USAID Health Financing Improvement Program

RAPID ASSESSMENT OF COMMUNITY-BASED HEALTH INSURANCE IMPLEMENTATION IN PASTORAL WOREDAS IN OROMIA AND SNNP: LESSONS FOR ADAPTATION AND SCALE-UP

December 2021

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The USAID Health Financing Improvement Program supports the Ethiopian government in its efforts to further strengthen and institutionalize health care financing reforms and initiatives to provide accessible, high quality, primary health care services for all Ethiopian citizens with reduced financial barriers. Led by Abt Associates, the program is implemented in collaboration with core partners Breakthrough International Consultancy, the Institute for Healthcare Improvement, and Results for Development, and resource partner Harvard T.H. Chan School of Public Health.

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Cover Photo: A pastoralist village in Dillo Woreda, Oromia Region. Credit: Ayenew Haileselassie.

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ACRONYMS

CBHI	Community-Based Health Insurance
EFY	Ethiopian Fiscal Year
EHIA	Ethiopian Health Insurance Agency
HCF	Heath Care Financing
HEW	Health Extension Worker
RHB	Regional Health Bureau
PSNP	Productive Safety Net Program
SNNP	Southern Nations, Nationalities, and Peoples' (Region)

1. INTRODUCTION

Community-based health insurance (CBHI) was started in Ethiopia in 2011, as a pilot program in 13 woredas selected from Amhara, Oromia, Southern Nations, Nationalities, and Peoples' (SNNP), and Tigray regions. Following two years of successful implementation of the pilot program and based on pilot evaluation findings and recommendations, the Government of Ethiopia decided to scale up CBHI across all regions of the country to improve access and utilization of health services for all with reduced financial barriers and to eventually achieve universal coverage.

This effort has been strengthened over time and currently 863 woredas across the country are at different stages of implementing CBHI schemes, of which 793 are functional. All regions and city administrations have worked to roll out CBHI to cover to their target populations. Regions with pastoral woredas are currently expanding CBHI to these areas. This includes the CBHI pioneer regions of Oromia and SNNP, whose populations are mostly agricultural/sedentary, and the predominantly pastoral developing regional states (Afar, Benishangul-Gumuz, Gambella, and Somali) that are relatively new to CBHI but have at least one woreda that is implementing it and plan to expand to more, applying lessons learned from established schemes.

Because of the social, demographic, economic, and geographical differences between pastoral and sedentary settings, CBHI parameters and implementation approaches may need to vary between the two. In pastoral settings, much of the population moves frequently, settlements are scattered, as are health facilities, and health services are inadequate. In such a context, CBHI implementation will require adaptation to succeed. For example, when households (or household heads and older children) do not stay in a permanent location year round, traditional community mobilization and other CBHI activities may not operate smoothly. Mobility of households requires mobility of CBHI benefits—if people move among catchment service providers, their benefits must follow to provide them financial access health care services. Moreover, the limited number of health facilities and inadequate health services among the scattered settlements may create barriers to physical access. Issues like these deter households from enrolling in CBHI.

Despite the different setting and way of life, pastoral woredas have used the same design parameters for their CBHI programs as have areas of sedentary farming; the CBHI program was not adapted for implementation in the pastoral context.

To consider this issue, this assessment was conducted to review the implementation status of five selected CBHI schemes in pastoralist woredas, three in SNNP and two in Oromia, and explore the successes and challenges faced in implementing CBHI in such woredas.

2. ASSESSMENT OBJECTIVE, METHODOLOGY, AND RATIONALE

2.1 OBJECTIVE

The objective of the assessment is to review the successes, failures, and implementation challenges of implementing CBHI in pastoral settings and to draw lessons for adaptation and scale-up in those settings.

2.2 METHODOLOGY AND DATA SOURCES

During field visits, the assessment team used a structured checklist to capture data and information during interviews and focus group discussions with the executive staff of CBHI schemes. The five woredas visited were purposefully selected to include those that had operated a relatively long time (about three years). The three woredas from SNNP region, namely, Gnangatom, Mali, and Bena-Tsemay, are in South Omo Zone; the two woredas from Oromia, namely, Dubluk and Dire, are in Borena Zone. Secondary quantitative data on the performance of the schemes since their establishment also were collected from the schemes. The qualitative information and quantitative data were summarized and are discussed in this report. Based on the findings, the report draws conclusions and makes recommendations about how to revise CBHI implementation parameters in order to improve CBHI performance in pastoralist areas.

