HEALTH SECTOR FINANCING REFORM/
HEALTH FINANCE AND GOVERNANCE (HSFR-HFG) PROJECT

COMMUNITY-BASED HEALTH INSURANCE PERFORMANCE AND IMPLEMENTATION CHALLENGES

A STUDY OF DATA FROM SAMPLE SCHEMES, KEBELES, AND HEALTH FACILITIES

May 2018
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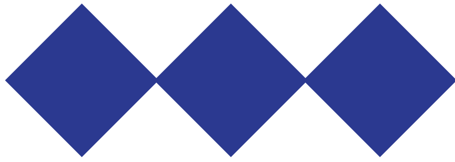

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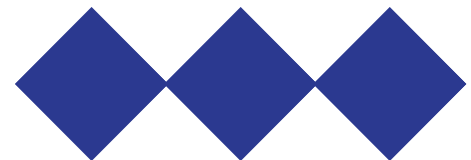

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ACRONYMS

CBHI	Community-based Health Insurance
EFY	Ethiopian Fiscal Year
EHIA	Ethiopian Health Insurance Agency
FMOH	Federal Ministry of Health
HH	Household
HSFR/HFG	Health Sector Financing Reform/ Health Finance and Governance
ID	Identification
IT	Information Technology
OPD	Outpatient Department
RHB	Regional Health Bureau
RV	Receipt Voucher
SNNP	Southern Nations, Nationalities and Peoples (region)
UHC	Universal Health Coverage
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

Over the past two decades, Ethiopia has taken measures to improve access to health care and achieve the goals of universal health coverage. As part of its health care financing strategy, the country introduced community-based health insurance (CBHI) in 2011. The program was initially piloted in 13 woredas located in Amhara, Oromia, Southern Nations, Nationalities and Peoples (SNNP), and Tigray regions in 2010/11 and is being expanded nationwide. As of the writing of this report, the CBHI program is being implemented in over 400 woredas located in the original pilot regions as well as in Benishangul-Gumuz and Harari regions and Addis Ababa and Dire Dawa city administrations.

This study documents the overall performance of the CBHI program in terms of population coverage, membership renewal, new member registration, and resource mobilization. It also examines the implementation challenges CBHI schemes face and measures taken to overcome them, as well as the contribution CBHI has made in improving access to health care across different population groups.

Study data were collected from 30 schemes, 30 kebele administrations, and 30 health facilities (one kebele and one health facility per scheme). The study employed purposive sampling. The availability of a relatively better data management system and more than one year of experience in providing services to CBHI members were used as selection criteria for schemes and kebeles included in the study. Magnitude of patient flow was used as the main criteria to select health facilities. To maintain geographical distribution within a region, schemes were selected from different zones. Three questionnaires were designed to capture quantitative and qualitative data from sampled schemes, kebeles, and health facilities. All collected data were coded and analyzed using SPSS software.

Findings

At the scheme level

Human resources: Two-thirds (67 percent) of the schemes reported that they had experienced staff turnover during Ethiopian fiscal year (EFY) 2009 (2016/17). The problem was more pronounced in Amhara and Oromia, where the majority (80 percent) of schemes reported staff turnover. The main causes of turnover were: seeking better salary and benefit package (reported by 80 percent of respondents), promotion to a higher position (40 percent), and transfer to another area (20 percent). High staff turnover could negatively affect overall CBHI implementation.

Enrollment: In total, the sampled schemes enrolled 308,847 households in 2016/17. Of these, 78.2 percent were paying members and the remaining 21.8 percent were indigents/non-paying. Among households that were active members in 2015/16, three-fourths (75 percent) of them renewed their membership in 2016/17. The remaining 25 percent did not. The average enrolment rate was 44.2 percent. The schemes altogether mobilized Birr 66,630,216 from contributions (registration and enrollment fees) and subsidies. Contributions from paying members accounted 82.6 percent of the resource mobilized.

***CBHI membership ID cards*:** As CBHI is primarily implemented in rural settings, the preparation of ID cards and timely distribution to members has been the major implementation challenge. Members are required to provide photographs for their ID card, but often cannot do so promptly due to lack of photographer in their area (82 percent). Other reported challenges include shortage of staff at the kebele level to prepare ID cards (75 percent), lack of kebele manager capacity to properly prepare member profiles used in ID cards in some kebeles (29 percent), poor quality of ID cards (25 percent), and delay in ID card printing by some woreda administrations (18 percent).

***Health service utilization*:** A total of 281 health facilities (211 health centers and 70 hospitals) had signed contracts with the study schemes. CBHI beneficiaries made 1,240,715 visits (new and repeat visits) in health facilities. Of these, 1,079,334 visits (87 percent) were made in health centers and 151,685 (13 percent) in hospitals. Of the hospital visits, 9,696 (6.4 percent) were admitted. The schemes reimbursed a total of Birr 58,315,896 (US$2,607,928) to contracted facilities for services rendered and covered under the insurance package. Of the total reimbursement, 67 percent (Birr 39,316,785/US$ 1,758,274) was paid to health centers and 33 percent (Birr 18, 999,111) to hospitals.

A comparison of health service utilization (outpatient visits) of CBHI members versus the non-insured shows that the insured population is 1.7 times more likely to visit health facilities for curative care services than the non-insured. When disaggregated by region, insured members in Amhara are nearly twice (1.9 times) more likely to visit health facilities for curative care services than the non-insured. In SNNP and Oromia, CBHI members are 1.7 times more likely to visit health facilities for curative services, and in Tigray they are 1.6 times more likely. These findings indicate that CBHI enables the insured population to use health care services more often than the non-insured population. Study findings also show that, in regions where CBHI coverage rates are higher (Amhara and Tigray), health services utilization among the insured women and children was higher (children on average by 14 percent; women by 47.5 percent) than the noninsured. This suggests that CBHI empowers women to make health service utilization decisions for themselves and their children and, therefore, CBHI can improve maternal health and child survival outcomes.

At the kebele level

***Community sensitization and mobilization*:** Eighty-seven percent of kebeles reported having their own advocacy and sensitization plan for CBHI and 73 percent had integrated their CBHI plan into the kebele's overall regular work plan. Kebeles undertook CBHI advocacy and sensitization activities at various places and used different forums and events to sensitize the community. Churches/mosques were the main sites of CBHI advocacy and sensitization activities; nearly 89 percent of kebeles conducted the activities there. CBHI advocacy and sensitization also was done at social gatherings like *iddir* (community mutual aid group) meetings (85 percent) and schools (70 percent). All kebeles reported that they used government public meetings as forums to sensitize the community; about 97 percent used development army meetings, which included testimonials from CBHI members who benefited from the program. Sixty-three percent reported that they made house-to-house sensitization visits. In Amhara, schemes also use kebele and *got* (component of the kebele administrative unit comprising of 40 to 50 households) council meetings as forums for community sensitization; these include testimonials from non-CBHI members who incurred high out-of-pocket expenses for health care to raise the awareness among the local population about the costs of not having CBHI. Seventy-seven percent of the kebeles conducted community sensitization and awareness creation activities during the harvest season (which their scheme's General Assembly had agreed upon as the period for renewal and new members' registration), while 35 percent did so on quarterly basis.

***Contribution collection*:** In 52 percent of kebeles, kebele cabinet members collect CBHI member contributions; 45 percent of them use kebele cash collectors and 38 percent use got leaders. In Amhara, schemes primarily use cash collectors at the kebele and got levels. Kebeles are expected to deposit contributions collected into the CBHI scheme account within one month of receipt. Fifty-three percent of kebeles reported that cash collectors submitted contributions collected to the kebele administrator on a weekly basis; the other 47 percent had no fixed period of submission – their cash collectors submitted contributions whenever they found it convenient. Lack of incentives for cash collectors (77 percent) and busy work schedule/workload of kebele leaders/kebele administrator and managers (42 percent) were the main reported challenges to effectively collecting member contributions and depositing collected cash on time.

At the health facility level

***Human resources*:** Only seven health facilities (23 percent) reported having the required staff to delivery health care services to the catchment population, while the remaining 23 facilities (77 percent) had human resource shortages or personnel who did not meet the regional requirements for the number and type of staff needed to effectively provide services to the facility's catchment population. With respect to vacant positions, lack of laboratory technicians was most common (reported by 83 percent of facilities), followed by pharmacy technicians (67 percent), nurses and environmental health workers (each 61 percent), health officers (48 percent), and midwives (26 percent). Regional variations were observed. All health facilities in SNNP and Tigray reported shortages of laboratory technicians. Lack of pharmacy technicians was more common in Oromia (80 percent) and lack of laboratory technicians and nurses in Amhara (78 percent).

***Revenue generation*:** The sampled health centers altogether collected Birr 18,974,809 (US$848,567) from user fees during the year under review (April 2016 to March 2017). Of this, 57 percent (Birr 10,551,873/US$471,887) was obtained from CBHI schemes in the form of reimbursement. This signifies that CBHI is playing a significant role in boosting the amount of revenue collected by health facilities and hence in increasing availability financial resources at service delivery points.

CBHI training and complaint handing: Seventy-five percent of health facilities reported that heads of facilities received training on CBHI implementation. Of these, 57 percent cascaded the training to staff at their facilities whereas the remaining 43 percent did not. With respect to complaints, the majority (85 percent) of health facilities reported beneficiaries complained about long waiting times to obtain health services followed by unavailability of drugs (52 percent) and disrespectful reception by staff (48 percent). Nearly 26 percent of health facilities reported unavailability of examination/laboratory and other diagnostic services. To address these complaints, 96 percent of health facilities discussed the complaints with staff; nearly 90 percent provided orientation to staff in general and card room workers in particular on respectful customer handing; 85 percent discussed the complaints during kebele council and woreda meetings and attempted to increase the supply of drugs.

Availability of drugs and diagnostics services in health facilities are the most important factors affecting household joining or renewing CBHI membership. If these problems go unaddressed, it might be difficult to sustain CBHI program achievements gained thus far.

1. INTRODUCTION

1.1 Background

For the past 20 years, the Ethiopian government has worked towards improving access to health care and universal health coverage (UHC). Understanding the pivotal role that health insurance could play in its health sector financing reform program, the government has been implementing community-based health insurance (CBHI) since 2011. The CBHI program is guided by a Health Insurance Strategy developed in 2008, which is in line with the broader Health Care and Financing Strategy of the country (FMOH 2008 and 1998). As indicated in the strategy, the objective of CBHI is to promote equitable access to health care, increase financial protection, promote cost sharing between the government and citizens, and enhance domestic resource mobilization for the health sector and social inclusion in health, mainly for rural households and for those who are engaged in the urban informal sector.

The government of Ethiopia introduced CBHI as a pilot program in 13 woredas in 2011. Informed by the experiences and lessons learned from the pilot, CBHI is being scaled up nationwide, with plans under the Health Sector Transformation Plan to cover 80 percent of the population in 80 percent of woredas with CBHI by the end of 2020 (FMOH 2015). As of the writing of this report, the CBHI program is being implemented in over 400 woredas located in the original pilot regions – Amhara, Oromia, SNNP, and Tigray – as well as in Benishangul-Gumuz and Harari regions and Addis Ababa and Dire Dawa city administrations.

