.52	-229,655
	D. Woyde	1,219,089.40	1,240,137.27	-21,048
	Damboya	1,859,072.25	1,713,059.34	146,013
	Total	3,484,212	3,588,902.13	-104,690
Tigray	Ahferom	2,056,577.00	1,134,207.87	922,369
	K/Awlaelo	1,637,561.00	687,016.92	950,544
	T/Adiabo	1,184,091.00	1,038,618.49	145,473
	Total	4,878,229	2,859,843.28	2,018,386
Grand Total		**22,667,175.67**	**16,902,083.85**	**5,765,092**

Source: HSFR/HFG Project

4. BASIC HOUSEHOLD CHARACTERISTICS

4.1 Basic Household Characteristics

The quantitative data gathered for this evaluation, as described in Chapter 1, came from a survey of 2,987 households and 462 patient exit interviews. Basic characteristics of sampled households' are presented in table 4.1 (a). Of total sampled households, 81 percent were men and 19 women; and 89.3 percent were in the productive age group (15-65 years) and nearly 11 percent aged (> 65 years). Though there are regional variations, nearly 80 percent of HH heads were married, 12.4 percent widowed, 6.5 percent divorced and nearly 2 percent were single. In regard to religion, about 61.3 percent of household heads were Orthodox Christians; 23.1 percent Muslims; 14.9 percent Protestants; and Catholic, no religion, and others account less than one percent each. In regard to ethnic composition, 30.2 percent were Amhara, 26.2 percent Oromo, 23.2 percent Tigryan, 6.6 percent Kambata, 7 percent Wolayta, Sidama 2.3 and Gedeo 2.6 percent each, and Guraghie 1.5 percent. Hadiya accounts less than one percent.

Table 4.1 (a): Characteristics of Sampled Households by Region

Distribution	Pilot woredas								Control woreda		All Region	
	Amhara		Tigray		Oromia		SNNP					
Gender distribution												
Male	518	86.33	415	69.17	703	88.10	462	78.04	332	83.63	2430	81.35
Female	82	13.67	184	30.67	95	11.90	128	21.62	65	16.37	554	18.55
Missing	0	0	1	0.17	0	0	2	0.34	0	0	3	0.10
Total	**600**	**100**	**600**	**100**	**798**	**100**	**592**	**100**	**397**	**100**	**2987**	**100**
Household size												
<=5	378	63	370	61.67	460	57.64	283	47.25	202	50.63	1,693	56.51
>5	222	37	230	38.33	337	42.23	309	51.59	197	49.37	1,295	43.22
Missing	0.00	0.00	0.00	0.00	1	0.13	7	1.17	0.00	0.00	8	0.27
Total	**600**	**100**	**600**	**100**	**798**	**100**	**599**	**100**	**399**	**100**	**2996**	**100**
Age Distribution												
Age 1-15	0	0	0	0	0	0	0	0	0	0	0	0
Age 16-65	524	87.33	520	86.67	712	89.22	543	91.72	368	92.70	2667	89.29
Age >65	76	12.67	80	13.33	84	10.53	45	7.60	29	7.30	314	10.51
Missing	0	0	0	0	2	0.25	4	0.68	0	0	6	0.20
Total	**600**	**100**	**600**	**100**	**798**	**100**	**592**	**100**	**397**	**100**	**2987**	**100**
Marital status												
Married	499	83.17	410	68.33	677	84.84	444	75.00	326	82.12	2356	78.88
Single	7	1.17	15	2.50	15	1.88	15	2.53	4	1.01	56	1.87
Divorced	31	5.17	85	14.17	24	3.01	26	4.39	28	7.05	194	6.49
Widow	61	10.17	88	14.67	79	9.90	106	17.91	36	9.07	370	12.39
Missing	2	0.33	2	0.33	3	0.38	1	0.17	3	0.76	11	0.37

Distribution	Pilot woredas								Control woreda		All Region	
	Amhara		Tigray		Oromia		SNNP					
Total	**600**	**100**	**600**	**600**	**798**	**100**	**592**	**100**	**397**	**100**	**2987**	**100**
Religion												
Orthodox	399	65.50	564	94.00	447	56.06	173	29.22	254	63.98	1831	61.30
Catholic	0	0	0	0	0	0	10	1.69	0	0	10	0.33
Protestant	1	0.17	2	0.33	14	1.75	364	61.49	64	16.12	445	14.90
Muslim	206	34.33	34	5.67	334	41.85	37	6.25	78	19.65	689	23.07
No religion	0	0	0	0	0	0	1	0.17	0	0	1	0.03
Other	0	0	0	0	2	0.25	6	1.01	1	0.25	9	0.30
Missing	0	0	0	0	1	0.13	1	0.17	0	0	2	0.07
Total	**600**	**100**	**600**	**100**	**798**	**100**	**592**	**100**	**397**	**`100**	**2987**	**100**
Ethnicity												
Amhara	600	100	4	0.67	103	12.19	53	8.95	141	35.52	901	30.16
Oromo	0	0	0		685	85.84	16	2.70	80	20.15	781	26.15
Tigryan	0	0	595	99.17	0	0	3	0.51	95	23.93	693	23.20
Gurage	0	0	0	0	2	0.25	42	7.09	0	0	44	1.47
Kambata	0	0	0	0	2	0.25	195	32.94	0	0	197	6.60
Hadiya	0	0	0	0	0	0	0	0	2	0.50	2	0.07
Wolayta	0	0	0	0	0	0	207	34.97	1	0.25	208	6.96
Sidama	0	0	0	0	0	0	69	11.66	0	0	69	2.31
Gedio	0	0	0	0	0	0	0	0	77	19.40	77	2.58
Other	0	0	0	0	5	0.63	5	0.84	1	0.25	11	0.37
Missing	0	0	1	0.17	1	0.13	2	0.34	0	0	4	0.13
Total	**600**	**100**	**600**	**100**	**798**	**100**	**592**	**100**	**397**	**100**	**2987**	**100**

Source: Household Survey

The 2,987 households had 15,633 members; and of these 50.2 percent were men and 49.4 percent women. Over half of household members are in the productive age group (16-65 years), 46.1 percent young and 2.7 percent in the old age group (65 years and above). Of all household members, 31.1 percent are married, 23 percent single, 3.1 percent widowed, and divorced 2.1 percent. Over half of household members are Orthodox Christians, 22.5 percent Muslims, and 17.3 percent Protestant and catholic 0.42 percent. In terms of ethnicity, Amhara, Oromo, Tigryan and Kembata have highest proportions (4.1 (b)).

Table 4.2 (b): Characteristics of household members by region

Distribution	Pilot woredas								Control woreda		All Region	
	Amhara		Tigray		Oromia		SNNP					
Gender distribution:												
Male	1516	51.46	1429	49.53	2180	51.74	1610	47.46	1119	50.93	7854	50.24
Female	1430	48.54	1450	50.26	2031	48.21	1739	51.27	1076	48.93	7726	49.42
Missing	0.00	0.00	6	0.21	2	0.05	43	1.27	2	0.09	53	0.34
Total	**2946**	**100**	**2885**	**100**	**4213**	**100**	**3392**	**100**	**2197**	**100**	**15633**	**100**
Household size:												
<=5	378	63	370	61.67	460	57.64	283	47.25	202	50.63	1,693	56.51
>5	222	37	230	38.33	337	42.23	309	51.59	197	49.37	1,295	43.22
Missing	0.00	0.00	0.00	0.00	1	0.13	7	1.17	0.00	0.00	8	0.27
Total	**600**	**100**	**600**	**100**	**798**	**100**	**599**	**100**	**399**	**100**	**2996**	**100**
Age Distribution:												
Age 1-15	1,296	4399	1,330	46.10	2,008	47.66	1,495	44.17	1,084	49.34	7,213	46.14
Age 16-65	1,545	52.44	1,457	50.50	2,084	49.47	1,829	54.03	1,066	48.52	7,981	51.05
Age >65	102	3.46	96	3.33	121	2.87	61	1.8	41	1.87	421	2.69
Missing	3	0.10	2	0.07	0.00	0.00	7	0.21	6	0.27	18	0.12
Total	**2,946**	**100**	**2,885**	**100**	**4,213**	**100**	**3,392**	**100**	**2,197**	**100**	**15,615**	**100**
Marital status:												
Married	1,038	35.23	831	28.80	1,386	32.90	924	27.24	681	31.00	4,860	31.09
Single	752	25.53	606	21.01	912	21.65	917	27.03	407	18.53	3,594	22.99
Divorced	67	2.27	114	3.95	53	1.26	44	1.30	42	1.91	320	2.05
Widow	79	2.68	99	3.43	121	2.87	133	3.92	48	2.18	480	3.07
Other	0.00	0.00	4	0.14	0.00	0.00	0.00	0.00	0.00	0.00	4	0.03
Missing	1010	34.28	1231	42.67	1741	41.32	1374	40.51	1019	46.38	6375	40.78
Total	**2946**	**100**	**2885**	**100**	**4213**	**100**	**2,020**	**100**	**1,173**	**100**	**15633**	**100**
Religion:												
Orthodox	2123	72.19	2687	93.14	2234	53.03	871	25.68	1,341	61.04	9256	59.21
Catholic	0.00	0.00	0.00	0.00	7	0.17	58	1.71	0.00	0.00	65	0.42
Protestant	7	0.24	2	0.07	73	1.73	2217	65.36	402	18.30	2701	17.28
Muslim	813	27.57	183	6.34	1879	44.60	203	5.98	443	20.16	3524	22.54
No religion	0.00	0.00	0.00	0.00	4	0.09	3	0.09	0.00	0.00	7	0.04
Other	0.00	0.00	0.00	0.00	10	0.24	28	0.83	6	0.27	44	0.28
Missing	0.00	0.00	13	0.45	6	0.14	12	0.35	5	0.23	36	0.23
Total	**2946**	**100**	**2885**	**100**	**4213**	**100**	**3392**	**100**	**2197**	**100**	**15,633**	**100**

Distribution	Pilot woredas								Control woreda		All Region	
	Amhara		Tigray		Oromia		SNNP					
Ethnicity:												
Amhara	2945	99.97	7	0.24	489	11.61	228	6.72	718	32.68	4387	28.06
Oromo	1	0.03	0.00	0.00	3,663	87.18	82	2.42	458	20.85	4214	26.96
Tigryan	0.00	0.00	2,875	99.76	0.00	0.00	5	0.15	511	23.26	3391	21.69
Gurage	0.00	0.00	0.00	0.00	10	0.24	224	6.60	2	0.09	236	1.51
Kambata	0.00	0.00	0.00	0.00	14	0.33	1272	37.50	0.00	0.00	1286	8.23
Hadiya	0.00	0.00	0.00	0.00	0.00	0.00	2	0.06	6	0.27	8	0.05
Wolayta	0.00	0.00	0.00	0.00	0.00	0.00	1139	33.58	7	0.32	1146	7.33
Sidama	0.00	0.00	0.00	0.00	0.00	0.00	394	11.62	0	0	394	2.52
Gedio	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	482	21.94	482	3.08
Other	0.00	0.00	0.00	0.00	21	0.50	30	0.88	8	0.36	59	0.38
Missing	0.00	0.00	3	0.10	6	0.14	16	0.47	5	0.23	30	0.19
Total	**2946**	**100**	**2885**	**100**	**4204**	**100**	**3381**	**100**	**2,197**	**100**	**15633**	**100**

Source: Household Survey

Among those who were above school age, 52.2 percent were reported to be literate (able to read and write); 40 percent were not able to read or write (Table 4.2). And 51.3 percent have ever attended school and 2.1 percent never attended school. Nearly 30 percent completed primary education (1-6), 16.4 percent secondary education (7-10), 1.5 percent preparatory education (11-12), and less than 1.2 percent college diploma and degree. And 41.3 percent were members of the CBHI scheme while 56 percent were non-members living both in pilot and control woredas.

Table 4.2: Educational Characteristics of Household Members Disaggregated by Pilot and Control Woredas

Distribution	Pilot woredas								Control woreda		All Regions	
	Amhara		Tigray		Oromia		SNNP					
Educational status and ever attended formal education												
Literate	1,502	52.12	1,463	52.42	2,099	50.75	1,820	54.82	1,097	50.88	7,981	52.21
Illiterate	1,162	40.32	1,104	49.56	1,716	4149	1,231	37.08	879	40.77	6,092	39.86
Missing	218	7.56	224	8.03	321	7.76	269	8.10	180	8.35	1212	7.93
Total	2882	100	2791	100	4126	100	3320	100	1,976	100	15285	100
Ever attended school?	1,437	49.86	1,453	52.06	2089	50.51	1,812	54.58	1,085	50.32	7,876	51.53
Never attended?	109	3.78	43	1.54	56	1.35	72	2.17	43	1.99	323	2.11
Missing	1336	46.36	1295	46.40	1991	48.14	1436	43.25	1028	47.68	7086	46.36
Total	**2882**	**100**	**1,496**	**100**	**4136**	**100**	**3320**	**100**	**2156**	**100**	**15285**	**100**
Highest grade ever completed												
No education	65	2.26	55	1.97	97	2.35	73	2.20	54	2.50	344	2.25
Primary education (G 1-6)	851	29.53	845	30.28	1,213	29.33	994	29.94	613	28.43	4,516	29.55

Distribution	Pilot woredas								Control woreda		All Regions	
	Amhara		Tigray		Oromia		SNNP					
Secondary education (G7-10)	438	15.20	477	17.09	657	15.88	587	17.68	354	16.42	2,513	16.44
Preparatory education (G11/12)	33	1.15	42	1.50	50	1.21	76	2.29	31	1.44	232	1.52
Certificate from VET/TTC	9	0.31	4	0.14	7	0.17	12	0.36	3	0.14	35	0.23
College diploma and degree	29	1.01	29	1.04	36	0.87	62	1.87	24	1.11	180	1.18
Non-formal education	94	3.26	17	0.61	42	1.02	23	0.69	31	1.44	207	1.35
Missing	1363	47.29	1322	47.37	2034	49.18	1493	44.97	1046	48.52	7256	47.48
Total	2882	100	1,469	100	4126	100	3320	100	2156	100	15285	100
Currently attending formal education												
Currently attending	831	28.83	799	28.63	1,207	29.18	1,029	30.99	655	30.38	4,521	29.58
Not currently attending?	685	23.77	665	23.83	909	21.98	798	24.04	462	21.43	3,519	23.02
Missing	1366	47.40	1327	47.55	2020	48.84	1493	44.97	1039	48.19	7245	47.40
Total	2882	100	2791	100	2,116	100	3320	100	2156	100	15285	100
Highest grade currently completed												
No education	14	0.49	13	0.47	12	0.29	13	0.39	7	0.32	59	0.39
Primary education (G 1-6)	530	18.39	503	18.02	756	18.28	618	18.61	399	18.51	2,806	18.36
Secondary education (G7-10)	259	8.99	251	8.99	379	9.16	331	9.97	228	10.58	1,448	9.47
Preparatory education (G11/12)	23	0.80	22	0.79	43	1.04	32	0.96	18	0.83	138	0.90
Certificate from VET/TTC	7	0.24	7	0.25	7	0.17	6	0.18	2	0.09	29	0.19
College diploma and degree	11	0.38	17	0.61	19	0.46	28	0.84	12	0.56	87	0.57
Non-formal education	1	0.03	2	0.07	3	0.07	10	0.30	2	0.09	18	0.12
Missing	2037	70.68	1976	70.80	2917	70.53	2282	68.73	1488	69.02	10700	70.00
Total	**2882**	**100**	**2791**	**100**	**4136**	**100**	**3382**	**100**	**2156**	**100**	**4,585**	**100**

Distribution	Pilot woredas								Control woreda		All Regions	
	Amhara		Tigray		Oromia		SNNP					
CBHI membership status												
CBHI member	1,248	43.30	1,188	42.57	1,762	42.60	1,387	41.78	0	0	6,319	41.34
Non-CBHI member	1,559	54.09	1,534	54.96	2,268	54.84	1,825	54.97	2087	95.80	8,539	55.87
Missing	75	2.60	69	2.47	106	2.56	108	3.25	69	3.20	427	2.79
Total	**2882**	**100**	**2791**	**100**	**4136**	**100**	**3320**	**100**	**2156**	**100**	**15285**	**100**

5. CBHI IMPACT ON FINANCIAL RISK PROTECTION, HEALTH CARE UTILIZATION, AND RESOURCE MOBILIZATION

5.1 Determinants of Enrollment

Respondents in the pilot woredas were asked about their knowledge of the CBHI schemes. Ninety-five percent of both members and non-members said that they were aware that schemes had been established. Households that responded to the question 'from where did you get information about CBHI?' said they got the information from a neighbor, a CBHI/official, or a house-to-house sensitization program. These three sources constitute 100 percent of awareness in Amhara, 81 percent in Tigray, 96 percent in Oromia, and 86 percent in SNNPR (Table 5.1). Eight-one percent of members and 76 percent of non-members responded that they had attended CBHI-related meetings before CBHI was implemented in their kebele/tabia. This clearly shows that the intensive sensitization work done by government and especially by HSFR/HFG project, as described in the preceding section, was effective.

Table 5.1: Sources of information about CBHI (%)

	Amhara	Tigray	Oromia	SNNP
Neighbor	52	44	25	31
CBHI officials	37	25	62	42
CBHI house-to-house awareness	11	12	9	13
All other sources	0	19	4	14

Source: Household Survey

The household survey showed that most households in the pilot woredas (both member and non-member) correctly understand the role and concept of CBHI. As shown in Table 5.2, more than 96 percent of member and 87 percent of non-member households know that not only the sick should enroll in CBHI. A larger percentage of members than non-members also know that both the poor and the non-poor should enroll, and that CBHI is not like saving scheme, that is, they will not earn interest on their premium payment nor will the premium be returned even if they do not use health services, but rather that the premium is a payment to finance future health costs.

Table 5.2: Responses about the Role and Concept of CBHI (%)

Issues of `understanding CBHI	Correct understanding in pilot woredas (in %)	
	CBHI members	CBHI non-members
Only those who fall sick should consider enrollment in CBHI. (Incorrect)	96	87
Only the very poor who cannot afford to pay for health care need to join the schemes. (Incorrect)	90	83
Under the CBHI program, you pay money (premiums) in order for the CBHI to finance your future health care needs, if need arise. (Correct)	82	76
The CBHI program is like a savings scheme; you will receive interest and get your money back. (Incorrect)	81	65
If you do not make claims through CBHI, your premium will be returned. (Incorrect)	81	65

Source: Household survey

Members were asked why they joined the CBHI scheme. Out of the 1,287 member households interviewed, 1,282 responded to the questions for a total of 2,625 responses (a household could provide more than one answer to a question). Regarding reasons for enrolling, 37 percent said to reduce the OOP payment when seeking care, 35 percent to seek more care so as to improve their health status, 18 percent because the premium is lower than the OOP payments, and 4 percent because government paid their registration fees and premiums (Table 5.3). The CBHI design in Ethiopia states that the decision on whether to join the scheme is taken at the kebele/tabia level, and households confirmed that there was no pressure to enroll either the community or the kebele/tabia administration during the enrollment process.

Table 5.3: Reasons for Joining the CBHI Scheme (Multiple Response) (%)

	Amhara	Tigray	Oromia	SNNP	Total
Frequent health hazards	5	3	3	2	3
To meet health services requirements	29	36	35	41	35
Cover health expenditure	34	33	41	39	37
Government financed registration and premiums	4	7	1	2	4
Premium is less than OOP payments	23	19	17	13	18
Pressure from the community members	1	0	0	1	1
Pressure from the kebele/tabia administration	4	1	0	1	2
Total (in percent)	**100**	**100**	**100**	**100**	**100**
Total number of responses	**686**	**659**	**744**	**536**	**2,625**

Source: Household survey

The survey also asked non-members in the pilot woredas why they did not enroll in the CBHI scheme. Out of the total 1,303 non-member households, only 1,252 responded to the question, for a total of 1,681 responses (again, a household could provide more than one answer to the question). Regarding reasons for not enrolling, 39 percent stated that the registration fees and the premium are not affordable; 17 percent didn't have adequate knowledge and information; 12 percent preferred to see the CBHI scheme in action first; and 10 percent stated that the payment schedule is not appropriate (Table 5.4). Availability and quality of health services did not seem to greatly affect their decision to enroll. Given that nearly 40 percent of eligible households did not enroll due to the affordability issue, regions and woredas should explore the feasibility of expanding the fiscal space for coverage of indigents to ensure that those without ability to pay are enrolled.

Table 5.4: Reasons for not enrolling in the CBHI schemes (multiple response) (%)

Reason for not enrolling	(%)
No frequent health hazards	4
Registration and premiums are unaffordable	39
CBHI payment schedule is not appropriate	10
Wanted to see the experience from others	12
Lack of information and knowledge	17
Inadequate availability of health services	1
Low quality of health services	2
Inadequate benefit package	1
Lack of confidence on the CBHI management	2
Other	11
Total (in %)	**100**
Total number of responses	**1,681**

Source: Household survey

Of the 1,287 CBHI member households covered in this survey, 1,169 (91 percent) enrolled in the scheme through own contribution. The remaining 9 percent are enrolled either through the local government subsidy (5 percent) or a contribution deducted from their "safety net" payment (4 percent). As can be seen in Table 5.5, there is variation among regions on the extent to which local government finance the membership premiums of indigents. From this household survey, Amhara and SNNP do seem to perform better.

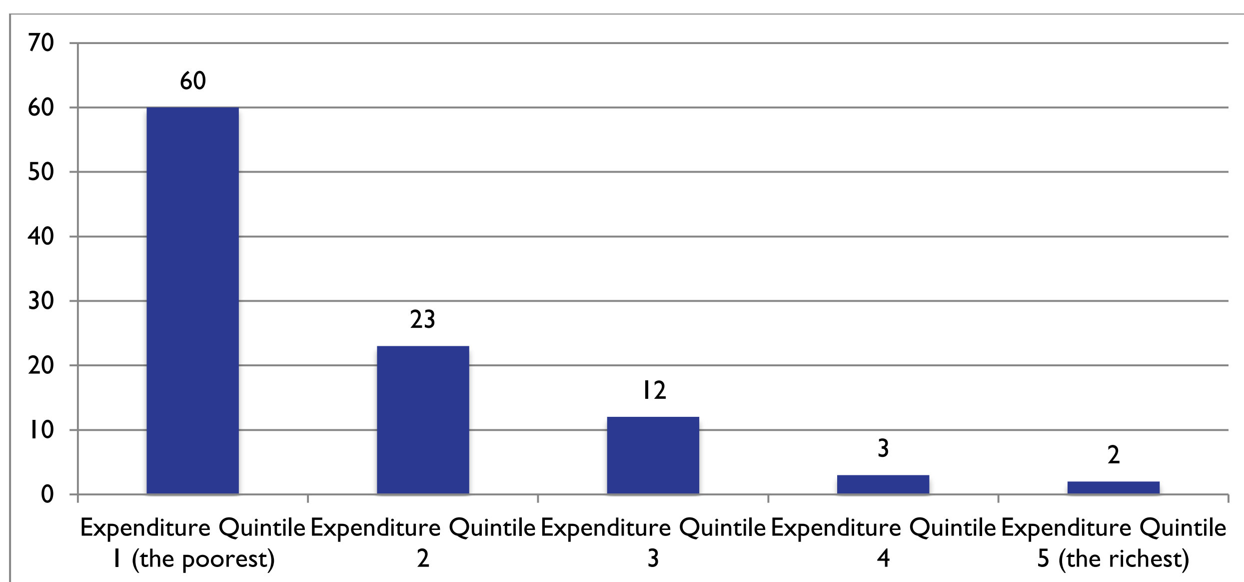
Table 5.5: Sources of finance for enrolling into CBHI pilots

	CBHI members in pilot districts: only members									
	Amhara		Tigray		Oromia		SNNP		ALL CBHI	
	Freq.	(%)	Freq.	(%)	Freq.	(%)	Freq.	(%)	Freq.	(%)
Own contribution	283	89	276	96	374	96	236	81	1,169	91
Deduction from their safety net	6	2	2	1	6	2	40	14	54	4
Local government	30	9	11	4	9	2	14	5	64	5
Total	319	100	289	100	389	100	290	100	1,287	100

Source: Household survey

We explored how far the targeted subsidy for CBHI is reaching the very poor when compared with the expenditure data we collected during the survey. Figure 5.1 shows that 83 percent of the targeted subsidy beneficiary households (indigents/non-paying members) came from the lowest two expenditure quintiles. Only 5 percent of the subsidy might have reached the richest two quintiles. This shows that beneficiary selection for the targeted subsidy is by and large fair. The major issue that emerged during the KIIs and FDGs was that not all indigent households received membership cards because they did not provide photographs of each family member or group photograph.

Figure 5.1: Distribution of Targeted Subsidy by Expenditure Quintiles (in %)



Source: Household survey

The household survey asked respondents whether they would renew their CBHI membership. About 97 percent confirmed that they would renew. This survey asked non-members if they planned to join the scheme in the future given what they have seen going on in the woreda; 80 percent of non-members said they did have plans to join the scheme in the future. However, some of the non-members gave inappropriate payment schedule as one of the reasons for not being enrolled. On the contrary, 88 percent of the CBHI members confirmed that the payment timing and schedule is acceptable (Table 5.4).

The survey also asked about the affordability of the registration fee and premium. As can be seen in Figures 5.2 and 5.3, 84 percent and 83 percent of CBHI members feel that the premiums and registration fee are either easily or somewhat affordable; affordability is an issue for only 16 percent of registered members. In contrast (as was presented in Table 5.4), affordability is an issue for 39 percent of non-members. This needs to be explored further to ensure that financial barriers are not preventing the very poor from joining.

Figure 5.2: Affordability of Premiums

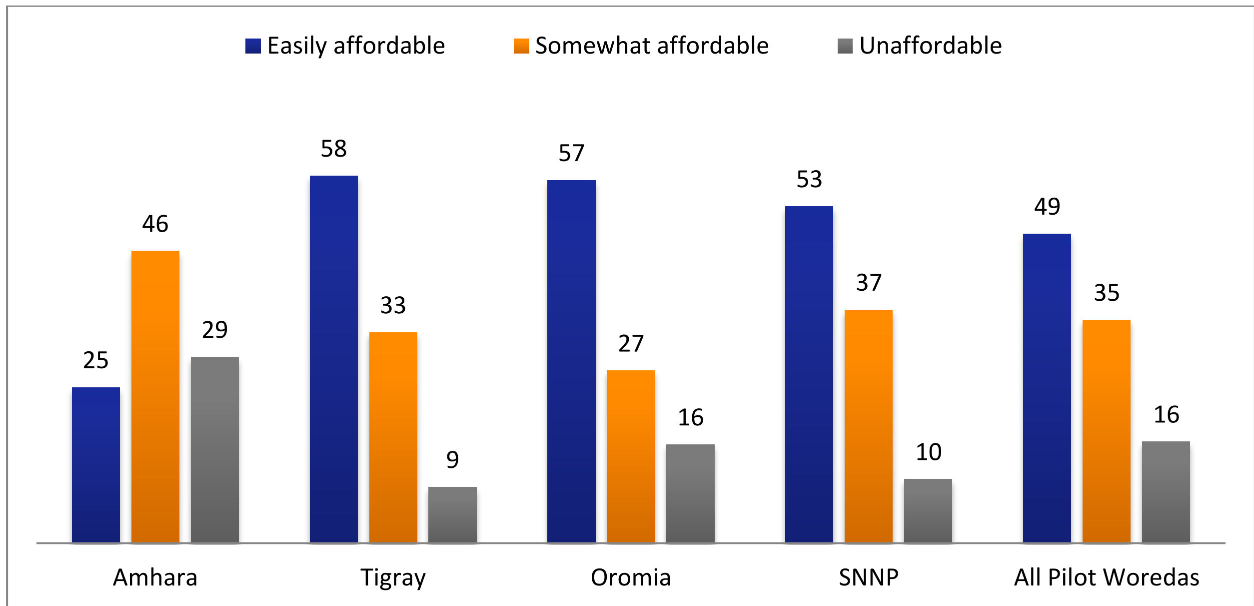
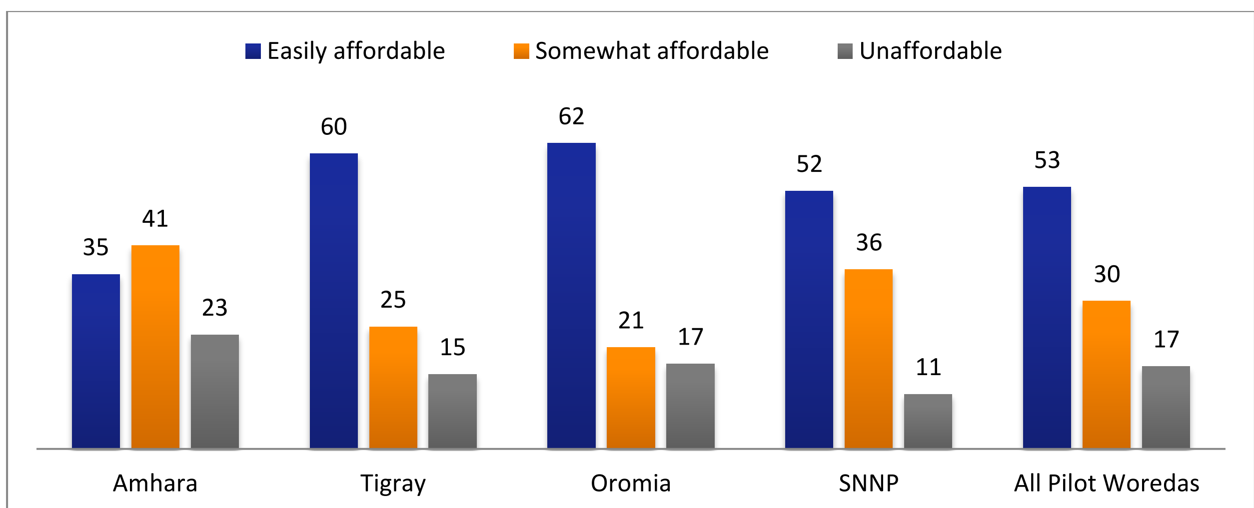


Figure 5.3: Affordability of Registration Fee



Source: Household survey

The household survey findings about the affordability of fees and premiums are supported by the FGDs. All four regional qualitative reports documented that all FGDs with CBHI members found that the premium is affordable if they get good services. Two FGD respondents in Damboya woreda stated the following:

> *"Some time ago I was admitted to the hospital (Durame) because I had TB, high blood pressure, and gastritis. When I was discharged, the total amount due was Birr 1,780, which would have been much beyond my means to pay. However, I was discharged without paying a single penny thanks to CBHI."*

> *"This is something that God has brought about for the poor. I am relieved of a huge expense, entering into debt, and paying interest. I have found a shield (protection)."*

The FGDs with non-members had mixed results. Some participants stated that contribution is affordable but explained that the services offered at facilities are not good and the services for the most common cause of sickness (e.g., malaria) are free and therefore there is no need to pay for CBHI. Others say that CBHI is very good initiative but they have other more pressing needs on which to spend their money.