2.3 RATIONALE

Pastoralist and semi-pastoralist areas cover 61% of Ethiopia's geography. There are 187 pastoral woredas in Afar, Benishangul-Gumuz, Gambella, Oromia, SNNP, and Somali regions. The majority of people living in these areas, close to 12 million people,[1] are pastoralists; they are mobile and adapt to the local natural, social, and economic conditions. Poor infrastructure and weak or absence of basic services characterize the areas.

The national health care service delivery model, which was developed more for settled farming communities, now is being applied in pastoralist and semi-pastoralist settings. Failure to adapt the models to the lifestyle of pastoralist communities has made their implementation less than effective. Like the service delivery model, the CBHI schemes established in pastoralist and semi-pastoralist settings follow implementation directives similar to those in agrarian settings. Hence, it is evident that, with the national scale-up of CBHI, the realities of pastoral life require modifications in both the service delivery aspects (supply side) and the CBHI implementation aspects (demand side). This assessment explored the specific features that require adaptation.

[1] Gebremeskel, Esayas Nigatu; Desta, Solomon; Kassa, Girma K. 2019. Pastoral Development in Ethiopia: Trends and the Way Forward. Development Knowledge and Learning; Washington, DC: World Bank.

3. PROFILES OF THE ASSESSED WOREDAS

The total population in the SNNP woredas assessed, Gnangatom, Mali, and Bena-Tsemay, is 24,379, 117,262, and 72,056, respectively, while in the Oromia woredas of Dubluk and Dire, it is 32,203 and 53,330, respectively.

According to the classification of woredas, four of the five woredas assessed are identified as pastoralist, while one (Mali) is classified as semi-pastoralist. As the numbers in Table 1 indicate, in Gnangatom, Dubluk, and Dire woredas, pastoralist communities are more dominant than in the other woredas. In Gnangatom, 83% of the total population is pastoralist, and 93% of the CBHI target population is also; in Dubluk and Dire, the respective percentages are 81% and 90%, and in Bena-Tsemay, they are 32% and 67%. In Mali, 32% of the total woreda population and 35% of the CBHI eligible population is pastoralist.

Table 1. Profile of the Woredas

Name of woreda	Number of kebeles in woreda			Population size of woreda	CBHI-eligible population	CBHI-eligible households		
	Total	Pastoralist	Semi-pastoralist			Total	Pastoralist	Semi-pastoralist
Gnangatom	21	20	1	24,379	21,703	4,420	4,111	309
Bena-Tsemay	34	27	7	72,056	64,130	14,881	9,970	4,911
Mali	28	10	18	117,262	104,364	18,905	6,752	12,153
Dubluk	13	12	1	32,203	28,983	6,038	5,434	604
Dire	11	10	1	53,330	47,997	9,998	8,998	1,000

4. ACCESS TO HEALTH SERVICES IN THE ASSESSED WOREDAS

The assessment team identified that distance between health service providers and health care users significantly deters pastoralist communities from accessing health care services. In the most extreme case among the five assessed woredas, in Gnangatom, there is one health center, and the nearby hospital (Jinka hospital) is 206 kms from the center of the woreda (Table 2). The one health center operates at a substandard level and suffers from lack of water supply. Distance is also a deterrent to health service access in other woredas. In Dubluk and Dire, the farthest kebeles are 30 kms and 45 kms from a health center, respectively.

Informants from CBHI schemes told interviewers that, apart from distance, unavailability of drugs, absence of or substandard laboratory services, and shortage of motivated health professionals are also service provision problems, as is unavailability of other infrastructure such as tap water and electricity.

