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

DOCTORAL (PHD) DISSERTATION

RESEARCHER GUTAMA NAMOMSA

SUPERVISOR PROF. MARIA BORDAS (Ph.D.)

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Declaration

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

I further declare that:

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

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

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

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

Signature: _____

Name: Gutama Namomsa

Date:

Signature of the Supervisor
Professor Dr. Maria Bordas

_____

Abstract in English

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

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

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

Abstract in Hungarian

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

hálózattal együtt, , valamint a program megértése és elfogadása akadályozták a közösségi részvételt. AZ egészségügyi szolgáltatókkal kötött szerződések tárgyalásának nehézségei kihívásokat jelentettek a CBHI programja számára. Politikai és bürokratikus folyamatok, különösen a bürokratikus akadályok, mint például a megfelelő tudatosság hiánya, a korlátozott pénzügyi források és a gyógyszerhiány, külső tényezők, mint a gazdasági instabilitás és a pénzügyi fenntarthatósággal kapcsolatos problémák, ezen belül az alacsony számú jelentkezők a programba, és az elégtelen állami támogatások, mind ahhoz vezettek, hogy a CBHI rendszerek széttagolttá váltak, és a költségek saját finanszírozásban való túlzott bizakodás akadályozta a pénzügyi fenntarthatóságot. A válaszadók szemszögéből nézve, a felmérés eredményeire és AZ egyéb forrásaira támaszkodva a disszertáció számos javaslatot tesz az etiópiai politikai döntéshozók számára. A javaslatok a disszertáció eredményei alapján feltárt hiányosságokat orvosolják és megoldásokat kínálnak.

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

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Glossary of Terms and Abbreviations

CBHI: Community-based health Insurance

EFDA: Ethiopia Food and Drug Authority

EHIA: Ethiopian Health Insurance Agency

EPRDF: Ethiopian People Revolutionary Democratic Front

FMOH: Federal Ministry of Health

GDP: Growth Domestic Product

GTP II: Growth and Transformation Plan II

HAD: Health Development Army

HCFS: Health Care Financing Strategy

HSTP-I: Health Sector Transformation strategy I

ILO: International Labour Organization

MDG: Millennium Development Goals

NGOs: Non-Government Organization

OOP: Out-of-pocket spending

SDGs: Sustainable Development Goals

SHI: Social health insurance

UHC: Universal Health Coverage

UN: United Nation

USAID: United States Aid Organization

WB: World Bank

1. INTRODUCTION AND BACKGROUND OF THE STUDY

Health is at the heart of the MDGs. The United Nations committed to attempting to accomplish the eight MDGs by 2015. Fighting poverty, hunger, sickness, illiteracy, damage to the environment, and prejudice against women were signed by nations as declarations. Later, MDGs are based on the above list of agreements that nations signed. In 2015, targets and indicators were included in each MDG to monitor progress from 1990 levels. According to the World Health Organization (2018), a number of these have a direct bearing on health. This declaration is the source of the Millennium Development Goals. Each MDG has 2015 targets and indicators to track progress from 1990 levels. Several of these are directly related to health (World Health Organization, 2018). While health is the primary focus of goals four, five and six, each MDG had some connections to health (Haines, A., & Cassels, 2004; Wagstaff et al., 2006; WHO, 2009). According to Buss et al. (2016) and UN (2015), goal 3 of SDG aims ‘’to confirm healthy lives and promote well-being for all at all ages’’ and outlines no objectives as well as four implementation strategies.