The Ethiopia Health Sector Financing Reform/Health Finance and Governance (HSFR/HFG) project conducted the present study of 30 CBHI-implementing woredas to: (1) document the overall performance of the CBHI program in terms of population coverage, membership renewal, new member registration, and resource mobilization; (2) examine the challenges schemes have faced in implementing CBHI and the measures taken to address them; and assess the contributions CBHI has made in improving access to health care across different population groups. This report presents key study findings and is organized in six sections. The introduction provides a general overview and explains the methodology used to collect and analyze data. The second, third, and fourth sections present study findings by scheme, kebele, and facility levels. The fifth section describes the contribution of CBHI in improving utilization of health care services. It is followed by the conclusion and recommendations for next steps in implementing CBHI.

1.2 Methodology

1.2.1 Sampling

The assessment employed purposive sampling techniques. The main criteria used for selecting CBHI schemes (and ultimately, kebeles and facilities) for inclusion in the study were: (1) availability of complete data on enrollment, renewal, and health service utilization at the scheme; (2) having more than one year of experience in providing benefit packages to CBHI members; (3) the magnitude of patient flow at the health facility with which schemes have contracted to provide the package of health services covered under CBHI. Based on these criteria, first, 30 schemes were selected. Thereafter, 30 kebeles (one kebele per scheme) with relatively better data management systems and 30 health facilities (one health facility per

scheme) with the highest reported number of outpatient (OPD) visits as compared to other health facilities that also had been contracted by schemes, were selected. Schemes in Amhara, Oromia, SNNP, and Tigray regions with over one year of experience in implementing CBHI made up the majority of schemes sampled. However, two schemes in SNNP (Mareko and Sodo) that had less than one year of experience, and two schemes in Tigray (Hawzen and Raya Azebo) that had one year of experience were included in order to provide data from these regions, since the majority of schemes in these regions have up to one year of experience.

1.2.1.1 Sample Coverage

As just noted, sampled schemes/kebeles and health facilities were selected from Amhara, Oromia, SNNP, and Tigray regions. The allocation of samples varies from region to region based on the total number of functional schemes in the regions.[1] To maintain geographical distribution within a region, schemes were selected from different zones.[2] The number and location of schemes, kebeles, and health facilities sampled for the study are shown in Table 1.

Table 1: Number of schemes, kebeles, and health facilities included in the study, by region

Region	Total functional schemes*	Sample size		
		Schemes	Kebeles	Health facilities
Amhara	102	10	10	10
Oromia	102	10	10	10
SNNP	49	6	6	6
Tigray	18	4	4	4
Total	271	30	30	30

*Functional schemes up to August 2017.

1.2.2 Instruments and Sources

Three questionnaires were developed to capture quantitative and qualitative data from sampled schemes, kebeles, and health facilities. Close-ended questions were used wherever possible to facilitate data analysis and reporting. Some open-ended questions were included to avoid prompting or leading interviewees in a particular direction. The instruments included basic indicators (such as those related to new member registration, membership renewal, resources mobilization, health service utilization, and reimbursement) that help document overall CBHI performance and its contribution(s) to improving access to health care services. The quantitative data at scheme, kebele, and health facility levels were extracted from records and the qualitative data were obtained by interviewing scheme coordinators, kebele managers, and facility heads. The quantitative data on enrollment at scheme level were collected for two years (2015/16 and 2016/17). Member contributions data were collected for 2016/17. Data on health service utilization, reimbursement, and health facilities retained revenue were collected for the

[1] A CBHI scheme is said to be functional when it has held a General Assembly meeting and has started providing benefit packages for its members. The General Assembly endorses the CBHI bylaw, elects CBHI board members, and decides on the date the scheme will begin providing benefit packages.
[2] A zone is an administrative unit comprising multiple woredas.

period April 9, 2016 to March 10, 2017. In addition, detail data on health service utilization by CBHI beneficiaries, disaggregated by membership type (paying and non-paying), age, and sex, were collected from schemes for the 2nd quarter of 2009 EFY (October 11 to January 8, 2017) for comparison purposes.

1.2.3 Data Collection

A total of 19 HSFR/HFG project staff from the central and regional offices, organized in nine teams (three in Oromia, and two each in Amhara, SNNP, and Tigray), were deployed to collect the data from schemes, kebeles, and health facilities sampled. The data collection was carried out June 11-29, 2017.

1.2.4 Data Processing and Analysis

Each data collection team coded data from the paper questionnaires on a computer using an encoding template (Excel spreadsheet) and submitted the coded spreadsheet to the HSFR/HFG central office in Addis Ababa. Data compilation and cleaning was conducted by the HSFR/HFG Monitoring and Evaluation team there. Verbatim responses to open-ended questions were reviewed and coded. The data were converted into SPSS for further analysis. Ordinary statistics such as simple average, range, and percentage, as well as graphs, were used to analyze the data.

1.2.5 Limitations of the Study

CBHI schemes, kebeles, and health facilities are sources of data for this report, and data quality problems were observed in some of these sources. In particular, scheme data related to service utilization and reimbursement were incomplete in some cases, as five health facilities had not submitted reimbursement claims for the third quarter (January 9 to April 8, 2017) at the time of data collection. Because schemes in SNNP have no fixed period for renewal and new member registration, it was difficult to identify active members and analyze coverage and membership renewal (retention) rates in SNNP schemes during the period under review.

The analysis of health service utilization by women and children in this study does not provide the full picture of the contribution of the CBHI program in improving the health of these groups, because the data used for comparison purpose were from only one quarter. Furthermore, the study employed a purposive sampling technique where sample selection is made based on judgment that cannot ensure representativeness. Hence, it is difficult to make generalization from the findings to the population of interest.

2. FINDINGS AT THE SCHEME LEVEL

2.1 Characteristics of sampled schemes

As indicated in Table 2, there are 931kebeles (859 rural and 72 urban kebeles) in the study schemes. The schemes altogether have an estimated eligible population size of 4,536,735 (988,449 households) in their catchment area residing in these kebeles. Of the total eligible population, 93 percent live in rural areas while the remaining 7 percent are urban dwellers.

Table 2: Number of kebeles and eligible population in the catchment area of study schemes, 2106/17

Region	No. study schemes	Total no. kebeles in the study schemes	Total eligible population in catchment area of study schemes			Schemes selected for the study
			Male	Female	Total	
Amhara	10	282	813,810	824,404	1,638,214	Dangila Zuria, Enarj Enawiga, Alefa, Kewot,Wadla, Dawa Chefa, Fogera, Kutaber,Denbecha, Mecha
Oromia	10	317	713,456	702,725	1,416,181	Munisa, Delo Mana, Aldea, Gimbichu, Limu-Kossa, Aleltu, Deder, Hidetu-Abote, Arsi-Negelle, Nejo Rural
SNNP	6	247	511,692	493,600	1,005,292	Damboya, Sodo, Shebedino, Mareko, Damot-Gale, Halaba
Tigray	4	85	233,291	238,695	471,986	Hawzen, kilte Awlaelo, Tahtay-Adiabo, Raya Azebo
Total	**30**	**931**	**2,272,249**	**2259,424**	**4,531,673**	

2.2 Human Resources

To assess institutional capacity of schemes in implementing the CBHI program, the assessment incorporated questions related to availability of required staff, vacant positions, training on the basics of CBHI, clinical audit and CBHI financial management provided to scheme staff, and the extent of and major reasons for attrition. Key findings are presented in the following sub sections.

2.2.1 Availability of required staff and turnover

All schemes included in the study (except Gimbichu in Oromia, where the coordinator position was vacant and Dawa Chafa in Amhara, where the accountant position was vacant) had their coordinator and accountant positions filled at the time of data collection. Except the Arsi Negelle scheme in Oromia, all schemes with an approved IT/data manager position reported that they had an IT/data manager. All schemes in Amhara had health officers at the time of assessment.

Although schemes were well staffed in terms of the number and type of personnel, two–thirds (67 percent) of the schemes reported that they had experienced staff turnover during the 2016/17 fiscal year. The problem of staff turnover was more pronounced in Amhara and Oromia, where the majority (80 percent) of the schemes reported staff turnover over the same period.

As presented in Table 3, seeking better salary and benefit package was reported as the leading cause (80 percent) of staff turnover; followed by promotion to a higher position (40 percent); transfer to another area (20 percent).[3] When disaggregated by region, seeking better salary was the main reason for staff turnover in Amhara, Oromia, and Tigray regions while promotion to a higher position was the most common in SNNP.

Table 3: Major reasons for staff turnover (multiple responses possible)

Reasons	Percentage of schemes' response, by region				Overall response
	Amhara	Oromia	SNNP	Tigray	
Seeking better salary and benefit package	75%	88%	50%	100%	80%
Promotion to a higher position	25%	50%	100%	-	40%
Transfer to other area	13%	38%	-	-	20%

2.2.2 Staff Training

Training health sector personnel can increase confidence and motivation in job performance; lower staff turnover rates; and provide the skills and abilities needed to better perform in their existing position or cope with new situations. HSFR/HFG, in collaboration with Regional Health Bureaus (RHBs) and the Ethiopian Health Insurance Agency (EHIA) has organized trainings on the basics of CBHI, clinical audit, and CBHI financial management for CBHI scheme personnel. Training on the CBHI basics mainly focuses on the principles of CBHI and regional CBHI directives and is supposed to be provided to all executive staff. Training on clinical audit is mostly provided to health officers, and financial management training to accountants. In most cases, however, executive staff take most or all of the trainings as they often shoulder dual responsibilities.

Study findings show that the majority (83 percent) of coordinators, 70 percent of accountants, 63 percent of IT/data managers and half (50 percent) of health officers (Amhara) had received training on CBHI principles and the regional CBHI directives. Eighty-three percent of coordinators, 62 percent of accountants, 59 percent of IT officers/data managers and 80 percent of health officers (in Amhara) had been trained in clinical audit. In regards to training on CBHI financial management, 79 percent of accountants, 54 percent of coordinators and 53 percent IT officers/data managers had received training. Eighty-three percent of coordinators, 72 percent of accountants and 70 percent of health officers and 90 percent of IT/data manager had received training on data management.

[3] Percentages do not add up to 100 because respondents were allowed to provide multiple answers to the question.

2.3 Enrollment

2.3.1 Enrollment of new members

As indicated in Table 4, the 30 CBHI schemes included in this study planned to enroll a total of 484,002 new paying households (HHs) in 2016/17. However, they managed to register only 70,608 new paying households (15 percent of what was planned).The overall scheme performance in this regard was very low; however, there was variation among regions. The enrollment rate for new households ranged from a low of 1.6 percent in SNNP (Halaba scheme) to 70.8 percent in Tigray (Tahtay Adiabo). This disparity is partly attributed to the fact that some schemes focus more on membership renewal activities to retain existing CBHI members than community mobilization and awareness creation activities to encourage new households to join. Schemes such as Kewot in Amhara, Adea and Gimbichu in Oromia, and Kilte Awlaelo in Tigray are examples of this practice.