After collecting data on the reasons for enrollment and non-enrollment, sources of financing for enrollment, and affordability of registration fees and premiums, the evaluation team used an econometric model to explore the factors that determined enrollment. (See Section 1 for a description of the model.)

As was described in the literature review, many factors, including gender of head of the household, having families with young children, families headed by the elderly, education, households income, and health status of household, influence the decision of households to join CBHI schemes.

The most significant variables that have positive association with enrollment in the CBHI pilot schemes in Ethiopia were found to be size of household, age of the head of the household, education, sex and cultivated land size (not own land) (Table 5.6). These determinants are statistically significant at a 1 percent degree of significance. Families with more members and with older heads are more likely to enroll in the pilot scheme than those who have fewer members and older heads. Also more likely to join are those who are literate and especially those who completed primary school. Female-headed households are more likely to join than male-headed ones. Another important determinant for membership is ownership of livestock as expressed in terms of total livestock units, which is statistically significant at 5 percent degree of confidence. The evaluation team looked into the regional variation in the enrollment determinants. Taking Amhara region as a reference group, the evidence suggests that there is no significant difference in enrollment between Amhara, Tigray and Oromia, while enrollment in SNNP is lower than in Amhara.

Table 5.6: Determinants of enrollment in CBHI

VARIABLES	(Enrollment in the pilot woreda) Model 1
Illness	0.0549
	(0.0697)
Household size	0.0533***
	(0.0116)
Age of head of family	0.0198***
	(0.00115)
Head sex (1/0)	-0.259***
	(0.0671)
Head literate (1/0)	0.161***
	(0.0447)
TLU	0.0127**
	(0.00584)
Land size covered by crops	0.0974***
	(0.0244)
Per capita expenditure	-0.000139
	(9.34e-05)
Tigray	0.00234
	(0.0641)
Oromia	-0.0465

VARIABLES	(Enrollment in the pilot woreda) Model 1
	(0.0589)
SNNP	-0.119*
	(0.0659)
Constant	-1.420***
	(0.102)
Observations	10,537

Source: Household survey
Standard errors are in parentheses. *** p<0.01, ** p<0.05, * p<0.1

5.2 Increased Utilization of Health Care Services

5.2.1 Health Service Utilization by CBHI Members and Non-members

The CBHI benefit package includes outpatient and inpatient services, laboratory services, imaging services, supply of drugs and related services with the exception of eyeglasses, dental implant, dialysis, etc. All government health centers that are situated in the woreda and fulfill the minimum standard of service delivery are contracted to provide services to members. When members in the pilot woredas live closer to public health centers in neighboring woredas, there are instances where these facilities are contracted based on community demand,6 despite the fact that – as stated in KIIs with representatives from the World Health Organization (WHO) and CBHI offices – these health centers have some gaps in their readiness to provide quality care. This shows that geographic access overrides woreda boundaries and/or readiness of health facilities and quality of care.

All pilot woredas have also signed service contracts with their region's referral hospitals. Three regions (Amhara, Oromia, and Tigray) entered contracts to ensure the possibility of interregional referrals. CBHI operational guidelines dictate that members can only get inpatient services free of charge if they have a proper written referral paper from a contracted health center and hospitals. The only exception to this is Yirgalem hospital, which residents in two Kebeles/Tabias are allowed to access directly because of the distance to Yirgalem health center. Members who do not follow the referral system are charged 50 percent of the hospital user fee as a bypassing fee. Members also can only be referred to the closest referral hospital. The only exceptions are members in (all) pilot woredas in Tigray region and Kuyu woreda in Oromia. In Tigray, all members can be referred to Mekelle and Ider referral hospitals. In Oromia, Kuyu pilot woreda allows its members to get services from Black Lion and Saint Paulos referral hospitals in Addis Ababa (Table 5.7).

[6] For example, in Amhara region, CBHI members in Tehuledere woreda can seek services at five health centers and Boru Meda hospital, all outside Tehuledere, in addition to the five health centers in Tehuledere. Residents of Debub Achefer can use two health centers outside the woreda. Similarly, residents of Damboya in SNNP can use one health center outside the woreda.

Table 5.7: Referral system

Region	Pilot woredas	Referral hospitals
Amhara	South Achefer	Felege Hiwot
	Fogera	Felege Hiwot and Debre Tabor
	Tehuledere	Dessie
Tigray	Kilte Awlaelo	Wukro, Mekelle and Ider
	Ahferom	Axum, Adwa, Mekelle and Ider
	Tahitay Adiabo	Axum, Suhul, Mekelle and Ider
Oromia	Gimbichu	Bishoftu and Adama
	Kuyu	Fichie, Adama, Tikur Anbesa, Saint Paulos
	Deder	Deder and Dire Dawa
	Limmu Kossa	Limmu Genet and Jimma
SNNP	Yirgalem town	Yirgalem
	Damboya	Durame
	Damot Woyde	Wolayta Sodo

Source: KIIs

Almost all health facilities visited asserted that they provide all services that are expected to be delivered at their level. However, some CBHI members are referred to higher-level government or private health facilities to access missing services such as CT scan, ultrasound, and in some cases X-ray. The retained revenue (from fees and CBHI reimbursements) generated by the facilities, particularly by the health centers, has enabled facilities to buy some of the required medical equipment.

All KII respondents (heads of visited health facilities, CBHI scheme managers, WorHOs, etc.) felt that CBHI has increased health service utilization because of the financial protection it offers, the awareness creation efforts made during scheme establishment, and the ongoing health-related lessons provided by the facilities, health extension workers, and the Health Development Army. FGDs with CBHI members in all pilot woredas confirmed that their health-seeking behavior has changed significantly: they not only seek services more, but they also seek them immediately when they feel sick.

The evaluation team tried to confirm this using secondary data collected from contracted heath facilities by comparing before and after CBHI. However, lack of consistent and reliable facility-level data made the comparison impossible.

Despite the increase in service utilization, the data from the household survey does not show a major difference in service utilization between members and non-members. This needs further investigation whether there is a response bias. Out of the 1,464 individuals who reported illness in the reference period (the four weeks preceding the survey), 689 were from CBHI member households and 583 were from non-member households (Table 5.8). Of those who reported illness, 1,049 individuals (71.7 percent) reported visiting health facilities. When we disaggregate this to members and non-members, 72.3 percent of members had visited health facilities while 69.3 percent of non-members from the pilot woreda and 76.6 percent from the control woreda also visited health facilities. The higher average from control woredas might have been a result of the smaller number of households sampled. The 72 percent average health facility rate by members is very close to the number of per capita visits (0.7) reported in Section 2. (We will further explore empirically the determinants of health seeking behavior and whether CBHI has an impact on changing the health seeking behavior of members relative to non-members (Table 5.13 and 5.14).)

Table 5.8: Seeking Health Care and Number of Visits

Distribution		Pilot woreda				Control woreda	
		CBHI Member		Non-CBHI member			
		#	(%)	#	(%)	#	(%)
Visiting health facilities for the illness felt in the last 4 weeks	Yes	498	72.3	404	69.3	147	76.6
	No	191	27.7	179	30.7	45	23.4
	Total	689	100	583	100	192	100
If yes, what type of service received	Outpatient	487	97.2	398	98.5	143	97.3
	Inpatient	14	2.8	6	1.5	4	2.7
	Total	501	100	404	100	147	100
Major reason for not visiting health facility	Did not feel it was necessary	90	47.4	75	42.61	22	48.9
	Facility too far	9	4.7	8	4.6	0	0
	Lack of money	30	15.8	54	30.7	16	35.6
	Problem of quality care	14	7.4	12	6.8	2	4.4
	Others	46	24.2	25	14.2	5	11.1
	Total	190	100	176	100	45	100
Number of visits	One time	368	73.5	298	73.0	107	73.8
	Two times	73	14.6	64	15.7	12	8.3
	Three times	60	12.0	46	11.3	26	17.9
	Total	501	100	408	100	145	100
Type of facility visited	HP	30	6.0	7	1.2	9	6.2
	HC	310	61.9	227	56.5	80	54.8
	Private clinic	64	12.8	95	23.6	27	18.5
	Public hospital	86	17.2	64	15.9	23	15.6
	Total	501	100	402	100	146	100

Source: Household survey

5.2.2 Service quality and patient satisfaction

We also explored the benefits that CBHI has brought to the quality of care, from the perspectives of health professionals, patients, and households.

In KIIs, health professionals in the visited health facilities asserted that establishment of CBHI schemes provided them with some degree of freedom to prescribe the appropriate diagnostic test and drugs without any worries about the ability of the CBHI member to pay. They explained that prior to CBHI they would either discuss with patients the patient's financial capacity or write prescriptions based on what they thought the patients could afford. CBHI has given them the freedom to order the appropriate prescription, which is a relief professionally and key to improve the quality of services.

The other factor that contributed to quality improvement in the health service is the ability of the CBHI schemes to mobilize financial resources and hence investment in the facility. As all contracted health facilities are implementers of health care financing reform, the resultant increase in patient flow due to CBHI scheme has increased the amount of resources in the hands of health facilities, allowing them to acquire more drugs, diagnostic facilities, and medical equipment. Furthermore, to

prepare for CBHI, additional resources were provided to contracted health facilities by the woreda, regional, and federal governments in cash and in kind to improve the quality of services.

There are, however, major challenges to the quality of services provided:

i. Contracted providers differ in their preparedness to deliver contracted services such as pharmacy services, laboratory facilities, reception, and other outpatient services, and this affects quality. There are also complaints about availability and quality of existing staff. As per the "Ethiopian Standard Agency" health centers (both rural and urban) are required to have 19 professionals and 13 support staff. However, Sulula health center in Tehuledere woreda (Rural HC) had 17 health professionals and eight support staff; while Woreta health center in Fogera woreda (Urban HC) had 33 health professionals and 24 support staff. This shows that variations on the availability of both professional and support staffs between these facilities.

ii. Contracted health facilities, especially in hospitals, experience drug stock-outs and so patients often must buy items from outside private retailers. Stock-outs in Pharmaceutical Fund and Supply Agency (PFSA) hubs have been the major reason that health facilities give for their own drug shortages. Fraud on the part of pharmacists at contracted health facilities – the pharmacists refer patients to private drug dealers who give them a "kickback" – is reported to exacerbate the shortage.[7]

These problems pose a major challenge to CBHI members, greater than to the general community. Paying out of pocket is a problem for members who have already paid a registration fee and premium and may have no household budget left for these contracted services. Even if a member has cash on hand, there are cases in SNNP where scheme bylaws prevent members from being reimbursed; in the other three regions, some members have received reimbursement at best and some none at all depending on whether they submit supporting documents. System-related challenges like the following are major problems:

Reimbursement first requires the pharmacist to put a stamp on the back of the prescription and record/register it in the member patient's file. Usually one of these procedures is not done. As a result, the member's reimbursement claim is rejected, leaving the member highly dissatisfied.[8]

Members patronize private drug dealers without full information on what is required for reimbursement (essentially, getting a receipt and submitting it with the prescription to the CBHI scheme), and again failure to follow procedures precludes reimbursement by the scheme.

Box 5.1: Best practices in handling CBHI member complaints

Amhara Region

In Amhara, woreda CBHI coordinators are trying to use CBHI General Assembly, board and annual meetings as public fora in which to hear and discuss members' comments and complaints. The FGDs participants in Tehuledere woreda also witnessed that these forums served this purpose and resulted in significant improvement in health service delivery both in the HCs and Dessie hospital.

SNNP Region

Although not specifically for CBHI, quarterly health facility forums chaired by WorHO Heads and Chief Administrators and attended by health facility managers and staffs, hear community feedback about the quality of the services provided in health facilities. Issues that can be resolved during the meeting are addressed immediately while those that need time are recorded, action taken later, and feedback provided to the community at the next forum. This has significantly improved service availability and quality in health facilities.

[7] This has been reported about one referral hospital in Amhara and one pilot woreda in Tigray.

[8] In KIIs, representatives of CBHI woreda offices and WorHOs and heads of contracted health facilities reported that health facilities failed to respect the contract, which requires health facilities to provide certain services. If a facility cannot do this, it supposed to contract with a third party to provide the service/s so that the CBHI member does not need to spend out of pocket.

Reimbursement requires members to travel to the woreda town – sometimes multiple times – on workdays to process and resolve issues regarding the reimbursement request.

iii. Medical equipment frequently breaks down, due mainly to absence of timely and proper maintenance but also negligence and mishandling by health workers.

iv. Neither CBHI offices nor WorHOs have a systematic mechanism by which to measure CBHI member satisfaction and collect and properly address complaints about the services provided by the schemes or the contracted health facilities. There are, however, best practices from which the woredas and regions can learn. Amhara (particularly in Tehuledere woreda) and SNNP regions used general assembly, board and annual meetings; and community fora respectively to treat this issue in an informal, non-standard way in the presence of health providers.

This assessment used PEIs to evaluate patients' perceptions about improvements in service quality since the CBHI schemes were established. Both CBHI members and non-members who were interviewed said they have seen improvements. As shown in Table 5.9, more CBHI members than non-members perceive improvement in all measures of quality of care.

Table 5.9: Patients' Perception of Improvement in Quality of Health Service Provision (%)

Improvement area	CBHI members			Non-CBHI non-members		
	Yes	No	Don't know	Yes	No	Don't know
Improvement in the overall quality	73.9	12.5	13.6	54.4	10.7	34.9
Availability of drugs/medical supplies	71.2	14.7	14.1	56.8	7.5	35.5
Availability of diagnostic facilities	73.2	12.8	14.0	52.7	10.3	37.0
Cleanliness of the facility	75.0	11.4	13.6	52.7	12.4	34.9
Short waiting time (from the time of arrival in the health facility up to seeing the health professional)	71.6	12.6	15.8	48.5	16.6	34.9
Short waiting time between services (between consultation and diagnostics)	72.1	12.0	15.8	48.5	17.2	34.3
Friendliness of staff	71.6	15.3	13.1	52.4	13.1	34.5
Attentiveness and adequate follow-up by the nursing staff (inpatient only)	87.5	0	12.5			
Quality of food and other inpatient facilities (inpatient only)	87.5	0	12.5			

Source: PEIs

The PEIs also asked patients to rate their level of satisfaction, from very satisfied to very dissatisfied, in the above areas. About 90 percent of respondents were either satisfied or very satisfied in all quality improvement areas. As seen in Table 5.10, there was no significant difference between members and non-members.

Table 5.10: Patients' level of satisfaction with service quality (%)

Quality measures	CBHI members				Non-CBHI non-members			
	Very satisfied	Satisfied	Neutral	Dissatisfied and very dissatisfied	Very satisfied	Satisfied	Neutral	Dissatisfied and very dissatisfied
Improvement in the overall quality of service	54.9	36.4	5.4	3.3	50.4	38.5	6.8	4.4
Availability of drugs/medical	54.1	37.7	4.9	3.3	50.9	40.8	6.5	1.8
Availability of diagnostic facilities	54.3	36.7	4.5	4.5	48.3	42.1	7.0	2.6
Cleanliness of the facility	52.7	38.6	6.5	2.2	48.9	41.3	6.5	3.3
Short waiting time (from the time of arrival in the health facility up to seeing the health professional)	52.5	36.1	6.5	4.9	44.6	39.6	8.3	7.5
Short waiting time between services (between consultation and diagnostics)	56.0	35.3	6.0	2.7	46.0	39.9	7.6	6.5
Friendliness of staff	56.8	35.5	5.5	2.2	50.9	41.2	4.3	3.6
Attentiveness and adequate follow-up by the nursing staff (inpatient only)	75.0	18.7	6.3	0	87.5	0	0	12.5
Quality of food and other inpatient facilities (inpatient only)	68.7	12.5	6.3	12.5	62.5	12.5	25.0	0

Source: PEIs

The household survey also assessed patients' perceptions about improvements in service quality. In regard to outpatient visits, more than 80 percent of the CBHI members were satisfied or very satisfied by the diagnosis, the cleanliness of the facility, and the courtesy of the staff. Non-CBHI members reported similar satisfaction levels (see Table 5.11).

Table 5.11: Outpatients' levels of satisfaction

Distribution			Pilot woreda				Control woreda	
			CBHI member		Non-CBHI member			
			Freq.	(%)	Freq.	(%)	Freq.	(%)
Level of satisfaction	Diagnosis	Very satisfied	148	30.1	140	35.1	51	35.2
		Satisfied	260	52.8	199	49.9	70	48.3
		Indifferent	51	10.4	43	10.8	15	10.3
		Dissatisfied	28	5.7	13	3.2	8	5.5
		Very dissatisfied	5	1.0	4	1.0	1	0.7
		Total	492	100	399	100	145	100
	Cleanliness	Very satisfied	133	27.0	121	30.3	46	31.5
		Satisfied	291	59.2	232	58.2	85	58.2
		Indifferent	53	10.8	38	9.5	14	9.6
		Dissatisfied	11	2.2	6	1.5	1	0.7
		Very dissatisfied	4	0.8	2	0.5	0	0
		Total	492	100	399	100	146	100
	Courteousness	Very satisfied	157	31.9	149	37.3	46	31.5
		Satisfied	249	50.6	189	47.4	72	49.3
		Indifferent	50	10.2	45	11.3	17	11.6
		Dissatisfied	28	5.7	12	3.0	9	6.2
		Very dissatisfied	8	1.6	4	1.0	2	1.4
		Total	492	100	399	100	146	100
	Waiting time	Very satisfied	138	28.1	126	31.6	47	32.2
		Satisfied	192	39.0	163	40.8	59	40.4
		Indifferent	86	17.5	55	13.8	24	16.4
		Dissatisfied	63	12.8	45	11.3	14	9.6
		Very dissatisfied	13	2.6	10	2.5	2	1.4
		Total	492	100	399	100	146	100
	Availability of drug	Very satisfied	133	27.3	120	30.2	41	27.9
		Satisfied	251	51.5	192	48.2	74	50.3
		Indifferent	50	10.3	53	13.3	15	10.2
		Dissatisfied	39	8.0	28	7.0	15	10.2
		Very dissatisfied	14	2.9	5	1.3	2	1.4
		Total	487	100	398	100	147	100

Distribution		Pilot woreda				Control woreda	
		CBHI member		Non-CBHI member			
		Freq.	(%)	Freq.	(%)	Freq.	(%)
Waiting time	Less than 30 min	262	54.2	250	62.6	91	61.9
	30-60 min	143	29.6	96	24.0	30	20.4
	1-3 hours	52	10.8	31	7.8	19	12.9
	3-6 hours	20	4.2	11	2.8	4	2.7
	>6 hours	6	1.2	11	2.8	3	2.1
	Total	483	100	399	100	147	100
Availability of drugs/supplies	Not available	32	6.9	12	3.0	4	2.9
	Rarely	171	36.6	131	33.1	54	38.8
	Always	264	56.5	253	63.9	81	58.3
	Total	467	100	396	100	139	100

Source: Household survey

The household survey also queried respondents about their level of satisfaction on services they received during their admission some time ago. As seen in Table 5.12, there is no significant difference between the responses of CBHI members and non-members. Indeed, most non-members were more satisfied than members. This might be related to higher expectations of members or response bias of non-members (the tendency to provide positive responses even if that is not true response).

Table 5.12: Inpatients' level of satisfaction

Distribution		Pilot woreda				Control woreda	
		CBHI members		Non-CBHI members			
		Freq.	(%)	Freq.	(%)	Freq.	(%)
Diagnosis	Very satisfied	20	50	12	48	8	61.54
	Satisfied	11	27.5	9	36	3	23.08
	Indifferent	5	12.5	3	12	0	0
	Dissatisfied	2	5	1	4.00	1	7.69
	Very dissatisfied	2	5	0	0.00	1	7.69
	Total	40	100	25	100.00	13	100
Cleanliness	Very satisfied	24	39.34	15	36.59	10	58.82
	Satisfied	22	36.07	22	53.66	6	35.29
	Indifferent	11	18.03	2	4.88	1	5.88
	Dissatisfied	4	6.56	1	2.44	0	0.00
	Very dissatisfied	0	0	1	2.44	0	0.00
	Total	61	100	41	100	17	100

Distribution		Pilot woreda				Control woreda	
		CBHI members		Non-CBHI members			
		Freq.	(%)	Freq.	(%)	Freq.	(%)
Courteousness	Very satisfied	22	36.67	13	31.71	10	58.82
	Satisfied	25	41.67	24	58.54	7	41.18
	Indifferent	8	13.33	3	7.32	0	0
	Dissatisfied	3	5	1	2.44	0	0
	Very dissatisfied	2	3.33	0	0	0	0
	Total	60	100	41	100	17	100
Waiting time	Very satisfied	21	34.43	15	36.59	10	58.82
	Satisfied	27	44.26	22	53.66	6	35.29
	Indifferent	9	14.75	3	7.32	0	0
	Dissatisfied	2	3.28	0	0	1	5.88
	Very dissatisfied	2	3.28	1	2.44	0	0
	Total	61	100.00	41	100	17	100
Drug supplies	Very satisfied	21	34.43	11	26.83	8	47.06
	Satisfied	20	32.79	25	60.98	6	35.29
	Indifferent	14	22.95	1	2.44	3	17.65
	Dissatisfied	5	8.20	4	9.76	0	0
	Very dissatisfied	1	1.64	0	0	0	0
	Total	61	100	41	100	17	100
Bed cleanliness	Very satisfied	16	26.23	13	31.71	8	47.06
	Satisfied	22	36.07	22	53.66	6	35.29
	Indifferent	17	27.87	4	9.76	3	17.65
	Dissatisfied	6	9.84	2	4.88	0	0
	Very dissatisfied	0	0	0	0	0	0
	Total	61	100	41	100	17	100
Staff care	Very satisfied	18	29.51	12	29.27	9	52.94
	Satisfied	30	49.18	26	63.41	6	35.29
	Indifferent	9	14.75	2	4.88	2	11.76
	Dissatisfied	2	3.28	1	2.44	0	0
	Very dissatisfied	2	3.28	0	0	0	0
	Total	61	100	41	100	17	100

Source: Household survey

The above points are anecdotal. In addition to collecting such information, the assessment also tried to estimate the impact of CBHI on health care utilization by employing an econometric method as discussed in Section 1.3.2. Equation 3 is estimated using three different control groups (non-members in pilot, control and both pilot and control woredas), individuals: model 1 compares CBHI members against non-members in pilot woredas, model 2 compares members in pilot woredas against non-members in the control woreda; and model 3 compares members in pilot woredas against all non-members in both pilot and control woredas using a logistic regression model. As shown in Table 5.13, CBHI members are more likely to seek health care when they feel ill. It is estimated that a CBHI member visiting a health facility when falling sick is 26.3 percent more likely than a non-members doing so in the pilot woredas and 20 percent more likely than overall non-members (in pilot and control woredas). This is consistent with the findings reported in the descriptive statistics.

Table 5.13: Regression results of health care utilization

Variables	Model 1	Model 2	Model 3
CBHI status	0.263*	-0.286	0.201
	(0.144)	(0.255)	(0.140)
Household size	0.0858**	0.120**	0.0987***
	(0.0351)	(0.0565)	(0.0337)
Head age	-0.0111**	0.00288	-0.00905**
	(0.00481)	(0.00746)	(0.00461)
Tropical Livestock unit	-0.0431**	-0.00312	-0.0364**
	(0.0185)	(0.0291)	(0.0181)
Constant	0.874**	0.126	0.606*
	(0.381)	(0.603)	(0.358)
Observations	1,051	519	1,173

Source: Household survey

Note: For readability purposes, we did not report the values of the coefficient of the following explanatory variables: household head sex and literacy, per capita expenditure, land size covered by crops, and regional variations. All are statistically insignificant.

Standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1

The frequency of health care utilization (Equation 4) is estimated using same three control groups, using zero truncated negative binomial model (see Section 1.3.2 for the explanation). As observed in Table 5.14, CBHI membership has significantly increased the intensity/frequency of health care utilization. This does not hold true when CBHI members are compared against non-members from the control woreda. The coefficient for CBHI, 0.31, is statistically significant at 5 percent level and indicates that the log count of the intensity of health facility visits for CBHI members is 0.31 more than for non-members in the pilot woreda.

Table 5.14: Regression results of frequency of health care utilization

Variables	(Model 1)	(Model 2)	(Model 3)
CBHI status	0.310**	-0.0790	0.230*
	(0.135)	(0.178)	(0.130)
Head literate	0.191	0.346**	0.257*
	(0.146)	(0.171)	(0.137)
Land size covered by crops	-0.174*	-0.214*	-0.123
	(0.0957)	(0.120)	(0.0831)
Tigray	-0.117	-0.387	-0.262
	(0.220)	(0.267)	(0.213)
Oromia	0.425**	0.311	0.424**
	(0.194)	(0.227)	(0.184)
SNNP	0.208	0.0125	0.246
	(0.210)	(0.243)	(0.196)
Constant	-0.455	-0.114	-0.536
	(0.417)	(0.475)	(0.397)
Observations	738	382	832
Alpha	0.40	0.11	.47
(LR test against Poisson, chi2(1)	667.55***	308.64***	739.33***

Source: Household survey

Note: For readability purposes, we did not report the values of the coefficient of the following explanatory variables: Per capita expenditure, household size, sex and age of household head, and TLU. All are statistically insignificant.
Standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1

5.2.3 Service provider and patients' moral hazard

A major issue that emerged from KIIs with heads of contracted health facilities, WorHOs, and CBHI offices and FGDs with CBHI members and contracted health facility workers was moral hazard by both providers and CBHI members. Provider staffs raised a number of ways in which some CBHI members, who no longer need to pay at point of service, misperceive their CBHI entitlements and overuse health care services:

- Members are rude in demanding their rights; for example, some expect to be seen without waiting their turn in the queue;
- They demand to be prescribed a particular drug without waiting for the decision of the health worker;
- They return to the facility before finishing the prescribed drug regimen and demand another treatment;
- They demand unnecessary diagnostics, injections, and prescriptions;

- They ask for drugs for their children without bringing the child in for a consultation and diagnosis;
- They demand referral before using services of a lower-level facility;
- They demand services without presenting a valid membership card.

Providers also pointed out that CBHI has increased their workload without increasing their financial (salary) and/or non-financial compensation.