Table 2. Number of Health Facilities and Distance

Woreda	Number of health facilities in woreda				Greatest distance from kebele to nearest health center (kms)	Average distance from hospitals to woreda capital (kms)
	Health post	Health center	Primary hospital	General hospital		
Gnangatom	14	1	0	0	55	206
Bena-Tsemay	32	6	0	0	21	42
Mali	32	5	1	0	25	30
Dubluk	12	4	0	0	30	40
Dire	13	3	1	0	45	60

5. ASSESSMENT OF CBHI COMMENCEMENT IN PASTORAL AREAS

The assessment team learned that regional health bureaus (RHBs) initiated CBHI schemes in the visited woredas. The RHBs and zonal health departments in consultation with the woreda administrations made the decision to establish a woreda scheme, followed by endorsement of the initiatives at kebele assemblies (community meetings). The success of the CBHI program in agrarian woredas and the policy decision of the Ministry of Health to implement CBHI nationwide as set out in the Health Sector Transformation Plan may have pushed the regional and local administrations in pastoral woredas to establish schemes before they had assessed the appropriateness of the generic scheme design to the specific needs of their populations. Kebele cabinet members, woreda administration officials, community leaders (religious, faith-based, and opinion leaders), woreda health office staff, and health extension workers (HEWs) became actively engaged in CBHI community mobilization, promotion, and awareness creation activities.

In sum, it is fair to say that, based on growth of CBHI membership in initial woredas over the years, CBHI formation in pastoralist areas secured political support, which incrementally secured support from the community. This, and the approach taken to create CBHI schemes before considering the availability of adequate health services in the areas, was similar in all five woredas visited.

6. MOVEMENT OF PASTORAL COMMUNITIES

In most of the woredas visited, the pastoralist households have a permanent place of residence where some of the family (mothers and small children) remain while the fathers and physically strong family members move their cattle to areas of grazing land and water for part of the year. In some kebeles, all community members (households) move together. The length of stay away from permanent residences changes, depending on season and environmental conditions. In Gnangatom woreda, pastoralists move for seasonal cultivation on the Omo River Basin when the water is at its normal level. A border security problem around the Turkana River is another reason for temporary migration.

In Mali woreda, sedentary and semi-pastoralist farming is the dominant lifestyle. Purely pastoralist communities live in 10 kebeles and leave their home base looking for grazing land and water for about three to four months each year. Only fathers and older children move around, while mothers and younger children stay behind.

In Bena-Tsemay, 27 of the woreda's 34 kebeles are purely pastoralists, rearing livestock for their livelihood. As in Mali, only the father and older children spend three to four months moving the cattle to better grazing land and water. The communities living in the other seven kebeles are supported by the government and have been given plots of fertile land to cultivate, but they also raise cattle and members leave their settlements seasonally, looking for grazing land.

In Dubluk and Dire woredas, pastoralist communities are dominant. Fathers and older children usually move herds locally across short distances within their woredas or occasionally to neighboring woredas. They move more widely, even across regions, during periods of large-scale drought.

In general, the pull factor for the pastoralist communities to move is the need for grazing land and water for their cattle, and the push factors are border security problems and drought. Patterns in their movement are not well documented, but the qualitative information collected by the assessment demonstrates that their mode of life poses unique challenges to the implementation of some aspects of CBHI.

Health services are rarely available in the temporary grazing areas, but the likelihood of moving into neighboring woredas where some health facilities might be available is very high. If non-residents visit a local health center, they usually must pay out of pocket for the services, as CBHI ID cards are left at home with mothers and younger children. In some cases, the schemes entered contract agreements with health centers in neighboring woredas. These health centers understand the situation and would allow the beneficiaries to utilize the services without ID cards. Issuance of multiple ID cards to a household would resolve this problem, but none of the schemes visited practice it as doing so is not explicitly stated in their bylaws.

7. APPLICATION OF CBHI DESIGN PARAMETERS IN PASTORALIST SETTINGS

7.1 TARGET POPULATION

The proportion of pastoralists in the CBHI targeted population is significant in all five woredas: In Gnangatom woreda, 93% of the CBHI target population is pastoralist; the remaining 7% are petty traders. In Bena-Tsemay, 67% of the target population is pastoralist and 33% is semi-pastoralist. In Dubluk and Dire, pastoral communities account for more than 90% of the target population. In Mali, the CBHI target population is 41% pastoralist and 59% semi-pastoralist.