Table 4: Number of new CBHI households enrolled in study schemes - planned and achieved, 2016/17

Region	No. of study schemes	Enrollment of new paying HHs		Achievement rate (%)	
		Planned	Achieved	Minimum	Maximum
Amhara	10	183,089	25,492	3.7	34.3
Oromia	10	156,526	24,310	3.6	39.8
SNNP	6	106,598	12,249	1.6	30.6
Tigray	4	37,788	8,557	5.6	70.8
Total	**30**	**484,002**	**70,608**	**1.6**	**70.8**

2.3.2 Membership Renewal[4]

The sustainability of CBHI schemes depends not only on initial enrollment level but also on the extent to which households renew their membership as renewals enable schemes to generate the resources required to cover reimbursement requests from health facilities. Among the 334,692 households that were active members in 2015/16, 250,488 households (75 percent) renewed their membership the following fiscal year. The remaining 84,208 households (25 percent) did not. Moreover, only 11 schemes (47 percent) managed to achieve renewal rate of more than 80 percent while the remaining 12 schemes (53 percent) achieved less than 80 percent of membership renewal.

As indicated in Table 5, significant variation in renewal rates was observed among schemes within the same region, ranging from 57.9 percent (Alefa) to 99.5 percent (Dembecha) in Amhara; 17.5 percent (Deder) to 98.3 percent (Aleltu) in Oromia; and 55.6 percent (Hawzen) to 85.9 percent (Tahtay-Adiabo) in Tigray.

[4] SNNP is excluded from this analysis as schemes in this region have no fixed period for membership renewal and new member registration. Schemes register members throughout the year, which makes it difficult to obtain reliable membership renewal data. Raya Azebo scheme in Tigray is also excluded as membership renewal had not started at the time of the assessment. Thus, the analysis on membership renewal refers to the remaining 23 schemes.

Table 5: Number of active member households, and households that renewed membership and renewal rates in 2015/16 and 2016/17

Region	No. of active member HHs in 2015/16	No. of HHs renewed membership in 2016/17	Overall renewal rate (%)	Ranges of renewal rate (%)	
				Min	Max
Amhara	193,989	157,605	81.9	57.9	99.5
Oromia	88,497	61,893	70.1	17.5	98.5
Tigray	52,206	30,990	71.3	55.6	85.9
Total	**334,692**	**250,488**	**74.5**	**17.5**	**99.5**

2.3.3 Indigent Selection

As part of Ethiopian government efforts to ensure equity in accessing health care among different population groups, kebele administrations are expected to select and create a list of the poorest of the poor households (indigents) that cannot afford the contribution amount to join a CBHI scheme, and share the list with woreda administrations for approval. Once approved, the CBHI contributions for those on the indigent list are paid by the regional government and/or woreda administration in the form of a targeted subsidy. For this study, schemes were asked whether woreda administrations approved indigent lists selected by kebeles. All schemes reported that indigent households were selected by their respective kebeles and lists approved by woreda administration.

According to regional CBHI directives, the list of indigent households should be revised on regular basis – i.e., every three years in Amhara, every two years in Oromia, and annually in SNNP and Tigray. The study found that 80 percent of the study schemes revised the list of indigent households. However, six schemes (Wadla in Amhara, Adea, Munisa, and Dollo Mena in Oromia, Shebedino in SNNP and Raya Azebo in Tigray) did not.

A total of 76,303 indigent households with 314,307 beneficiaries were selected for CBHI coverage by woreda administrations during 2016/17 (Table 6). Of the total number of indigent households, male headed households accounted nearly 58 percent while the remaining 42 percent were female headed. When disaggregated by region, there were more female-headed indigent households selected to join CBHI in Tigray (66 percent) and Amhara (53 percent).

The proportion of indigent households selected from the total number of eligible households has significant variation across regions ranging from 4 percent in SNNP to 10 percent in Oromia and Tigray, overall average being 8 percent. According to the CBHI Scale-up Strategy (EHIA 2015), in 2015 the proportion of population below the poverty line (poor) was estimated at 26 percent. Based on this estimate, the total number of households below the poverty line in the study woredas is around 256,997 households. Of these, 30% are the poorest of the poor (indigent) households enrolled in the CBHI program. In order to enhance social inclusion in the health insurance system, a mechanism to cover the remaining 70 percent (180,694) poor households in the CBHI program is needed.

Table 6. Number of indigent HHs selected for CBHI coverage and beneficiaries, 2016/17

Region	Male-headed HHs	Female-headed HHs	Total HHs	% Indigent HHs of total CBHI-eligible HHs	Total Beneficiaries
Amhara	13,591	15,084	28,675	8	120,829
Oromia	20,458	7,665	28,093	10	130,724
SNNP	6,392	2,483	8,876	4	41,175
Tigray	3,631	7,028	10,659	10	21,579
Total	**44,072**	**32,260**	**76,303**	**8**	**314,307**

2.3.4 Overall enrollment status

A total 308,847 households (with 1,458,084 beneficiaries) registered with schemes during 2016/17 (Table 7).[5] Of the total number of registered households, on average 78 percent were paying members while the remaining 22 percent were indigents/non-paying and eligible for CBHI membership through the targeted subsidy. The proportion of non-paying households enrolled in CBHI (out of the total number of households enrolled) was higher in Oromia (33 percent) followed by Tigray (27 percent) and Amhara (16 percent).

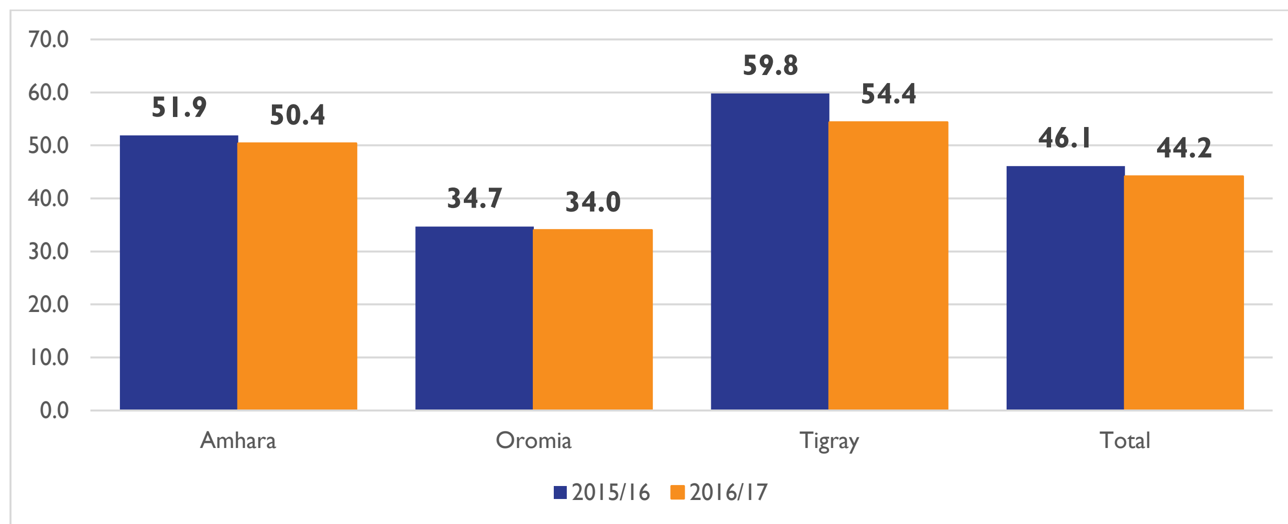
Table 7. Households enrolled in CBHI, 2016/17

Region	Households enrolled				% indigent HHs
	Paying	Non-paying	Total	Total Beneficiaries	
Amhara	154,422	28,675	183,097	787,317	16
Oromia	58,110	28,093	86,203	413,774	33
Tigray	28,888	10,659	39,547	174,007	27
Total	**241,420**	**67,427**	**308,847**	**1,458,084**	**22**

[5] Refers to active households i.e., households that renewed their membership and newly enrolled in 2016/17. The Raya-Azebo scheme in Tigray is excluded as membership renewal had not started at the time of the study.

The average regional household enrollment rates in the study schemes/areas in 2016/17 were low compared to their level in the preceding year. The overall average enrollment rate decreased from 46.1 percent (2015/16) to 44.2 percent (2016/17), nearly 2 percentage points. This was caused by a decrease in total number of active members (from 334,692 to 308,847 households in 2016/17) which was a result of low membership renewal and low enrollment of new households in some schemes (Figure 1).

Figure 1. Average enrollment rate in study schemes, 2015/16 and 2016/17



2.4 CBHI Membership Identification Card Issuance

CBHI membership identification card (ID card) preparation and distribution are among the critical tasks in CBHI implementation. As indicated in the CBHI Implementation Directive, schemes are expected to print and distribute sufficient ID cards to each kebele. Then kebeles prepare the IDs (fill in beneficiary profiles and attach photos) and submit them to the schemes for validation. The schemes validate the IDs and issue (send them back) to kebeles for distribution. To assess the management of ID cards, schemes were asked whether they had distributed sufficient copies of ID cards and to indicate the number of ID cards issued by the scheme to kebeles and distributed to members.

Except Deder scheme in Oromia, all study schemes reported that they had distributed sufficient copies of ID cards to each kebele in 2016/17 Deder scheme did not distribute sufficient copies because of a reported lack of budget. All except three schemes in SNNP reported that they distributed ID cards (though kebeles) to all active member households. Schemes that did not distribute all ID cards were: Damot Gale, Halaba, and Shebedino.

Given the fact that CBHI is being primarily implemented in rural settings where infrastructure (roads, electricity) is typically poor, the preparation and timely distribution of ID cards to members has been the major challenge in CBHI implementation.

Schemes were asked about the major challenges they encountered in relation to ID card preparation and distribution. The main reported challenges were: Member delays in submitting photographs due to lack of photographer in the area (82 percent); shortage of staff at the kebele level to prepare ID cards (75 percent); lack of capacity to prepare ID cards in some kebeles (29 percent); poor quality of photographs which cannot be used for ID cards (25 percent); and delays in printing of ID cards by some woreda administrations (18 percent). To mitigate these problems, schemes reported taking the following measures: photographers made house to house visit to take pictures (68 percent); woreda

administration provided camera to kebele managers (42 percent); woreda cabinet members were assigned to take pictures (37 percent); used micro enterprises to take pictures (32 percent) and kebele managers used their own mobile camera (23 percent). Moreover, schemes like Dello Mena and Deder in Oromia used Health Extension Workers to take pictures and prepare ID cards, and Sodo scheme in SNNP deployed health center heads to coordinate photographing of CBHI member households in their catchment areas.

2.5 Financial Management

2.5.1 Resources Mobilized

Contributions (including registration fees) from paying members and from government (in the form of general and targeted subsidies) are the two sources of revenue to CBHI schemes. The general subsidy granted to the schemes by the federal government is allocated based on the total contribution of all members and it is intended to increase affordability of CBHI contributions to the members. Targeted subsidies are granted by regional governments and woreda administrations in the form of contributions on behalf of indigents (in SNNP, woreda administrations cover the entire contribution of indigents).