According to the MDG report of 2014, Ethiopia had successfully achieved six of eight MDGs. Ethiopia had made significant progress on MDG 5, improving maternity health, but did not achieve the target. Now, Ethiopia is implementing the Sustainable Development Goals, with the 10-year development plan (2021-2030) of the Ethiopian government, all achieved and non-achieved MDG. Health-related goals are part of this plan. A lot of Ethiopian households had trouble getting health care because of low medical insurance availability and low private sector involvement. To address this issue, a healthcare financial plan (HCFP) was enacted in 1998 and had the goals of enhancing household engagement, maintaining enduring service quality and boosting productivity (Ethiopian Health Insurance Agency [EHIA], 2021). A cost-sharing health care system, in which you and your medical insurance company split the expenses of covered medical treatments, has viable alternatives in the form of CBHI plans (eHealth Insurance, 2021; Norris, 2023), Deductibles, coinsurance, and co-payments are examples of cost-sharing that you must pay out of pocket (Cost-Sharing Definition | Association Health Plans, n.d.).Premiums, balance billing, and non-covered services are not included in cost sharing. Cost sharing may differ depending on the type of health insurance plan and the provider network (Association Health Plans, n.d.; Blue Cross NC, 2020).

Community-based health insurance results in good use of medical services. Minimise unexpected expenses made for health costs at the time of illness and ultimately result in a universal healthcare system that is fully operational and sustainable (Carrin et al., 2005). Ethiopia introduced the CBHI scheme as a means of health program implementation, particularly universal access to health, in 2010 (Ethiopian Health Insurance Agency [EHIA], 2021).

About the organization that organizes, supports, and finances community-based health insurance in Ethiopia, the Ethiopian Health Insurance Agency (EHIA) helped start the CBHI program in 2011 (Tilahun, 2022). The project's executive and overseeing units are the Ethiopian Health Insurance Service and the Ministry of Health, while operations are managed by smaller national coordinating units (Tilahun, 2022). Steering committees for health insurance have been formed at the regional (district) and local administrative/village (Ganda) levels (ibid). These committees oversee setting up and running CBHI programs. The design, piloting and scaling up of the programs are also significantly influenced by international agencies (Abt Associates, 2019).

Premiums collected by community members are used to fund all health and curative services for families (Yilma et al., 2015). In addition, the government will provide a 25% subsidy (Tilahun, 2022). Upon receipt of these premiums, money is transferred directly to the village councils, who, after which pay the district headquarters (Tilahun, 2022). Finally, they will reimburse medical facilities and hospitals. Enrollment in the CBHI is assessed at the household level rather than by government officials (Solomon et al., 2015). To avoid biased and unfair membership selections, participants must be registered through a household to be recognized as members of the scheme. At the pilot stage, awareness activities give local villages the option of joining the scheme if most local communities agree and are willing (Solomon et al., 2015). Aside from this, communities can choose whether to participate in the initiative. Once a household applies to take part, Local leaders and the public sort and choose the family they think are the less fortunate to obtain additional government subsidies for indigent people (Yilma et al., 2015)—each woreda represented by a general assembly and community-elected trustees (Yilma et al., 2015).

The Ethiopian government developed HCFS in 1999. This strategy had four interconnected goals: identifying more funding for the medical field, mobilizing and deploying these funds to the medical field, improving resource efficacy, and assigning marginal funds to improve the standard

of treatment. Several reforms have resulted from the HCFS, together raising user costs, keeping fees, using resources created by care providers, and putting health insurance programs into place.

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The health insurance strategy also includes community-based health insurance. Despite the need for increased health care services due to the need for better citizen health and faster socioeconomic growth, Ethiopia has a low level of health insurance coverage. The cost-sharing approach between the government and beneficiaries is meant to minimize financial difficulties, enabling beneficiaries to receive sustainable healthcare services while lowering financial barriers at the point of service delivery via health insurance, despite the contentious nature of the universal coverage debate. Therefore, the goal of community-based health insurance and social health insurance is to offer free health care coverage to all residents at the point of service. Ethiopia uses government funding, out-of-pocket expenses at the time of service, donor monies, charitable endeavours, and insurance sources to carry out its policy related to health (Ethiopian Health Insurance Agency [EHIA], 2015). This study explores the overall implementation of the CBHI strategy and the challenges encountered in the execution of the CBHI in the regional state of Oromia.