With the scale-up of CBHI to pastoralist areas, it is important to document the number of CBHI members (enrollment) by livelihood as well as the utilization of CBHI services by pastoralists and others. Disaggregation shows the correlation between enrollment and service utilization by mode of life. These data enable evaluation of the extent to which the current scheme arrangement, which brings together pastoralists, semi-pastoralists, and petty traders under one scheme, benefits the pastoralist community. It is likely that the major beneficiaries of CBHI services are the non-pastoralists; pastoralists use CBHI benefits less because of their distance to the health facility, their movement outside the catchment area of the contracted health facilities, and other barriers.

7.2 MEMBERSHIP AND CONTRIBUTION

The unit of CBHI membership is the household. There is no restriction on household size. The core family that includes the household head, the spouse, and minor children, pays a contribution of 240 birr per annum; each additional family member pays 48 birr per annum. If a man has more than one wife, he pays an additional 120 birr per wife per year. Both membership unit and contribution level are set in the region-wide CBHI implementation directives. The directives set different payment amounts for urban and rural (agrarian) settings, and the agrarian rates are applied to the pastoralist communities but offer no special provisions for the pastoralists' situation, such as their distance from health services, movement, and travel hardships due to a poor transport system and harsh arid environment. In some communities, focus group discussions reported one reason for the reluctance to renew CBHI membership is the amount of the contribution payment, and this is a matter for further investigation. However, some woredas have coped with this challenge by leveraging the strong local solidarity and social structures and have achieved remarkable results. For example, the performance over the last three years in Dubluk and Dire woredas has been exceptional; enrollment rates there reached over 80% and renewal rates are 100% throughout.

7.3 CBHI ID CARDS

As per the regional CBHI directives, one CBHI ID card is provided to a household. The assessment team identified this as a challenge for pastoralist communities due to the separation of most pastoralist households for several months a year as one group shepherds livestock while the other stays behind. In such situations, the CBHI ID card stays with the group that stays behind; the herders carry no ID card.

Another common obstacle is preparing and issuing ID cards because it is difficult to get a photograph of all eligible household members at the same time. However, Dubluk and Dire woredas resolved this obstacle: every CBHI member (both paying and non-paying) was given a household ID card within the period of registration. This was achieved by having HEWs take a photograph of each registering member and their family at the time of registration, while woreda health offices recruited photo studios to

immediately print the photo. In Dubluk, the woreda health office allocates a budget to cover the cost of printing the photo.

7.4 TIME OF CBHI CONTRIBUTION COLLECTION

Regional directives specify that contribution collection happens once in a year, between October and January in SNNP and December and February in Oromia.

Bena-Tsemay, collection follows the schedule of the SNNP regional directive (October – January). However, Mali has moved it to between September and December to begin mobilization activities early. In Gnangatom, where over 90% of the targeted population is pastoralist, the collection period is extended by one month, from December through March, since this is when pastoralist communities return to their permanent residences.

In Dubluk and Dire woredas, collection takes place between December and February as specified in the Oromia regional directive. This time is acceptable to both woredas as it follows the main rainy season (usually September–November), and it is the time when grazing lands and water are available locally and so households remain in their localities.

This information shows that reality has already dictated adjustments in the timing of community mobilization and contribution collection. Community mobilization and contribution collection is the most difficult activity in the pastoralist community because of their migration (where, when, and for how long), which often is unpredictable. The timing of collection should be flexible and open to adjustment since no fixed time fits all residents.

7.5 SUBSIDIES FOR CBHI SCHEMES

CBHI schemes receive a targeted subsidy (for CBHI membership of indigents) and a general subsidy. In SNNP, the targeted subsidy has come from the woreda budget until now. A new regulation now states that the region, zone, and woreda will share in financing the subsidy at 40%, 30%, and 30%, respectively. In Oromia, the targeted subsidy is provided by the woredas and region in a proportion of 30% and 70%.

In all five woredas visited, CBHI scheme staff claimed that all indigents of the community (10% of the total population) were covered (based on fiscal space limitation). Even Gnangatom, a Productive Safety Net Program (PSNP) woreda, claims that coverage of the poor is adequate. However, the issue of targeting indigents in safety-net covered communities and the synergy of the CBHI and PSNP programs should be explored by stakeholders including the government's federal and regional sector offices, local government counterparts, and development partners.