Schemes were asked whether they had received targeted and general subsidies for 2016/17. All schemes (except Alefa in Amhara where the woreda administration did not allocate targeted subsidy) reported that they had received targeted subsidy from regional government and woreda administration. None of the schemes had received general subsidy from the federal government in 2016/17.

As shown in Table 8, schemes mobilized Birr 66,630,216 (US$ 2,979,751)[6] from CBHI contributions (including CBHI membership registration and renewal fees) and subsidies. The amount of revenue collected differs by region, and depends on the number of CBHI members and the contribution amount set. Of all sources of revenue to the schemes, contributions from paying members was the predominant source of revenue accounting for 82.6 percent of the total financial resources while targeted subsidies represented 17.4 percent. The share of subsidies from total resource also varied across regions depending on the number of indigent households selected and the amount of targeted subsidy paid per household in the respective regions. It was higher in Tigray (29 percent) and Oromia (25 percent) and lower in SNNP (11 percent).

Table 8. Total revenue mobilized and relative share of revenue by source, 2016/17

Region	Total resources mobilized	Share of revenue by source (%)		
		Contribution	Targeted subsidy*	
			Regional gov't	Woreda admin
Amhara	34,973,429	86	9	5
Oromia	13,225,144	75	13	12
SNNP	10,986,925	89	0	11
Tigray	7,444,718	71	19	10
Total	**66,630,216**	**82**	**10**	**8**

* Federal government did not allocate a general subsidy in 2016/17.

[6] Currency conversion based on the average exchange rate for 2016/17, which was US$1= Birr 22.361.

2.5.2 Scheme Expenditure

Schemes enter into contract agreements with health providers (hospitals and health centers) to provide services per the benefit package for CBHI beneficiaries and to be reimbursed by schemes. Payment of reimbursement requests from health providers are the main expenditure for schemes. Schemes were asked to provide the number of facilities with which they had signed contracts, the number of health facilities that submitted their claims as per the agreement, and the amount paid to health facilities for services rendered to CBHI beneficiaries.

A total of 281 health facilities (211 health centers and 70 hospitals) had signed contracts with the study schemes. According to the contract: providers are expected to submit their claim within 10 days after the reporting quarter ends; schemes shall pay 75 percent of the claimed amount upon receipt; and the remaining 25 percent payment shall be made after schemes undertakes clinical audits of contracted facilities. Schemes reported that 85 percent of the health centers and 5 out of 7 hospitals (71 percent) submitted claims on regular basis.

A total of 1,240,715 visits (outpatient and inpatient) were made by insured patients in 281 contracted health facilities (211 health centers and 70 hospitals). The schemes reimbursed a total of Birr 58,315,896 (US$2,607,927) to the facilities for services rendered. Of the total reimbursement, 67 percent (Birr 39,316,785/US$ 1,758,275) was paid to health centers while and 33 percent (Birr 18, 999,111/US$ 849,654) to hospitals. The magnitude of health care cost differs across regions depending on the number of patient served and type of disease/illness (Table 9).

The overall average cost per out-patient department (OPD) visit was estimated at Birr 36.8 (US$ 1.7) in health centers and Birr 155.1 (US$ 6.9) in hospitals while cost per in –patient (IP) admission in hospitals was Birr 583.5 (US$ 26.1).[7] The average unit cost for health care services per visit differed across regions. In health centers it ranged from nearly Birr 32 (US$ 1.4) in SNNP to Birr 45 (US$ 2.0) in Tigray, and average unit cost for OPD in hospital ranged from Birr 70 (US$ 3.1) in SNNP to Birr 218 (US$ 9.7) in Oromia, and unit cost for admission ranged from about Birr 282 (US$ 12.6) in Tigray to nearly Birr 711 (US$ 31.7) in Amhara.

The average health care cost for an OPD visit both in health centers and hospital is much higher during the review period compared with the 2011/12 (pilot period): Birr 21.6 vs Birr 36.8 in health centers and Birr 63.7 vs 155 in hospital (HSFR 2012). This implies that the unit cost on average increased by 70 percent in health centers and more than double (143 percent) in hospitals over the last six years - mainly attributed to the ever increasing cost of drugs and diagnostics, which accounted for most of the health care costs (FMOH, 2017).

[7]The reimbursed amount and hence the unit cost may not fully represent the medical costs of insured patients as some health facilities received 75 percent of the claim and the remaining 25 percent was released after schemes conducted health facility clinical audits. Moreover, some health facilities that did not submit claims for the 3rd quarter of 2009 EFY (2016/17) and the reimbursed amount did not include out-of-pocket reimbursement.

Table 9. Number of health facility visits and amount reimbursed, by region for the period April 2015/16 to March 2016/17

Region	No. contracted health facilities	Total Visits	Amount reimbursed by schemes (birr)	Average unit cost (birr)		
				Health center	Hospital	
				OPD	OPD	IP
Amhara	106	712,395	32,493,067.00	35.4	164.9	710.7
Oromia	79	234,331	11,764,919.00	37.2	218.4	542.3
SNNP	47	114,725	4,230,032.00	31.9	69.9	641.3
Tigray	49	179,264	9,827,878.00	45.0	100.3	281.7
Total	**281**	**1,240,715**	**58,315,896.00**	**36.8**	**155.1**	**583.5**

Seventy-three percent of schemes reported that they have had encountered challenges while settling claims. Delays in receiving reimbursement requests from health facilities (78 percent), failure by schemes to undertake clinical audit in all contracted health facilities on quarterly basis (69 percent), and financial constraints of the scheme (30 percent) were the major reported challenges. Schemes that reported experiencing financial constraints in 2016/17 were: Dangila-Zuria, Kewot, Fogera and Mecha in Amhara; Dollo Mana, Deder, Limu Kossa and Arsi Negelle in Oromia; and Tahtay Adiabo in Tigray. High costs of drugs and increased out of pocket-(OOP) reimbursements are among the possible reasons for financial constraints. Low CBHI coverage in Oromia is also another cause of financial constraint, as most of the schemes in this region have started providing benefit packages to CBHI beneficiaries with enrollment rates much lower than the minimum rate set by the region (50 percent). Further investigation would be required to identify the root causes of the financial constraints and to design mechanisms to support financial sustainability of schemes in the long run.

2.5.3 Clinical Audit

Schemes are expected to undertake clinical audits of contracted health facilities on a quarterly basis to monitor the quality of services rendered by contracted health facilities and determine whether the provision of services (included in claims) was justified, given the standard and the terms of the contract agreement.

Schemes were asked whether they regularly carried out clinical audits in health facilities. Twenty-five out of 30 schemes (83 percent) reported that they undertook clinical audits on a quarterly basis. The remaining five schemes (Arsi Negelle and Munisa in Oromia, Kilte Awlaelo, Hawzen, and Tahtay Adiabo in Tigray) did not do regular audits. Reasons for this were the workload of scheme coordinators in Tigray,[8] and staff turnover and lack of budget for transport in Oromia.

Findings from the clinical audits indicate that there are: poor medical recording/incomplete patient history (76 percent), arithmetic errors (28 percent), and facilities that used higher user fees than the rate set by the region when computing costs incurred to provide benefits package for the CBHI beneficiaries (24 percent).

[8] The CBHI coordinators in Tigray have dual responsibility, they serve as curative case team leader in their respective woreda health office and as CBHI coordinator. The lack of a separate, full time CBHI team leader/coordinator hampers implementation, including the conduct of clinical audits.

2.5.4 Transaction Recording, Reporting and Auditing

As per CBHI finance manual, schemes are expected to record and post financial transactions and prepare summary reports on regular (monthly and quarterly) basis (EHIA 2016). Schemes were asked whether they register and post financial transaction in ledgers, and prepare financial reports and bank reconciliation regularly. Twenty-four schemes (80 percent) reported that they registered financial transactions. Of these, 73 percent posted the transaction into ledger cards. With regards to financial reports, a little over half (53 percent) of schemes reported that they prepared income statements while only 47 percent prepared a balance sheet on a regular basis. Nearly 57 percent reported that they prepared bank reconciliation regularly. With the exception of Mareko, all schemes in SNNP failed to prepare financial reports. Only four schemes in Oromia prepared income statements and two schemes reported that they produced balance sheets. The reported reasons for not preparing financial reports include: lack of technical capacity (35 percent; some accountants are new recruits), time constraints (31 percent), negligence (19 percent), and absence of accountant (15 percent).

Regarding financial audits, schemes were asked to state whether they had ever been audited by their Woreda Finance and Economic Development office and to state the major audit findings. Accordingly, 22 schemes (73 percent) reported as they had been audited. Of these, five schemes (16.7 percent) were audited in 2014/15 EFY and 16 schemes (53 percent) in 2016/17 EFY. The major reported audit findings included: delay in collecting receipt vouchers (RV) used to collect member contributions from kebeles (33 percent), delay in depositing contributions collected (30 percent), mismatch in the amount stated on the second and third copies of the RV (27 percent), failure to sign on RV by cash collectors (19 percent), and loss of cash and loss of RV (9 percent each) (Table10).

Table 10. Major scheme financial audit findings (multiple responses possible)

Major finding	% Response
Delay in collecting RVs from kebeles	33%
Delay in depositing contribution collected	30%
Mismatch in the amount stated on 2nd and 3rd copies of RV	27%
Failure to sign on RV by cash collectors	19%
Loss of cash	9%
Loss of RV	9%

Schemes were also asked about the number of RVs they distributed to and collected from kebeles after use. The results of this assessment also support the audit findings. Schemes reported that of the total 17,676 RVs distributed, 20 percent (3,587) were in use by kebeles at the time of assessment although the registration of new households and membership renewal season is over in most schemes. This means on average 120 RVs per scheme were at the hands of kebele officials. The number of RVs still in use by kebele officials (and hence not returned) was higher in Tigray (1,020) and Oromia (1,009) followed by Amhara (918) and SNNP (640). A total of 12 RVs (6 in Damboya, SNNP, 4 in Raya Azebo, Tigray, 1 RV each in Gimbichu and Aleltu, Oromia) were also reported as lost. This shows that the management of RVs remains a major challenge.

2.6 Performance Monitoring and Evaluation

Monitoring scheme performance on monthly and/or quarterly basis is an essential condition for sustainability of the scheme. Timely and reliable monitoring and evaluation provide accurate information/evidence that enable managers and decision-makers to improve scheme performance. Scheme monitoring is conducted by having scheme performance review meetings, performing supportive supervision, and through reporting. Schemes were asked whether they kept member registration forms in the required/specific folder, encountered challenges in the quality of data reported from kebeles, reviewed scheme performance, and prepared performance reports on monthly and/or quarterly basis. The results are presented as follows.

2.6.1 Data Management and Performance Reporting

All schemes except Dangila in Amhara kept member registration forms received from kebeles in a folder. Folders are part of the scheme data management system. Of these, 60 percent reported that they received updates on member profiles from kebeles (updates such as changes in household members due to death, birth, residence, migration and/or change in household status). The remaining 40 percent did not.