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

1.1. Research Objectives

The study's primary objectives are listed below:

- To examine the significant contents of the CBHI Strategy and pitfalls.
- To analyze the influence of the CBHI strategy on formulation and implementation within the West Shewa Zone.
- To examine the level of community participation and engagement in the implementation of CBHI.
- To assess the challenges of community-based health insurance implantation in the west Shewa zone.
- To analyze the effect of administrative capacity, workforce, and resource allocation on CBHI implementation in West Shewa Zone
- To examine the status of stakeholder coordination on the implementation of CBHI in the west Shewa zone.
- To investigate the influence of the influence of traditional community support systems and local health practices on CBHI implementation.
- To analyze the effects of Community-Based Health Insurance (CBHI) implementation on health outcomes and the reduction of financial hardship among members.

1.2. Formulation of the Scientific Problem

The WHO reports that annually, 150 million people face financial hardship and 100 million fall into poverty due to healthcare costs. Despite limitations like small risk pools and low funding, community-based health insurance is increasingly used to finance healthcare in developing countries (Kebede et al., 2014; Oriakhi & Onemolease, 2012). Annual member contributions, general and targeted subsidies, and other creative revenue streams, including bazaars and donations, are Ethiopia's primary sources of funding for CBHI.

Except for SNNPR, where districts pay the entire amount, targeted subsidies cover payments for low-income households, with 70% coming from regional and 30% from district administrations. To boost CBHI finances, the federal government provides an additional 10% subsidy (EHIA, 2020). Premiums have been Br. 350 ($6.60) in Addis Ababa since 2019 and Br. 240 ($4.53) in other areas.

Numerous studies have explored community-based health insurance (CBHI), with emphasis on households' willingness to enrol and the factors influencing dropout or low participation. Research in Ethiopia and other low and middle-income countries has identified a variety of influencing factors, including socioeconomic conditions, perceived service quality, healthcare accessibility, and awareness levels (Ashagrie et al.,2020; Cheno et al., 2021; Deksisa et al. 2020; Garedew et al., 2020; Atnafu & Tariku, 2020; Agago, Woldie & Ololo, 2014; Eseta et al., 2020; Gutama, 2019). In addition, studies from Nigeria, Ghana, Sudan, India, and Pakistan reflect similar concerns, particularly around affordability, trust in healthcare systems, and institutional factors contributing to enrollment or dropout (Thakur, 2016; Onasanya, 2020; Oriakhi & Onemolease, 2012; Herberholz & Fakihammed, 2017; Nsiah-Boateng et al., 2019; Khuwaja et al., 2021). Systematic reviews have further highlighted structural and policy-related barriers that continue to impede the broader uptake of CBHI in sub-Saharan Africa (Shewamene et al., 2021; Nageso et al., 2020). Those studies conducted on the effect of CBHI on Financial Protection (Abajobir et al., 2021; Nannini et al., 2021; Aikins et al., 2021; Koon et al., 2021; Dwivedi et al., 2020; Bodhisane & Pongpanich, 2019; Mekonen et al., 2018). The studies on how CBHI affects broader welfare and how the economy affects risk coping and sock management (Hirvonen et al., 2021; Shigute et al., 2020; Erlangga et al., 2019; Nannini et al., 2021; Dror et al., 2016).

Despite the growing body of literature on community-based health insurance (CBHI), there remains a scarcity of evidence addressing the implementation and challenges of CBHI in Ethiopia, particularly in the Oromiya region and in relation to the specific objectives of this study. While limited studies have touched on these issues, Habiyonizeye (2013) identified moral hazard and adverse selection as the two major insurance-related concerns CBHI schemes must confront. However, that study was mainly based on a literature review and informal interviews, which may not provide enough empirical depth to explore the complexities of CBHI operations fully. Similarly, the current research focus is closely related to the national cross-sectional study carried out by Mirach et al. (2023). However, it only used quantitative methods, like many of the reviewed studies, which left room for more in-depth, mixed-methods research. Quantitative analysis of the degree of health policy implementation might not be enough to promote evidence-based policy discussion.

Second, as pointed out already, the CBHI scheme involves multiple actors whose interests can converge or diverge, having an impact on strategy, policy design, and execution. In Ethiopia, however, the role of different actors in CBHI strategy formulation and implementation, as well as the extended support and demand of other actors, including the local community and beneficiaries, have not been well documented.