In the three woredas of SNNP, though timely release of the subsidies is often problematic, all levels are committed to the subsidy, and there were no reports of complaints. However, in the two woredas of Oromia, scheme staff reported that the region does not always transfer the full targeted subsidy, although the woreda consistently transfers its portion on time. Scheme staff in all the five woredas had no complaints about the general subsidy, as the Ethiopian Health Insurance Agency (EHIA) consistently transfers 10% of the total resources mobilized by the schemes.

7.6 BENEFIT PACKAGE

The benefit package as stated in the regional directives is generous and adequate. The challenge is access to the benefits because of distance, health facility readiness and quality of services, and limited options associated with the catchment areas imposed by the directives. Jinka hospital is the major hospital service provider to the scheme members of Gnangatom, Mali, and Bena-Tsemay CBHI schemes, while Yabelo General Hospital is the major hospital service provider for beneficiaries in Dubluk and Dire.

The SNNP directive restricts the CBHI schemes to making agreements only with facilities in their woreda, except for the referral hospital. The assessment team noted that no agreement has been signed by the visited CBHI schemes outside their woreda. This practice denies CBHI members the advantages of portability of CBHI membership and limits their options, especially for pastoralists, who move frequently. Sometimes pastoralists temporarily settle closer to facilities in neighboring woredas and with better health services but cannot access care without paying out of pocket, because the scheme to which they belong has no contractual agreement with the schemes in the neighboring woredas.

In Oromia, there is no such restriction. Although Dire has not entered into any contractual agreement with health centers outside the woreda, Dubluk has contracted two health centers in neighboring woredas.

7.7 PROVIDER PAYMENT METHOD

In line with the provision in the regional directive, fee-for-service is the provider payment method used to pay the health facilities for services utilized by CBHI beneficiaries.

7.8 GOVERNANCE AND ORGANIZATIONAL STRUCTURES AND MANAGEMENT

General assembly: In line with the regional CBHI directives, in all the five woredas visited, a general assembly is composed of kebele representatives who are CBHI members and woreda sector office heads, and is chaired by the woreda administrator. General assembly meetings are to take place once a year; this has happened in three (Mali, Dire, and Dubluk) of the woredas visited, whereas in two (Bena-Tsemay and Gnangatom), only one meeting has been held.

Woreda CBHI board: As indicated in the directives, the woreda CBHI board is very important for monitoring and providing directions to the schemes. Almost all sector offices and representatives of the CBHI scheme selected through the general assembly are members of the board; like the general assembly, the woreda administrator chairs the board. The board should meet every quarter. In Gnangatom and Bena-Tsemay, board meetings are not held regularly and discussions are not well documented in the meeting minutes; the weakness of the boards is partly attributed to the weakness of the schemes there. In Mali, performance in terms of meeting regularity is encouraging. In Dire and Dubluk, board meetings are held regularly, and have contributed to the outstanding achievements in membership registration and renewals.

CBHI scheme staff: As per the CBHI scheme executive structure in SNNP, the human resources running the schemes are one coordinator, one health professional, one finance person, and one data manager. None of the schemes visited has a health professional (or they do not stay in the post); consequently, no clinical auditing of claims is done. The schemes are suffering from a high attrition rate and demotivated staff, associated with low salaries, lack of career development, and an unfriendly working environment. The human resource situation in both Gnangatom and Bena-Tsemay are below the standard, because of frequent staff turnover associated with low salaries. In Gnangatom, the coordinator manages all activities of the scheme, without a finance or data manager. There is no computer to facilitate scheme activities. The current human resource situation and scheme weakness need attention to make the schemes successful.

The CBHI executive structure in the woredas visited in Oromia has four staff: a coordinator with a health profession background, an accountant, a data officer, and a health care financing (HCF) officer. Both schemes have these staff. The HCF officer monitors proper implementation of HCF reforms in health facilities contracted by the CBHI scheme, in addition to his/her role in executing routine CBHI activities. The CBHI scheme is housed within the woreda health office as one work process owner with

autonomy for managing the CBHI funds and making timely reimbursements of health facilities as per contracts.

Kebele engagement in CBHI: The SNNP regional directive outlines the tasks of the kebele cabinet, CBHI kebele unit, and HEWs without considering the unique nature of pastoralist communities. The vast area and mobility of the pastoralist community affects the performance of routine CBHI critical activities by the kebeles. CBHI forms are not properly filled and handled. Pictures of members are not properly taken. Household data, receipts, and distribution of ID cards are frequently mishandled. In pastoralist kebeles, HEWs have limited capacity to handle CBHI activities. Further assessment of pastoralist community engagement and exploring practical and relevant mechanisms are needed.