Most schemes reported experiencing data quality problems due to illegible hand writing and incompleteness of member registration forms, IDs, etc. coming from kebeles (93 percent), discrepancies between reported figures on membership (and hence members contributions) and source documents (70.4 percent), and double counting (22 percent).

Schemes are expected to review their performance in terms of new household enrollment, membership renewal, contribution collection, service utilization and reimbursement. They also are required to produce and submit progress reports to concerned bodies (Zonal CBHI Coordination Office and Ethiopian Health Insurance Agency (EHIA) branch offices). All except two schemes (Arsi Negelle and Munisa in Oromia) reviewed scheme performance quarterly. All schemes but Arsi Negelle produced performance reports on quarterly basis. Regarding frequency of reporting, all schemes except Arsi Negelle produced monthly reports and the majority (90 percent) of schemes produced quarterly reports.

Reports are among the communication mechanisms through which stakeholders obtain regular feedback on the progress being made and challenges faced in CBHI implementation. Reporting also helps to demonstrate accountability and gain support to make corrective decisions that improve scheme performance. As per the CBHI Data Management Manual, schemes are expected to submit performance report to Zonal CBHI Coordination Offices and to EHIA branch offices. All schemes in Amhara, SNNP and Tigray submitted performance reports to both of these offices. In Oromia, only two schemes (Deder and Nejo) did so and eight schemes submitted reports only to the Zonal CBHI coordination office. This indicates a weak reporting relationship between schemes in Oromia and EHIA branch offices. Furthermore, most schemes (67 percent) submitted performance reports to Woreda CBHI Board of Directors, and 37 percent and 20 percent of the schemes indicated submitting reports to Woreda Administration and Woreda Health Office, respectively.

2.6.2 CBHI Organization and Governance

The CBHI directives in the four study regions stipulate that each scheme shall have a Board of Directors that oversees their governance.[9] Board responsibilities include: reviewing quarterly financial and activity reports, following up on the proper execution of scheme operations as per in their approved annual plan, and present annual reports to the General Assembly. For this study, schemes were asked to state whether their board met on quarterly basis to review scheme performance, and identify major implementation challenges, and actions taken by the scheme and/or woreda administration to overcome the challenges.

Sixty percent of the schemes reported that their board met on quarterly basis to review performance in 2016/17 and the remaining 40 percent stated that their board did not. Low quality of health care service (90 percent), low new household enrollment and membership renewal rate (80 percent), and weak performance in ID card preparation and distribution (60 percent) were the major challenges identified by the board. The woreda administrations had taken actions to overcome some of the above mentioned challenges for example by deploying woreda cabinet members to their respective kebeles to provide overall technical support (86 percent) and declared a "CBHI week" to mobilize/increase CBHI enrollment (68 percent).

All the schemes except three (Adea, Arsi Negelle, and Munisa) in Oromia indicated that woreda administrations conducted General Assembly meetings on annual basis. It was reported that the General Assembly participants identified: Low new enrollment (92 percent), poor quality services at health facilities (85 percent) and low renewal rate (73 percent) as major implementation challenges.

Woreda-level review meetings are one of the mechanisms woreda administrations use to monitor progress of scheme. They are expected to conduct review meeting on quarterly basis. Schemes were also asked whether their respective woreda administrations had conducted a woreda-level review meeting in 2016/17. All schemes except Arsi Negelle and Munisa in Oromia and Halaba in SNNP, reported that woreda administrations had conducted woreda-level CBHI review meetings. The number of review meetings conducted varied across woredas. Woredas in Amhara and Tigray on average conducted three review meetings in 2016/17, while those in Oromia and SNNP held two review meetings.

The CBHI woreda-level review meeting participants identified: Low new household enrollment (92 percent), low membership renewal (89 percent), and poor-quality health services, i.e., unavailability of drugs and undesirable handling of beneficiaries in the facility (77 percent) challenges to be addressed. To overcome these challenges, 24 schemes (92 percent) reported that they held discussions with health facility staff on the quality of service provision, 23 schemes (86 percent) discussed observed gaps with kebele leaders and provided technical support, 16 schemes (62 percent) reported that they developed a strategy with woreda administrations to enhance enrollment.

Overall, low enrollment and renewal rates were identified as major implementation challenges and discussion points in the meetings held at different levels (Board of Directors, General Assembly, and woreda-level review meetings) during 2016/17. However, the performance of some of the schemes in terms of new enrollment and membership renewal was low as the decisions passed by these meetings are either partially or fully not translated into action.

[9] A Board of Directors is comprised of nine members and accountable to the General Assembly. The Board includes a woreda administrator (board chairman), woreda health office head, woreda finance and economic development office head, woreda women and children affairs office head, woreda communication office head, and three CBHI members who are also members of the General Assembly. General Assembly meetings are held by woreda administrations.

3. FINDINGS AT THE KEBELE LEVEL

3.1 Community Sensitization and Mobilization

As stated in CBHI Implementation Manual (EHIA 2016), kebele cabinets are responsible for undertaking advocacy and sensitization activities to encourage enrollment/renewal and provide CBHI-related information to community members in their kebeles. Kebele managers were asked whether they had a community sensitization plan, and whether they integrated this plan into their overall kebele development agenda.

Of the 30 kebeles assessed, 26 kebeles (87 percent) reported having their own community sensitization plan and 73 percent had integrated their CBHI plan into the kebele overall development agenda. Kebeles undertook sensitization activities at various places and used different forums and events. Churches/mosques were the main places where nearly 89 percent of the kebeles conducted CBHI advocacy and sensitization followed by social gatherings like *iddir* meetings (85 percent) and also schools (70 percent). All kebeles reported that they used community meetings called by the government to sensitize the community, about 97 percent used development army meetings and CBHI members who benefited from the program. Sixty-three percent reported that they (kebele cabinet members, sometimes assisted by health extension workers) made house to house visits. In Amhara, schemes also use kebele councils and got[10] meetings as forums for community sensitization, and non-CBHI members who incurred high out of pocket expenses for health care to raise the awareness among the local population about the costs of not having CBHI. In terms of frequency, 77 percent of the kebeles performed community sensitization and awareness creation activities during the harvest season (which is the agreed upon period for renewal and new member registration), while 35 percent did so on a quarterly basis.

3.2 CBHI Membership ID Card Preparation and Distribution

Kebeles are expected to receive sufficient blank IDs from their scheme, create member and beneficiary profiles, prepare IDs for members (fill in beneficiary names and attach photographs), send the prepared IDs to the scheme for approval, and finally, collect the approved IDs from the scheme and distribute to members. The majority (80 percent) of kebeles reported that they received sufficient IDs from their respective scheme and prepared CBHI member ID cards. Kebeles were also asked to report the major challenges they faced in the preparation and distribution of ID cards. Nearly 85 percent reported delays in the submission of photographs by members, and 50 percent indicated that the busy work schedule of kebele officials impacted the timely preparation and distribution of IDs.

Kebele respondents reported the following as the main factors contributing to the delay in the submission of member photographs to be included on ID cards: Unavailability of all family members when photographers and/or kebele cabinets take photographs (85 percent); inability of some household members, including the elderly, to easily reach photo shops (30 percent) and unavailability of mobile photographers (26 percent) were reported as the main factors attributed to the delay in the submission of members' pictures. To address these problems, kebele cabinets and got/village leaders conducted

[10] Got is a component of the kebele administrative unit comprising 40–50 households

house to house campaigns to inform members to take photos during market days and submit photographs to kebeles (82 percent) and recruited mobile photographers (12 percent).

3.3 Contribution Collection

As indicated in the CBHI implementation manual, kebeles are supposed to collect contributions from new paying CBHI members at registration, and then on an annual basis for membership renewal. RVs are to be issued each time a contribution is collected. The kebele administrator/cashier is then required to give all of the money collected along with the second copy of the RV to the schemes. The schemes check the amount of money collected and the receipts, and prepare bank deposit slips for the kebele administrator/cashier to deposit the money into the schemes' bank accounts.

Kebeles were asked to state who collects CBHI member contributions, the amount collected, whether they have member contributions in hand that had not yet been deposited, and major challenges they encountered in collecting contributions.

The responses obtained indicate that kebeles used different actors to collect contributions. Kebele cabinet members were used in 52 percent of the kebeles; and kebele cash collectors (elected by the community, not government employees) and got leaders were used in 45 percent and 38 percent of the kebeles, respectively. In Amhara, contributions were primarily collected by cash collectors at kebele and got levels (90 percent). As stated in CBHI finance manual, kebeles are expected to deposit contributions collected into the scheme account within one week of receipt if the collected amount exceed birr 2,000 and within one month otherwise. Cash collectors at got level also need to submit the collected contribution to the kebele administrator within one week. The study found that cash collectors at got level submitted collected contribution to kebele administrators on weekly basis in 53 percent of the kebeles; they had no fixed period of submission in the remaining 47 percent of the kebeles and hence, submitted the contributions when convenient to them.

Kebeles altogether collected Birr 3,137,871 (US$140,327) from paying members during 2016/17. Of this, 96 percent (Birr 3,020,367) was deposited into scheme bank accounts and the remaining 4 percent (Birr 117,504) was maintained in the hands of cash collectors/kebeles at the time of data collection (Table 11). The total amount of contributions not yet deposited varied across region and ranged from Birr 142 in Amhara to Birr 114,995 in Oromia. The case in Oromia, goes against the finance manual. The main reason for this was delayed initiation of membership renewal and new enrollment on the part of the woreda administration. Lack of incentive to cash collectors (77 percent) and busy work schedule/ workload of kebele leaders, kebele administrator and managers (42 percent) were the main reported challenges to effectively collecting member contributions.

Table 11: CBHI membership registration and renewal contributions collected, deposited and not yet deposited (in hand) at kebeles

Region	Amount of contribution (birr):		
	Collected	Deposited	In hand
Amhara	1,533,052.00	1,532,910.00	142.00
Oromia	761,485.00	646,490.00	114,995.00
SNNP	350,407.00	349,400.00	1,007.00
Tigray	492,927.00	491,567.00	1,360.00
Total	**3,137,871.00**	**3,020,367.00**	**117,504.00**

3.4 Performance Monitoring

Kebeles are expected to keep the second copies of membership application forms in a specific folder and encode member profiles in a member registry book. They are also supposed to update member profiles (household head and family members) whenever changes occur in the composition of the household members, such as due to birth, death, and migration. The study data collectors checked registry books and found that 22 out of 30 kebeles (73 percent) encoded member profiles into a registry book while the remaining eight kebeles did not. In 2016/17, two-thirds (67 percent) of kebeles updated member profiles and shared data with the associated CBHI scheme while the remaining 33 percent did not.