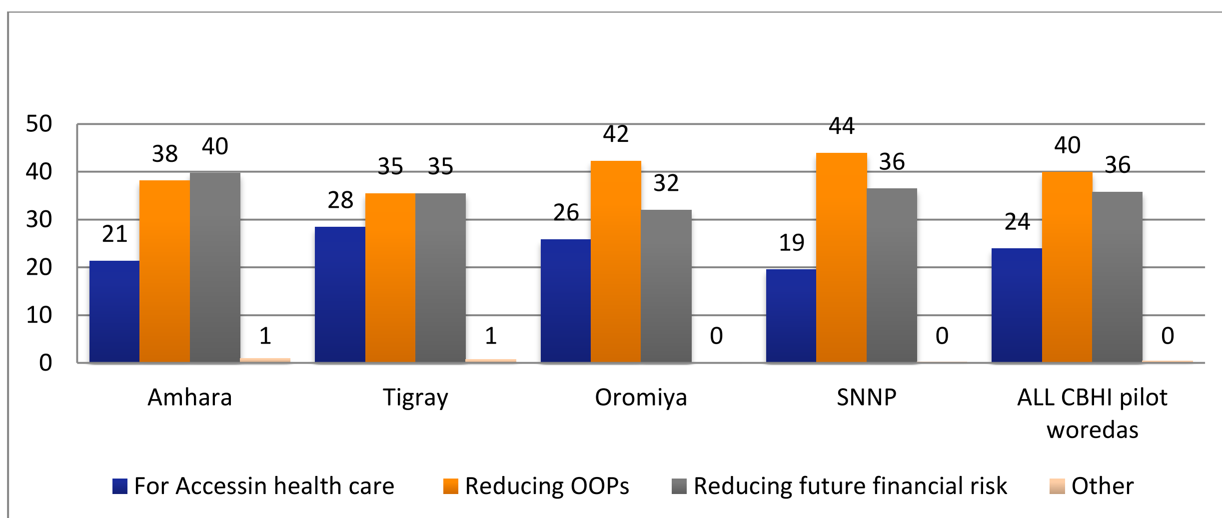
There also have been cases of reported moral hazard on the part of providers and their staff, such as the following:

- Lack of courtesy and poor treatment by some staff, especially at the health center level;
- Over-prescription of services including drugs and diagnostics; prescribing drugs with similar effect/function at the same time; prescribing the same medicine repeatedly although it is not helping the patient;
- Unnecessary referral to private wings and private clinics or else providing long appointments etc. at the hospital level; and
- Irregularities during medical audit.

5.3 Improving Financial Access/Financial Risk Protection

Of the total CBHI members surveyed in this evaluation, 82 percent have used their membership to access health care. When asked what benefits they gained as a result of membership, 40 percent stated that CBHI reduced their OOP payments; another 36 percent stated that it will reduce the risk of future spending on health, and another 24 percent responded that it increased their access to care (see Figure 5.4).

Figure 5.4: Reported Benefits of CBHI Membership



Source: Household survey

The analysis of the PEIs shows that very few CBHI members incurred OOP expenses during their visit to a facility. Of the total 184 members interviewed, only four paid for the consultation, three for diagnostics, and five for drugs. In contrast, of the 278 non-CBHI members interviewed in the pilot and control woredas, 244 paid for the consultation, 110 for diagnostics, and 249 for drugs (see Table 5.15). The average per person payment of members (Birr 13) is half that of non-members (Birr 26). This is likely due to the fact that there are few observations relating to drugs and inpatient services with average payments of ETB 224.9 and 766 respectively that biased the mean in the case of CBHI members.

Table 5.15: Incidence of and Average OOP Payments by CBHI Members, from PEI Survey

Service for which OOP payment incurred	CBHI members			Non-CBHI members		
	# cases with OOP payment	Average payment (Birr)	% of total observation	# cases with OOP payment	Average payment (Birr)	% of total observation
Consultation	4	9.3	2.2%	244	6.4	87.8%
Diagnosis	3	45.0	1.6%	110	23.4	39.6%
Drugs	5	225.0	2.7%	249	42.5	89.6%
Inpatient	1	766.0	0.5%	5	132.0	1.8%
Transport	7	41.4	3.8%	16	31.0	5.8%
Total PEI respondents/observations	184	12.8		278	25.8	

Source: PEIs

Similarly, we estimated and compared the incidence of OOP payments and average OOP payments between members and non-members using descriptive statistics (see Table 5.16). The incidence of OOP payment was more for non-members for all service categories. The difference here is that in all categories, the average OOP payment was lower for members than for non-members. Members pay on the average about half of non-member OOP payments when accessing care.

Table 5.16: Incidence of and average OOP payments made by CBHI members and non-members, household survey

Service for which OOP payment incurred	CBHI members		CBHI non-member	
	# HHs reported OOP	Average payment (Birr)	# HHs reported OOP	Average payment (in Birr)
Transport	59	20.02	68	25.72
Consultation	36	1.25	59	9.6
Diagnosis	35	19.86	51	50.96
Drug	40	41.03	58	80.02
Total HH members visited facility	159	22.40	124	44.65

Source: Household survey

Given the above descriptive statistics, it is necessary to go beyond the averages. For that, we tried to explore the extent to which households risk falling below a defined poverty threshold due to OOP health expenditure and the changes in the magnitude and depth of impoverishment.

By using the non-food consumption expenditure, payment for health (including transport) showed a significant impact on household impoverishment. At a 15 percent threshold, about 7 percent of CBHI members are impoverished by OOP payments on health. The corresponding impoverishment level for non-members is 19 percent. The figures at a 25 percent threshold are 3 percent for members and 9 percent for non-members. This shows that CBHI members have less chance to be impoverished as a result of OOP payments than non-members. The same analysis goes for poverty overshoot, the intensity of poverty (see Table 5.17).

Table 5.17: Poverty head count and overshoot between members and non-members due to OOP payments at 15% and 25% non-food expenditure thresholds

As a share of non-food expenditure	15%		25%	
	Mean	Std. Err.	Mean	Std. Err.
CBHI members				
Head count	6.83%	0.019	3.11%	0.0039
Overshoot	1.37%	0.007	0.93%	0.006
Mean positive overshoot	40.09%	0.147	30.09%	0.147
Non-CBHI members				
Head count	19.38%	0.040	9.18%	0.029
Overshoot	3.80%	0.0135	2.48%	0.011
Mean positive overshoot	37.09%	0.091	27.09%	0.091

Source: Household survey

We also attempted to estimate the head count, poverty gap, and normalized poverty gap for members and non-members by adopting Soumitra Ghosh's 2010 model (Ghosh 2010). In this model, while the poverty headcount measures the number of households living below the poverty line as a percentage of total households, the poverty gap captures the depth of poverty or the amount by which poor households fall short of reaching the poverty line. Since there are no universally accepted cut-off values or thresholds for defining the catastrophic nature of health care payments, generally, the catastrophic headcount has been defined as the percentage of households spending more than 5–25 percent of their total consumption expenditure on health care. However, it is evident from other empirical studies that 10 percent of total expenditure is widely accepted as the standard, because this represents an approximate threshold at which the household is forced to cut down on subsistence needs, sell productive assets, incur debts, or be impoverished (Van Doorslaer et al. 2006). In this evaluation, we used half and two-thirds of the median adult equivalent consumption expenditure as a cut-off point to calculate the head counts and poverty gaps.

Our estimate clearly shows that the poverty impact of OOP payments is less for CBHI members than for non-members. The estimate shows that an additional 1 percent of CBHI member households fell below the threshold poverty as a result of OOP payments. For CBHI non-members, it was 5.5 percent. The poverty gap for members was Birr 58, for non-members Birr 143. Table 5.18 presents the estimated head counts and poverty gaps for members and non-members.

Table 5.18: Estimated Impact of OOP Payments on Poverty Headcount and Poverty Gap on CBHI Members and Non-members

Poverty measures	CBHI member		Non- member		All	
Poverty Headcount (in %)						
Poverty line	1/2 [2]	2/3[3]	1/2	2/3	1/2	2/3
Pre-payment headcount (pre-HP)	13.75	28.14	17.35	27.55	14.73	28.68
Post-payment headcount (post-HP)	14.94	26.62	22.83	31.52	18.29	31.30
Poverty impact-head count (post-HP- pre-HP)	1.19	-1.52	5.48	3.97	3.56	2.62
Poverty gaps (in birr)						
Prepayment gap (Pre-G)	77.14	220.15	127.63	328.11	90.70	259.18
Post payment gap (Post-G)	134.81	360.93	270.55	647.49	167.08	452.65
Poverty impact-gap (Post-G- Pre-G)	57.67	140.78	142.92	319.38	76.38	193.47
Normalized poverty gaps (in %)						
Prepayment normalized gap (pre-NG)	3.57	7.634	4.77	9.20	3.89	8.34
Post payment normalized gap (Post-NG)	4.34	8.71	6.54	11.74	4.86	9.89
Normalized poverty impact (Post-NG- pre-NG)	0.77	1.076	1.77	2.54	0.97	1.55

Source: Household survey

Note: HP=poverty head count, G=poverty gap, NG=normalized poverty gap

[1] Members and non-members at household level in the pilot woreda

[2] Half of the median of the respective per adult equivalent consumption expenditure

[3] Two-thirds of the median of the respective per adult equivalent consumption expenditure

To analyze catastrophic health expenditures in more detail, a regression analysis, based on a dichotomous choice (logistical regression) model, was developed to predict the probability of catastrophic health expenditures in households. The share of health care expenditure in non-food expenditure is equal to 1 if the share is greater than a 15 percent (model 1) and 25 percent (model 2) threshold level and 0 otherwise. Our estimate clearly shows that, controlling for other factors, being a member is negatively related to impoverishment due to OOP payments. The estimate is significant at 1 percent degree of confidence (see Table 5.19).

Table 5.19: Regression result of the impact of CBHI membership on levels of impoverishment

Variable	(Cut off 15%)	(Cut off 25%)
	Model 1	Model 2
CBHI membership status (1=CBHI member)	-1.405***	-1.347*
	(0.532)	(0.736)
Household size	0.0650	0.0474
	(0.133)	(0.180)
Sex of head of HH (1=Male)	-0.282	-0.686
	(0.622)	(0.798)

Variable	(Cut off 15%)	(Cut off 25%)
	Model 1	Model 2
Age of head of HH	0.0357**	0.0221
	(0.0174)	(0.0227)
Literacy level of HH head (1=literate)	-0.572	-0.659
	(0.622)	(0.910)
TLU	-0.0804	-0.180
	(0.124)	(0.214)
Land size covered by crops	-0.918*	-1.338
	(0.543)	(1.004)
Per capita expenditure	0.000838	0.000115
	(0.000995)	(0.00141)
Tigray	-0.429	-0.687
	(0.841)	(1.338)
Oromia	0.400	0.530
	(0.718)	(1.036)
SNNP	0.671	0.874
	(0.720)	(0.985)
Constant	-2.713**	-1.853

Source: Household survey

Standard errors are in parentheses. *** $p<0.01$, ** $p<0.05$, * $p<0.1$

All three estimates clearly show that OOP payments in general have an impoverishing impact on households. However, the impact on CBHI members is much less than that of the non-members. With the likelihood that user fees will be revised upward to reflect the changes in the cost of care, this impact will likely grow. The analysis, therefore, provides evidence that scaling up CBHI schemes in other woredas will have a beneficial pay-off by reducing the incidence and severity of poverty in those woredas.

Box 5.2: Best experience in CBHI scheme ownership and leadership, Damot Woyde, SNNP

Damot Woyde woreda is the best performer in terms of giving guidance to and ensuring the sustainability of its CBHI scheme. There is good ownership at the woreda level. There are regular Board of Directors and General Assembly meetings and quarterly reviews of performance at which regional, woreda, kebele/Tabia, and community representatives discuss progress and challenges with the CBHI scheme. In addition, the various officials at woreda level get up-to-date information about CBHI performance as confirmed during KIIs. All KII respondents agreed that the woreda chief administrator is quite strong and experienced in leading CBHI issues. They also stated that there is good follow-up on CBHI, for example: 1) each woreda cabinet member is given CBHI as a major priority area to closely follow-up; and 2) there is a monthly review of premium collection and the deposit from each kebele.

Such strong ownership and commitment by woreda officials has translated into immediate results. Accordingly, the Damot Woyde scheme is the only scheme in SNNP that is operating at a surplus. The scheme also pays health facilities on time. In addition, a visit to CBHI office shows that it is well organized, with good record keeping and compilation capacity. All required data were readily available and compiled into six-month and annual performance reports, something not seen in any other pilot woreda in the SNNP.

5.4 Roles of Different Parties on CBHI Design, Implementation and Management

5.4.1 Governance and Management of CBHI Schemes

CBHI regional steering committees have been functional lately. Zones had little or no role in the CBHI implementation, though this is changed in the pilot expansion woredas. Woreda steering committees were established, but they are also not functional – currently the woreda cabinet is involved in CBHI implementation. At the kebele/tabia level, provisional KHIICs were established, but now there are only the regular kebele/tabia management structures, which are involved in premium collection on voluntary basis.

Woreda schemes are housed within the woreda administration; the scheme thus gets free office space, along with utilities, transport, and communication services, and stationery supplies. Two schemes in Tigray namely Ahferom and Tahitay Adiabo are located in the premises rented from private landlords. This has an impact on the moral of staffs and limited their day-to-day personal interactions with woreda officials. The woreda administration pays salaries of the CBHI executive staffs. Furthermore, CBHI schemes receive operational budget from woreda administration though it is usually tight.

CBHI directives task woreda administrators and their offices with providing leadership to the scheme including setting up the General Assembly and the Board of Directors, and ensuring that these governance bodies meet regularly and often, and provide the required leadership to the scheme. However, in all pilot woredas except Damot Woyde, this is barely happening. General Assemblies meet annually in all pilot regions. In most schemes, the board does not meet regularly, meaning that important decision making is delayed or does not happen. For example, the board of the Yirgalem scheme used to meet when CBHI started (in 2010/11 and 2011/12); it has not met since then. Boards and General Assemblies in pilot woredas in Amhara region (except in Fogera woreda) used to have quarterly meetings attended by members and health facility staff, to solicit feedback and then deliberate and make the necessary corrections. Regular meetings stopped when HSFR/HFG per diem support ended. In addition, the number of representatives from the community has been reduced from nine to four. The board in Tehuledere woreda (Amhara) no longer has representatives from the community; the remaining three board members are from the woreda government. Frequent turnover of woreda administrators is another reason for irregular board meetings. For example, since CBHI was launched two and half years ago, the mayor of Yirgalem City has been changed three times.

Recently, there have been attempts to close this gap in leadership. For example, the Yirgalem City mayor has assigned each sub-city with closely following up and reporting weekly on CBHI progress. In Damboya (SNNP), CBHI is a regular agenda item in weekly Cabinet meetings. Each Cabinet member is given list of kebele/tabias to follow up – membership renewal, contribution collection, and so forth are monitored and reported on. Tehuledere woreda has adopted a similar practice.

The weak leadership and commitment at the woreda level is affecting progress at the kebele/tabia level. Kebeles/Tabias are responsible for member registration, follow-up, and collection and deposit of premiums. However, major gaps have been documented. Almost all regional assessments reported that Kebeles/Tabias have too many other workload demands and lack incentive to carry out their CBHI tasks. There is no staff assigned to carry out CBHI tasks at the kebele/tabia level; hence, busy staff members do it on voluntary basis. Also, kebele/tabias lack a budget to cover travel expenses of officials who travel to woredas to deposit CBHI funds or to do other tasks. Thus, collected funds are not often deposited promptly. Kebeles/Tabias do not continually remind members to renew membership. When households do pay, payment information on their member ID cards is not updated on a timely basis – there have been reports of ID cards not being stamped or receipts not issued for several months. Thus, health facilities cannot serve them without charge. This has discouraged membership renewal in some woredas. In Tigray and Oromia regions,

kebele/tabia administrations have been accused of renewing delayed memberships without enforcing the one-month waiting time and without collecting back payment; this practice encourages households to renew only when health service is needed immediately, pushing the scheme toward financial difficulty. In addition, financial mismanagement has been reported in a few woredas, for example:

- In 2004 EFY (2011/12) in Damboya woreda (SNNP), one kebele/tabia general manager was caught collecting a premium without issuing a receipt. Another general manager, also in Damboya, was caught depositing Birr 40,000 into his personal account. The money was immediately returned and the general manager terminated.
- In Fogera woreda (Amhara), one CBHI scheme employee stole Birr 600,000 and disappeared. After long discussion, the regional government replaced the money stolen by the employee. This practice of the region can be used to convince the community that their money is secured and the government is playing the role of the last resort insurer.
- In Kuyu woreda (Oromia), Birr 50,000 was collected but not deposited in the CBHI account and 103 receipts are in the hands of kebele/tabia chairpersons. As a result, the scheme didn't undertake financial audits.

One important way in which the government is showing its commitment to CBHI is the provision of general and targeted subsidies. As has been described, regions and woreda administrations provide the targeted subsidy to cover the membership of indigent households. The FMOH and lately EHIA through the general subsidy subsidize 25 percent of premiums based on enrollment. When CBHI started, the FMOH provided Birr 40,000 for each contracted health center to support procurement of drugs, medical supplies, and/or equipment. In a few cases, the regional government sent resource to health centers to fulfill some essential missing infrastructure such as electricity/generator, water supply, shelves and tables, and doors and windows. For example in SNNP, health centers in Damot Woyde woreda received Birr 360,000 and those in Damboya received Birr 301,000.

Findings show that the woreda subsidy is deposited into the CBHI account on time but the federal subsidy is not. At the time of this assessment, the SNNP subsidy from the federal government had been delayed for almost six months. Closer investigation of the indigent financing process at the woreda level highlighted major gaps. Woredas' budget constraints in all four regions have resulted in under coverage of deserving indigent families. In Tigray and Amhara, the situation is aggravated by the assumption that 10 percent of the population of each woreda is indigent, which is far from the reality. Recently, Amhara changed this approach to assume that 10 percent is indigent only in food-insecure woredas, and 5 percent in food-secure woredas. FGDs in Tigray documented the agreement of almost all participants that the process of indigent selection in each kebele/tabia is fair and transparent.

Apart from government bodies, an important participant in CBHI design and implementation is the HSFR/HFG project, which provides the schemes with major technical, financial, and in-kind support. The project assisted CBHI from the beginning, conducting the feasibility study, drafting the directive/operational manual, designing the model for the schemes, and participating in the training and sensitization of regional and woreda managing bodies, community elders/leaders, and the community. In the early days, the project assigned a full-time CBHI coordinator to each pilot scheme and in the larger woredas an additional technical/field officer. The project supported CBHI offices with computers, furniture, and consumable items. It is still following the operation of the schemes, encouraging regular meetings of board and General Assemblies.

Community groups are other key stakeholders in CBHI. Community members have permanent seats on the high-level decision-making bodies of CBHI. In the CBHI General Assembly, in addition to the two community representatives per kebele/tabia, the kebele/tabia chairman and got leader are community representatives as they are community members elected by the community. Community representatives from selected Kebeles/Tabias, also represent the community on the Board of Board of Directors.

Also, one community member (two or more in Amhara) is represented on the Health Facility Management Board/Committee, a high-level management body for HFs. The board/committee is responsible for reviewing and approving the facility's annual operational and financial work plan, reviewing and approving its utilization plan for the internal revenue, approving user fee revision proposals, and other tasks.

In addition, a new quarterly health facility community forum was created in SNNP in 2005 EFY (2012/13). The WorHO and health facilities organize the forum, which is held in both health centers and hospitals. The WorHO /woreda administrator chairs the forum; community members, elders, religious leaders, and other community leaders and health facility staffs participate. The community raises issues/complaints they have with the health service in general and with the CBHI scheme in particular. Issues are discussed and, where possible, resolved. Those issues that cannot be resolved during the forum are registered by the WorHO for later action. The community is informed about the progress in the next forum. This forum has truly empowered the community and has gone a long way in improving the quality of health service. In Kuyu woreda (Oromia), CBHI members submitted complaints about the management of Kuyu hospital to the Zonal Health Desk, which resulted in a new hospital manager being appointed. Similarly, CBHI members in Limmu Kossa woreda call mobile numbers of the woreda administrator, WorHO head, and/or CBHI coordinator when they are dissatisfied with facility services.

5.5 Increased Resource Mobilization

5.5.1 Community premium contributions

The CBHI schemes have been able to mobilize contributions in all the pilot woredas. The mobilization appears to have been stronger in the initial mobilization period than in the recent years. The total amount of community contribution from the 13 pilot woredas through June 2013 was approximately Birr 22.7 million (see Table 5.20). By region, Amhara and Oromia have mobilized appreciably more than the other two regions. The early initiation of CBHI in Amhara as well as its higher enrollment rate is the reason for its better collection. Oromia's performance is explained by the fact that it has an additional (fourth) scheme and a higher premium than the other regions.

Table 5.20: Community contributions/premiums ('000 Birr)

Region/Woreda	Cumulative		
	Jun-11	Jun-12	Jun-13
Amhara Region			
S. Achefer	346.15	2,772.68	2,881.68
Fogera	272.37	1,761.27	1,670.21
Tehuledere	635.7	1,973.72	3,339.65
Total Amhara	**1,254.22**	**6,507.67**	**7,891.54**
Oromia Region			
Deder	287.28	1,496.00	1,293.32
Gimbichu	308.05	2,012.09	2,901.87
Kuyu	36.68	736.33	607.02
Limmu Kossa	12.28	1,200.00	1,610.99
Total Oromia	**644.29**	**5,444.42**	**6,413.20**

Region/Woreda	Cumulative		
	Jun-11	Jun-12	Jun-13
SNNP Region			
Yirgalem	29.59	245.89	406.05
Damot Woyde	295.88	736.84	1,219.09
Damboya	105.43	584.62	1,859.07
Total SNNP	**430.90**	**1,567.35**	**3,484.21**
Tigray Region			
Ahferom	54.65	1,949.44	2,056.58
Kilte Awlaelo	56.1	1,548.51	1,637.56
Tahitay Adiabo	24.29	840.91	1,184.09
Total Tigray	**135.04**	**4,338.86**	**4,878.23**
Grand Total	**2,464.45**	**17,858.30**	**22,667.18**

Source: HSFR/HFG Project

The major drivers of the community contribution rate are the enrollment rate, the proportion of non-paying members in the total CBHI membership, and the contribution level. Community contribution levels are not affected by the proportion of non-paying members as their share is covered by the woreda and/or regional governments are paying indigents' premiums. On the other hand, the lower the enrollment rate and/or contribution levels, the lower is the collection of contribution from the community. Table 5.21 shows the regional and national averages of the drivers of the premium collection from the community.

Table 5.21: Membership rate, contributions, and non-paying membership rate (June 2013)

Region	Enrollment rate (%)	Contributions per household per year (Birr)	% non-paying members from total enrolled HHs
Amhara	57.86	144	19.18
SNNP	61.20	126	6.15
Oromia	36.09	180	7.14
Tigray	47.36	132	5.00
National	47.88		15.44

Source: HSFR/HFG Project

As has been noted, community contributions have declined over the years. The decline in 2013 over 2012 suggests drop in both membership renewals and new registrations. Fogera woreda is one example of this: It was reported that about 33 percent of all its CBHI members in year 2013 were non-paying (subsidized) members and total membership declined by 23 percent from 2012. Such circumstances – where enrollment is low, membership is declining, and contributions are not paid by members of the community – jeopardizes the financial sustainability of a scheme. A large share of government-subsidized memberships raises the important question of the point of CBHI as compared with other forms of government financing (SHI and tax-based). The effectiveness and relevance of CBHI hinges on its ability to collect a reasonable share from the community.

5.5.2 Reimbursement to health facilities (in 000 Birr)

One of the expected benefits of CBHI is increasing the revenue that health facilities can generate and retain for their own use. Up to the end of June 2013, CBHI schemes reimbursed about Birr 21.4 million to contracted health centers and hospitals. KIIs and FGDs with health facility staff confirmed this.

Table 5.22: Reimbursement to health facilities

Region/Woreda	June 2012	June 2013
Amhara Region		
S. Achefer	399.81	2,080.11
Fogera	890.41	2,451.87
Tehuledere	1,283.86	3,033.38
Total Amhara	**2,574.08**	**7,565.37**
Oromia Region		
Deder	118	647.95
Gimbichu	60.65	633.01
Kuyu	73.37	202.99
Limmu Kossa	228.33	1,404.01
Total Oromia	**480.35**	**2,887.97**
SNNP Region		
Yirgalem	169.34	636
Damot Woyde	461.89	1,240
Damboya	339.7	1,713
Total SNNP	**970.93**	**3,588.90**
Tigray Region		
Ahferom	120.33	1,134.21
Kilte Awlaelo	146.57	687.02
Tahitay Adiabo	178.69	1,038.62
Total Tigray	**445.59**	**2,859.84**
Grand Total	**4,470.95**	**16,902.08**

Source: HSFR project

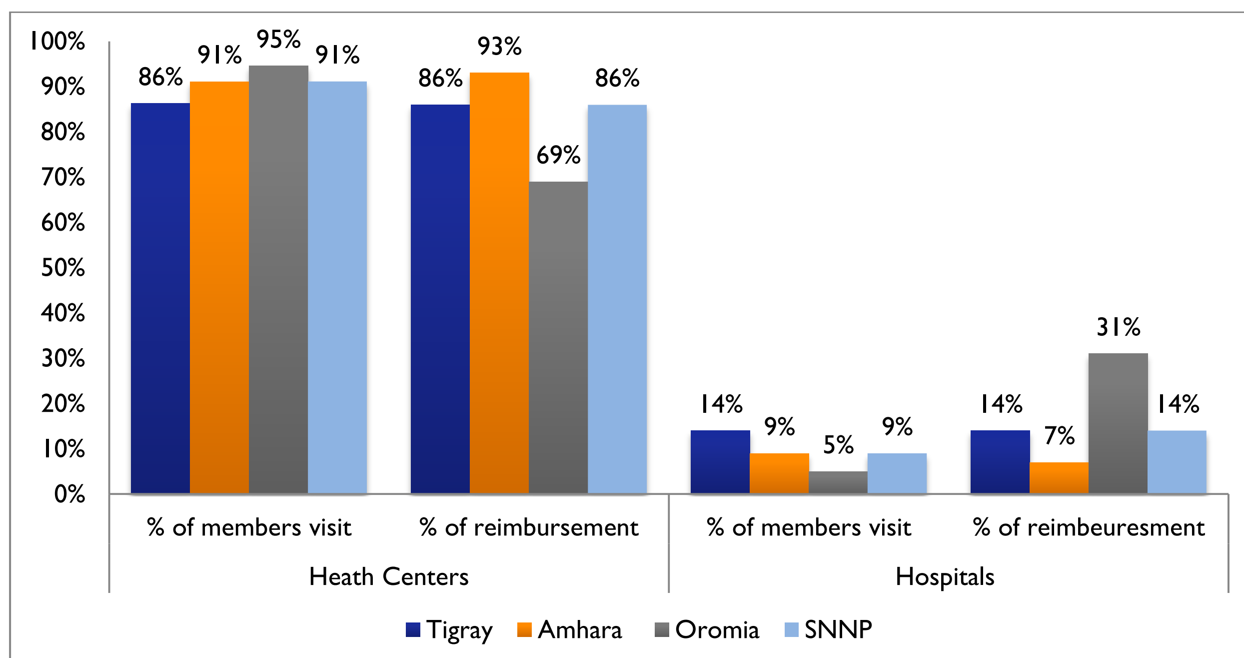
In 2011/12 and 2012/13 fiscal years, the majority of the reimbursement amount goes to health centers – in Amhara, SNNP, and Tigray, about 91 and 88 percent respectively (Table 5.23). This obviously means that hospitals get 9 and 12 percent of the reimbursed amount. In the case of Oromia, hospitals earned 41 and 31 percent of reimbursement in 2011/12 and 2012/13, respectively.

Table 5.23: Share of CBHI Reimbursements Paid to Health Centers and Hospitals

Regions	2011/12		2012/13	
	HC	Hospitals	HC	Hospitals
Amhara	95%	5%	93%	7%
Oromia	59%	41%	69%	31%
SNNP	96%	4%	90%	10%
Tigray	94%	6%	86%	14%
National	91%	9%	88%	12%

The data clearly show a link between utilization and reimbursement of health facilities in three regions (Amhara, SNNP, and Tigray) in 2012/13 (Figure 5.5). In Oromia, hospitals account only for about 5 percent of CBHI members' utilization but received about 31 percent of reimbursement in that year. This shows that, overall, CBHI schemes seem to provide the intended utilization (at lower-level facilities) and payment patterns. The reasons for the large share of reimbursement going to hospitals in Oromia need to be identified so as to reduce the undesirable impact on scheme financial status.