In the two woredas of Oromia, the kebele section of the woreda CBHI scheme comprises a chairperson, a manager, and HEWs. Each kebele has 3–5 HEWs, most of whom are male and are routinely engaged in CBHI activities. The kebele section executes operational activities including enrollment of new members, renewal of existing members, collection of contributions, photographing members and preparing and distributing ID cards, and data management. The kebele cabinet also oversees the overall activities of the kebele CBHI section and coordinates and participates in community sensitization during the mobilization period.

8. FINANCIAL POSITION OF ASSESSED SCHEMES

It is too early to assess the financial status of the visited schemes, since they are only three years old. As shown in Table 3, the most recent account balances of the schemes show each has a reasonable amount of money. The reasons for this positive financial position need to be explored further. Though this assessment did not capture complete financial data of the three schemes visited in SNNP, Table 3 shows the financial picture of the schemes. Lack of a finance person and reluctance to undertake a financial audit are challenges or major concerns in these schemes.

The two schemes visited in Oromia have performed outstandingly in enrollment and renewal as well as in effective collection of contributions. They have the required staff fully deployed, and they do financial and clinical audits regularly. The schemes have had a positive balance at the end of each year; and their bank account balances are 1,271,063 birr (Dubluk) and 2,681,784 birr (Dire) after paying the health facility claims of the second quarter of Ethiopian fiscal year (EFY) 2013 and before the general subsidies of the current year were transferred.

The scheme in Gnangatom uses Omo Microfinance Institution for its deposit and payment requirements as it was the only financial institution operating in the woreda until a branch of the Commercial Bank of Ethiopia opened there recently. Using Omo Microfinance Institution has an advantage in contribution collection because its agents are deployed throughout the kebeles and play a significant role in facilitating the contribution collection. However, the institution has serious liquidity problems that limit its ability to pay the reimbursement requests of the health center in a timely way. This means the health center frequently has a budget shortfall that prevents it from procuring the necessary drugs and supplies and thus from providing quality services. The scheme has opened an account in the new bank branch and has started to deposit the revenue it generates there, and the remaining cash balance in the Omo Microfinance account is being audited prior to being transferred. Similar challenges may be affecting schemes that use microfinance institutions for their financial management.

Table 3. Financial Position of Assessed Schemes

Item	EFY 2011					EFY 2012					EFY 2013 (Hamle - Tahsas)				
	Gnang-atom	Bena-Tsemay	Mali	Dubluk	Dire	Gnang-atom	Bena-Tsemay	Mali	Dubluk	Dire	Gnang-atom	Bena-Tsemay	Mali	Dubluk	**Dire**
Total Revenues	**857,726**	**1,586,960**	**3,070,674**	**939,697**	**841,065**	**0**	**582,153**	**1,604,332**	**1,303,543**	**1,824,137**	**854,800**	**549,949**	**2,452,116**	**1,174,425**	**2,067,600**
Contributions	725,371	1,586,960	3,070,674	742,000	540,750		197,896	1,590,740	1,098,090	1,534,500	818,140	437,149	2,279,748	1,124,550	1,995,300
Targeted Subsidy	51,750			94,492	156,628		205,000		86,466	130,337	36,660	112,800	172,368	49,875	72,300
General Subsidy	80,605			103,205	143,687		179,257	13,592	118,987	159,300				0	0
Total Expenditures	**0**	**1,883**	**0**	**538,196**	**349,693**	**9,186**	**448,677**	**41,263**	**786,378**	**494,322**	**14,231**	**10,340**	**1,424,339**	**503,990**	**536,760**
Payments to Health Centers		1,883		485,430	191,786	9,186	448,677	41,263	627,140	378,205	14,231	10,340	1,424,339	384,907	413,348
Payments to Hospitals				52,766	157,907				159,238	116,117				119,083	123,412
Surplus (Deficit)	857,726	1,585,077	3,070,674	401,501	491,372	-9,186	133,476	1,563,069	517,165	1,329,815	840,569	539,609	1,027,777	670,435	1,530,840
Current Bank Balances											**706,735**	**1,460,131**	**1,458,611**	**1,271,063**	**2,681,784**

9. CONCLUSION AND RECOMMENDATIONS

9.1 ADAPT CBHI DIRECTIVES TO PASTORAL SETTINGS

The assessment team concluded that some parameters of the CBHI implementation directives do not fit the pastoralist way of life. The directives should be modified to consider the following CBHI implementation parameters and performance improvement measures.