Kebeles were asked to state whether CBHI member/beneficiaries communicate their complaints regarding health care service provision to them and how kebeles addressed them. Nearly 94 percent of the kebeles confirmed that CBHI beneficiaries communicated their complaints; and major reported grievances included: unavailability of drugs in health facilities (60 percent), long waiting time to obtain services (26 percent), improper/unethical handling of beneficiaries in health facilities (20 percent), and delay in out of pocket reimbursement (13 percent). About 80 percent reported that they shared the grievances received with the woreda administration/woreda health office, 92 percent mentioned them during quarterly review meetings, and 62 percent reported them during provider–community forums.

Kebeles were also asked whether they received supportive supervision from different government offices that are supposed to support CBHI implementation during 2016/17. Nearly 79 percent of the kebeles reported that they received supportive supervision visits from scheme executive staff, 71 percent from woreda administration, 61 percent from woreda health office while 32 percent and 11 percent from the EHIA and RHB, respectively.

Supportive supervision is believed to help kebele leaders to improve their performance. It also considered an opportunity to improve knowledge and skills. Supervisory teams are expected to provide feedback on issues that need to be strengthened and improved. Ninety percent of kebeles reported having received feedback during supportive supervision visits. Of these, 70 percent received oral feedback, 19 percent received both oral and written, and 10 percent received written feedback only.

The major problems identified and communicated to kebeles during supportive supervision were: low enrollment and renewal rate (65 percent), poor data management –incomplete member application forms and failure to use registry books (42 percent), delay in ID cards preparation and distribution (27 percent), failure to deposit contributions collected from paying members into the scheme account in a timely manner (15 percent) and weak advocacy and sensitization campaigns (12 percent). To overcome the aforementioned problems, 48 percent of the kebeles reported that they intensified door to door sensitization campaigns in collaboration with health extension workers (HEWs) to increase enrollment and membership renewal, 17 percent properly filled in the incomplete member application forms and started registering member profiles in the registry book, and 10 percent reported that they gave due attention to ID preparation and distribution and hence distributed all ID cards to members.

4. FINDINGS AT THE HEALTH FACILITY LEVEL

4.1 Catchment Area Population

A total of 30 health facilities (28 health centers and 2 hospitals) were included in the study. These facilities provide health care services for an estimated 1.9 million people. Of these, nearly 51 percent are men and the remaining 49 percent are women. Each health centers on average serves 37,157 people. The size of the catchment area population in health centers, however, varies from region to region. The highest catchment area population is observed in SNNP (41,556), followed by Oromia (39,123), Amhara (37,542), and Tigray (26,271).

4.2 Institutional Capacity of Health Facilities

The quality of health care service provision in a given health facility is determined, among other factors, by the availability and adequacy of well trained and experienced health personnel and by the availability and functionality of infrastructure. Health facility heads were asked whether they have the required number and type of staff needed to effectively provide services to the catchment population as per regional standards, and to report on the availability and functionality of infrastructure and essential utilities (such as electricity, water, and telephone) as these affect the quality of the health care service provided to the CBHI beneficiaries. The main findings are presented in the following section.

4.2.1 Human Resources

Of the 30 facilities assessed, only seven (23 percent) reported that they had the required staff while the remaining 23 facilities (77 percent) had human resource shortages/did not fulfill regional standards. Shortage of laboratory technicians was the most commonly reported problem (83 percent), followed by pharmacy technicians (67 percent), nurses and environmental health workers (each 61 percent), health officers (48 percent) and midwives (26 percent). Regional variations were observed in terms of availability of the required health professionals. All health centers in SNNP and Tigray reported shortages of laboratory technicians. Shortage of pharmacy technicians was more common in Oromia (80 percent) while laboratory technicians and nurses in Amhara (78 percent). Filling the gap with qualified and competent professionals should therefore be considered as one of the prerequisites to improve the quality of health care services.

4.2.2 Availability of Essential Utilities and Infrastructure

With respect to availability of utilities, nearly two-thirds (67 percent) of the facilities had telephone service and the vast majority (90) had electric power supply. Less than half (47 percent) reported having a functional generator (to be used during power outages) and 90 percent of facilities had a clean water supply. All except one health center (*Tere* health center in Kewot woreda, Amhara) had a functional latrine/toilet. A private examination area was available in 28 facilities (93 percent). All but one facility (*Jare Dembeka* health center in Mareko woreda, SNNP) had a functioning refrigerator. Overnight beds for emergency cases and an incinerator was available in 28 (93 percent) and 27 (90 percent) health facilities, respectively.

4.3 Financial Resources

Health facilities are allowed to retain and use internally generated revenue to make improvements that increase the quality of health care service delivery. This is one of the FMOH's health care financing reforms. Health insurance is also expected to affect service delivery through its impact, among others, on the financing of health services. CBHI schemes are supposed to increase health facility internally generated revenue of by increasing utilization and therefore fees/reimbursements to facilities for the services provided. Health facilities were asked to provide: (1) the total amount of revenue generated during the last year (April 9, 2016 to March 10, 2017); (2) the share of financial resources obtained from schemes in the form of reimbursements from the CBHI program out of their total internal revenue; and (3) the amount of retained revenue used to procure drugs and medical supplies.

As indicated in Table12, the health centers altogether collected Birr 18,974,809 (US$848,567) from user fees during the review period. [11] Of this, Birr 10,551,873(US$471,887) was generated from CBHI schemes in the form of reimbursement. The share of financial resources obtained from schemes significantly varied across health centers depending on the number of visits made by insured beneficiaries, CBHI coverage rate, and the associated unit cost of care. It ranged from 19.3 percent in SNNP to nearly 99 percent in Amhara. The average proportion of user fees collected from CBHI schemes to total retained revenue of health centers was higher in Amhara (64.5 percent) and lower in Oromia (49.4 percent).

All in all, revenue obtained from CBHI schemes on average constituted 57.1 percent of health centers retained revenue. This signifies that CBHI is playing a significant role in boosting the amount of revenue collected by health facilities and hence in increasing availability resources (finance) at points of service delivery.

Table 12. Health centers' retained revenue and share of CBHI program, April 9, 2016 to March 10, 2017

Region	No. of sampled health centers	Total retained revenue from user fees	Revenue obtained from schemes as reimbursement	Share of health center financial resources from CBHI program (%)		
				Min	Max	Mean
Amhara	10	7,672,178	4,785,118	30.9	98.7	64.5
Oromia	9	6,651,535	3,003,198	25.3	70.0	49.4
SNNP	5	2,521,694	1,355,736	19.3	80.9	52.1
Tigray	4	2,129,402	1,407,821	39.7	78.1	61.8
Total	**28**	**18,974,809**	**10,551,873**	**19.3**	**98.7**	**57.1**

With regard to procurement of drugs and medical supplies, health centers in total allocated Birr 14.8 million (US$661,866) during the period under review. Of this, 23 percent (Birr 3.4million/US$152,050) was government budget and the remaining 77 percent (Birr 11.4 million/US$509,816)) was allocated from health facility retained revenue. Of the total budget allocated, nearly 14 million (94 percent) was used to procure drugs and medical supplies. The average share of retained revenue utilized for the procurement of drugs and medical supplies differed across regions. It was higher in Tigray (73 percent) followed by Amhara (70 percent), SNNP (69 percent) and Oromia (57 percent). This indicates that in all

[11] Hospitals did not provide complete data on revenue and hence the reported figures in this section refer only to health centers.

four regions the retained revenue in health centers was mainly used to increase availability of drugs and medical supplies. Furthermore, 93 percent of the health centers also reported that the CBHI program contributed to the improvement in availability of drugs and medical supplies as well as medical equipment while 75 percent indicated that the CBHI program improved the availability of utilities like water supply, electricity, etc. In addition, 25 percent of health centers also mentioned that they constructed additional blocks for maternal services using the revenue obtained from schemes.

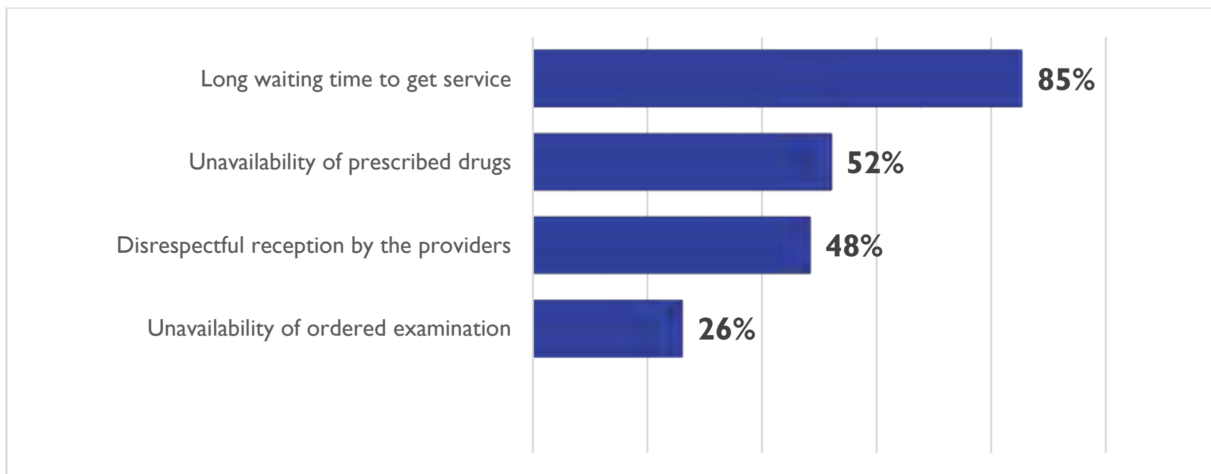
4.4 CBHI Training

HSFR/HFG, in collaboration with RHBs and the EHIA, has organized trainings on the basics of CBHI for health care providers as their involvement in implementing the program is essential. Health facilities were asked whether they received training on CBHI implementation and if they had cascaded the training to all health facility staff. Seventy-five percent of health facilities reported that heads of their facilities had received the training on CBHI implementation. Of these, 57 percent cascaded the training to staff and the remaining 43 percent did not.

4.5 Complaint Handling

Health facilities were also asked to indicate major reported complaints from CBHI beneficiaries and how they resolved them, major challenges encountered in providing services to CBHI beneficiaries, and measures taken to overcome these challenges. With respect to complaints, the majority (85 percent) of health facilities reported beneficiaries complained about long waiting times to obtain health services followed by unavailability of drugs (52 percent) and disrespectful reception by staff (48 percent). Twenty-six percent reported unavailability of examination/laboratory and diagnostic services to enable them to get examinations ordered by care providers (Figure 2).

Figure 2: Percentage of major reported service delivery complaints by CBHI beneficiaries reported by health facilities (more than one response possible)



To resolve the reported complaints, 96 percent of facility heads reported that they discussed the complaints with the staff; nearly 90 percent provided orientation to staff in general and card room workers in particular on respectful customer handing; 85 percent discussed the complaints during kebele council and woreda-level meetings and 50 percent attempted to increase supply of drugs.

Increases in patient flows coupled with shortage of laboratory technicians in most health facilities led to long waiting times. Facility heads reported that, unlike in previous years, budget was not the cause for drug and medical supplies. Rather, it was attributed to unavailability of drugs and medical supplies at Pharmaceutical Fund and Supply Agency (PSFA) hubs where health facilities purchase drugs and medical supplies. As a result, some health centers in SNNP reported that they borrowed drugs from health centers with low patient flows, and some health centers in Amhara send patients with drug prescriptions to other health centers.