Figure 5.5: Utilization and CBHI Reimbursement in Health Centers and Hospitals, 2012/13



5.5.3 Government subsidies

As has been described, CBHI design in Ethiopia allows for three types of government subsidies to the schemes: targeted and general subsidies and financing the scheme management costs (salaries, office space, and operational costs). The regional and woreda governments finance premiums for indigents, using different arrangements. In Tigray, the region and woredas split targeted subsidy 70/30 percent. In Amhara, it is a 90/10 percent split. In SNNP and Oromia, woredas pay the entire contribution for indigents. Woredas pay scheme salaries and operational costs in all pilots. The federal government pays the 25 percent general subsidy, which is applied to premiums of all CBHI members, paying and non-paying.

Through the end of June 2013, the total amount of subsidy going to schemes in all 13 pilot woredas was Birr 16.5 million; the general subsidy was Birr 9.7 million and targeted subsidy was Birr 6.8 million. This represents about 42 percent of the total revenue generated by the schemes. General and targeted subsidies constituted 25 and 17 percent of the total revenue collected, respectively. Of the total revenue generated from all pilot schemes, 35.3 percent was from Amhara, 27.3 percent in Oromia, 24.2 percent in Tigray and 13.1 percent in SNNP. This is due to appreciable variation in the proportion of contribution collected and the targeted subsidy received from regional government and woreda administration. The general subsidy on the other hand is almost comparable across regions (Table 5.24).

Table 5.24: Government Subsidy to CBHI Pilot Schemes up to June 2013 ('000 Birr)

Region	Sources of finance					As % of total revenue generated by the schemes		
	Contribution	General Subsidy	Targeted Subsidy	Total	% of overall total	Contribution	General Subsidy	Targeted Subsidy
Amhara	7,891.54	3,469.71	2,462.70	13,823.95	35.3	57.1	25%	18%
Oromia	6,413.20	2,802.54	1,487.52	10,703.26	27.3	59.9	26%	14%
SNNP	3,484.21	1,393.18	260	5,137.39	13.1	67.8	27%	5%
Tigray	4,878.23	2,019.83	2,590.47	9,488.53	24.2	51.4	21%	27%
Total	**22,667.18**	**9,685.26**	**6,800.70**	**39,153.13**	**100**	**57.9**	**25%**	**17%**

Source: HSFR/HFG Project

In addition to the subsidies, government provides other support to schemes and providers. Woredas provide the schemes in-kind support in the form of office space, stationery, and transportation. They also pay salaries of the three CBHI staff. The FMOH has given each health center a subsidy of Birr 40,000 to improve availability of drugs and medical supplies. In addition, some regional governments gave grants to selected health centers to purchase missing infrastructure such as electricity/generator, water supply, shelves and tables, door/window, laboratory supplies. No hospital in any region reported CBHI-related support from the federal or regional government. The FMOH and RHBs provide technical assistance to CBHI-contracted health facilities.

The above arrangement clearly shows that there is very strong government commitment to CBHI. If this support continues during scale-up, it will have great financial implications for the governments. While this government support is one feature of the CBHI design, too much subsidy also negates the relevance and added value of CBHI. Scale-up should therefore balance effective premium mobilization and government financing.

5.5.4 Resource balance of the pilot program

As seen in Table 5.25, the pilot schemes have collected Birr 22.7 million as contributions from paying members and Birr 9.7 million and Birr 6.8 million from the general and targeted subsidy, respectively. They have reimbursed Birr 16.9 million to health facilities, which leaves a balance of Birr 22.3 million.

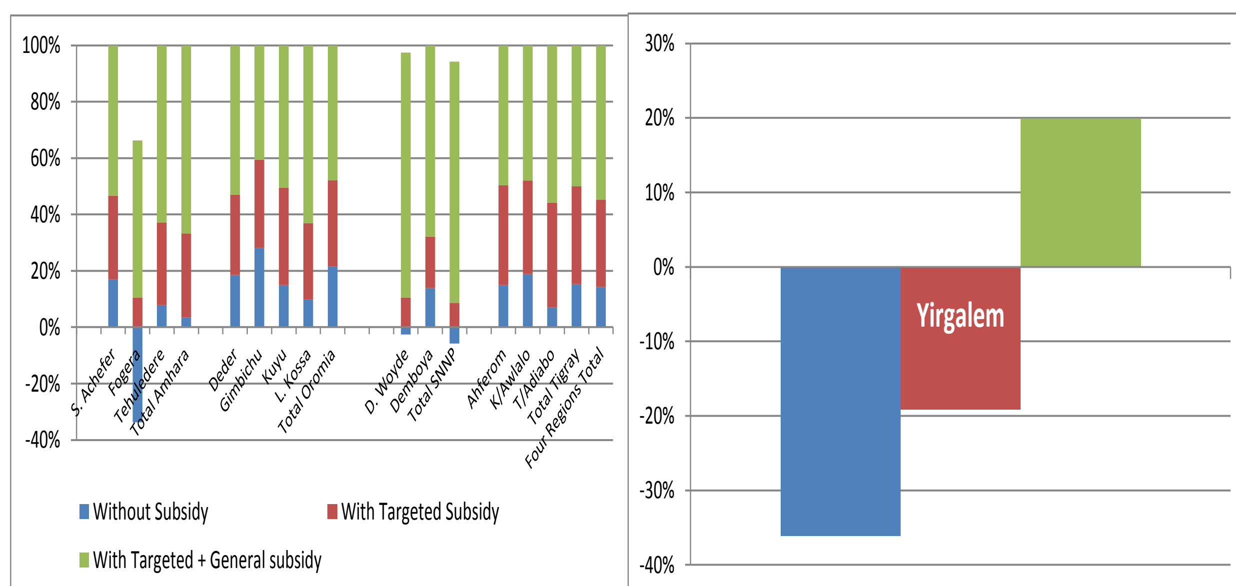
Table 5.25: Balance, all CBHI pilot schemes, June 2013 ('000 Birr)

Region/ Woreda	Premium collected	Targeted subsidy	General subsidy	Premiums + subsidy	Reimbursed to health facilities	Balance	
						Before general subsidy	After general subsidy
Amhara							
S. Achefer	2,881.68	609.02	1,116.55	4,607.24	2,080.11	1,410.59	2,527.14
Fogera	1,670.21	1,022.97	1,051.94	3,745.12	2,451.87	241.31	1,293.25
Tehuledere	3,339.65	830.72	1,301.22	5,471.58	3,033.38	1,136.99	2,438.21
Total Amhara	**7,891.54**	**2,462.70**	**3,469.71**	**13,823.95**	**7,565.37**	**2,788.87**	**6,258.58**
Oromia							
Deder	1,293.32	350	852.9	2,496.22	647.95	995.37	1848.27
Gimbichu	2,901.87	243.75	763.14	3,908.76	633.01	2512.61	3275.75
Kuyu	607.02	527.47	427.74	1,562.23	202.99	931.5	1359.24
L. Kossa	1,610.99	366.3	758.76	2,736.05	1,404.01	573.28	1,332.04
Total Oromia	**6,413.20**	**1,487.52**	**2,802.54**	**10,703.26**	**2,887.97**	**5,012.75**	**7,815.29**
SNNP							
Yirgalem	406.05	108	248.22	762.27	635.71	-121.66	126.56
D. Woyde	1,219.09	107	624.79	1,950.88	1,240.14	85.95	710.74
Damboya	1,859.07	45	520.17	2,424.24	1,713.06	191.01	711.18
Total SNNP	**3,484.21**	**260**	**1,393.18**	**5,137.39**	**3,588.90**	**155.31**	**1,548.49**
Tigray							
Ahferom	2,056.58	1,249.50	887.19	4,193.26	1,134.21	2,171.87	3,059.06
Kilte Awlaelo	1,637.56	723.58	747.67	3,108.81	687.02	1674.12	2421.79
Tahitay Adiabo	1,184.09	617.39	384.98	2,186.46	1,038.62	762.86	1,147.84
Total Tigray	**4,878.23**	**2,590.47**	**2,019.83**	**9,488.54**	**2,859.84**	**4,608.86**	**6,628.69**
Overall Total	**22,667.18**	**6,800.70**	**9,685.26**	**39,153.13**	**16,902.08**	**12,565.80**	**22,251.05**

Source: HSFR/HFG Project

As Figure 5.6 shows, overall, CBHI schemes were able to finance their costs from revenue generated from paying and non-paying members' contributions, the reimbursement made to the health facilities stands at about 75% of contributions. However, scheme in Fogera, Yirgalem and Damot Woyde have had negative balance (schemes owe more money from health facilities). The general subsidy is important for these schemes (Fogera, Yirgalem and Damot Woyde) to keep them solvent. When targeted subsidy is included, all woredas expect Yirgalem have had positive balance and the claims ratio 57.4 percent. When general subsidy is included to this total (contribution & targeted subsidy), the claims ratio become 43.2 percent. The schemes account balances are healthy though those in the SNNP appear to be weaker than other schemes.

Figure 5.6: Ability of Schemes to Finance Health Service Costs (in %)



Source: HSFR/HFG Project

It should be noted that in Oromia, despite a high level of hospital claims, the schemes have financial surpluses due mainly to lower utilization rates. In Tigray, woredas have done well in terms of resource mobilization over the entire period of CBHI but in 2013 there was a decline in members' contributions, especially renewals. This is partly because CBHI members are not fully aware that they have to contribute every year; also, some members are deliberately not renewing until they need health services, which they often get without waiting for one month as CBHI rules require. This "free-rider culture" jeopardizes scheme financial sustainability by distorting community expectations with false promises on what CBHI can deliver.

There are major but different reasons for the financial weakness of the three schemes named above. The financial status of Yirgalem suggests that the premiums and the benefit package are not appropriate for the urban context (see Box 5.3). In Fogera, absence of new enrollment, high dropout rate and increasing health services utilization rate are the major reasons for bad performance of the scheme during 2013. Deder woreda has seen a huge (83 percent) drop in member contributions, from Birr 1.2 million in 2012 to just over Birr 200,000 in 2013. The woreda is paying for members' health care services in 2013 with revenue from contributions in 2012 and from government subsidies. This portends future insolvency; the dramatic drop in enrollment calls for further investigation.

These findings suggest several points: First, the decline in membership must be reversed. Second, different design parameters may be needed for urban schemes, such as sliding-scale premiums that take into account differences in ability to pay. Third, a copayment may be needed, especially in urban woredas and others with high utilization rates. Finally, the current CBHI design has no provision for risk pooling among the pilot schemes – each scheme must cover all health service costs that accrue

to it. As it scales up CBHI, Ethiopia should consider establishing regional and national risk pools with clear scheme contribution criteria and assignment of regional and federal pool responsibilities.

5.6 Resource mobilization potential during the scale-up

5.6.1 Assumptions

The resource mobilization potential of CBHI schemes during scale-up has been explored based on three sets of assumptions. The first set is the policy decisions already made by each regional government for scaling up, particularly with regard to the number of expansion woredas, premiums and registration fees, scheme organization, indigents' coverage rate, and government subsidy structures. The second set assumes that scheme performance in terms of service utilization and reimbursements to health facilities will be similar to the averages of their respective regional pilot woredas. The third is related to the number of indigents to be financed by government. Here, three scenarios were considered: regional averages of pilot performance in each region; 10 percent of eligible households in woredas; and full coverage (29 percent of CBHI-eligible population, the percentage based on the national average poverty line) of people who are expected to be below poverty line. The projection is made only for a year and does not take into account any change such as inflation. It is assumed that the challenge of declining premium collection after initial kick-off will be rectified as there is no point to scale-up unless this situation is not addressed. The assumptions considered for projecting the resource mobilization potentials are summarized in Table 5.26.

Box 5.3: Lessons from Yirgalem woreda scheme

The financial status of the Yirgalem scheme is very weak and jeopardizes the existence of the scheme. The scheme has only Birr 68,000 in its bank account, and it owes health facilities Birr 352,283. It has not reimbursed health facilities for two quarters, which is affecting the quality and number of services the facilities are providing to scheme members. The main reasons for this dire financial situation are:

- As a city, health service utilization in Yirgalem is significantly higher than other pilot areas. The higher utilization is attributable to a high number of patients with
- Diabetes and other chronic conditions; these patients visit health facilities frequently and receive expensive treatment.
- Some kebele/Tabias have been allowed to use Yirgalem hospital as the first point of contact, meaning the scheme incurs the higher hospital costs.
- The 10.50/month/household premium seems very low for an urban context.
- There is no co-payment to rationalize utilization.

When scaling up to the urban context, the CBHI program should consider introducing higher premium rates per households, with sliding/stratified contributions, taking steps to ensure a large membership base and therefore a large risk pool, and developing a different payment agreement when hospitals are used as the entry point to care.

Table 5.26: Assumptions for Projecting Resource Mobilization During Scale-up

	Amhara	Oromia	SNNP	Tigray
Number of pilot woredas	3	4	3	3
Number of expansion woredas	39	59	47	15
Paying members in pilot woredas (June 2013)	40,513	35,750	18,556	26,962
Non-paying members in pilot woredas (June 2013)	9,612	2,750	1,217	2,067
Eligible households in expansion woredas	1,177,322	2,158,600	503,000	547,491
Participation rate (enrollment rate)	57.90%	36.10%	61.20%	47.40%
Non-paying members/indigents (% of eligible HHs)	10%	10%	10%	10%
Average contributions per household per year	144	180	126	132
Membership fee	10	10	10	10
Service utilization rate health center	96%	30%	93%	38%
Service utilization rate hospitals	11%	13%	13%	6%
Average number of beneficiaries per household	3.54	4.72	4.75	4.32
Average cost per visit health center	28.39	37.97	28.19	38.31
Average cost per visit hospitals	100	100	90	140
Premiums subsidy				
Woreda subsidy of indigents contributions	30%	30%	100%	30%
Regional subsidy of indigents contributions	70%	70%	0%	70%
Federal subsidy of all CBHI members	25%	25%	25%	25%
Woreda subsidy for CBHI management salary and operating expenses				
Number of employees per woreda	3	3	3	3
Average salary	2,300	2,300	2,300	2,300
Social security contribution (% of gross salary)	8%	8%	8%	8%
Average operating cost per month	4,000	4,000	4,000	4,000

Source: Performance during pilot period and policy decisions

5.6.2 Projections

Table 5.27 summarizes the projections of community contributions, government subsidy, reimbursement to health facilities, and overall balance based on the above assumptions. The total amount of resources that can be mobilized from community premiums in all (pilot and scale-up) schemes will be approximately Birr 345 million per year. Oromia region is estimated to mobilize the largest amount (Birr 146 million), while SNNP region is estimated to mobilize the least (Birr 42.4 million); Amhara has the potential to mobilize Birr 106 million, Tigray Birr 50 million.

Our estimations show that the total reimbursed to health facilities will be Birr 316.5 million per year. In Oromia, reimbursement is projected to be Birr 110 million and the resource balance with subsidy Birr 135 million (i.e., a surplus). In Tigray, these amounts are projected to be Birr 38.2 million and Birr 36.7 million. In Amhara, a high participation (enrollment) and high utilization rate project a surplus of Birr 57 million. The projected surplus in SNNP is just Birr 1.4 million suggesting there may be a need to increase the user fee from its assumed level of Birr 126 per household per month.

Table 5.27: Projected Income, Subsidies, Expenditure, and Balance ('000 Birr)

	Amhara	Oromia	SNNP	Tigray	Sum
Income					
Income from registration fee	6,131.04	7,011.60	2,770.68	3,015.75	18,929.06
Annual Income from premium:					
Pilot woredas	5,833.87	6,435.00	2,338.06	3,558.98	18,165.91
Scale-up woredas	94,120.78	132,643.71	37,248.63	43,366.89	307,380.00
Total income	106,085.69	146,090.31	42,357.37	49,941.62	344,474.98
Subsidy					
General subsidy-federal gov't	37,486.11	57,331.17	14,579.92	16,955.54	126,352.74
Targeted subsidy:					
Regional government	13,660.42	29,055.88	-	5,633.05	48,349.35
Woreda	11,626.27	21,110.23	13,865.34	4,887.80	51,489.64
Total subsidy	62,772.81	107,497.28	28,445.27	27,476.38	226,191.74
Expenditure					
Reimbursement to health facilities	105,746.53	109,999.51	62,528.21	38,220.60	316,494.85
Management salary and operating expenses	5,771.81	8,657.71	6,871.20	2,473.63	23,774.35
Total expenditure	111,518.34	118,657.22	69,399.41	40,694.23	340,269.20
Balance	57,340.16	134,930.36	1,403.22	36,723.77	364,043.56

Source: Based on assumptions in Table 5.26

5.6.3 Fiscal implications of scale-up

For the first indigent coverage scenario, 10 percent of eligible households, the subsidy from the federal government is estimated at Birr 93.9 million per year for the four regions. Regional governments will have to be ready to allocate Birr 32.1 million in targeted subsidy, with each regional government allocating as follows: Oromia Birr 19.5 million, Amhara Birr 8.6 million, and Tigray nearly Birr 4.0 million. There is no regional subsidy budget in SNNP as the woreda is assumed to cover the entire targeted subsidy.

Woreda subsidies, covering indigents and CBHI staff salaries and office running costs, total Birr 22.4 million per year. On average, each pilot expansion woreda has to subsidize Birr 254,474.06 per annum. The highest average is estimated to be Birr 183,571.17/woreda in SNNP, and the lowest Birr 113,655.21 in Tigray. Woreda administrations need to be aware of the fiscal commitment required when introducing a CBHI scheme.

For the second scenario, coverage of indigents will be the average of the pilot woredas in the region: Amhara 11.1 percent, Oromia 2.6 percent, SNNP 3.8 percent, and Tigray 11.5 percent. The third scenario assumes that indigents will be 29 percent of eligible households. As seen in Table 5.28, the total subsidy jumps to Birr 203.1 million from Birr 148.3 million per year if we apply the 29 percent case; woreda subsidies in particular will increase on average to Birr 221,925.76 from Birr 121,963.07 per woreda per year. It is clear that 29 percent is not feasible from the budgetary standpoint. Table 5.28 shows the fiscal implication of the scaling up to the originally planned 161 woredas and to all non-pastoralist woredas of Ethiopia, assuming that pilot case participation continues, under the three scenarios. The fiscal implications of CBHI scale up if 50%, 75% and 100% participation take place are indicated under annex E, F and G.

Table 5.28: Projected Government Subsidy Requirements under Three Scenarios ('000 Birr)

Pilot Case Participation Rate

	161 Expansion Woredas			All Non-Pastoralist Woredas		
Region	10%	Pilot Case	29%	10%	Pilot Case	29%
Total Budget						
Amhara	30,658.27	35,629.89	40,952.53	252,437.71	308,954.69	369,462.08
Oromia	87,851.16	82,485.50	123,532.82	325,609.55	303,086.47	475,388.08
SNNP	14,162.58	13,536.03	17,258.57	126,485.43	114,441.90	185,996.15
Tigray	15,674.42	14,815.21	21,343.68	44,690.52	41,579.91	65,215.20
Addis Ababa				50,500.67	50,500.67	73,883.75
Other Non-Pastoralist Regions				18,238.35	18,238.35	26,870.59
Total	**148,346.43**	**146,466.63**	**203,087.61**	**817,962.23**	**836,801.98**	**1,196,815.84**
Federal Budget						
Amhara	18,334.21	18,334.21	18,334.21	189,711.72	189,711.72	189,711.72
Oromia	60,014.88	60,014.88	60,014.88	246,380.00	246,380.00	246,380.00
SNNP	5,534.74	5,534.74	5,534.74	95,036.83	95,036.83	95,036.83
Tigray	9,991.66	9,991.66	9,991.66	33,662.76	33,662.76	33,662.76
Addis Ababa				38,193.78	38,193.78	38,193.78
Other Non-Pastoralist Regions				13,695.07	13,695.07	13,695.07
Total	**93,875.48**	**93,875.48**	**93,875.48**	**616,680.15**	**616,680.15**	**616,680.15**
Regional Budget						
Amhara	8,626.84	12,106.98	15,832.83	43,908.19	83,470.08	125,825.25
Oromia	19,485.40	15,729.43	44,462.56	55,460.69	39,694.53	160,305.65
SNNP	0.00	0.00	0.00	0.00	0.00	0.00
Tigray	3,977.93	3,376.49	7,946.42	7,719.44	5,542.01	22,086.71
Addis Ababa	0.00	0.00	0.00	8,614.82	8,614.82	24,982.98
Other Non-Pastoralist Regions		0.00	0.00	3,180.30	3,180.30	9,222.87
Total	**32,090.17**	**31,212.90**	**68,241.81**	**118,883.43**	**140,501.74**	**342,423.46**
Woreda Budget						
Amhara	3,697.22	5,188.70	6,785.50	18,817.80	35,772.89	53,925.11
Oromia	8,350.88	6,741.19	19,055.38	23,768.87	17,011.94	68,702.42
SNNP	8,627.85	8,001.29	11,723.84	31,448.61	19,405.07	90,959.33
Tigray	1,704.83	1,447.07	3,405.61	3,308.33	2,375.15	9,465.73
Addis Ababa				3,692.07	3,692.07	10,706.99
Other Non-Pastoralist Regions				1,362.99	1,362.99	3,952.66
Total	**22,380.78**	**21,378.25**	**40,970.32**	**82,398.65**	**79,620.10**	**237,712.24**

	161 Expansion Woredas			All Non-Pastoralist Woredas		
Region	**10%**	**Pilot Case**	**29%**	**10%**	**Pilot Case**	**29%**
Average Woreda Budget (161 Woredas)						
Amhara	88.03	123.54	161.56			
Oromia	132.55	107.00	302.47			
SNNP	172.56	160.03	234.48			
Tigray	94.71	80.39	189.20			
Addis Ababa						
Other Non-Pastoralist Regions						
Total	**121.96**	**117.74**	**221.93**			

SECTION 4. POLICY RECOMMENDATIONS

6. POLICY AND PROGRAMMATIC IMPLICATIONS OF EVALUATION FINDINGS ON SCALE-UP

This evaluation of the CBHI pilot schemes in Ethiopia shows that CBHI members are using health services more (26 percent more) than the non-members. It also documented that the impoverishing effect of OOP payments (including non-facility expenditures) on CBHI members is much less than that of non-members. It found the premiums and registration fees are affordable for members. Although there are issues with reimbursement, adequacy/quality of services, and the financial status of CBHI schemes in a few woredas, CBHI was generally able to mobilize additional resources for the health sector. This clearly supports the government plan to scale up CBHI to other woredas.

This scale-up of CBHI in Ethiopia as a path to achieving UHC should be guided by best practices from around the world and the lessons learned from the current pilots. Internationally, best practice revolves around the four basic actions that WHO recommended as ingredients or pillars toward UHC:

- Promoting equitable access by removing financial barriers, especially direct payments;
- Making prepayments compulsory;
- Creating large risk pools for financial sustainability; and
- Having governments cover the health costs of people who cannot afford to contribute.

Table 6.1 presents the major issues of CBHI pilot schemes, the major recommendations for scale-up, and the institution(s) suggested to take the recommendations forward.

Table 6.1: CBHI Issues, and Evaluation Recommendations for Action and Responsible Party

Issue	Recommendation	Responsible party
In Amhara, Tigray, and SNNP regions, political and administrative leaders engaged actively in sensitizing the community about the benefits of CBHI. The establishment of KHIIs responsible for community sensitization played a crucial role in enhancing enrollment. Members of the woreda cabinet were assigned specific kebeles/tabias to sensitize and follow up and this was made one of their performance measurement criteria (e.g., Tehuledere and Yirgalem).	**Foster political commitment, government ownership, and leadership at regional and woreda levels, and better organization at the community level.** Before scaling up CBHI, there is thus a huge need for extensive **orientation** of zonal, woreda, and kebele/tabia officials. Consider Tehuledere woreda's experience of introducing CBHI activity as part of the overall woreda checklist that the woreda cabinet is using as a follow-up and support mechanism.	**Regional Government, Woreda Chief Administrator**
Although there has been success in communicating CBHI principles to communities, gaps remain. Some better-off individuals like those we met in Damboya and Damot Woyde consider CBHI an intervention for indigents/poor households only. In contrast, there are instances of CBHI covering high medical	**Give ample time and effort to community sensitization.** Experiences like that of Ider and Mekelle hospitals should be well documented and used to promote CBHI enrollment and renewal via media such as leaflets, signboards, or regional radio and TV. There is a need to review the current sensitization strategy and tools to make sure that the lessons are incorporated and used during scale-up. Given that the sensitization in	**RHB, Woreda Chief Administrator, Woreda Health Office, Woreda Cabinet, Kebele/Tabia**

Issue	Recommendation	Responsible party
costs at Ider and Mekelle hospitals, which would have been catastrophic had it not been for CBHI scheme.	the pilot woredas was daunting, as KIIs at all levels revealed, a major effort, even more than during the pilot, is required for scale-up. It is crucial to link kebele/tabia/community sensitization and follow-up with the Health Extension Program and the Health Development Army for a more effective result.	**Administration**
In some pilot areas, health providers did not have adequate awareness of CBHI principles and of what is expected of them. This is one reason for reports of provider's discourteous treatment of members during health service utilization.	**Do targeted sensitization of health providers.** This is needed to improve health provider understanding of CBHI functioning, reduce confrontations with clients, and improve courtesy toward clients. There is a huge need for extensive orientation of health facility staff (health centers and hospitals) before scaling up CBHI. Regions need to factor in the financial and technical implications of orientation programs.	**RHB, WorHO, CBHI scheme**
Currently, all regional CBHI schemes charge similar premiums and registration fees regardless of household income and location (town, rural area) of scheme. This in the long term will not be fair and will compromise the financial sustainability of schemes as evidenced in Yirgalem. As scale-up proceeds and enters urban areas, the risk of moral hazards is likely to increase.	**Consider different design parameters and test them during scale-up.** The FMOH and RHBs could explore the feasibility of introducing different and stratified premiums for more equity and sustainability. It is also important to consider introducing some sort of co-payment per incidence or visit, especially a certain percentage of drug costs (say, 5-10%). The most successful CBHI country, Rwanda, has moved from uniform to stratified payment. This could be piloted in a few woredas to judge feasibility.	**EHIA, FMOH, and RHBs**
There were reports that the schemes provided services to members who had not paid their premiums. In most pilot woredas, there is a tendency to accommodate the interest of members rather than the interest of the scheme. The practice of overlooking timely renewal has created apathy on the part of the community; there is a tendency to hold off renewal until there is a health need. It will be difficult to un-do such practices, which damage membership and in particular the sustainability of scheme in the long run.	**Enforce scheme regulations on renewal.** Membership should be considered active when, and only when, it is renewed. There should be a clear system and enforcement mechanism to enforce prompt membership renewal; for example, those who do not renew their membership within three months should be considered as having quit the scheme and having to register as new members, with a waiting period for services.	**RHB, WorHO, CBHI scheme**
Household survey results, KIIs, and community FGDs showed that the current premium rate is affordable. However, the financial sustainability of some schemes is questionable. Some schemes have deficits after just two years. Although other mechanisms can also be considered, such as risk pooling among schemes at different levels, it is necessary to review and revise the premium so that it is commensurate with reimbursements that the schemes pay to the health facilities at a rate that allows the facilities to improve service availability and quality.	**Review and revise premium levels during scale-up.** This may need an analysis of the willingness and ability to pay of the scaled-up woredas.	**EHIA, FMOH, and RHBs**