- **CBHI ID cards:** Because of the mobile nature of the pastoralist communities, CBHI ID cards should be issued to individuals or multiple cards should be issued to a household, so the staying and departing segments of the household each have one and can use their ID card to access health services, whether inside or outside their home woreda.
- **Amount of contribution:** The current household contribution levels, currently the same for agrarian and pastoralist communities, should be re-set at different levels because the two groups do not access health care services equally—pastoral communities face challenges to access, such as distance from health facilities and thus use fewer services and harsh living conditions. To promote equity and fairness, contribution levels should be revised.
- **Targeted subsidy:** The targeted subsidy provided to the schemes should be transferred fully and on schedule. As seen in the two schemes in Oromia over the past three years, the region provided less than its required share of the targeted subsidy given the number of indigents in each woreda. In addition, to make targeting of poor households efficient and transparent and enhance coverage of more vulnerable groups it is recommended to explore possible synergies between CBHI and PSNP targeting.
- **Mobility of benefits outside catchment or official area of residence:** The current SNNP CBHI directive, which requires CBHI members to use health facilities in their catchment areas only, should be revised to allow pastoralists to use facilities outside the catchment area as they seek pasture for their livestock.
- **Improving capacity of CBHI executive staff:** EHIA, RHBs, and development partners should prioritize CBHI executive staff in pastoralist areas in terms of recruitment/deployment, retention, capacity building, and incentivizing.
- **Strengthening linkages between CBHI scheme at woreda and kebele levels:** The relation and collaboration between the woreda CBHI scheme and the kebeles/community is very weak partly due to the vast area and mobility of the community in pastoralist woredas. Attention to the unique nature of the pastoralist communities should be given when designing mechanisms to enhance the engagement of these communities in CBHI. The schemes, in consultation with the community, should explore and adopt innovative options and approaches, such as using college students, veterinarians, and community workers to support sensitization and community awareness raising of CBHI.
- **Enhance accountability in the CBHI governance and management structure:** Revisit CBHI regional directives in terms of governance and management of CBHI, delineation of roles and responsibilities of RHBs (including zonal and woreda offices) and Ethiopia Health Insurance Agency branch offices to ensure accountability and establish a system of checks and balances (by instituting provider and purchaser systems).

9.2 IMPROVE AVAILABILITY OF ADEQUATE HEALTH SERVICES (SUPPLY SIDE)

There are very few health facilities in remote pastoralist areas because the population-based formula used for resource allocation in such woredas does not take into consideration the size of the areas and their scattered settlements, remoteness, availability of infrastructure, hardship in travel, and other factors. The typical health services delivery model also is less appropriate in these areas. As a result, pastoralist communities suffer. CBHI cannot succeed without improving access to quality health services in pastoral settings. The following could be considered to improve access:

- Advocate for improving access to quality health services before launching CBHI in new pastoral woredas, while working aggressively on improving access to quality health care services in pastoral woredas where CBHI is already established and functional.
- Advocate for allocating adequate budget to the health facilities in pastoral woredas and strengthening HCF reform implementation focusing on quality improvement.
- Explore options to improve access to health services through mobile clinics, facilitation of ambulatory services, and construction of tailored health facilities in pastoral woredas based on the needs of the pastoral communities.
- Consider upgrading health posts to provide curative health services by assigning the necessary staff. Upgrading health posts is underway in regions across the country, therefore advocate for prioritizing the initiative particularly in pastoral woredas.
- Explore engaging non-governmental organizations and private providers through well-designed incentive mechanisms to improve access to health services and commodities in hard-to-reach areas. For example, outsource clinical services such as diagnostics and the procurement of drugs and supplies to improve the quality of health service provision in these areas.
- Assess the possibilities for creating and implementing incentives for providers (human resources and institutions) through performance-based financing to enhance the effectiveness of CBHI in pastoral and hard-to-reach areas.