Availability of drugs and the required diagnostics in health facility are among the most important factors for household to join or renew CBHI membership[12]. If these problems are not addressed, it might be difficult to sustain achievements gained so far.

Although CBHI beneficiaries have become assertive in demanding their rights; sometimes they make what is perceived by facility personnel as unreasonable demands. Health facilities were asked if they came cross such challenges while providing services to CBHI beneficiaries and to report on what approaches they used to address them. All health facilities reported that they faced problems that resulted from unreasonable complaints from beneficiaries at the time of service provision. These include: demanding services without presenting membership ID card (93 percent), high preference to be served in hospitals (86 percent), expecting to be seen without waiting their turn (64 percent) and demanding unnecessary diagnostics and injections (29 percent).

To resolve these problems, all health facilities reported that they provided orientation to CBHI beneficiaries as part of health education to raise their awareness and 82 percent of Health facilities organized provider-community forums on the identified problems.

[12] Ethiopian Economics Association. An Assessment of Community Based Health Insurance Scheme in Rural Ethiopia: Understanding Enrollment, Dropout, Re-enrollment, Service Utilization and Regional Disparities, August, 2016, Addis Ababa.

5. CBHI CONTRIBUTIONS IN IMPROVING HEALTH CARE SERVICE UTILIZATION AMONGST DIFFERENT POPULATION GROUPS

5.1 Health Service Utilization among CBHI Beneficiaries

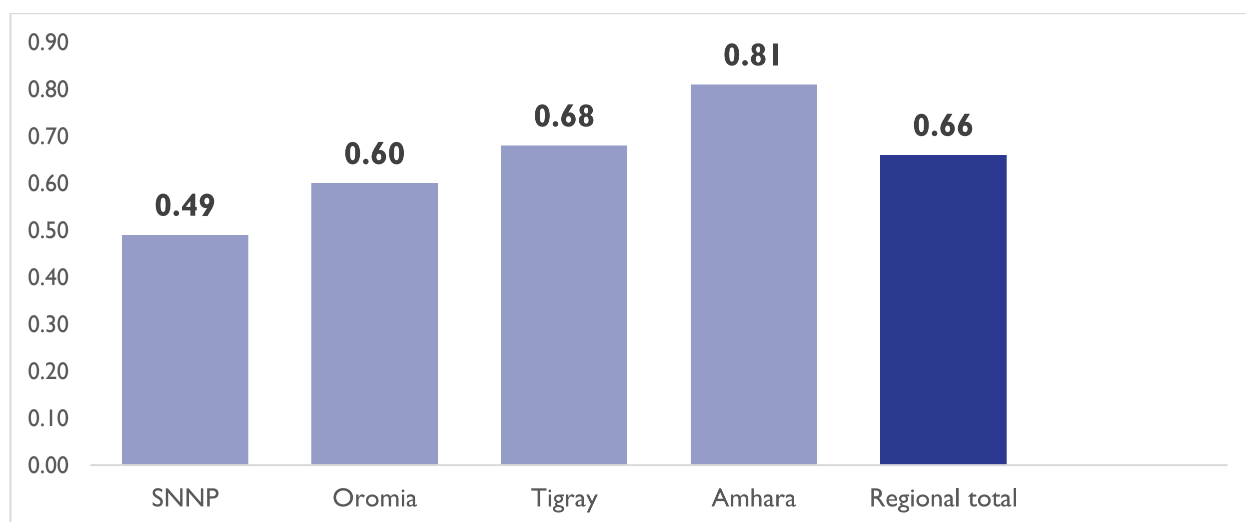
During the review period (April 9, 2016 to March 10, 2017), CBHI beneficiaries in the study schemes made 1,240,715 visits (new and repeat visits) to 281 contracted health facilities (211 health centers and 70 hospitals). Of these, 1,079,334 visits (87 percent) were made in health centers while the balance 151,685 (13 percent) in hospitals. Of the visits made in hospitals, 9,696 (6.4 percent) were admitted.

As shown in Figure 3, the per capita OPD utilization rate for CBHI beneficiaries was 0.66 during the review period.[13] This is almost double the national per capita utilization rate (0.36) for curative health care services in same period.[14] The OPD attendance rate is higher in Amhara (0.81) and lower in SNNP (0.49). The low utilization rate in SNNP was reported to be caused by delayed ID preparation and distribution to members as 50 percent of CBHI beneficiaries in Shebedino and Mareko schemes and 20 percent of members in Halaba did not obtain membership ID cards until March 2017.

[13] OPD utilization rate for CBHI beneficiaries in a given scheme is computed as OPD visits made by CBHI beneficiaries in a given year divided by total CBHI beneficiaries of the scheme in that year.

[14] The national utilization rate reported by the FMOH for the same period was 0.63. However, this rate includes visits made for exempted services such as immunization, family planning, ante- and post-natal care, delivery, etc. Since the utilization rate reported for CBHI beneficiaries only includes visits when a health facility user fee is charged, the utilization rates for insured CBHI beneficiaries and non-insured groups should be compared by adjusting the national per capita attendance to reflect utilization of curative care services that are provided with fees.

Figure 3. Average per capita health service utilization rate of CBHI beneficiaries in sampled schemes by region, April 9, 2016 to March 10, 2017



5.2 Among Insured and Non-Insured

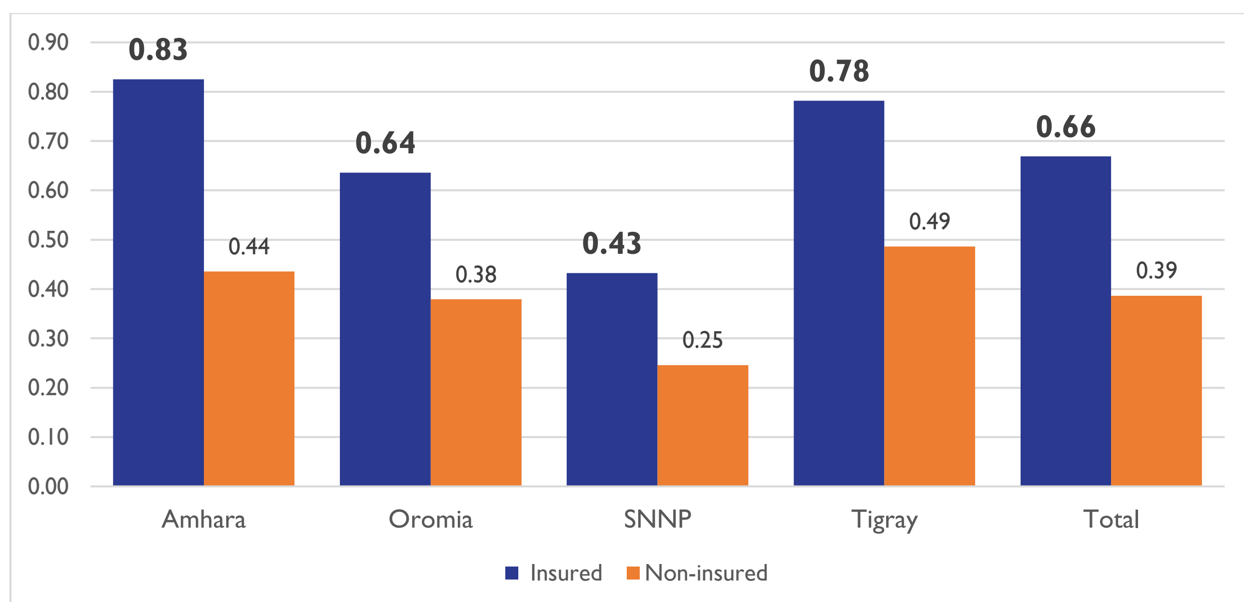
A comparison of the health service utilization/OPD attendance rate by insured versus non-insured also shows that per capita OPD attendance was higher among insured than non- insured across all regions.[15] In SNNP the rate was 0.43 for members versus 0.25 for non-insured; and 0.83 versus 0.44 in Amhara. The overall average utilization rate for all health centers included in the assessment was 0.66 versus 0.39 visit per person per year (Figure 4).[16]

In terms of comparative utilization, this means that insured members in Amhara were nearly twice (1.9 times) more likely to visit health centers for curative care services than the non-insured; 1.7 times more likely in Oromia and SNNP; and 1.6 times more likely in Tigray. Overall, on average, the insured population was 1.7 times more likely to visit health centers for curative care services than the non-insured during the period under review. This finding indicates that the CBHI program enables insured members to use health care services more often than non-members.

[15] OPD attendance rate refers to that of health centers.

[16] The utilization rate for the non-insured in a given facility is computed as OPD visits made by the non-insured in a year divided by the total non-insured population, which is the difference between catchment area population and CBHI beneficiaries in the catchment area.

Figure 4. Average health service utilization rate among insured and non-insured population in sampled health centers, April 9 2016 to March 10, 2017



5.2.1 Among Paying and Non-Paying Beneficiaries

CBHI is supposed to increase poor household demand for health care (and hence health service utilization) by extending financial protection to poorer segments of society who are otherwise deprived of such coverage. To examine whether indigent beneficiaries are accessing health care services, schemes were asked to provide the number of visits made by paying and non-paying beneficiaries in the sampled health facilities for the quarter (October 11, 2016 to January 8, 2017).

The data indicates that CBHI beneficiaries made a total of 64,338 visits in the sampled health centers. Of these, the majority (88 percent) of visits were made by paying beneficiaries while the remaining 12 percent (7,929) by indigents (non-paying CBHI beneficiaries whose membership fees are paid by government subsidy)(Table 13). As indigents constitute 23 percent of the enrolled households in the sampled schemes, the level of utilization is skewed more towards paying beneficiaries. Health service utilization by non-paying beneficiaries varied across regions. It was higher in Oromia (36 percent) - as indigent households represent 33 percent of households enrolled in the schemes in Oromia - and lower in other regions (7 percent in Amhara, 3 percent in SNNP and 4 percent in Tigray).

Delays in ID cards preparation, distribution and allocation of targeted subsidies, inability to produce photographs, and indirect costs such as transport and other costs might partly attribute to the low level of service utilization by non-paying members in SNNP and Tigray.

Table 13: Visits made by paying and non-paying beneficiaries in sampled health centers, Oct. 11, 2016 to Jan. 8, 2017

Region	Number of visits			% visits made by indigents (b/c)
	Paying HHs (a)	Non-paying HHs (indigent/ targeted subsidy)(b)	Total (c)	
Amhara	31,005	2,412	33,417	7
Oromia	8,769	4,893	13,662	36
SNNP	7,771	262	8,033	3
Tigray	8,864	362	9,226	4
Total	**56,409**	**7,929**	**64,338**	**12**

5.2.2 Among Women and Children

Ethiopia has made significant progress towards improving the health of women and children. According to the recent Ethiopia Health and Demographic Survey, maternal and child mortality reduced by 53 percent and 60 percent, respectively, between 2000 and 2016 (CSA and ICF 2017). In addition, a set of high impact interventions are being implemented to end preventable child and maternal death in the country.