Wang et al. (2012) state that there is no one-size-fits-all approach to designing health insurance systems; instead, policymakers tailor schemes to meet the specific needs of their populations and contextual realities. The purpose of this study is to address a gap in the literature by acknowledging that health insurance systems vary significantly across countries in terms of their structure and design.

1.3. Research Questions

The study's primary research question was

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

Specifically, the following questions were identified:

- What is the status of CBHI implementation in different parts of West Shewa Zone, Oromiya National Regional State?
- What are the primary contents of the CBHI strategy and pitfalls, if any?
- What is the outcome of community-based health insurance on healthcare access, utilization, and financial protection for vulnerable populations in the West Shewa Zone?
- What are the main challenges of CBHI programs in Ethiopia, including issues related to governance, financing, administration, and accountability?
- How does the level of community participation and engagement influence the effectiveness of CBHI implementation in different districts of the West Shewa Zone?
- How does the regulatory and policy framework in Ethiopia facilitate or hinder the growth and functioning of CBHI schemes?

- What are the main elements affecting the adoption and enrolment rates of CBHI schemes among various socioeconomic groups in the West Shewa Zone?
- What is the effect of CBHI implementation on the health outcomes of enrolled individuals?
- How does CBHI impact the level of financial hardship experienced by its members due to health-related expenses?

1.4. The Hypothesis of the study

1. CBHI programs in Ethiopia cover outpatient and inpatient care, critical drugs, maternity and child health services, and specific diagnostic tests. However, specialized and high-cost medical procedures have limited coverage, requiring beneficiaries to seek additional financial assistance.
2. The effectiveness and longevity of the CBHI plan in Oromia National Regional State depend on the degrees of involvement of the community and its contribution to its development.
3. The West Shewa Zone of Ethiopia will benefit from improved healthcare access and protection of finances through the implementation of CBHI, but obstacles will need to be overcome, including inadequate funding, inadequate infrastructure, low enrolment and participation rates, and a lack of knowledge among the target population about the benefits of health insurance.
4. Effective execution of the CBHI strategy in the West Shewa Zone relies heavily on coordination and cooperation between governmental entities, NGOs, and community leaders.
5. In the West Shewa Zone, incorporating traditional community support structures and local healthcare practices in the CBHI strategy results in higher program adoption and sustainability.

1.5. Description of the variables

1) **CBHI implementation**: In the west Shewa, the variable describes the introduction and operationalization of community-based health insurance. It involves tasks including creating policies, recruiting members, creating benefit plans, and establishing payment systems.

2) **Healthcare Access**: This variable assesses how easily West Shewa Zone inhabitants can get the necessary medical care. Affordability of services, accessibility to healthcare facilities, and availability of healthcare practitioners are some variables that may contribute to improved healthcare access.

3) **Financial Protection:** This factor evaluates how well residents are shielded from the financial hazards connected to medical costs. Some elements that contribute to financial protection are out-of-pocket costs, health insurance, and the degree of financial risk sharing.

4) **Challenges:** The term "challenges" describes the impediments or challenges encountered in the West Shewa Zone when implementing CBHI. Challenges may include factors such as affordability of premiums, lack of awareness about the benefits of insurance, low participation rates among community members, financial sustainability, insufficient infrastructure, and administrative inefficiencies.

Challenges of CBHI include low enrolment rates, financial sustainability, insufficient infrastructure, administrative inefficiencies, a lack of awareness, and cultural obstacles. Enrollment, utilization, financial protection, and health gains are indicators of the performance of CBHI, which aims to improve healthcare access, low out-of-pocket expenses, and improve health outcomes.

1.7. Significance of the study

Universal health care has gained international attention, and health-related goals are part of sustainable development goals. This thesis is an attempt to close a gap in the body of knowledge on this subject. Furthermore, there is a dearth of information regarding the obstacles and implementation of CBH, specifically in the study area, as well as the suggested study objectives. This dissertation contributes in the following ways to the body of existing literature:

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

Access to Healthcare: CBHI programs are designed to advance access to healthcare facilities, especially for disadvantaged and marginalized groups. The research can help develop strategies to guarantee that these initiatives effectively reach and benefit the targeted areas by identifying obstacles and implementation gaps.