Issue	Recommendation	Responsible party
The CBHI strategy and its operational manual clearly reflect government's commitment to protect the very poor in the form of the indigent payment. Government financing of the premiums is considered one of the best proactive and major pillars if CBHI is to contribute toward UHC. The implementation so far is mixed: Amhara and Tigray are doing well while Oromia and SNNP need to enhance their effort. The household survey clearly shows that targeting of indigent is generally fair. The percentage of people considered as indigent even in well-performing regions and woredas is still far below the estimated households that are below poverty line. However, it is necessary to base renewal of indigents on clear criteria or a poverty assessment.	**Subsidy for indigents is the right strategy to protect the very poor from impoverishment.** The need to allocate a budget for this at the regional/woreda level is critical. This strategy needs to be enhanced and replicated in the scale-up woredas. The fiscal impact on these woredas will be similar to that in the pilot woredas and they may be able to afford it. However, regions need to mobilize more resources for this subsidy, as the numbers of indigents will increase. Poor households that just fail to meet indigent criteria are falling through the cracks because of the budget limitation and hence there is a need to increase resources to ensure these households are enrolled in CBHI. The cost of photographs of indigent households for the membership ID is one barrier that needs to be addressed during scale-up.	**FMOH, Regional government, Woreda government**
Currently, each pilot scheme covers all the health service costs that accrue to it and there is no risk pooling among pilot schemes. As documented in other countries, CBHI can only be successful when there is risk pooling at regional and national levels. This is recommended by WHO and implemented in the most successful country, Rwanda.	**Enhance scheme solidarity at the woreda and regional levels.** Regional and national risk pools should be established during scale-up. Woreda schemes could contribute a share of their premium to a regional scheme. The regional scheme could pay for accessing regional referral hospital for health care adhering the referral system and subsidize schemes that are under financial stress. A national pool would play a role similar to the regional one.	**EHIA, Regional government, Woreda government**
Currently, with the exception of Kuyu (Oromia) and Kilte Awlaelo (Tigray), referral is limited to the nearby hospital unless the nearby hospital is a regional hospital. This is a good practice that other regions could learn from. Patients tend to self-refer to hospitals or to health centers in woreda towns, bypassing nearby facilities. To curtail this practice, a bypass fee was introduced in some regions (Amhara); patients who visit a hospital without referral slip are required to pay 50% of their expenses (the scheme reimburses only 50%). To avoid this penalty, patients visit a nearby health center and follow the referral system. However, it appears that unnecessary referrals take place due to patients' pressure on health personnel.	**Strengthen the referral system to provide effective health services for members.** Together with the establishment of regional and national CBHI risk pools, it may be necessary to include at least regional referral hospitals and one federal referral hospital in the referral system. Evidence from the financial feasibility assessment, however, should inform such expansion of the referral system. To avoid unnecessary referrals, a systematic review of utilization patterns and referral linkages should be done.	**FMOH, RHB, ZHD, WorHO, CBHI scheme**

Issue	Recommendation	Responsible party
There is general agreement that the defined benefit package is adequate. The only suggestion for expansion is improving quality of care in health facilities, specifically to make available ambulance services to transport patients from health centers to hospitals. It is also agreed that benefits are simple and easy to communicate so community expectations are clear. This should continue during scale-up; added detail could complicate understanding and generate suspicion.	**Continue investing in service providers to improve quality of care and manage benefit expectations.** The facility-community forums launched in some regions last year, although not specifically related to CBHI, is an initiative that will improve quality and responsiveness of health providers. This is something that CBHI scale-up woredas may need to establish or strengthen.	**FMOH, RHB, ZHD, WorHO, CBHI scheme**
Some health facilities are not complying with the contract they signed. They do not provide the complete benefit package. They lack drugs and medical supplies and so refer members to other facilities for certain services and commodities. Qualitative study results have shown that availability of drugs and required diagnostics at the facility of first contact is the most important factor for households to join and/or sustain CBHI membership. If these problems are not addressed, CBHI achievements in pilot woredas might not be maintained there, let alone successful scaled up.	**Address unavailability of drugs, supplies, and some diagnostics.** FMOH and regional governments invested on facility preparedness when CBHI started and ensured member satisfaction with the services provided. This is a best practice that the FMOH and regional governments should replicate by assessing readiness of facilities and then mobilizing resources to finance the gaps. They also need to engage and work more with the PFSA and its hubs to address inadequate supply of drugs and supplies.	**FMOH, RHB, ZHD, WorHO, CBHI scheme**
As noted above, some contracted health facilities lack drugs and medical supplies and so refer members outside the network for services and commodities. It is often difficult and sometimes impossible for these members to get reimbursed for the cost they incurred at out-of-network facilities.	**Consider contracting the private sector providers** as part of regional and national risk pools, to ensure there is a participating provider nearby and preferred by the community, and willing to meet CBHI quality and other requirements including charging fees similar to the public providers.	**EHIA, RHB, ZHD, WorHO, CBHI scheme**
Currently, the kebele/tabia administration plays a critical role in registering scheme members and collecting premiums. However, there are challenges in many woredas in following up and collecting premiums, enrolling new members, and promptly collecting and transferring and/or depositing the premiums collected. The existing structure (premium collection on a voluntary basis) is not adequate.	**Review and adjust the current registration and premium collection systems.** It is necessary to consider alternative ways of providing incentives and accountability at the kebele/tabia level. Establishing a structure at that levels (premium collection by kebele/tabia management structures on voluntary basis) will enhance accountability in effectively registering new households, renewing membership, collecting contributions, and channeling them to the scheme. If this doesn't work, consider introducing incentives like those of the revenue authority (2% of money collected), to motivate the kebele/tabia administration to promptly collect and transfer/deposit premiums.	**Regional government, Woreda government**

Issue	Recommendation	Responsible party
Resources required financing subsidies (both targeted and general) and covering administrative costs to run the scheme. Projected resource requirements are too large to be financed by the woreda or region alone. As the number of woredas and kebeles/ tabias implementing the CBHI program in four regions rapidly increased, the HSFR/HFG project downgraded its financial support for operational costs such as per diem, fuel, vehicle and other travel expenses. This has limited CBHI teams' regular supportive supervision in sections/kebeles/tabias. There is no longer dedicated staff at each scheme to monitor member enrollments and renewals, and premium collection and deposits at the kebele/tabia level.	**Mobilize additional resources at the regional and federal levels to meet the resource requirements of scale-up.** The adoption of current design elements for scale-up (30/70 share of financing contribution between woreda and regions; 25% subsidy for all members by FMOH, and current premium rates) will increase the fiscal burden for the regions and FMOH. The 30% indigent financing is projected to be an average Birr 300,000 per woreda per year and woredas might not be able to cover it. Regions need to mobilize about Birr 30 million and the FMOH about Birr 120 million per year. When viewed as a move toward UHC, the fiscal implication is not that great; however, regions and the FMOH need to be aware of what is needed and mobilize these additional resources. **Establish/strengthen CBHI coordination and technical support at federal, regional, zonal, and woreda levels** to support operations and steer the CBHI schemes at woreda levels.	**EHIA, Regional government, RHB, Woreda government, and WorHO**
Recruitment and retention of CBHI team remains a challenge. According to the current structure, the CBHI executive team has 3 staff (team leader/health coordinator, accountant, and ICT person). In addition, there is one focal person for the team, which is assigned by the woreda administration. The staffing challenge remains due to delays in sharing an approved position and structure by the regional civil service office with woreda administrations. Moreover many existing staffs do not meet the academic and work experience required for these positions. In addition, the CBHI staffs have not been able to benefit from salary increases and other benefits that are part of the career structure. Currently most of them are also lent by other government offices, usually health centers. All these have created job insecurity for the staffs. As a result, many of them seek alternative employment; turnover is high.	**The structure of CBHI teams should be approved at the regional level and adequately budgeted in all the woredas.** This should include revising the salary scale and career structure of CBHI staff (making them at least comparable to those of health center staff), allocating an adequate operational budget on a regular basis, properly pinning down the structure and give it the appropriate housing within the government structure but with semi-autonomous status (as part of the EHIA or learning from the experience of regional/sub-regional structures of the Food, Medicines, Health Care Administration and Control Authority, FMHACA). In addition, there is a need to revisit the staffing structure and assign adequate staff to properly run the schemes.	**Regional government, Regional Civil Service Commission, RHB, Woreda administration, WorHO**
The involvement of the ZHD and WorHO in the CBHI implementation is limited. Most CBHI responsibility falls on the woreda administration. When there is turnover of the administrator or lack of political commitment, scheme functioning is seriously affected.	**Enhance the involvement of the ZHD and WorHO in CBHI management.** It is necessary to develop a sense of ownership of CBHI by zonal and woreda health officials. Such a push should come from above. Bringing CBHI under the WorHO should be considered given its direct relation with the health sector. The woreda administration should continue to do community sensitization and mobilization from initiation through the implementation of the CBHI program.	**Regional government, RHB, EHIA**

Issue	Recommendation	Responsible party
Even though information management was given attention in the pilot design, there is still a significant gap in generating, storing, sharing, and using CBHI data at all levels. Basic information such as membership renewals, premium collection, reimbursement to health facilities, members' service utilization is often inconsistent, out of date, and not available at the scheme levels.	**Enhance CBHI information management system.** During scale-up, it is necessary to explore the major issues around database management and reporting, and to design and implement an appropriate financial administration and management system (FAMS). If CBHI schemes are going to lead toward UHC in the informal sector, an electronic database management system at scheme, region, and national levels is needed.	**EHIA, RHB, WorHO**
Except in Oromia, more than 85% of CBHI reimbursements are paid to health centers, reflecting the high level of services provided to CBHI members by health centers compared to hospitals. The routine monitoring data suggest that CBHI schemes are contributing to the strengthening of financial capacities of lower levels of the health delivery system. In addition, there is an overall increase in utilization of health services as a result of CBHI.	**Do further research to assess how CBHI changes patterns of utilization in different levels of the health delivery and referral system.** This assessment could further document the effect of CBHI on efficiency in the use of resources in the health system in pilot woredas. Related to this is a need to investigate the impact of CBHI on the use of maternal health and other preventive services.	**FMOH, EHIA, HSFR/HFG**

Box 6.1: Results of effective communication

Effective communication and good understanding resulted in community members effectively defining what CBHI is as evidenced by a member and a non-member:

> *"CBHI is like Iddir [insurance for funeral services]. You become a member of iddir to ensure that you get buried when you die, and you become a member of CBHI so that you do not die (to ensure that you accessed the required health service before it is too late"), FGD participant in Yirgalem.*

Non-CBHI members in Damboya were appreciative of CBHI even though they could not afford to join. One FGD participant stated that

> *"ማአጤማ 'MA'ATEMA' [Kambata/ Amharic for CBHI] mean a hidden wealth and we consider it like that. CBHI is like our bank account….It is the most important of government strategies introduced.*

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ANNEXES

ANNEX A: LITERATURE REVIEWED: EVIDENCE ON CBHI

Annex A.1: Positive and Negative Factors Influencing Uptake of CBHI and SHI in Sub-Saharan Africa, and Implications for Policymakers

Factor	Examples of countries	Issues identified and policy implications	References
Factors positively linked to uptake			
Provision of uniform benefit packages	Ghana	Benefits should be predefined and comprehensive, with good coverage of the likely disease burden Provision of services at accredited facilities helps to ensure uniformity of benefits offered	NHIS [Ghana] [9]; Odeyemi & Nixon [6]
Adequate public financing/realistic pricing	Ghana, Rwanda, Burkina Faso	Use of funds from taxation is necessary to allow funding to be progressive and to encourage/enable the less well-off to join through subsidies and fee exemptions Targeted subsidies positively influenced enrollment in Nouna, BF, although there is also a danger of adverse selection	NHIS [Ghana]; Odeyemi & Nixon; Logie; Schmidt; De Allegri; Parmar; Souares
Elimination or minimization of copayments	Rwanda	Increases in subsidies to the point where co-payments are eliminated could lead to as much as 100% coverage User fees were found to be linked to substantial inequality in utilization, with medical visits being more common among the better-off uninsured	Dhillon [30]; Schneider & Hanson [31]
Strong desire/ willingness to join	Cameroon, Nigeria	Greatest willingness noted among poorest households in Nigeria Policymakers should commission research to determine willingness to pay; social marketing can encourage participation	Donfouet [14]; Onwujekwe [26]
Avoidance of focus on maximization of health revenue	Rwanda	CBHI participation and a focus on the generation of health care revenues are mutually exclusive	Schmidt [29]
Improvements in education and socio-economic status	Burkina Faso	Enrollment in schemes may increase with social and economic progress and development over the long term	De Allegri [35]
Provision of maternal health care benefits	Senegal, Mali, Ghana, Rwanda, Nigeria	Inclusion of maternal health care benefits drives interest in CBHI on the demand side, and CBHI is a primary contributor to strong maternal health services Scheme organizers should ensure that packages are comprehensive, as excessive limitation discourages uptake	Smith [28]; Bucagu [19]; Adinma [21]
Awareness of the limitations of traditional medicine	Burkina Faso	Further research is needed, but this observation emphases the value of improved education and communication	De Allegri [35]

Factor	Examples of countries	Issues identified and policy implications	References
Negative factors that discourage or limit uptake			
Excessive requirement for OOP expenditure, inability to pay	Uganda, Burkina Faso, Guinea, Senegal, Nigeria	Major determinant of enrollment; even where implementation has been predominantly successful, the very poorest populations may still find participation financially difficult OOP expenditure remains significant in health care systems in many countries (despite actions such as abolition of user fees in government institutions in Uganda) Regressive flat-rate payments are a problem in Nigeria, and inability to pay premiums is the single biggest obstacle in Uganda. No mechanism is in place to help those who cannot afford to join Ambiguous and contradictory health care funding policy is a significant problem that must be addressed	Basaza; Dong; Criel; Onwujekwe; Metiboba; Jütting
Social exclusion due to religion or ethnicity	Senegal	Noted in Senegal, where the Roman Catholic Church supports the *mutuelles*, and where Christians were reported in 2003 to be more likely than Muslims to enroll. In interviews, Muslims were under the mistaken impression that CBHI was open to Christians only	Jütting [27]
Lack of legal framework	Guinea, Benin	Failure to provide proper governance or official framework for CBHI schemes is linked to low enrollment	Soors
Lack of government (or donor) support	Uganda, Burkina Faso, Nigeria	Small budgets, low enrollment, and lack of government support cause schemes to fail. Schemes need substantial support to build their sustainability; technical and policy decisions should account for this	Kyomugisha [34]; De Allegri [35]
Excessively rigid enrollment requirements or institutional rigidity	Uganda, Burkina Faso	Failure to recruit the required number of people in a village has been a key feature affecting schemes in Uganda (mandatory 60% of a group or 100 families per village) Rules for group membership should reflect what is achievable	Basaza [32,33]; De Allegri [35]; Onwujekwe [25]; Onwujekwe [23]
Mismatch of values expressed by promoters and subscribers; failure to match benefits with willingness to pay	Senegal, Burkina Faso, Nigeria	Need to align expectations/needs of promoters (focus on financial sustainability) and subscribers (who look for sustainability and solidarity) Increase participation of members in decision making; failure to engage beneficiary participation in Nigeria has been pinpointed as a major problem Ensure that prospective members are willing to pay for the benefits offered, and that the market in any locality matches the theoretical one on which projections are based	Ouimet [12]; Dong [15-17]; Onwujekwe [23]; Onwujekwe [24]; Metiboba [7]
Lack of information	Uganda, Burkina Faso, Nigeria	Governments and promoters must ensure that schemes are properly and accurately publicized, and the public properly informed; lack of knowledge can lead to skepticism Lack of information is a significant problem in Nigeria Authorities must ensure that government and health officials are fully informed about the packages offered	Basaza [13]; De Allegri [35]; Dienye [22]; Onwujekwe [23]; Metiboba [7]
Poor quality of health care	Uganda, Guinea	Concerns relate to cleanliness, long queues before being seen, and lack of some prescribed medicines Noted as the main reason for lack of interest in the Maliando Mutual Health Organization in Conakry, Guinea	Basaza [32,33]; Criel [39]

Factor	Examples of countries	Issues identified and policy implications	References
Lack of trust; perception that schemes are unfair or even unnecessary; dislike of health care personnel and cultural resistance	Uganda	Belief that non-members are treated better in hospital than scheme members	Basaza [32,33]; Kyomugisha [34]
		Integrity of fund managers and transparency of operation: "Nothing is done to ensure that fund managers account to scheme members" (Ugandan interview respondent)	
		Some members pay premiums continuously but never fall sick	
		"I wasn't bothered since I am young and not likely to fall sick"; "If I do not fall sick, I should not pay for someone else" (Ugandan survey respondents)	
		Schemes must be fair, well run, and affordable, and the public sufficiently well-informed to appreciate the need for coverage and mutuality	
High drop-out rates	Burkina Faso	Related to other factors noted in this table: affordability, health needs and demand, quality of care and household characteristics	Dong [36]
		Improve perception of schemes by heads of households, ensure that large households are able to maintain contributions (e.g., flexibility in payment options); ensure that service offered meets expectations (e.g., in line with education, etc.)	

Annex A.2: CBHI development model: potential and pitfalls for scaling up

Model Type	Characteristics	Potential	Challenges and pitfalls
Basic model	• Proto-type bottom-up financial protection model • Voluntary-based membership • Main sources of revenue is membership premium • Managed by community committee or health facility • Services offered could be either or both outpatient and inpatient • Payment mechanisms: Fee-for-service and capitation	• Make available risk protection mechanism at local level; • Raise awareness and knowledge for health insurance; • Reduce OOP payments; and • Increase utilization of health services by members	• Not politically and financially supported by government and this undermines scheme's stability; • Voluntary membership has risk of adverse selection that may undermine financial sustainability; • Limited benefit package limiting schemes attractiveness; • Coverage is also another issue. Most of the CBHI schemes in West Africa are voluntary, small, and with very low coverage; • Limited risk pool (not large enough to make them sustainable).
Enhanced CBHI	• The adaptation to basic model basic above include: • Local government political endorsement, including the poorest of the poor through government subsidies, • Building networks for scheme management and service delivery	• Government political endorsement increasing CBHI's political stability/legitimacy; • Government and/or other donors' subsidies increase scheme capacity to reach the poorest of poor, thereby increasing the equity of CBHI coverage; • Government also may provide financial support or a re-insurance mechanism to protect against	• Lack of political, financial, and technical commitment and stewardship at the national level prevents isolated schemes from scaling up; • Fragmentation of a large number of separate small funders limits broader risk pooling; • Financial risk protection is still constrained by limited membership contributions from

Model Type	Characteristics	Potential	Challenges and pitfalls
		expenditure fluctuations and maintain financial sustainability; • Small schemes form a regional or national network that can provide professional technical and managerial support on design and management; • A group enrolment requirement will reduce adverse selection; and • Introduction of other payment mechanisms to control costs, and case management techniques, will limit expenditure fluctuations.	low-income informal sector members; • Contribution capability and benefits may not be consistent across schemes, which leads to the inequity in health financing and service access; • Lack of professional and standardized management limits scheme efficiency and effectiveness; and • Ability to ensure the availability of the service, to improve the quality.
Nation-wide Scheme	• New characteristics of a nationwide scheme include • Government political commitment, stewardship, legislation, • Funding support, • Regional-level professional management, and • Continuing community-level support •	• Political commitment, stewardship, and guidance, along with legislation and regulation backup; • Continuing strong community support in resource mobilization and fraud and abuse controls enable scale-up of CBHI nationally; • Increasing the size of risk pools at the regional or higher level and establishing risk equalization mechanisms to allocate resources across insurance schemes allows for cross-subsidy between high-risk and low-risk regions; • Government regular budget support makes additional financial resource available and sustainable; • Increased government leadership and financial and technical support enhances CBHI management capacity and helps control overhead costs; • Strategic service purchasing makes the scheme more effective and efficient; and • Government establishment and implementation of M&E systems ensures scheme more sustainable.	• Though has potential to scale up CBHI for achieving UHC, it faces challenges including: • Continue to increase enrolment rate by reaching hard-to-reach populations without introducing mandatory mechanisms; • Control the costs of health services; • Ensure long-term financial sustainability; and • Integrate CBHI with other existing health insurance schemes, such as tax-based or SHI covering formal sector populations. •

Source: Wang and Pielemeier (2012)

ANNEX B: HOUSEHOLD SURVEY QUESTIONNAIRE

INSTRUCTIONS FOR HANDLING AND COMPLETING CBHI QUESTIONNAIRE

- Please use only black ball points to complete questionnaire
- Only eligible and trained data collectors should write on these questionnaire
- Please fill the header in each page
- Data correction: Cross-out the mistake (mistake has to remain readable), write the correction alongside together with your initials and date of correction. In case of non-self-explanatory mistakes, please add the reason for correction. Do not use type write correction fluid (Tipp-Ex)

E.g. (DD/MM/YYYY) ~~2~~ 4 / 0 3 / 2 0 1 6

1 MMK

- In open boxes/numeric fields please enter

Numbers | 4 | 9 | Or ticks | ☐

- Always enter digits **right aligned** and fill **open spaces** to the left with **zeroes**

| 0 | 4 | 9 |

- Please mark data which could not be recorded as follows: **Cross out boxes** and write **"NOT DONE"** on the side
- Date: Day. Month. Year: (GC)

0 4 / 0 3 / 2 0 1 6

Date **Month** **Year**

- Please enter initials in the following order: First letter of the first name, First letter of the middle name, First letter of the surname

| M | M | K |

- Please do not omit to date and sign the pages where required.

COMMUNITY BASED HEALTH INSURANCE (CBHI) EVALUATION

HOUSEHOLD QUESTIONNAIRE (VERSION ONE)

DATA COLLECTION VISIT DATES: (DD/MM/YYYY)

CBHI Survey:			/			/	2	0	1	

Start time (hh:mm) |__||__||__||__|Interview end time |__||__||__||__|

FOR FIELD USE (DATA COLLECTOR AND SUPERVISOR) AND OFFICE USE (DATA ENTRY CLERKS)

	Collected by	**Supervised by**	**Checked by**	**Entered by**
Initials	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|
Date	Day |__||__| Month |__||__| Year|__|__|__|__|	Day |__||__| Month |__||__| Year|__|__|__|__|	Day |__||__| Month |__||__| Year|__|__|__|__|	Day |__||__| Month |__||__| Year|__|__|__|__|
Full name				
Signature				

FORM ONE: AREA IDENTIFICATION OF THE SELECTED HOUSEHOLD

1.1	1.2	1.3	1.4	1.5	1.6	
Region	**Zone**	**Woreda**	**Kebele/Tabia**	**Village/got**	**Full name of Household Head**	
					1.7 Household Participate	
					CBHI **(tick below)**	Not in CBHI **(tick below)**
					Rural **(tick below)**	Urban **(tick below)**

CRITERIA FOR RESPONDENT

Only head of household or spouse can be used as respondents. The head of HH has to be a living member of the HH and determined by the HH members themselves. The head of HH can be female. (If the head of household or spouse cannot provide information the interviewer can ask the de facto head of HH (e.g. member who earns main income.)

TICK THE ONE YOU INTERVIEW

1.8 HOUSEHOLD HEAD ☐

1.9 SPOUSE ☐

1.10 DE FACTO HEAD ☐

FOR OFFICE USE ONLY (ADDIS ABABA)

Status	Name	Signature	Date
Editor			
Editor-Verifier			

FORM TWO: HOUSEHOLD CHARACTERISTICS

Serial numbers of the household members	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8
	Name of the household members	**Relation to household head**	**HH Size**	**Sex**	**Marital Status**	**Age**	**Religion**	Ethnicity
	Please give me your full name and list names of each household member, starting with household head followed by spouse	1=Head 2=Spouse 3=Son/daughter 4=Mother/Father of head/spouse 5=Sister/Brother of head/Spouse 6=Adopted/ Foster children 7=Other Relatives 8=Paid domestic worker 9=Non-Relatives	[number]	1=male 2=female	1=Married 2=Single 3=Divorced/Separated 4=Widowed 6= Other (specify) This is only for ages above 15 otherwise fill n/a.	[years]	1=orthodox Christian 2=Catholic 3=Protestant 4=Other Christian 5=Muslim 6=None 7=Other (specify)	1=Amhara 2=Oromo 3=Tigryan 4=Gurage 5=Kambata 6=Hadya 7=Wolayta 8=Sidama 9=Agew 10=Gedio 11=Other (specify)
01		**1=head**						
02								
03								
04								
05								

06								
07								
08								
09								
10								

FORM THREE: EDUCATION OF HOUSEHOLD MEMBERS: For only household members age five and above otherwise fill N/A.

Serial numbers of the household members	3.1	3.2	3.3	3.4		3.5	3.6		3.7
	Name of the household members Copy all the household members from form two question number 2.1.	Can [name] read and write in any language?	Has [name] ever attended school (formal education)	What is the highest grade [name] completed?		Is [name] currently attending school?	Which grade is [name] currently attending?		Is [name] currently member of CBHI scheme?
	Copy only household members age greater than 5	1=Yes [skip 3.3] 2=No	1=Yes **[skip to 3.4]** 2=No **[skip to3.5]**	0=none 1=Grade 1 2=Grade 2 3=Grade 3 4=Grade 4 5=Grade 5 6=Grade 6 7=Grade 7 8=Grade 8 9=Grade 9 10=Grade 10	11= Grade 11 12=Grade 12 13=Certificate from TVET/TTC 14=College Diploma 15=University 16=Non-formal education 17= Adult education 18=others (specify)	1=Yes **[skip to 3.6]** 2=No	0=none 1=Grade 1 2=Grade 2 3=Grade 3 4=Grade 4 5=Grade 5 6=Grade 6 7=Grade 7 8=Grade 8 9=Grade 9 10=Grade 10	11= Grade 11 12=Grade 12 13=Certificate from TVET/TTC 14=College Diploma 15=University 16=Non-formal education 17= Adult education 18=others (specify)	1=Yes 2=No

01							
02							
03							
04							
05							
06							
07							
08							
09							
10							

FORM FOUR: HOUSEHOLD LIVESTOCK OWNERSHIP

Types of livestock		**Number of livestock currently own**
Ask the household if they have any of the following livestock assets	Do you have these animals? 1=Yes 2=No	How many of these animals do this household currently own?
		[Number]
CATTLE		
4.1 Plough oxen		
4.2 Fattened ox		
4.3 Cows		
4.4 Heifer		
4.5 Bull		
4.6 Calf		
SMALL RUMINANTS		
4.7 Goat		
4.8 Sheep		
4.9 Fattened sheep		
TRANSPORT ANIMALS		
4.10 Donkey		
4.11 Horse		
4.12 Mule		
OTHER		
4.13 Chicken		
4.14 Beehives		
4.15 Others (Specify)		
4.16 Others (Specify)		

FORM FIVE: HOUSEHOLD ASSETS

Types of assets	**Do you have these assets**	**Number of assets currently own**
Ask the household they have any of the following assets	1=Yes 2=No	How many of these items do this household own?
		[Number]
5.1 Modern beds		
5.2Chairs/bench		
5.3 Radio/TV (working)		
5.4 Computer/laptop		
5.5 Mobile/cell-phone/wireless		
5.6 Modern stoves		
5.7 Bicycle		
5.8 Knapsack sprayer		
5.9 Water pump		
5.10 Motorbike		
5.11 Other (specify)		

FORM SIX (1): LAND USE AND PRODUCTION IN THE LAST 12 MONTHS.