CBHI can help empower women to use health services as they can access health care services for themselves and their children/dependents with their CBHI ID card (since CBHI beneficiaries do not need to pay for care at the point of service) and therefore do not need to ask a male head of household for money.

OPD data collected from the health centers shows that during the study quarter children under five years made a total of 13,896 curative care visits (Table 14). Of these, 48 percent (6,714 visits) were made by insured children. Service utilization among insured children differ across regions. In Amhara and Tigray, where CBHI coverage rates were higher, the insured were more likely (by 18 percent in Amhara and 10 percent in Tigray) to use health care services than non-insured. The opposite was true in Oromia and SNNP.

Women of reproductive age (15-49 years old) made a total of 25,545 curative care visits during the same period. Of these, nearly 65 percent (16,561 visits) were made by insured women. Health service utilization by insured women was found to be much higher in Tigray (78 percent) and Amhara (77) compared with non-insured women while no significant difference was observed among the insured and non-insured in Oromia and SNNP during the same period. Health service utilization by insured women in Oromia and SNNP was significant compared to the low CBHI coverage in these regions.

Table14. Health service utilization among CBHI insured women and children in sampled health centers, Oct. 11, 2016 to Jan. 8, 2017

Region	OPD visits by children under 5 years			OPD visits by women (15-49 years of age)		
	CBHI members and non-members	(CBHI beneficiaries (members)	% share CBHI beneficiaries (members)	CBHI members and non-members	CBHI beneficiaries (members)	% share of CBHI beneficiaries (members)
Amhara	4,816	2,851	59	11,316	8,691	77
Oromia	3,498	1,591	46	6,321	3,148	50
SNNP	2,872	772	27	4,987	2,441	49
Tigray	2,711	1,500	55	2,921	2,281	78
Total	**13,896**	**6,714**	**48**	**25,545**	**16,561**	**65**

6. CONCLUSIONS

The study findings indicate that though there are variations among regions in implementing CBHI, the program is playing a pivotal role in the Ethiopia health system. The following are the major conclusions from the study:

6.1 CBHI improves access and utilization of health services, and mobilizes domestic resources for health

Enrollment and resource mobilization: The sampled schemes provided CBHI coverage for a total of 308,847 households (with 1,458,084 beneficiaries) in 2016/17. The enrollment rate on average reached 44.2 percent of eligible households. In terms of membership renewal, schemes on average achieved 75 percent renewal rate. Of the total registered households, 78 percent were paying members while the remaining 22 percent were indigents/non-paying whose contributions were paid by regional governments and woreda administrations. Schemes mobilized Birr 66,630,216 (US$ 2,979,751) from CBHI contributions (including CBHI membership registration and renewal fee) and subsidies in 2016/17. Contributions from paying members accounted 82.6 percent of the total financial resources while targeted subsidies represented 17.4 percent.

Health service utilization: CBHI is improving access to health care services which is demonstrated by higher per capita service utilization rates by the insured population as compared with to the non-insured. Overall, the insured population in the sampled schemes are an average of 1.7 times more likely to visit health centers for curative care services than the non-insured. Insured beneficiaries in Amhara are nearly twice (1.9 times) as likely to visit health centers for curative care services than the non-insured, and 1.7 times as likely in Oromia and SNNP and 1.6 times more likely in Tigray. Moreover, in regions where CBHI coverage rates are higher (Amhara and Tigray), health services utilization among insured women and children was higher (children on average by 14 percent; women by 47.5 percent) than the non-insured. This indicates that CBHI can help empower women to make decisions for themselves and their children to use health care services since no payment is required at the time of a health facility visit, and hence can improve maternal health and child survival outcomes.

Financial resources of health facilities: CBHI enhances the amount of revenue collected by health centers and hence is increasing the availability of resources at points of service delivery. Sampled health centers generated Birr 10,551,873 (US$471,887) from CBHI schemes in the form of reimbursements in 2016/17. This constituted 57 percent of the health centers' retained revenue. The vast majority (94 percent) of retained revenue is invested at the facility-level to improve the quality of health services by procuring drugs and medical supplies.

6.2 CBHI program has faced different implementation challenges

Schemes, kebeles and health facilities experience various implementation challenges that could impact the sustainability of the CBHI program. The study identified the following major challenges:

Significant scheme staff turnover: Most (75 percent) schemes experienced staff turnover; the principal cause was scheme personnel seeking better salary and benefit packages elsewhere. The problem was more pronounced in Amhara and Oromia where 80 percent of the schemes reported experiencing this. Unless curbed, high staff turnover will negatively affect overall CBHI program implementation as scheme daily activities are managed by scheme personnel. In Tigray, where there is not a full time CBHI team leader/coordinator, daily implementation of scheme activities and undertaking of clinical auditing is particularly hampered.

Low new enrollment rates: Low enrollment and renewal rates were identified as major implementation challenges and were discussion points at meetings held at different levels (Board of Directors, General Assembly and woreda-level review meetings). However, the decisions passed at these meetings to improve enrolment and re-enrolment are either partially acted upon or not acted upon by schemes. Schemes on average managed to achieve only 15 percent of new enrollment projections. This was partly attributed to the fact that some schemes focus more on membership renewal activities to retain existing CBHI members than on community mobilization and awareness creation activities to encourage new households to join. Schemes such as Kewot in Amhara, Adea and Gimbichu in Oromia, and Kilte Awlaelo in Tigray are examples of this practice.

Failure to distribute ID cards to members in a timely manner: Scheme and kebele failure to timely distribute ID cards hinders CBHI members from utilizing health care services as having an ID card is a prerequisite to access services at the point of service delivery. The problem was more pronounced in SNNP were 50 percent of CBHI members in Shebedino and Mareko schemes and 20 percent of members in Halaba did not obtain membership ID cards on time and hence could not access health services. This may negatively affect re-enrollment as these members might not be willing to renew membership in the future.

Kebele delays in submitting RVs to schemes and depositing collected cash on time: Of all RVs distributed, 20 percent were in the hands of kebeles (and hence not returned to schemes) at the time of data collection, even though the registration of new households and membership renewal season was over in most schemes. Moreover, almost half of the kebeles had no fixed period to deposit the collected cash to scheme bank accounts. This could create opportunities for using the cash for illegal purposes.

Poor service delivery in health facilities: The quality of care in health facilities are among the most important factors for households to join or renew CBHI membership. Beneficiaries complained about long waiting times to obtain health services at health facilities, unavailability of drugs, and disrespectful reception by health facility staff. Shortage of drugs and medical supplies are attributed to unavailability of drugs and medical supplies at Pharmaceutical Fund and Supply Agency (PSFA) hubs where health facilities purchase them. If these problems are not addressed, it might be difficult to sustain achievements gained thus far in increasing access to health care (as measured by per capita utilization) and financing of the health system through health insurance.

7. RECOMMENDATIONS

The implementation challenges faced by schemes, kebeles and health facilities need to be mitigated in order to make the CBHI program more successful and sustainable. Based on the findings of this study, we suggest the following points for consideration by the Ethiopian government counterparts that implement the program – i.e., EHIA, regional governments, RHBs, and woreda administrations).

Improve career structure and benefits for CBHI scheme staff: The salaries of scheme personnel –needs to be increased in light of the high level of workload. One way of doing this is by revising the job grades to a higher level which will allow career progression. Scheme staff also need to get benefits such as trainings in their field and field allowances (per diem) while undertaking supportive supervision at kebeles and conducting clinical audit at health facilities.

Recruit fulltime scheme coordinator for Tigray: Schemes in Tigray region need to have a full time coordinator to oversee the daily scheme activities and undertake clinical audits of health facilities in a timely manner.

Systematize advocacy and sensitization activities of kebeles to increase CBHI new enrollment and renewal: (a) Kebeles are the main engine for community mobilization as they are in close contact with the community. It is recommended that they formalize CBHI community mobilization activities by incorporating them into their annual work plan and work accordingly to achieve enrollment and reenrollment targets. (b) Regions might use experiences of non-CBHI members who incurred high out of pocket payments for health care at community mobilization events to raise awareness. Schemes in Amhara that used this approach along with other commonly used outreach methods achieved higher coverage rates. (c) There is a need to further investigate the root causes of low membership renewal observed in some schemes and to design an approach to encourage households that drop out from membership to rejoin. Increased renewal (broad participation) is needed to make a scheme viable over the long run.

Enhance level of commitment and ensure accountability: Key actors at all levels of the health system (e.g., regional governments, woreda administrations, and EHIA) need to be committed to implementing and following up on the implementation of resolutions passed at Board, General Assembly and woreda-level review meetings (e.g., resolutions to increase new enrollment and reenrollment, improve ID card distribution, improve health services quality, etc.). Furthermore, mechanism(s) that ensure accountability should be put in place at all levels if review meetings are going to make an impact. One way of doing this is by including CBHI in the performance goals and performance evaluation criteria of kebeles and woreda administrations.

Develop mechanisms to better ensure timely issuance of CBHI ID cards to members: (a) Innovative ways to enable CBHI member households to get their CBHI ID cards more quickly should be introduced so that members can access health care services. Examples include s involving secondary school students in completing CBHI membership application forms, preparing ID cards, and participating in outreach programs to take photos, etc.) (b) Regarding indigent households, the role of regional and woreda administrations should not be limited to indigent selection and budget allocation. They should also work to enable indigent households to obtain their CBHI IDs such as by covering the cost of photographing. (b) It is also important to involve health extension workers in taking members' photos, and in the preparation and distribution of ID cards.

Implement CBHI incentive payment directive to incentivize kebele cash collectors: The CBHI Scale-up Strategy (EHIA 2015) proposed kebele cash collectors to receive 2 percent of the contribution they collect as incentive to remunerate any cost they might incur in implementing CBHI. The EHIA has developed a prototype directive to guide the implementation of the incentive mechanism. Regional governments and woreda administrations need to implement the proposed directive which will provide incentives to all cash collectors at the kebele level and motivate them to undertake their work in a timely manner.

Advocate to improve quality of health services: EHIA in collaboration with RHBs should advocate to PFSA, FMOH and other relevant government authorities to improve the quality of health services in general and to increase the availability of drugs and medical supplies at contracted health facilities, in particular.

Strengthen clinical auditing of health facilities: The EHIA and the CBHI schemes need to undertake routine clinical auditing at health facilities every quarter. In addition, ad hoc clinical auditing should also be carried out in select health facilities. The ad hoc auditing needs to be done by a committee composed of actors from federal and regional institutions such as the FMOH and its relevant agencies, universities, RHBs and zonal health departments.

Increase CBHI membership for poorest households: To enhance social inclusion in the health insurance system and ensure UHC, the Ethiopian government should consider identifying ways to provide CBHI coverage to all households below the poverty line. Ways to accomplish this could be to expand the targeted subsidy allocation and/or to link CBHI with government social security programs such as the Productive Safety Net Program.

ANNEX A: REFERENCES

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