Reducing financial obstacles to healthcare services is one of CBHI's primary goals. This study's findings can shed light on how well these programs are meeting this goal, as well as provide ideas on how to properly organize insurance policies to provide better financial security for participants.

Sustainability and Scalability: Understanding the obstacles encountered during the execution of CBHI enables to design of long-term sustainability and scalability plans. The plan includes resolving finance, administrative efficiency, community participation, and local capacity-building challenges.

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

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

Lessons from the Case of Oromiya National Regional State: Beyond Ethiopia Lessons learned from the Oromiya case could have implications. The study's conclusions and suggestions can help other nations and regions dealing with similar challenges in putting CBHI into practice.

1.8. Scope of the Study

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

1.9. Limitation of this Research

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

2. LITERATURE REVIEW

2.1. Social Protection

2.1.1. Defining Social protection

The insecurity faced by employees in both industrialized and less developed nations is primarily due to inadequate and inconsistent income, which can take different forms. It is considered a means to ensure a minimum wage that is steady for employees, deprived of the guarantee of the state as in the past. Social protection aims are not limited to alleviating impoverishment; nonetheless, as well as minimize the risk of individuals falling into poverty through no fault of their own. Compared with conventional labour standard-based measures, the broadened purpose of social protection is more grandiose and extends beyond the workplace. It still does not provide a minimum income guarantee, however. Approximately 90% of workers in developing nations are employed in the informal sector, which is outside the purview of traditional social safety nets. There is an urgent need for creative and customized protection strategies to handle their unique income-related threats. The burden of implementing new protective measures largely falls on the workers themselves, who have limited earnings, making the challenge evident (Canagarajah & Sethuraman, 2001).

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

According to ILO Convention No. 102, social protection includes a variety of programs such as assistance for kids and parents, motherhood, unemployment, illness, old age, disability, survivors, and healthcare. A combination of tax-funded, non-contributory programs like social assistance and contributory schemes like social insurance are used to meet these needs. While social security and social protection are often used interchangeably, social protection has grown in popularity. There are several names for social protection, and it lacks a commonly agreed-upon definition.

Conditional cash transfers, disaster relief, and agricultural subsidies are all examples of social protection measures (Midgley, 2012). Most definitions given on social protection in different circulations include three main dimensions: susceptibility, the level of hardship, which is regarded as intolerable, as well as a socially and publicly appropriate reaction (Lund & Srinivas, 2000). Government measures done in reaction to degrees of danger, risk, and poverty that are considered socially unacceptable within a government or community are referred to as social security (Mulligan & Sala-i-Martin, 1999). Social security covers the security needs of those who are not poor during life events like pregnancy, childrearing, marriage, and death, as well as the extreme deprivation and vulnerability of the poorest. Social assistance and social insurance are the two main reactions (Van Ginneken, 1999).

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

Bismarck's model of work-based incomes and the uniform flat-rate scheme used in Denmark were two social security models instituted in the late 19th century. Bismarck's model was based on work-based earnings, where workers contributed a portion of their earnings towards social security and, in return, received limited coverage and benefits in cases of disability. Conversely, the Danish model was founded on the idea of nationality, where social security benefits were not linked to contributions but were available to all citizens, albeit with meagre benefits (Gordon, 1988). The German Chancellor, following Bismarck's model, enacted a series of bills in the 1880s and 1890s, encompassing the 1889 Old Age and disability insurance bill, the 1883 Illness Insurance Cost, and the 1884 Accident Insurance Bill. Three main characteristics of the German social security system were income-based proportionate benefit distribution, self-financed and independent pension organizations, and mandated insurance coverage (Gordon, 1988). Other social retirement plans were developed throughout Europe because of these ideas and laws, such as the Swiss Pension Act, the Swedish mandatory old-age pension, and the British Old Age Pension Act and Insurance Act. During WWII, Britain developed a flat-rate social security system Rather than using Bismarck's model, providing universal benefits for all employees through public institutions (Veit-Wilson, 1992; Gordon, 1988). Most continental European countries favoured the Bismarckian model of social security due to its decentralized organizational structure, while the Beveridgean model provided benefits close to the poverty level. Scandinavian countries adopted