CROP CODES	NUMBER	QUESTIONS	ANSWERS						
CEREALS 1= Teff	6.1	Did you rent/lease out land over the last 12 months?							
2=Barely 3=Wheat 4=Maize	6.2	How much land did you rent/lease out in hectares?							
5=Sorghum 6=Finger millet	6.3	Did you rent/lease in land last 12 months?							
7=Oats 8=Rice **PULSES**	6.4	How much land did you rent/lease in hectares?							
9=Bean 10=Peas	6.5	How much cropland was irrigated in the last 12 months in hectares?							
11=Boleke 12=Chickpeas	6.6	How much cropland does your household own in hectares?							
13=Lentils 14=Grass peas 15= Haricot beans	6.7	How much cropland (own and rented/lease in) was cultivated by the household over the last 12 months in hectares (annual and perennial)?							
16= Fenugreek 17= Soya beans 18=Gibto	6.8	Which crops did you grow/cultivate in the last 12month Production period? **[write crop codes]**							
OILSEEDS 19=Nueg 20= Linseed	6.9	How much land (in hectares) was cultivated with [crop] in the last 12 months **[listland size for each crops]**							
21= Groundnuts 22= Sunflower 23= Sesame	6.10	In the past 12 months, how many Kilo grams of each cropdid you produce/harvest? **[list production volume for each crop]**							
24= Rapeseed **ROOT CROPS**	6.11	In the past 12 months how many kilo grams did you sell? **[list amount sold for each crops]**							
25=Beet root 26=Carrot 27= Red onion 28= White onion 29= Potatoes	6.12	What was the price of your sell per kg? **[list sell price for each crops]**							

30= Sweet potatoes 31=others **VEGETABLES** 32=Lettuce 33=Head Cabbage 34= Tomatoes 35= Green peppers 36= Red peppers 37= Others **FUITS AND OTHER CASH CROPS** 38=Avocado 39=Lemon 40=Zeytun 41=Mango 42=Orange 43=Papaya 44=Pinapple 45=Gesho 46=Sugar cane 47=coffee 48=chat 49=Others										

FORM SIX (2): HOUSING CHARACTERISTICS (URBAN ONLY)

6.13	In what type of dwelling does the household head live? 1= Permanent building 2= Semi-Permanent 3= Temporary 4= Traditional	***Indicate code:*|__|**
6.14	Do you have a domestic worker living with you? 1=Yes 2=No	***Indicate code:*|__|**
6.15	Is your dwelling owned by your household or rented, or do you reside here without payments? 1= Owned by family or one of its members 2= Rented 3= Occupied without payment 4= Other (specify_________)	***Indicate code:*|__|**
6.16	What is the **main** type of material for the floor in your house? 1. Mud/crow dung 2.Stone 3.Cement/bricks 4.Wood 5.Grass 6.Iron sheets 7.Tiles 8.Other (specify)	***Indicate code:*|__|**
6.17	What is the **main** type of material that your walls are made of? 1. Mud/crow dung 2.Stone 3.Cement/bricks 4.Wood 5.Grass 6.Iron sheets 7.Tiles 8.Other (specify)	***Indicate code:*|__|**
6.18	What is the **main** type of material that your roof is made of? 1. Mud/crow dung 2.Stone 3.Cement/bricks	***Indicate code:*|__|**

	4.Wood 5.Grass 6.Iron sheets 7.Tiles 8.Other (specify)	
6.19	What is your main source of cooking fuel? 1 = Firewood 2 = Charcoal 3 = Kerosene 4 = LPG (Gas) 5 = Electricity 6 = Other (specify) ____________	***Indicate code:|__|***
6.20	What is your main source of lighting? 1.Electricity 2.Kerosene 3.Gas 4.Candle 5.Firewood 6.Solar 7.Other (specify) ____________	***Indicate code:|__|***
6.21	What is the main source of water for the household? 1. Piped into residence 2. Piped into the compound or plot 3. Public well 4. Public tap 5. Well/borehole with pump in the compound/well in the residence or compound or plot 6. Rainwater collection 7. Well without hand pump 8. Pond/River/Stream/Dam 9. protected spring 10. Unprotected spring 11.Others (specify)	***Indicate code:|__|***

6.22	What type of toilet facility does the household use? 1.Own flush toilet with sewage/septic tank 2.Shared flush toilet in area 3.Traditional pit latrine 4.Ventilated Improved Pit Latrine 5.Bush or field 6.Bucket Latrine 7.Other:_____ (specify)	***Indicate code:|__|***

FORM SEVEN: HEALTH CARE UTILIZATION: Outpatient Treatment (when the patient is gets consultation and/or other services without being admitted to stay at health facility)

Serial numbers of the household members	**7.1**	**7.1**	**7.2**	**7.3**	**7.4**	**7.5**	**7.6**	**7.7**		
	Name of the household members Copy all the household members from form two question number 2.1	How do you rate the health status of [name]?	Has [name] fallen ill in the last 4 weeks?	What was the major cause of illness for [name]?	Has [name] visited any health facility for the illness felt in the last 4 weeks?	If yes to 7.4, what type of service did [name] receive?	What was the major reason why [name] did not visit a health facility?	Number of visits		
	Copy only household members age greater than 5	1=very good 2=good 3=acceptable 4=poor 5=very poor	1=Yes 2=No [skip to the next household member]	1=fever 2=lungs & breathing (cough) 3=stomach & bowel ache 4=teeth & gums 5=headache 6=joint pain 7=pain in the chest 8=irritation of the eye 9=watery faeces 10=blood stained faeces 11=vomit 12=wound 13=other, specify	1=Yes [skip to 7.6] 2=No [skip to the next household member]	1=outpatient 2=inpatient 3=both	1= did not feel it was necessary 2=facility too far 3= lack of money 4=did not feel that I would get quality care e 5= no CBHI coverage 6=other, specify	[number]		
								1st time	2nd	3rd
01										
02										

03										
04										
05										
06										
07										
08										
09										
10										

FORM SEVEN: HEALTH CARE UTILIZATION -Outpatient Treatment (CONTD.)

Serial numbers of the household members	Name of the household members Copy all the household members from part two question number 2.1	7.8 Type of facility visited	7.9 Distance to the health Facility (in Kilo meter)	7.10 Travel time (in hours)	7.11 Reason for choice of this facility	7.12 Is [name] enrolled in CBHI?
		1=Health post 2=Health center 3=Private clinic 4=Mission/NGO clinic 5=Public hospital 6=Private hospital 7=Mission/NGO hospital 8=Pharmacy/drug store 9=traditional healer 10: home service by HEWs 11=Other (specify)	[Number]	[Number]	1=Proximity 2=Inexpensiveness 3=Staff are always available 4=Medicines are available 5=Short waiting time 6=Staff are more compassionate 7=Staff more capable 8=CBHI coverage 9=Referral from first visited facility 10=other, specify	1=Yes 2=No
01						
02						
03						
04						
05						
06						
07						
08						
09						
10						

Serial numbers of the household members	**Name of the household members** Copy all the household members from part two question number 2.1	**7.13** How much money has the household spent for transportation, consultation diagnosis, and medicine				**7.14** Main source of financing 1=Own saving 2=Reduce HH food consumption (if the HH purchases food) 3. Reduce HH nonfood consumption 4=Sell of assets 5=Sell of food stocks 6=Borrowing 7=Remittance (in cash or in kind) 8= Community based health insurance (CBHI) 9= fee waivers from Kebele/Tabia/woreda 10= Increase sell of labor 11=provided free for all 12= Other (specify)______	**7.15** How satisfied is [name] with 1=Very satisfied 2=Satisfied 3=Indifferent 4=Dissatisfied 5=very dissatisfied				**7.16** Waiting time 1= Less than 30 minutes 2=30 to 60 minutes 3= 1to 3 hours 4=3 to 6 hours 5= 6 hours and more 5=More than a day		**7.17** Availability of drugs/supplies 1=Not available 2=Rarely available 2=Usually available 3= always available
		Transport	Consultation	Diagnostics	Medicine		Diagnostics	Cleanness of facility	Courteousness of staffs	Waiting time	Availability of drugs/supplies		
01													
02													
03													
04													
05													
06													

07													
08													
09													
10													

FORM SEVEN: HEALTH CARE UTILIZATION- maternal and child health services

Serial numbers of the household members		7.18	7.19	7.20				7.21	7.22	7.23	7.24	7.25			
	Name of the household members Copy all the household members from form two question number 2.1	Were there pregnant women in this household in the last 12 months?	Did [name] have antenatal care visit to a health facility during her pregnancy?	Number of visits				Type of facility visited for ANC	Did [name] deliver in a health facility?	Type of facility for delivery	Did [name] receive immunization/? (to be asked only for household members who are under 5 years of age)	If yes, state number of times immunization was received			
	Copy only household members age greater than 5	1=Yes [indicate HH member code below] 2=No [skip to 7.24]	1=Yes 2=No [skip to 7.22]	[number]				1=Health post 2=Health center 3=Private clinic 4=Mission /NGO clinic 5=Public hospital 6=Private hospital 7=Mission /NGO hospital 8=Pharmacy/drug store 9=traditional healer 10: home service by HEWs 11=Other (specify)	1=Yes 2=No [skip to 7.24]	1=Health post 2=Health center 3=Private clinic 4=Mission/NGO clinic 5=Public hospital 6=Private hospital 7=Mission/NGO hospital 8=Pharmacy/ drug store 9=traditional healer 10: home service by HEWs 11=Other (specify)	1=Yes 2=No [skip to 7.26]				
					2nd time	3rd time									4th time
01															
02															
03															
04															
05															
06															

07															
08															
09															
10															

FORM SEVEN: HEALTH CARE UTILIZATION inpatient Treatment (when the patient is admitted by health professional to stay at health facility)

Serial numbers of the household members		7.26			7.27	7.28	7.29	7.30
	Name of the household members Copy all the household members from part two question number 2.1 or 3.2.	Number of hospitalization in each episode			Health care facility	Distance to the facility	Travel time to the facility	Reason for choice of this facility
	After copying, use for only household members' age greater than 5 other wise fill n/a	[fill number of days]			1=Health post 2=Health center 3=Private clinic 4=Mission/NGO clinic 5=Public hospital 6=Private hospital 7=Mission/NGO hospital 8=Pharmacy/drug store 9=traditional healer 10=Other (specify)	[kilometers]	[hours]	1=Proximity 2=Inexpensiveness 3=Staff are always available 4=Medicines are available 5=Short-waiting time 6=Staff are more compassionate 7=Staff more capable 8=CBHI coverage 9=Referral from first visited facility 10=other, specify
		1st	2nd	3rd				
01								
02								
03								
04								
05								
06								
07								
08								
09								
10								

FORM SEVEN: HEALTH CARE UTILIZATION inpatient Treatment (CONTD.)

Serial numbers of the household members	Name of the household members Copy all the household members from part two question number 2.1 Copy only household members' age greater than 5	7.31 How much money has the household spent on				7.32 Main source of financing	7.33 How satisfied is the [name] with						7.34 Waiting time	7.35 Availability of drugs/supplies
						1=Own saving 2=Reduce HH food consumption (if the HH purchases food) 3. Reduce HH nonfood consumption 4=Sell of assets 5=Sell of food stocks 6=Borrowing 7=Remittance (in cash or in kind) 8= Community based health insurance (CBHI) 9= fee waivers from Kebele/Tabia/woreda 10=Increase sell of labor 11=provided free for all 12= Other (specify)____	1=Very satisfied 2=Satisfied 3=Indifferent 4=Dissatisfied 5=very dissatisfied						1= Within a day 2=within a week 3= within two weeks 4=Within a month 5=After a month	1=Not available 2=Rarely available 2=Usually available 3= always available
		Transport	Diagnostics	Medicine	Bed		Diagnostics	Cleanness of facility	Courteousness of staffs	Waiting time	Cleanness of bed and food	Professional care		
01														
02														

03																
04																
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10																

FORM EIGHT: CBHI MODULE

Part I: Awareness of CBHI (including both CBHI and non-CBHI woreda

1. Have you ever heard about community based health insurance program (CBHI)? [non-CBHI members only]

   1=Yes

   2=No ***Indicate code:|__|If No skip to 2***

2. From whom did you hear about CBHI?

   1= neighbors/friends

   2= CBHI officials in public meeting

   3= CBHI house to house awareness creation campaigns ***Indicate code:|__|***

   4= mass media: ETV, radio

   5= health professionals in health facilities

   6=others, specify____

3. Perceptions about CBHI [put ticks on the space provided]

	Correct (1)	**Not correct (2)**	**Do not know (3)**
3.1 Only those who fall sick should consider enrollment in CBHI.			
3.2 Only the very poor who cannot afford to pay for healthcare need to join the schemes.			
3.3Under CBHI program, you pay money (premiums) in order for the CBHI to finance your future health care needs?			
3.4 CBHI program are like savings scheme, you will receive interest and get your money back.			
3.5 If you do not make claims through CBHI, your premium will be returned.			

4. When did you enroll into CBHI? ____________ [CBHI members only]

Part II: Participation (Only CBHI woredas)

5. Have you or any of your HH members attended any CBHI related meetings/training **before CBHI was implemented** in your kebele/tabia?

   1 = Yes

   2 = No ***Indicate code: |__|***

6. In these meetings, did you or any of your HH members discuss and agree the timing/time interval of the regular contribution (premium)?

   1=Yes

   2=No (if no, go to 15) ***Indicate code: |__|***

Part III. (Re-) Enrollment (Only CBHI woreda)

7. Is your HH member enrolled in the CBHI program?

   1 = Yes

   2 = No *Indicate code:* |__|

8. Why has your household decided not to enroll in the CBHI program (multiple responses allowed-list in order of importance)? **(code 2)** ____, _____, _____

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

   2=the registration fee and premiums are not affordable

   3 = want to wait in order to confirm the benefits of the scheme from others *Indicate code:* |__|

   4 = we do not know enough about the CBHI scheme *Indicate code:* |__|

   5 = there is limited availability of health services *Indicate code:* |__|

   6= the quality of health care services is low

   7 = the benefit package does not meet our needs

   8= Lack of confidence in scheme management

   9 = other reasons, please specify

9. Do you plan to enroll in the CBHI scheme in the future?

   1=Yes

   2=No *Indicate code:* |__|

10. Is your household enrolled in any other solidarity group (e.g. iddir, equb, microfinance, other informal systems etc) active in your area?

    1=Yes

    2=No *Indicate code:* |__|

11. Are all members of your household enrolled in the CBHI program?

    1=Yes

    2=No *Indicate code:* |__|

12. If no to question 13, why are some members of the HH are not enrolled in CBHI?

    1=members are healthy

    2=do not have enough money to pay for all *Indicate code:* |__|

    3=members are not nuclear family members

    4=others, specify

13. Why has your household or any of your HH members decided to enroll in the CBHI program (multiple answers allowed-list in order of importance)?

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

2= our HH members need health care

3= To finance health care expenses

4= CBHI registration and premium is paid by the government **_Indicate code:_** |__|

5=Premium is low compared to the user fee price to obtain medical treatment **_Indicate code:_** |__|

6= Pressure from other family members/community **_Indicate code:_** |__|

7= Pressure from the kebele/tabia administration

8= others please specify

14. Who paid for the enrollment fee?

1=HH contribution

2= local government (coverage for Indigent HH) **_Indicate code:_** |__|

15. How long does it take, after payment of registration fee and premium, to start utilizing health services? __________ days

16. Where Do you pay the premiums

1=at the CBHI office

2=Kebele/Tabia administration

3=Official comes and collects **_Indicate code:_** |__|

3=others, please specify----------------------

17. When you current membership expires would you renew your CBHI membership for the following year? 1=Yes

2=No (if yes, go to question19) **_Indicate code:_** |__|

18. If yes, what is the highest amount you are willing to pay to renew your membership? ______ ETB

19. If no, why do you plan not to renew your CBHI membership (multiple responses allowed-list in order of importance)?

1= Illness and injury does not occur frequently in our HH **_Indicate code:_** |__|

2= the registration fee and premiums are not affordable **_Indicate code:_** |__|

3= there is limited availability and poor quality of health services **_Indicate code:_** |__|

4 = The quality of service (waiting time, staff attitude, medicine, diagnostics) for CBHI members is not as good as for out of pocket paying patients (non-CBHI members)

5= other, specify

20. Have you made use of your CBHI membership to cover health costs?

 1=Yes

 2=No **_Indicate code:_** |__|

21. Why has your household not benefitted from CBHI?

 1 = No one in my HH has visited health facilities

 2= We still pay other additional costs for treatment (specify)

 3= The quality of service (waiting time, staff attitude, medicine, diagnostics) for CBHI members is not as good as for out of pocket paying patients (non-CBHI members)

 4= Delays in issuance and distribution of CBHI ID cards

 5=others, specify

Part IV: Affordability and expectations

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

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

 1=disagree, 2=indifferent, 3=agree **_Indicate code:_** |__|

23. The CBHI registration fee is

 1=easily affordable 2=somewhat affordable 3=unaffordable **_Indicate code:_** |__|

24. The CBHI regular contribution (premium) is

 1=easily affordable 2=somewhat affordable 3=unaffordable **_Indicate code:_** |__|

Part V: CBHI experience

(The following questions should be asked only to households who are enrolled in the CBHI program)

1. The local CBHI agent tries hard to solve CBHI implementation problems

 1= Disagree 2= indifferent 3=Agree Indicate code: |__|

2. The community (CBHI members) have the right to guide and supervise the activities of the CBHI management

1= Disagree 2= indifferent 3=Agree Indicate code: |__|

3. Health professionals treat patients of CBHI membership as much as out of pocket paying patients (none members)

 1= Disagree 2= indifferent 3=Agree Indicate code: |__|

4. The CBHI benefit package meets the requirements of my household.

 1= Disagree 2= indifferent 3=Agree Indicate code: |__|

5. The local CBHI management is trustworthy.

1= Disagree 2= indifferent 3=Agree Indicate code: |__|

6. I am satisfied with the experience at the local CBHI office when I go to register?

1= Disagree 2= indifferent 3=Agree Indicate code: |__|

7. I am satisfied with the local CBHI office when I go to pay the regular contribution (premium)?

1= Disagree 2= indifferent 3=Agree Indicate code: |__|

8. I am satisfied with quality of healthcare services provided by the contracted provider?

1=Excellent 2=Good 3=Fair 4=Poor 5=Very poor 6=I don't know Indicate code: |__|

9. Have you benefited from the CBHI scheme?

1=Yes 2=No Indicate code: |__|

10. If yes to question 9, how does your household benefit? (Multiple responses possible-list in order of importance) (code 5)

1= Increased access to health care

2 = Reduced costs of health care

3 = Reduced concerns about expected health care costs Indicate code: |__|

4 = Others, please specify

11. If No to question 9, why do you think your household has not benefited? (multiple responses possible-list in order of importance) (code 6)

1 = No one in my HH has visited health facilities

2= We still pay other additional costs for treatment (specify) Indicate code: |__|

3= The quality of service (waiting time, staff attitude, medicine, diagnostics) for CBHI members is not as good as for out of pocket paying patients (non-CBHI members)

4= Delays in issuance and distribution of CBHI ID cards

5=others, specify

FORM NINE: FOOD EXPENDITURE AND FOOD CONSUMPTION IN THE LAST SEVEN DAYS:

9.1	9.2	9.3			9.4			9.5			
Food Types	Did your household consume this food?	Did you purchase any in the last week? How much was purchased? How much was spent? If the household did not purchase any write zero.			Did you consume this food from your own harvest or your own stock? If the household did not use any from the stock write zero			Did you receive this food as a GIFT, as Wage IN KIND, loan? How much? If the household did not get any fill zero. Write the codes of source listed below on this page.			
	1=Yes 2=No	**Amount**	**Unit**	**Total Expenditure**	**Amount**	**Unit**	**Est. cost**	**Amount**	**Unit**	**Est. cost**	**Source**[9]
Teff											
Barley (Gebis)											
Wheat/ Durahh (Sinde)											
Maize(Bekolo/Bahir mashla)											
Sorghum (Mashila; dagusa)											
Millet (Zengada)											
Lentils (Misir)											
Horse Beans (Bakela)											
Cow Peas (Ater)											
Chick Peas (Shimbra)											
Milk/yoghourt (ergo)											
Beef (yekebitsiga)											
Mutton (yebeg)/goat											
meat(yefiyelsiga)											
Chicken											

[9] 1= Relatives 2= neighbors 3= Government 4= NGO 5= Food for work 6= Daily labor 7= Loan 8= crop by crop exchange 9=Other (specify)

9.1	9.2	9.3			9.4			9.5			
Food Types	Did your household consume this food?	Did you purchase any in the last week? How much was purchased? How much was spent? If the household did not purchase any write zero.			Did you consume this food from your own harvest or your own stock? If the household did not use any from the stock write zero			Did you receive this food as a GIFT, as Wage IN KIND, loan? How much? If the household did not get any fill zero. Write the codes of source listed below on this page.			
	1=Yes 2=No	**Amount**	**Unit**	**Total Expenditure**	**Amount**	**Unit**	**Est. cost**	**Amount**	**Unit**	**Est. cost**	**Source**[9]
Eggs											
butter/cheese											
tella/tej											
birra (bottled)											
Chat											
araqi/kathikala											
soft drinks											
Coffee											
Sugar											
Honey											
Salt											
cooking oil											
spices/karia/berbere											
bread (dabo)											
macaroni/spaghetti											
Potatoes											
sweet potatoes											
green leafy vegetables											

FORM TEN: NON-FOOD EXPENDITURE: THE LAST 12 MONTH TOTAL EXPENDITURE IN BIRR. FORNON PURCHASED ITEM FILL ZERO.

	10.1	10.2	10.3		10.1	10.2	10.3
	TYPES OF EXPENDITURE	Did you purchase?	EXPENSE		TYPES OF EXPENDITURE	Did you purchase?	EXPENSE
		1=Yes 2=No	BIRR			1=Yes 2=No	BIRR
1	EXPENDITURE ON CLOTHES AND RELATED			3.9	Rent for oxen		
1.1	Clothes/shoes/fabric for MEN			3.10	Compensation, penalty and credit		
1.2	Clothes/shoes/fabric for WOMEN			3.11	others		
1.3	Clothes/shoes/fabric for BOYS			4	EXPENDITURE ON HEALTH		
1.4	Clothes/shoes/fabric for GIRLS			4.1	Modern medical treatment and medicines		
1.5	Cloth/shoes/fabric for babies			4.1.1	Drugs		
1.6	Linens (sheets, towels, blankets)			4.1.2	Fees		
1.7	Cosmetics (hair oil, butter, perfume)			4.1.3	Transportation		
1.8	Others			4.1.4	Lodging/board		
2	EXPENDITURE ON HOUSEING AND RELATED			4.1.5	Others		
2.1	Kitchen equipment (cooking pots, etc.)			4.2	Traditional medicine and healers		
2.2	Furniture			4.2.1	Drugs		
2.3	Lamp/torch			4.2.2	Fees		
2.4	Sieve (wonfiet), gourd (kil), sefed, mesob, etc			4.2.3	Transportation		
2.5	Transport (other than health purpose, crop production and crop sale)			4.2.4	Lodging/board		
2.6	Building materials			4.2.5	Others		
2.7	Repair and maintenance			5	EXPENDITURE ON EDUCATION		
2.8	Matches			5.1	Education (school fees)		
2.9	Batteries			5.2	Others		
2.10	Candles (tua'af), incense			6	EXPENDITURE ON AGRICULTURAL INPUTS AND LIVESTOCKS		
2.11	Hand soap, Laundry soap,			6.1	Fertilizer		

	10.1	10.2	10.3		10.1	10.2	10.3
	TYPES OF EXPENDITURE	Did you purchase?	EXPENSE		TYPES OF EXPENDITURE	Did you purchase?	EXPENSE
		1=Yes 2=No	BIRR			1=Yes 2=No	BIRR
	/OMO/endod/ besana leaves						
2.12	other personal care goods (including sendel, matentetc)			6.2	Pesticides (incl. fungicides and herbicides)		
2.13	Others			6.3	Seeds and young plants (chigegn)		
3	EXPENDITURE ON SOCIAL OBLIGATIONS			6.4	Labor for crop production		
3.1	Ceremonial expenses (gold, dowry for spouse)			6.5	Transport related to crop production and crop sale		
3.2	Contributions to IDDIR			6.6	Labor for herding		
3.3	Donations to the church			6.7	Animal feed		
3.4	Taxes and levies			6.8	Veterinary services/medicines		
3.5	Compensation and penalty			6.9	other expenses		
3.6	Voluntary contributions (including ereban)			7	DEATH RELATED EXPENDITURE		
3.7	Rent (other than oxen and land			7.1	Funerals and Teskar		
3.8	Rent for land						
GRAND TOTAL							

ANNEX C: SAMPLE KEBELE/TABIA SELECTION MINUTE OF ONE WOREDA

የማአጤመ የግምገማ ጥናት ለቤተሰብ ጥናት የቀበሌ አመራረጥ ስምምነት
(የማአጤመ አባል ለሆነ ወረዳ)

ቀን 21/04/06

በ [illegible] ክልል፤ በ [illegible] ወረዳ ውስጥ በአጠቃላይ 20 ቀበሌዎች ይገኛሉ፡፡ ከነዚህ ቀበሌዎች ውስጥ 5 ቀበሌዎች ለሎጂስቲክስ አስቸጋሪ በመሆናቸው ከናሙናነት እንዲወጡ ተደርጓል፡፡ ቀሪዎቹ 15 ቀበሌዎች በናሙናነት ለመመረጥ ዕጣ ውስጥ ገብተዋል፡፡ ከእነዚህም ቀበሌዎች በሎተሪ መልክ ዕጣ ወጥቶ የሚከተሉት ቀበሌዎች ተመርጠዋል፡፡ እነዚህም፤

1. --- [illegible]
2. --- [illegible]
3. --- [illegible]
4. --- [illegible]
5. --- [illegible]

ይህ ናሙና በተሰጠው መመሪያ መሰረት በጋራ የመረጥን መሆኑን በፊርማችን እናረጋግጣለን፡፡

የመረጃ ሰብሳቢ ተቆጣጣሪ

ስም [illegible]

ፊርማ [illegible]

የወረዳው ማአጤመ ቡድን አስተባባሪ

[illegible]

[illegible]

ANNEX D: SAMPLE GOT SELECTION MINUTE

የማስጤሙ የግምገማ ጥናት ለቤተሰብ ጥናት ጎጦች/መንደሮች/የልማት ቡድኖች አመራረጥ ስምምነት

ቀን 01-05-06

በ......[illegible]...... ክልል፣ በ......[illegible]...... ወረዳ በ......[illegible]...... ቀበሌ ውስጥ በአጠቃላይ ......23...... ጎጦች/መንደሮች/የልማት ቡድኖች ይገኛሉ። ከነዚህም ውስጥ ......0...... ጎጦች/መንደሮች/የልማት ቡድኖች ለሎጂስቲክስ አስቸጋሪ በመሆናቸው ከናሙናነት እንዲወጡ ተደርጓል። ቀሪዎቹ ......3...... ጎጦች/መንደሮች/የልማት ቡድኖች በናሙናነት ለመመረጥ ዕጣ ውስጥ ገብተዋል። ከእነዚህም ጎጦች/መንደሮች/የልማት ቡድኖች በሎተሪ መልክ ዕጣ ወጥቶ የሚከተሉት ጎጦች/መንደሮች/የልማት ቡድኖች ተመርጠዋል። እነዚህም፣

1. [illegible]
2. [illegible]

ይህ ናሙና በተሰጠው መመሪያ መሰረት በጋራ የመረጥን መሆኑን በፊርማችን እናረጋግጣለን።

የመረጃ ሰብሳቢ ተቆጣጣሪ	የቀበሌ ስራ አስኪያጅ
ስም ......[illegible]......	......[illegible]......
ፊርማ ......[signature]......	......[signature]......

ANNEX E: FISCAL IMPLICATION OF CBHI SCALE UP, 50 PERCENT PARTICIPATION

Projected Government Subsidy Requirements under Three Scenarios ('000 Birr)

50% Participation Rate

Region	161 Expansion Woredas			All Non-Pastoralist Woredas		
	10%	Pilot Case	29%	10%	Pilot Case	29%
Total Budget						
Amhara	36,848.62	43,222.50	50,046.40	252,437.71	308,954.69	369,462.08
Oromia	75,007.49	70,536.11	104,742.21	325,609.55	303,086.47	475,388.08
SNNP	18,171.75	17,161.17	23,165.28	126,485.43	114,441.90	185,996.15
Tigray	15,674.42	14,815.21	21,343.68	44,690.52	41,579.91	65,215.20
Addis Ababa				50,500.67	50,500.67	73,883.75
Other Non-Pastoralist Regions				18,238.35	18,238.35	26,870.59
Total	**145,702.28**	**145,734.99**	**199,297.57**	**817,962.23**	**836,801.98**	**1,196,815.84**
Federal Budget						
Amhara	22,996.40	22,996.40	22,996.40	189,711.72	189,711.72	189,711.72
Oromia	50,301.18	50,301.18	50,301.18	246,380.00	246,380.00	246,380.00
SNNP	8,545.19	8,545.19	8,545.19	95,036.83	95,036.83	95,036.83
Tigray	9,991.66	9,991.66	9,991.66	33,662.76	33,662.76	33,662.76
Addis Ababa				38,193.78	38,193.78	38,193.78
Other Non-Pastoralist Regions				13,695.07	13,695.07	13,695.07
Total	**91,834.43**	**91,834.43**	**91,834.43**	**616,680.15**	**616,680.15**	**616,680.15**
Regional Budget						
Amhara	9,696.56	14,158.27	18,935.00	43,908.19	83,470.08	125,825.25
Oromia	17,294.42	14,164.45	38,108.72	55,460.69	39,694.53	160,305.65
SNNP	0.00	0.00	0.00	0.00	0.00	0.00
Tigray	3,977.93	3,376.49	7,946.42	7,719.44	5,542.01	22,086.71
Addis Ababa	0.00	0.00	0.00	8,614.82	8,614.82	24,982.98
Other Non-Pastoralist Regions		0.00	0.00	3,180.30	3,180.30	9,222.87
Total	30,968.91	31,699.21	64,990.14	118,883.43	140,501.74	342,423.46
Woreda Budget						
Amhara	4,155.67	6,067.83	8,115.00	18,817.80	35,772.89	53,925.11
Oromia	7,411.89	6,070.48	16,332.31	23,768.87	17,011.94	68,702.42

Region	161 Expansion Woredas			All Non-Pastoralist Woredas		
	10%	Pilot Case	29%	10%	Pilot Case	29%
SNNP	9,626.55	8,615.98	14,620.08	31,448.61	19,405.07	90,959.33
Tigray	1,704.83	1,447.07	3,405.61	3,308.33	2,375.15	9,465.73
Addis Ababa				3,692.07	3,692.07	10,706.99
Other Non-Pastoralist Regions				1,362.99	1,362.99	3,952.66
Total	22,898.94	22,201.35	42,473.00	82,398.65	79,620.10	237,712.24
Average Woreda Budget (161 Woredas)						
Amhara	98.94	144.47	193.21			
Oromia	117.65	96.36	259.24			
SNNP	192.53	172.32	292.40			
Tigray	94.71	80.39	189.20			
Addis Ababa						
Other Non-Pastoralist Regions						
Total	125.96	123.39	233.51			

ANNEX F: FISCAL IMPLICATION OF CBHI SCALE UP, 75 PERCENT PARTICIPATION

Projected Government Subsidy Requirements under Three Scenarios ('000 Birr)

75% Participation Rate

Region	161 Expansion Woredas			All Non-Pastoralist Woredas		
	10%	Pilot Case	29%	10%	Pilot Case	29%
Total Budget						
Amhara	50,917.62	60,478.43	70,714.29	252,437.71	308,954.69	369,462.08
Oromia	107,116.67	100,409.59	151,718.74	325,609.55	303,086.47	475,388.08
SNNP	23,446.96	21,931.10	30,937.26	126,485.43	114,441.90	185,996.15
Tigray	21,683.13	20,394.33	30,187.03	44,690.52	41,579.91	65,215.20
Addis Ababa				50,500.67	50,500.67	73,883.75
Other Non-Pastoralist Regions				18,238.35	18,238.35	26,870.59
Total	**203,164.37**	**203,213.45**	**283,557.31**	**817,962.23**	**836,801.98**	**1,196,815.84**
Federal Budget						
Amhara	33,592.30	33,592.30	33,592.30	189,711.72	189,711.72	189,711.72
Oromia	74,585.43	74,585.43	74,585.43	246,380.00	246,380.00	246,380.00
SNNP	12,506.32	12,506.32	12,506.32	95,036.83	95,036.83	95,036.83
Tigray	14,508.46	14,508.46	14,508.46	33,662.76	33,662.76	33,662.76
Addis Ababa				38,193.78	38,193.78	38,193.78
Other Non-Pastoralist Regions				13,695.07	13,695.07	13,695.07
Total	**135,192.50**	**135,192.50**	**135,192.50**	**616,680.15**	**616,680.15**	**616,680.15**
Regional Budget						
Amhara	12,127.73	18,820.29	25,985.39	43,908.19	83,470.08	125,825.25
Oromia	22,771.87	18,076.91	53,993.32	55,460.69	39,694.53	160,305.65
SNNP	0.00	0.00	0.00	0.00	0.00	0.00
Tigray	5,022.27	4,120.11	10,975.00	7,719.44	5,542.01	22,086.71
Addis Ababa	0.00	0.00	0.00	8,614.82	8,614.82	24,982.98
Other Non-Pastoralist Regions		0.00	0.00	3,180.30	3,180.30	9,222.87
Total	**39,921.86**	**41,017.31**	**90,953.71**	**118,883.43**	**140,501.74**	**342,423.46**

Region	161 Expansion Woredas			All Non-Pastoralist Woredas		
	10%	Pilot Case	29%	10%	Pilot Case	29%
Woreda Budget						
Amhara	5,197.60	8,065.84	11,136.60	18,817.80	35,772.89	53,925.11
Oromia	9,759.37	7,747.25	23,139.99	23,768.87	17,011.94	68,702.42
SNNP	10,940.64	9,424.78	18,430.94	31,448.61	19,405.07	90,959.33
Tigray	2,152.40	1,765.76	4,703.57	3,308.33	2,375.15	9,465.73
Addis Ababa				3,692.07	3,692.07	10,706.99
Other Non-Pastoralist Regions				1,362.99	1,362.99	3,952.66
Total	**28,050.01**	**27,003.63**	**57,411.10**	**82,398.65**	**79,620.10**	**237,712.24**
Average Woreda Budget (161 Woredas)						
Amhara	123.75	192.04	265.16			
Oromia	154.91	122.97	367.30			
SNNP	218.81	188.50	368.62			
Tigray	119.58	98.10	261.31			
Addis Ababa						
Other Non-Pastoralist Regions						
Total	**154.26**	**150.40**	**315.60**			

ANNEX G: FISCAL IMPLICATION OF CBHI SCALE UP, 100 PERCENT PARTICIPATION

Region	161 Expansion Woredas		All Non-Pastoralist Woredas	
	10%	29%	10%	29%
Total Budget				
Amhara	64,986.62	91,382.17	252,437.71	369,462.08
Oromia	139,225.84	198,695.27	325,609.55	475,388.08
SNNP	28,722.17	38,709.24	126,485.43	185,996.15
Tigray	27,691.84	39,030.38	44,690.52	65,215.20
Addis Ababa			50,500.67	73,883.75
Other Non-Pastoralist Regions			18,238.35	26,870.59
Total	**260,626.47**	**367,817.06**	**817,962.23**	**1,196,815.84**
Federal Budget				
Amhara	44,188.19	44,188.19	189,711.72	189,711.72
Oromia	98,869.68	98,869.68	246,380.00	246,380.00
SNNP	16,467.44	16,467.44	95,036.83	95,036.83
Tigray	19,025.26	19,025.26	33,662.76	33,662.76
Addis Ababa			38,193.78	38,193.78
Other Non-Pastoralist Regions			13,695.07	13,695.07
Total	**178,550.57**	**178,550.57**	**616,680.15**	**616,680.15**
Regional Budget				
Amhara	14,558.90	33,035.78	43,908.19	125,825.25
Oromia	28,249.31	69,877.91	55,460.69	160,305.65
SNNP	0.00	0.00	0.00	0.00
Tigray	6,066.61	14,003.59	7,719.44	22,086.71
Addis Ababa	0.00	0.00	8,614.82	24,982.98
Other Non-Pastoralist Regions		0.00	3,180.30	9,222.87
Total	**48,874.82**	**116,917.28**	**118,883.43**	**342,423.46**
Woreda Budget				
Amhara	6,239.53	14,158.19	18,817.80	53,925.11
Oromia	12,106.85	29,947.68	23,768.87	68,702.42
SNNP	12,254.73	22,241.79	31,448.61	90,959.33
Tigray	2,599.98	6,001.54	3,308.33	9,465.73
Addis Ababa			3,692.07	10,706.99
Other Non-Pastoralist Regions			1,362.99	3,952.66
Total	**33,201.08**	**72,349.20**	**82,398.65**	**237,712.24**

Region	161 Expansion Woredas		All Non-Pastoralist Woredas	
	10%	29%	10%	29%
Average Woreda Budget (161 Woredas)				
Amhara	148.56	337.10		
Oromia	192.17	475.36		
SNNP	245.09	444.84		
Tigray	144.44	333.42		
Addis Ababa				
Other Non-Pastoralist Regions				
Total	**182.57**	**397.68**		

ANNEX H: PATIENT EXIT INTERVIEW QUESTIONNAIRE

Cover Section A: Informed Consent

Instruction to Interviewer:

Meet with the HF Head or any other person in charge and explain the purpose of the study and inform them that you want to conduct patient exit interview at the outpatient level (at health center) and outpatient and inpatients levels(at a hospital) and request an agreement to conduct one. Have the HF Head/ Person in charge or any other assigned staff takes you to the pharmacy/inpatient department. Identify 5 CBHI members and 5 non-members (HC outpatient) and 4 CBHI members and 4 non-members (hospital outpatient). For inpatient interview, meet with Head Nurses of each Inpatient Department. Get a list of inpatients that are ready to be discharged on the day from each. Also, check the ones that are CBHI members and select 2 inpatients among CBHI members ready to be discharged on that day and conduct the interview.

Once you meet with the interviewee use the consent for below:

የቅድመ መረጃ ፍቃድ

ጤና ይስጥልኝ! የማህበረሰብ አቀፍ የጤና መድህን መረጃ ሰብሳቢ ነኝ፡፡ በቅድሚያ ለምንጠይቅዎት ጥያቄዎች መልስ ለመስጠት ጊዜዎን በመስጠትዎ እናመሰግናለን፡፡ መንግሥት ባለፉት ሁለት ዓመታት በወረዳው ውስጥ የማኅበረሰብ አቀፍ የጤና መድህን መጀመሩ ይታወቃል፡፡ ይህ ፕሮግራም በኅብረተሰቡ የጤና አጠቃቀም፤የአገልግሎት ጥራትና ወጭን በመቀነስ ረገድ ያሳደረውን ለውጥ በማጥናት ላይ እንገኛለን፡፡ የማኅበረሰብ አቀፍ የጤና መድን እንዴት መሻሻል እንዳለበት የእርስዎን አስተያየት እንጠይቃለን፡፡

እርሰዎ በአጋጣሚ ተመርጠዋል፡፡ መጠይቁ 20 ደቂቃ ይፈጃል፡፡ የሚሰጡት ምላሽ ሁሉ ሚስጢራዊ ሲሆን ከአማካሪዎቹ እና ከቃለ መጠይቅ አድራጊው ውጪ ጥቅም ላይ አይውልም፡፡ በዚህ ጥናት የሚሳተፉት በፈቃደኝነት ብቻ ነው፡፡ በዚህ ጥናት በፈቃደኝነት ለመሳተፍ መስማማትዎን በቃል እንዲያረጋግጡልኝ በአክብሮት እጠይቃለሁ፡፡

Cover Section B: Background

1.Date:

Day	Month	Year
|__|__|	|__|__|	|__|__|__|__|

2.Name of Interviewer:________________________________

3.Name of Regional Coordinator:_______________________

4. Facility information

a. Name:_____________________________________

b. Region: ***Indicate code:*** **|__|**

c. Woreda: ***Indicate code:*****|__|**

Region	Woreda
1=Amhara	11=South Achefer
	12=Fogera
	13=Tehuledere
	14=Dembia (Control woreda)
2=Tigray	21=Kilte Awlaelo
	22=Afeherom
	23=Tahitay Adiabo
	24=Raya (control woreda)
3=Oromia	31=Gimbichu
	32=Kuyu
	33=Deder
	34=Limukossa
	35=Merti (control woreda)
4=SNNP	41=Yirgalem city administration
	42=Dambova
	43=Damot Woyde
	44=Wonago (control woreda)

5. Level of Facility ***Indicate code:*** **|__|**

1=Regional referral Hospital

2=General Zonal Hospital

3=Primary District Hospital

4=Health Center

6. Patient No.____

Section1: Patient's Background

Question	Response		
1- Age (in completed years)	|__||__| **years**		
2- Sex (fill as observed)	1=Male	2=Female	***Indicate code:*** |__|
3- highest educational attainment 1=Illiterate 2=reading and writing 3=primary education (Grade 1-6) 4=secondary education (Grade 7-12) 5=vocational training 6=tertiary education 7=under age	***Indicate code:*** |__|		
4- Residence	1=urban	2=rural	***Indicate code:*** |__|
5- marital status 1=never married 2=married 3=living together 4=divorced/separated 5=widowed	***Indicate code:*** |__|		
6- Occupation/employment 1=employed/self-employed (e.g. farming) 2=non-employed (above 18 years) 3=student 4=other, specify_______________	***Indicate code:*** |__|		
7 – Are you a member of CBHI? 1=Yes 2= No	***Indicate code:*** |__|		
8 – Are you a fee waiver beneficiary? ***(Only for control Woreda)*** 1=Yes 2= No	***Indicate code:*** |__|		

Section2: Service utilization and quality

9- For how long have you used this health facility? ***(state number of months)***	**|__||__| |__|months**
10- What were the reasons for you visit today? ***(multiple response is possible)***	
1=Diarrhea	***Indicate code:*** |__|
2=Fever	***Indicate code:*** |__|
3=Respiratory problem	***Indicate code:*** |__|
4=Cough	***Indicate code:*** |__|
5=Nausea/vomiting	***Indicate code:*** |__|
6=Head ache	
7=Stomachache	
8=Toothache	
9=Joint/muscle pain	
10=Delivery	
11=Injury	
12=eye problem	
13=other(specify)___________________	
11- Which services did you obtain during this visit/stay? ***(multiple response is possible)***	
1=Consultation/card	***Indicate code:***|__|
2= Diagnosis (lab and other)	***Indicate code:***|__|
3=Drugs and medical supplies	***Indicate code:***|__|
4= Inpatient services (bed/food)	***Indicate code:***|__|
5=Delivery	***Indicate code:***|__|
6=Surgical procedure	
7=others, specify	
12- If the answer to question 11 is 3, were you able to get the prescribed drugs/supplies?	
1= fully (all prescribed) 2= partially (only some of them) 3= none ***(go to question 14)***	***Indicate code:*** |__|

13. If the answer to question 12 is 1 or 2, where did you get it from?	
1= within the visited facility 2= being sent to other CBHI contracted facilities (including drug retailers) 3= being sent to other facility/drug stores	***Indicate code:*** |__|
14. If the answer to question 12 is 3, what is the reason?	
1= unavailability within the facility visited 2= unable to buy	***Indicate code:*** |__|
15- How satisfied are you with the service you received during this visit/stay? ***(Indicate the code for questions 15.1-15.9)***	1=Very satisfied 2=satisfied 3=Neither satisfied nor dissatisfied 4=dissatisfied 5=Very dissatisfied
15.1= overall quality of service?	***Indicate code:*** |__|
15.2=Availability of drugs/medical supplies?	***Indicate code:*** |__|
15.3=Availability of diagnostic facilities?	***Indicate code:*** |__|
15.4=Cleanliness of the facility?	***Indicate code:*** |__|
15.5=Waiting time (from the time of arrival in the health facility up to seeing a health professional?	***Indicate code:*** |__|
15.6=Waiting time between services (e.g. between consultation and diagnosis)?	***Indicate code:*** |__|
15.7=Friendliness of staff?	***Indicate code:*** |__|
15.8= Attentiveness and adequate follow up by the nursing staff? ***(inpatient only in hospitals)***	***Indicate code:*** |__|
15.9= Quality of food and other inpatient amenities? ***(inpatient only in hospitals)***	***Indicate code:*** |__|
16- Have you observed any improvement in service quality since this health facility has been contracted by the CBHI scheme ***(mention the year)*** ***(to be asked in CBHI pilot woreda only)*** – ***(put code as appropriate for questions 16.1 to 16.9)***	1=Yes 2=No 3=Don't observe
16.1= overall quality of service?	***Indicate code:*** |__|
16.2= Availability of drugs/medical supplies?	***Indicate code:*** |__|
16.3= Availability of diagnostic facilities?	***Indicate code:*** |__|
16.4= Cleanliness of the facility?	***Indicate code:*** |__|
16.5= Waiting time (from the time of arrival in the health facility up to seeing a health professional?	***Indicate code:*** |__|
16.6= Waiting time between services (e.g. between consultation and diagnosis)	***Indicate code:*** |__|

16.7=Friendliness of staff?	***Indicate code:*** |__|
16.8=Attentiveness and adequate follow up by the nursing staff? **(inpatient only)**	***Indicate code:*** |__|
16.9=Quality of food and other inpatient amenities? **(inpatient only)**	***Indicate code:*** |__|
17-For how long did you wait before you had consultation with staff today or the last time you had consultation?	
1= Less than 30 minutes	***Indicate code:*** |__|
2=30 to 60 minutes	
3= 1 to 3 hours	
4=3 to 6 hours	
5= 6 hours and more	
18 - For how long did you wait between services (e.g. between consultation and diagnosis) today or the last time you had to utilize various services?	
1= Less than 30 minutes	***Indicate code:*** |__|
2=30 to 60 minutes	
3= 1 to 3 hours	
4=3 to 6 hours	
5= 6 hours and more	
19 - Is this health facility your preferred service point for your future health care needs? 1=Yes because I am satisfied with the service quality 2= Yes because I do not have another option 3= No	***Indicate code:*** |__|
20 – Do health professionals treat CBHI members and non-CBHI members equally, with impartiality?	
1= Yes 2= No 3 = No comment	***Indicate code:***|__|
21 - How much did you pay for the service you obtained (in ETB)? (for non-members and members who utilized a service which is not covered by CBHI e.g. dental service, eye glass etc) ***(ask the patient the type of service they acquired check against the list of CBHI service package)***	
1=Consultation	____________***ETB***
2=Diagnosis	____________***ETB***
3=Drugs and medical supplies	____________***ETB***
4= Inpatient services	____________***ETB***
5= transport ***(for inpatient only)***	____________***ETB***
6=others, specify	____________***ETB***
22 – How affordable is the fee you paid for the service?	

1= affordable	
2=somewhat affordable	***Indicate code:*|__|**
3=not affordable	

Section3: CBHI Related

Question	Response
23- Are you enrolled in a CBHI scheme in your woreda? 1=Yes 2=No (go to 28)	***Indicate code:***|__|
24 – When did you become a CBHI member?	**Write the year** |__|__|__|__|
25 – Why did you decide to enroll in CBHI? ***(multiple response is possible)***	
1=Illness and/or injury occurs frequently in our household	***Indicate code:***|__| ***Indicate code:***|__| ***Indicate code:***|__| ***Indicate code:***|__|
2= To finance health care expenses	
3= household is exempt from registration fee and premium payment	
4=Premium is low compared to the user fee price to obtain medical treatment	
5= Pressure from other family members/community	
6= Pressure from the CBHI office	
7= Others, please specify	
26 – Do you plan to renew your CBHI membership? 1= Yes 2=No (go to 29)	***Indicate code:***|__|
27 - How do you feel about the adequacy of the benefit package?	
1=very adequate 2= somewhat adequate 3= inadequate 4=I do not know	***Indicate code:***|__|

28 – If you are not a CBHI member, why did you decide not to enroll in CBHI? ***(multiple response is possible)***	
1=Illness and injury does not occur frequently in our household	***Indicate code:***|__| ***Indicate code:***|__| ***Indicate code:***|__| ***Indicate code:***|__| ***Indicate code:***|__| ***Indicate code:***|__|
2=The registration fee and premiums are not affordable	
3=Want to wait in order to confirm the benefits of the scheme from others	
4= We do not know enough about the CBHI scheme	
5= There is limited availability of health services	
6= The quality of health care services is low	
7= The benefit package does not meet our needs	
8= CBHI management staff is not trustworthy	
9= Waiting time to access services is longer for CBHI members	
10=I am fee waiver beneficiary	
11= Other reasons, please specify	
12= I don't know	
29 – If you have decided not to renew your CBHI membership, state the reason. ***(multiple response is possible)***	
1=Illness and injury does not occur frequently in our household	***Indicate code:***|__| ***Indicate code:***|__| ***Indicate code:***|__| ***Indicate code:***|__| ***Indicate code:***|__|
2=The registration fee and premiums are not affordable	
3= There is limited availability of health services	
4=The quality of health services is low	
5= CBHI management staff is not trustworthy	
6= The quality of service for CBHI members is worse than for non-CBHI members	
7= Waiting time to access services is longer for CBHI members	
8= Other, specify	

ANNEX I: KEY INFORMANT INTERVIEW

3.1 Ethiopian Health Insurance Agency (EHIA), Resource Mobilization and Utilization Directorate and State Minister (Jointly)

INSTRUCTION TO THE INTERVIEWER
This document is meant to be used as a general guide for the CBHI Evaluation team members during interviews with a broad range of stakeholders. Find the manager or the most senior person responsible at this level. After introducing yourself and greetings, eexplain briefly the purpose of the interview, the interview process and thank them for seeing us.   **Provide the following information and obtain verbal informed consent to take part in the interview.**   **The purpose of this assessment is to gather data to evaluate the impact of pilot CBHI schemes from different perspectives including improving financial access, quality of health services, increasing resource mobilization and community participation. This assessment will also provide recommendations for the scale-up of the pilot schemes at national level.**   **If there are questions for which someone else is the most appropriate person to provide that**   **Information, I would appreciate if you introduce me to that person.**   **Any information you will provide as part of this interview will be held strictly confidential. Any reference to the information you provide in our analysis will be made without mentioning or implicating your name in any way.**

Interviewee (Name and Title):   **Phone no:**   **Date:**

Generally, can you talk about your organization and your responsibilities in relation to the CBHI piloting and its scaling up?

1. What is your expectation from this CBHI evaluation?
2. What are the primary policy purposes of CBHI in Ethiopia?
3. What are the roles and responsibilities of various levels of government authorities with regards to CBHI policy making, design and implementation?
    a. FMOH
    b. EHIA
    c. Regional government/BOFED/RHB
    d. Zonal authorities
    e. Woreda government/WOFED/WorHO
4. Can you please describe for us the role FMOH and EHIA played in supporting the CBHI schemes (viz. subsidizing the schemes, improving the quality of services by providers, training and skill upgrading plans for CBHI staff etc?)

5. Are the CBHI schemes working? What do you think are the main achievements of CBHI in the pilot woredas, in terms of

    a. Access to care?
    b. Quality of care?
    c. Utilization of services?
    d. Equity?
    e. Mobilization of resources to health facilities?
6. The achievement of the CBHI in terms of enrolment and coverage of the poor varies from region to region and woreda to woreda. What strategies have worked in successful regions and woredas? Any best practices you have identified?
7. The pilot scheme design was implemented and tested for some time now. What are the major successes and challenges in the scheme parameters:
    a. Benefit package?
    b. Level of premiums?
    c. Membership scenario (HH vs. individual basis)
    d. Reimbursement amounts?
    e. Referral mechanism?
    f. Payment to the health facilities on timely manner?
    g. CBHI management schemes?
    h. Institutional arrangement (staff size, etc.,)
    i. Staff skills and capacity?

Do you think there is need to revisit some of these design parameters?

8. Design Parameters (benefit package, level of premium, membership scenario (household vs. Individual), contribution frequency etc.) vary slight across regions.
    a. What is the plan of the FMOH/EHIA for future scale up? Do you plan to proceed with different design parameters?
    b. Have benefit packages been assessed in line with government policy priorities and needs of community members/eligible households, etc.? If not, is there plan to do so before scale up?
9. The performance of schemes in terms of enrolment varies from region to region and from woreda to woreda? What do you think are the major factors for this regional and woreda variation in enrolments? Are you aware of any complaints of CBHI members in terms of service coverage, premiums and quality of service? What should be done to encourage non- members to join and members to be satisfied?
10. Are there instances of fraud and abuse in CBHI financial resources management in the pilot woredas? If yes, what actions have been taken?
11. Who are the major stakeholders in the initiation and scale-up of CBHI schemes? Can you please describe how you these stakeholders have reached the decision to scale up the CBHI schemes to 160 Woredas? What were the criteria used to select the woredas? Have the fiscal implications of scale-up been calculated?
12. What is the organizational and operational readiness for scale up? IS EHIA legally mandated to lead CBHI? What is EHIA's organizational relation with regional governments? Does EHIA have the required organizational arrangement and capacity appropriate to support, lead and regulate CBHI schemes?
13. FINANCING SCALEUP –

a) What is status of readiness and willingness of Federal Government to finance general subsidy to scale up CBHI?

b) Given your close working relationships with the regions, are the regional and woreda governments ready to take the fiscal implications of the scaling up?

c) What is the plan regarding financing of the scale-up? What are sources of government subsidy (targeted and general subsidy), i.e. donor funding vs own/government revenue? What is the possibility of having regular budgeting and budget codes for general health insurance and CBHI? Is there a political and legal base to do so? How to make them legally obligated in the future?

d) What is the plan to ensure financial sustainability of CBHI schemes? What about reinsurance to CBHI schemes? Risk pooling among different schemes in the region and then at national level among all schemes? Which authority will be mandated to protect CBHI schemes from problem of insolvency and complete collapse?

14. What do you think are the major lessons learned to inform the scale up process?

3.2. Regional and Woreda Health Office Heads

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If there are questions for which someone else is the most appropriate person to provide that

Information, I would appreciate if you introduce me to that person.

Any information you will provide as part of this interview will be held strictly confidential. Any reference to the information you provide in our analysis will be made without mentioning or implicating your name in any way.

Interviewee (Name and Title):

Region:

Zone:

Woreda:

Date:

Tel No.:

Roles and Responsibilities

1. What are the roles and responsibilities of various levels of government authorities with regards to CBHI policy making, design and management?
    a. FMOH
    b. EHIA
    c. Regional government/BOFED/RHB
    d. Regional steering committee
    e. Zonal authorities
    f. Woreda government/WOFED/WorHO

Have all been fully engaged in the process? If not, what can be done to better engage these authorities during the future scale up?

2. How do you assess the policy guidance, financial and technical support received from FMOH and EHIA? How about commitment and support from regional government in terms of budget allocation for general and targeted subsidy?
3. Who else is providing the required technical support?

Experience and Impact of the Schemes

4. Given the experiences of the pilot woredas, what were the strength and weaknesses regarding the

- Legal frameworks,
- Directives, by-laws, manuals and guidelines,
- Sensitizing the community
- The structures and recruitment of staff

5. The pilot scheme design was implemented and tested for some time now. What are the major successes and challenges in the scheme parameters:
    a. Benefit package?
    b. Level of premiums?
    c. Membership scenario (HH vs. individual basis) Reimbursement amounts?
    d. Referral mechanism?
    e. Payment to the health facilities on timely manner?
    f. Enabling the schemes to cover all health related expenses through its income?
    g. Affordability to member?
    h. Fairness compared to benefit package?
    i. CBHI management schemes?
    j. Institutional arrangement (staff size, dual assignment, etc.,)?
    k. Staff skills and capacity?

What are the major complaints of members in this regard, if any?

6. What are the successes and challenges in mobilizing the community to enrol/renew membership in CBHI? What proportion of the woreda population is currently enrolled? What strategy has worked and what hasn't?
7. Has the targeted (and general) subsidy allowed pilot woredas to adequately include indigents in the CBHI? Are there indigents who are left out? And how significant are they in number? To what extent do you see CBHI as one of the mechanisms to increase access to health care equitably? Discuss challenges in this regard, if any.
8. Could you tell us about the successes, challenges and the areas that need improvement regarding the defined benefit package and the views of CBHI members on its coverage and adequacy as well as availability of these services in the health facilities?
9. How successful has the CBHI scheme been in negotiating agreeable terms and contract with service providers – in terms of service quality, fee, and reduction in unnecessary services/prescription (moral hazard) etc.? What are the successes and challenges in contract administration?
10. Does the implementation of the CBHI scheme have any impact (positive or negative) on the health facilities in terms of increasing resources, improving quality of care, motivation of the staff?

Health Service Utilization and Quality

11. Have you seen any difference between CBHI woredas and non CBHI Woredas in terms of utilization of services? If there is increase in patient flow, how successful have facilities been in coping with this demand surge? How about coping with further demand increase with the scale up? Please provide evidence.
12. How is the referral of the CBHI members being carried out? Any specific challenges given that they are likely to claim preferential treatment? Any specific measures introduced? Lessons learned for scaling up.
13. To what extent are health facilities providing quality health care services for CBHI schemes as well as other clients? How does your organization support facilities to make them respond to increased demand for quality care?

Management

14. The management of the schemes is heavily dependent on the scheme managers. How do you view CBHI management and staffing structure? Any successes and challenges regarding retention and motivation of CBHI management team? What should scaling up woreda learn in this regard?
15. How and to what extent is the community involved in the management of CBHI scheme viz. CBHI design and administration? Discuss
16. How and to what extent is the community involved in the management of health service delivery in the district? Discuss
17. What is the role of the woreda administration in enrolment drive, allocation of resources and staff recruitment? What worked and what didn't? What are the innovative strategies in successful woredas that should be scaled up?

Financial Status

18. Overall, what is the financial status of the CBHIs?
19. If the surplus of the CBHIs is increasing over time, why is this so? Are the beneficiaries not utilizing services? Is the user fees paid too low? Or are the premiums higher? Can you explain this for us?
20. Have the regional health bureau/Woreda health office invested any additional resources on health facilities (human resources, water and electricity, other equipment) to ensure that CBHI members get quality services? If yes, please describe the investments made
21. Can the health bureau/other woredas be able to do such investments in the scaling up woredas?
22. What was the role of the FMOH in improving quality of care and CBHI scheme in the pilot woredas? Please describe the support you received from FMOH for the CBHI schemes?

Scale up

23. What do you think are the challenges of the scaling up to other woredas for regional and woreda governments?
24. In scaling up the CBHI to other woredas, what should be the criteria for selecting the woredas for scaling up in terms of
    a. Availability of health facilities
    b. Budget allocation
    c. Economic status of households
    d. Others

Data to be collected from the RHB and Woreda offices from secondary Sources

1. Outpatient and inpatient visits

No	Item	CBHI Woredas	Non-CBHI Woredas
1	Total population		
2	Total outpatient visits in 2005 EFY		
3	Total inpatient visits in 2005 EFY		

2. Financial support from the FMOH (in ETB)

No		For the region (amount in ETB)	For the pilot woreda (Amount in ETB)
1	25% subsidy for the premiums		
2	Investment for health facilities		
3	Subsidy for the tertiary care		
4	Any other, specify		

3. Implication of the CBHI scaling up

No		
1	# of woredas to be scale up	
2	Total # of estimated households in the scaling up woredas	
3	Estimated number of indigents in the scaling up woredas	
4	Estimated regional subsidy for indigents in scaling up woredas	
5	Estimated woreda subsidy for indigents in the scaling up woredas	
6	25% subsidy for the premiums from FMOH for the scaling up woredas	
7	Salaries for scheme managers in the scaling up woredas	
8	Investment for health facilities in the scaling up woredas	
9	Subsidy for the tertiary care, if any	
10	Any other support, specify	

3.3. Regional/Woreda Finance Bureau/Office

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If there are questions for which someone else is the most appropriate person to provide that

Information, I would appreciate if you introduce me to that person.

Any information you will provide as part of this interview will be held strictly confidential. Any reference to the information you provide in our analysis will be made without mentioning or implicating your name in any way.

Interviewee (Name and Title):

Phone no:

Region:

Zone:

Woreda:

Date:

General

1. Are you aware of the CBHI schemes that are piloted in your region/woreda?
2. Generally, can you talk about your BOFED/ WOFED's role in the implementation of the CBHI in the pilot woredas/ woreda and your relationship, if at all, with the scheme management?
3. What do you think are the major achievements (impacts) of CBHI scheme in the Region/ woreda?
4. Not all residents of the pilot woreda are enrolled into the CBHI scheme. What do you think are the major reasons for not enrolling in CBHI or renewing their membership?
5.

Experience and Impact of the Schemes

6. What is the perceived or actual contribution of the CBHI on the following:
    a. Access to care?
    b. Quality of care?
    c. Equity?
    d. Affordability?
7. Given the experiences of the pilot woredas, what were the strength and weaknesses regarding the
    - Legal frameworks,
    - Directives, by-laws, manuals and guidelines,
    - Sensitizing the community
    - The structures and recruitment of staff
8. Looking at the operationalization of CBHI pilots, how successful have the schemes been in
    - Funding the indigent

- Other design parameters (setting of premiums, benefit packages, premium payment frequency, enabling the schemes to cover all health related expenses through its income etc.)

What were the strengths and weaknesses?

9. What are the major challenges and successes in the implementation of CBHI?

Scale up

10. FMOH and regional government have agreed to scale up the CBHI in new woredas. We would like to understand the budget implication of this scaling up. Please provide the following data.
11. What is your opinion regarding the possibility of assigning budget code and appropriating budget for CBHI schemes (targeted subsidy) especially in line with the envisaged expansion to 160 woredas and eventually to scale-up to all woredas in the county?
12. In scaling up the CBHI to other woredas, what should be the criteria for selecting the woredas for scaling up in terms of
    a. Availability of health facilities
    b. Budget allocation
    c. Economic status of households
    d. Others
13. Learning from the pilots so far, what would you advise for the heads of WOFEDs that are going to scale up CBHI in their woreda?

Data to be collected from Secondary Sources in BOFEDs/WOFEDs

Budget implications of scaling up

Number	Major budget items for consideration	Expenditure in 2005 EFYIn ETB
1	Total Regional/ woreda population (# of households)	
2	Number of indigent households supported by the region/woreda	
3	Subsidy to the indigent members from the woreda allocation	
4	Any other regional subsidy for CBHI schemes	
5	Salary for CBHI scheme managers	
6	Any investment in health centres to improve quality of care, specifically targeting CBHI woredas	
	Total	

3.4. CBHI Management Team

INSTRUCTION TO THE INTERVIEWER

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If there are questions for which someone else is the most appropriate person to provide that

Information, I would appreciate if you introduce me to that person.

Any information you will provide as part of this interview will be held strictly confidential. Any reference to the information you provide in our analysis will be made without mentioning or implicating your name in any way.

Interviewee (Name and Title):

Region:

Zone:

Woreda:

Date:

Telephone No.

Tell us a little about your functions in the management of the CBHI scheme?

Enrollment

1. What is the status and progress of the woreda in enrolling its residents into CBHI? What are the successes and challenges?
2. What do you think are the major reasons for some people not to enrol into the scheme or failure to renew membership?
3. Does your scheme have partnership with microfinance institutions in your area? If so, how much of the CBHI contribution was mobilized through microfinance institutions?

Service Utilization and Reimbursement

4. How far CBHI members are using the health service in the contracted facilities? Do you think most of the members are using the services in the recommended (referral system) manner?
5. How often do you reimburse health facilities for services used by CBHI members? What are the mechanisms by which you check whether the invoices sent from the health facilities are right? Do you have adequate capacity to check on health facilities? Are there instances by which health facilities tried to overstate the reimbursement request amount?
6. Do you face a problem of unnecessary care seeking behaviour by CBHI members and unnecessary or over prescription of services including drugs, diagnostics etc. by health care providers (client and provider moral hazard)? Discuss how such circumstances, if they exist, affect the financial viability of the scheme?

Service Quality and Patient Satisfaction

7. Are there mechanisms whereby you are able to check on the patient perceived quality of service in contracted health facilities i.e. waiting time, availability of staff, availability of services, drugs and supplies etc.? Discuss. If so, are these regular checks or in response to complaints from your members? Do your findings show any change in service quality? Cite examples
8. Is there any other organization that conducts quality check up on health facilities? Do you get feedback from such an organization?
9. How do you assess members' satisfaction about the services provided by the schemes and also health service providers? Do you have a standard client compliant management mechanism? Describe how, if at all, action is taken based on feedbacks? What are the major complaints forwarded by your members?

Financial Status of the Scheme

10. Who is assisting you in collecting the premiums? Have the kebele/administration and/or saving and credit association collect and bring the contribution on time? What are the main successes and challenges in the collection of premiums?
11. How healthy is the situation of the CBHI scheme in terms of its finances? Please describe the financial status of the scheme to us? Please give us evidence in the table below

Organizational Status

12. How successful has the CBHI scheme been in recruiting and retaining core staff? Discuss successes and challenges in this regard.
13. How frequently does the Board of Management meets? What are the average attendance ratios of Board members?
14. What is the support you are receiving from RHB, WorHO, woreda administration and Abt regional office (training, supervision, administrative support etc.)? Are you satisfied? What needs to improve?
15. What is your overall assessment of the schemes? What do you recommend for the future in terms of organizational structure, staffing, budgeting, key design issues etc?

Secondary Data to be collected from CBHI Management team:

1. **Status of enrolment**

No.	Item	Number of population	
		2004 EFY	**2005 EFY**
1	Total woreda population		
2	New Enrollment		
	Premium payment		
	Government subsidy		
3	Renewal of membership		
	Premium payment		
	Government subsidy		
4	**Total members in the woreda**		

2. Utilization of services by CBHI members in the woreda

		2004 EFY	2005 EFY
1	Total CBHI members		
2	# of members that went for OPD visits in the health centers		
3	# of members in the health centers using in-patients services (if any)		
4	# of members that used hospital OPD services if any		
5	# of members that used inpatient services in hospitals		
6	# of members that used private clinics and pharmacies		

3. Financial status of the Woreda CBHI Scheme

		2004 EFY	2005 EFY
1	Total income of the CBHI scheme (ETB)		
	Total CBHI members		
2.1	Reimbursement for the cost of OPD visits in the health centers (ETB)		
2.2	Reimbursement for the cost of inpatient services in health centers (if any) (ETB)		
2.3	Reimbursement for the cost of hospital OPD services if any (ETB)		
2.4	Reimbursement of the cost of hospital inpatients services in hospitals (ETB		
2.5	Reimbursement for cost of services in private clinics and pharmacies (ETB)		
2.6	Administrative cost (ETB)		
2	Total cost of the scheme (ETB)		
3	Surplus/deficit of the scheme (ETB)		

3.5. Health Facilities-Hospitals and Health Centers

INSTRUCTION TO THE INTERVIEWER

This document is meant to be used as a general guide for the CBHI Evaluation team members during interviews with a broad range of stakeholders. Find the manager or the most senior person responsible at this level. After introducing yourself and greetings, eexplain briefly the purpose of the interview, the interview process and thank them for seeing us.

Provide the following information and obtain verbal informed consent to take part in the interview.

The purpose of this assessment is to gather data to evaluate the impact of pilot CBHI schemes from different perspectives including improving financial access, quality of health services, increasing resource mobilization and community participation. This assessment will also provide recommendations for the scale-up of the pilot schemes at national level.

If there are questions for which someone else is the most appropriate person to provide that

Information, I would appreciate if you introduce me to that person.

Any information you will provide as part of this interview will be held strictly confidential. Any reference to the information you provide in our analysis will be made without mentioning or implicating your name in any way.

Interviewee (Name and Title):

Region:

Zone:

Woreda:

City:

Name of health facility:

Ownership:

Date:

Telephone No.

Tell us a little about your health center or hospital (beds, services, area of service, population covered, number of staff, size and makeup of the facility governance body,)?

1. Are you a provider of health services to CBHI scheme members in the woreda? If yes, in your opinion, what is the impact of the CBHI on utilization of services? How about impact on quality of services? Give evidence
2. How do you perceive CBHI in terms of creating additional demand for health care – do you perceive it as creating additional workload and pressure to the health facility or as creating an opportunity to strengthen the capacity of your facility?
3. What incentives and disincentives CBHI schemes created on the facility and your staff?
4. After the establishment of CBHIs, are there differences in members and non-members in claiming their rights-i.e. requesting for better service? Please elaborate.
5. The CBHIs have their benefit packages. Are you able to provide all the services listed in the benefit package (for your level) to members of the CBHIs? If not what are the major gaps?
6. What are the major complaints from CBHI members on the quality of your services?
7. What is payment modality you are using to get reimbursements from CBHI members (fee for service or capitation)? If there is a difference between the payment modes of CBHI schemes and Non-members? Which mode of payment is advantageous for the health facility and why?

8. How frequently do you request and collect reimbursement for the expenses you incurred for CBHI members? Do you face any challenge in the process?
9. What is the impact of CBHIs in increasing your retained fees?
10. What kind of support did you receive from RHB and FMOH to improve quality of care because you are a CBHI provider?
11. What do you think RHB and FMOH should do for health facilities in the scaling up woredas to help them meet quality of care requirement? How about to cope with the surge in health service demand?

Secondary Data to be collected at facility level

	CBHI members	**Non CBHI members**	**Total for the facility**
Total catchment population			
Outpatient visits for 2003 EFY			
Outpatient visits for 2005 EFY			
Total referral made to a hospital or received from a health center in 2005 EFY			
Number of inpatients in 2003			
Number of In-patients in 2005			
Total retained fee in ETB			

3.6. KII for HSFR/HFG project (National and Regional Levels)

INSTRUCTION TO THE INTERVIEWER

This document is meant to be used as a general guide for the CBHI Evaluation team members during interviews with HSFR/HFG project staff at national and regional levels. After introducing yourself and greetings, explain briefly the purpose of the interview, the interview process and thank them for seeing us.

Provide the following information and obtain verbal informed consent to take part in the interview.

The purpose of this assessment is to gather data to evaluate the impact of pilot CBHI schemes from different perspectives including improving financial access, quality of health services, increasing resource mobilization and community participation. This assessment will also provide recommendations for the scale-up of the pilot schemes at national level.

If there are questions for which someone else is the most appropriate person to provide that

Information, I would appreciate if you introduce me to that person.

Any information you will provide as part of this interview will be held strictly confidential. Any reference to the information you provide in our analysis will be made without mentioning or implicating your name in any way.

Interviewee (Name and Title):

Federal/ Region:

Date:

Telephone No.

1. Can you describe for us the processes under which the CBHI scheme design is developed, directives and byelaws developed? What was the role of:
    a. Federal FMOH and EHIA?
    b. Regional councils?
    c. RHB/BOFED?
    d. Woreda and members?
    e. Any role for health providers?
2. What are the major issues around kick starting the CBHI schemes in the pilot woredas and what are the lessons that can be drawn on how to start in the scaling up process?
3. Given the design parameters are now being tested, what do you think are the major successes and challenges in implementation? Which design parameters needs a re-look during the scaling up?
4. What is the successes and challenges in the pilot woredas, in terms of:
    a. Mobilizing the community to prepay and enrol in CBHI?
    b. Regional/woreda efforts to support indigents?
    c. Renewing membership?
    d. Utilization of services (outpatients, inpatient services)?
    e. Quality of services provided by health facilities
    f. Perception of members on quality of services?
    g. Role of members in the management and oversight of schemes at woreda levels?
    h. Woreda administration and WOFED support in the management?
    i. Reimbursement of health facilities?
    j. Moral hazards from providers?
    k. Moral hazards from members?

5. What do you think are the replicability of the current design to the identified scale up woredas? What are the best practices? Any issues around
    a. Readiness of health facilities?
    b. Fiscal implication to the federal, regional and woreda governments?
    c. Technical assistance to support the scale up?
    d. Sustainability of the schemes?
    e. Any need on enhancing pooling beyond the woreda levels?

ANNEX J: FOCUS GROUP DISCUSSION GUIDE

4.1 CBHI Members

INSTRUCTION TO THE INTERVIEWER
This document is meant to be used as a general guide for the CBHI Evaluation team members to conduct focused group discussions with members of CBHI. Facilitators of the FGD should start by explaining briefly the purpose of the discussion, the evaluation process and thank them for coming to the meeting.

Woreda: __________

FGD No: __________

Composition of f FGD Participants:

1. **Number of males:---------**

2. **Number of Females:__________**

3. **Number of youth________________**

4. **Number of adults______________________________**

Date: _____________

1. How much do you pay for membership (registration +membership)? Is the amount affordable to you and your community? What about the payment scheduling?
2. What types of households joined CBHI schemes and why?
3. Indigent targeting - Some members of the CBHI get their contributions by the government as they are recognized as indigents.
   a. Were you involved in the identification of indigents?
   b. Do you think the selection process is transparent and fair?
   c. Are there some people who are not included and others inappropriately included in the targeted groups?
   d. What do you suggest to improve the process?
4. Since you become member of the schemes, what are the major benefits you got?
5. What is the community's perception regarding the benefit package of CBHI?
6. What is the community's perception about the quality of care received from CBHI contracted facility in terms of:
   b. Waiting time?
   c. Availability of staff?
   d. Attitude and motivation of staff?
   e. Availability of diagnostic facilities?
   f. Availability of essential medicines?
   g. Cleanliness of the facilities?
   h. The referral system?
7. Are health service providers serving CBHI members better than non-CBHI members or vice versa, and why?
8. What do you think should be done to enrol the non-members of your community into the CBHI in your community? What should be adjusted to keep current members including you as a member of the scheme?

9. Do you participate in the management of the scheme? If so, what is your role in this regard?

4.2: NON-CBHI Members

INSTRUCTION TO THE INTERVIEWER
This document is meant to be used as a general guide for the CBHI Evaluation team members to conduct focused group discussions with non-members of CBHI. Facilitators of the FGD should start by explaining briefly the purpose of the discussion, the evaluation process and thank them for coming to the meeting.

Woreda: __________

FGD No: __________

Name of FGD Participants:

1. **Number of males:---------**

2. **Number of Females:__________**

3. **Number of youth_________________**

4. **Number of adults_____________________________**

Date: _____________

1. Are you aware of the existence of the CBHI Scheme in your woreda?
2. Were you requested to become a member of the CBHI scheme? How were you communicated?
3. Why did you decided not to join the CBHI scheme?
4. Do you know how much is paid by the CBHI members? What do you think about the affordability of the pre-payment scheme (registration fee and membership Fee)?
5. Do you think that members of the CBHI schemes in the community are benefiting? Please describe what you have seen and heard as their benefit? Do the benefits you heard make paying worth in your opinion?
6. Are health service providers serving CBHI members better than non-CBHI members or vice versa, and why?
7. What should be changed in the current CBHI scheme set up (payment levels, payment scheduling, benefit package, service availability etc.) to make you a member of a CBHI scheme?

4.3 Health Workers

INSTRUCTION TO THE INTERVIEWER
This document is meant to be used as a general guide for the CBHI Evaluation team members to conduct focused group discussions with the staff of the CBHI contracted facility. Facilitators of the FGD should start by explaining briefly the purpose of the discussion, the evaluation process and thank them for coming to the meeting.

Woreda: __________

Facility Name___________

FGD No: __________

Name of FGD Participants:

1. **Number of males:---------**
2. **Number of Females:**__________
3. **Number of youth**_________________
4. **Number of adults**_____________________________

Date: _____________

1. What do you think is the impact of CBHI in changing the health seeking behaviour of its members? Compared to the non-CBHI members and also comparing the situation before the start of the CBHI pilot, is there a change in seeking care by members? Please discuss the changes (OPD visits, for exempted services like immunization and deliveries etc.)?
2. Was your facility ready to provide quality care to members of CBHI? What were its strengths and weaknesses in service delivery when CBHI started? What kind of support have you received from the federal and regional level to improve health facility? Was it adequate?
3. What is the change that CBHI has brought to your facility in terms of
    a. Increased financial mobilization from its members?
    b. Increased community participation in facility management?
4. What is the impact of CBHI on the health staff in term of:
    a. Increased workload?
    b. Disagreement and conflict with members of CBHI when they claim their rights?
5. Are there any efforts being made to motivate the health staff with any sort of incentives? If yes, please discuss
6. What do you think should be done to motivate and encourage staff as well ensuring the readiness of facilities when scaling up CBHI scheme to other woredas?

ANNEX K: PEOPLE INTERVIEWED

Annex K.1. Amhara

Area	KII	Name/position	Date
Tehuledere	Woreda administration	Chief Administrator	1 Jan 2014
	WHO	Head	1 Jan 2014
	WoFED	Deputy head	1 Jan 2014
	CBHI office	Ibrahim	2 Jan 2014
	Sulula HC	Head	1 Jan 2014
	Haik HC	Head	2 Jan 2014
	Dessie hospital	Executive manager	2 Jan 2014
Achefer	WHO	Head	15 Jan 2014
	CBHI office	Getu	10 Jan 2014
	Lalibela HC	Head	10 Jan 2014
	Durbete HC	Wondim Anley	10 Jan 2014
Fogera	WHO	Head	6 Jan 2014
	CBHI office	Goshu	9 Jan 2014
	Alember HC	Dejach	6 Jan 2014
	Woreta HC	Belayneh Birhanu, Head	9 Jan 2014
Dembia	Woreda administration	Amsalu, Chief administrator	14 Jan 2014
	WHO	Deputy	14 Jan 2014
	WoFED	Deputy	14 Jan 2014
Bahir Dar	RHO	Bayeh, HCF Officer	13 Jan 2014
	BoFED	Girma, Deputy head	13 Jan 2014
	Regional CBHI office	Genet, Abay	13 Jan 2014
	Felege Hiwot hospital	Chief Executive manager	13 Jan 2014

Annex K.2: Oromia

Woreda	Institution	Name	Position
Kuyu	Woreda Administration	Mamo Shiferaw	D/Administrator
	Woreda Administration	Dereje Mengistu	CBHI Coordinator
	Wored Health Office	Desta Legese	D/Head
	Woreda Finance Office	Berhane Dejene	Office Head
	Kuyu Hospital	Benyam G/Amlak	Representative
	Beriti Health Center	Leulseged Tesfaye	Office Head
	Kareta Health Center	Getu Worku	Office Head
Gimbichu	Woreda Administration	Tadese Kasaye	Administrator
	Woreda Health Office	Teketel Kebede	CBHI Coordinator
	Woreda Health Office	Abebe Mamo	Office Head
	Woreda Finance Office	Berehanu Kassaye	Office Head
	Chefedonsa Health Center	Melkam Degaga	Office Head
	Aredagoro Health Center	Abiye Mekonnen	Office Head
Limmu Kossa	Woreda Administration	Habtamu Fufa	Office Head
	Woreda Administration	Goji Gari	CBHI Coordinator
	Woreda Health Office	Debesa Gobena	Office Head
	Woreda Finance Office	Gezahegne Merja	D/Head
	Limugenet Health Hospital	Nega Abajemal	Office Head
	Limugenet Health Center	Abagiya	Office Head
	Embuye Health Center	Seifedin Husien	Representative
Deder	Woreda Administration	Dagnu Hailu	Office Head
	Woreda Health Office	Abdo Alia	CBHI Coordinator
	Woreda Health Office	Abyot Assefa	Office Head Representative
	Woreda Finance Office	Meaza Bekele	Core Process Owner
	Deder Hospital	Mohamed Abdurahman	Manager
	Qufanzek Health Center	Dagne Bodane	Office Head
	Kobo Health Center	Mohamed Ibrahim	Office Head
Merti	Woreda Administration	Ahmed Hamid	Administrator
	Woreda Health Office	Desta Kuma	Office Head
	Woreda Finance Office	Aman Koteb	Office Head
	Abomsa hospital	Fanus Dechasa	Manager
	Abomsa Health Center	Ejeta Waqtola	Office Head
	Gologota Health Center	Tahir Gebi	Office Head

Annex K.3: Tigray

No.	Woreda	Institution	Name of Interviewee	Position
1	Raya and Azebo	Bala Health Center	Berhe Gashae	Head Nurse
2	Raya and Azebo	Lemlem Karl Henz Hospital	Berhanu H/ Sellasie	CEO
3	Raya and Azebo	Mehoni Health Center	Gebregziabher Tsadik	Medical Director
4	Raya and Azebo	WOFED	Frewewini Tekeste	Head
5	Raya and Azebo	Woreda Health Office	Woldemichael G/Medhin	Head
6	Raya and Azebo	Woreda Administration	Haftu G/Kiros	Administrator
7	Kilte Awlalo	Wukro Hospital	Dr. Mehari Desalegn	Medical Director
8	Kilte Awlalo	Wukro Hospital	Alem G/Tsadik	CEO
9	Kilte Awlalo	Negash Health Center	Birhane G/Aania	Director
10	Kilte Awlalo	Negash Health Center	Hirit Asfa	Finance
11	Kilte Awlalo	Agulae Health Center	Tirete Zeleke	Director
12	Kilte Awlalo	CBHI Coordination Office	Taeme G/Hiwot	Coordinator
13	Kilte Awlalo	Woreda Health Office	Fitsum W/Aregay	Head
14	Kilte Awlalo	Woreda Administration	Tsegaye Hadgu	Administrator
15	Kilte Awlalo	WOFED	Kalayu G/Hiwot	Head
16	Region	HSFR/HFG	Goitom	Regional Coordinator
17	Region	Health Bureau	Berihu	Core Process Owner/CBHI
18	Region	BOFED	Abebu Tadesse	
19	Ahiferom	Woreda Administration	Gebremedihin Alemayehu	Administrator
20	Ahiferom	Woreda Health Office	Tewelde Yigzaw	Coordinator for CBHI
21	Ahiferom	CBHI Coordination Office	G/Kirstos Berha	Coordinator
22	Ahiferom	CBHI Coordination Office	G/Medhin Asgedom	Finance
23	Ahiferom	Enticho Health Center	G/Egziabher Hailsellasie	Director
24	Ahiferom	WOFED	Hailay Yohanes	Head
25	Ahiferom	Mezbir health Center	Tsega Berhane	Head
26	Adwa Town	Adwa Hospital	Meuz Abrha	CEO
27	Tahitay Adiabo	CBHI Coordination Office	Haftom G/Giorgis	Coordinator
28	Tahitay Adiabo	WOFED	Tsige Gesese	Finance
29	Tahitay Adiabo	Woreda Health Office	Teklay Tesfay	Head
30	Tahitay Adiabo	Mai Kuhli Health Center	Zeratsion Girmay	Head
31	Tahitay Adiabo	Sheraro Health Center	Merid Mekonen	Director
32	Shire Town	Suhul Hospital	Maasho Fiseha	CEO

Annex K.4: SNNP

No.	Name	Position	Institution	Type of Interview
	Ashenafi Wagisso		HSFR/HFG, SNNPR	KII
	Aklilu Tukela	Development Plan Preparation, Monitoring and Evaluation Core Process Owner at the Vice Bureau Head Level	BOFED, SNNPR	KII
	Aschalew Ledetu	CBHI Core Process Owner	CBHI Executive Team, Yirgalem City Administration	KII
	Woyneshet Legesse	Accountant		KII
	Sr. Meheret Arega	Head	Yirgalem Health Center	KII
	Fantaye Teshome	Procurement and Payment Coordinator		KII
	Bethlehem Wondimu	Pharmacy	Yirgalem Hospital	FGD, staff
	Dagem Desta	OPD		
	Aregahegn B	Laboratory		
	Tigist Yirgu	Gyn/Obs		
	Ayalnesh Asegagn	Medical		
	Meseret Bereda	OPD	Yirgalem HC	FGD, staff
	Amarech Annulo	Emergency		
	Alemnesh Babu	Pharmacy		
	Tamene Petros	Head	WOFED, Yirgalem	KII
	Admassu Arsicha	General Manager	Yirgalem Hospital	KII
	Tsegaye Gatiso	Head	WorHO, Yirgalem	
	Endashaw Esrael	Mayor	Yirgalem City Administration	KII
	Yohannes Nako	Deputy Head	WorHO, Wonago	KII
	Meselu Debela	Medical and Renaissance Core Process Head	WorHO, Wonago	KII
	Tamrat Jilo	Head	Wonago HC	KII
	Aster Beshir	Deputy Chief Administrator	Wonago Woreda	KII
	Asrat Tesfaye	Head	Hasse Haro HC, Wonago	KII
	Dr. Dagnachew Yohannes	Medical Director	Dilla Hospital	KII
	GEbiso Hamito	CBHI Non-Member	Abosto kebele/tabia, Yirgalem	Community FGD
	Girma Dabusa			
	Fikru Yewa			
	Zenebe Senbeto			

No.	Name	Position	Institution	Type of Interview
	Mulunesh Darba	CBHI Member	Abosto kebele/tabia, Yirgalem	Community FGD
	Hameso Hasene			
	Getachew Woldie			
	Amarech Hussein			
	Mamo Gelana			
	Zerihun Yilma			
	Muluken Dubale	Head	Damboya HC, Damboya	KII
	Bediru Botoko	CBHI Coordinator	Damboya Woreda	KII
	Getachew Alemu	Chief Administrator	Damboya Woreda	KII
	Hasabe Hibso	Head	WorHO, Damboya	KII
	Dessalegn Mathewos	Head	Funto HC, Damboya	KII
	Tigist Amare	Acting Head/OPD		
	Worknesh Wanna	Emergency	Funto HC, Damboya	Staff FGD
	Tigist Amare	OPD		
	Belaynesh Kebebe	Pharmacy		
	Mitiku Gebre	Laboratory		
	Workie Ayele	Pharmacy	Damboya HC, Damboya	Staff FGD
	Kefle Abule	OPD		
	Terefe Yacob	Laboratory		
	Tadele Mekango	OPD/Emergency		
	Degefu Kirgano	Head	WOFED, Damboya	KII
	Elias Anse	CBHI Member	Geramba kebele/tabia, Damboya	Community FGD
	Asemo Abute			
	Da'o Egena			
	Markoye Wedlebo			
	Hemeto Banboro	CBHI Member (Got Leader)		
	Mathewos Meharu	CBHI Non-Member	Geramba kebele/tabia, Damboya	Community FGD
	Sayle Irgina			
	Habtamu Tadesse	CEO	Durame Hospital	KII
	Matusala Basa	Head	WorHO, Damot Weyde	KII
	Wondimu Gedebo	Head	WOFED, Damot Weyde	KII
	Meselech Shirko	CBHI Members	Bilu Bedesa kebele/tabia, Damot Weyde	Community FGD
	Yohannes Tora			
	Ayelech Gebeyehu			
	Balcha Kora			
	Dawit Dana			
	Olana Kolcha			
	Matewos Minamo			
	Felekech Molla			

No.	Name	Position	Institution	Type of Interview
	Motote Bobe	CBHI non-members	Bilu Bedesa kebele/tabia, Damot Weyde	Community FGD
	Labiso Lambebo			
	Tesfaye Biqamo			
	Azera Bine			
	Bereket Berhanu	Head	Koyo HC, Damot Weyde	KII
	Tegegn Badecho	Head	Bedesa HC, Damot Weyde	KII
	Mulugeta	Under 5 OPD	Bedesa HC, Damot Weyde	Staff FGD
	Alemnesh	OPD		
	Aster	Delivery		
	Zegene Woyesha	Chief Administrator	Damot Weyde Woreda	KII
	Abebayehu Likebo	Pharmacy	Koyo HC, Damboya Weyde	Staff FGD
	Tsedale Simeon	Laboratory		
	Meseret Beyene	MCH		
	Tesfanesh Bursamo	OPD		
	Getu Mamo	General Manger	Wolayta Sodo Hospital	KII
	Zekariyas Zewde	Health Coordinator	Damot Weyde CBHI Team	KII
	Akale Gunta	Accountant		

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