the Danish model but provided versatile universal services to deal with income inequalities (Conde-Ruiz & Profeta, 2003; Esping-Andersen, 1990; Esping-Andersen, 1999).

Social insurance programs became positive alternatives to social assistance programs after the First World War and were extended to cover unemployment and occupational diseases during the interwar period. The systems became more comprehensive and generous in the 1960s due to sustained economic growth and favourable conditions (Gordon, 1988). Healthcare in the USA is predominantly business-oriented, driven by private insurance and market dynamics. Nonetheless, social security programs like Medicare and Medicaid offer crucial coverage for low-income, aged, and disabled individuals (Centers for Medicare and Medicaid Services, [CMS]). Additionally, hospitals are mandated to offer emergency care irrespective of the patient's financial situation, adding a layer of protection in critical situations. Social aid programs, including financial support for single mothers and disabled individuals, also exist but are more limited compared to European systems.

In contrast, European countries follow a different model, where social protection, including healthcare, is seen as a constitutional right. In these systems, the government oversees guaranteeing the well-being of all citizens through well-established social welfare institutions (OECD & European Union, 2023). This approach creates a stark difference from the U.S., where the responsibility for healthcare largely rests with individuals or private entities, and Social protection is not guaranteed under the constitution (Artiga et al., 2020).

While the U.S. includes social programs like Medicare and Medicaid, these are narrower in scope compared to European models, which prioritize universal access to healthcare as part of a broader welfare state. Neoliberal economic policies in the 1980s led to the privatization of social security schemes and scepticism about their effectiveness in the 1990s due to growing criticism of development deficiencies (Gordon, 1988). As a result, a new paradigm of development is emerging, which emphasizes the importance of encouraging long-term investment, market sensitivity, human capital, institutions and mechanisms that respond to stimuli, market-friendly state intervention, and social equality for sustainable economic development (Piasecki, 2017).

When we see the definition and concepts of social protection programs in less developed countries, there are few pieces of literature that state this concept. NGOs and commercial enterprises have expanded social protection programs in recent years, but there are ongoing debates regarding the scope and funding of these initiatives (Barrientos & Hulme, 2016). One of the

significant challenges lies in the lack of a standardized definition for social protection, which complicates policy development and research in this area (Devereux & Sabates-Wheeler, 2004). Two primary approaches to understanding social protection programs are income or cash transfers and non-traditional programs. These non-traditional initiatives include a wide variety of amenities that range from healthcare and education support to employment programs and meal service (Mastrorillo et al., 2022). However, the broad scope of these programs creates ambiguity regarding what should be considered social protection. This lack of focus can lead to confusion about the goals and effectiveness of the programs, making it challenging to measure their impact or develop clear policies (World Bank, 2023).

The lack of a standardized definition complicates policy and research in the areas of social protection programs. Two major approaches used to understand social protection programs are income or cash transfers, and non-traditional programs include a wide variety of services or initiatives. These could range from healthcare and education support to employment programs, food assistance, and beyond. However, the **problem** with this approach is that it might be **too broad**, covering so many different types of programs that it becomes unclear what exactly should be included under "social protection." This **lack of focus** can lead to confusion about the goals and effectiveness of the programs, making it harder to measure their impact or create clear policies.

Both approaches have limitations. The first approach eliminates specific projects, while the second is overly broad. Some academics and groups focus on specific programs within the larger category of social security. According to ILO (2011), It encompasses a wide variety of methods and activities for safeguarding individuals from negative consequences. Its goal is to protect individuals and families from unforeseen events that negatively impact their well-being.

Health Care continues to be one of the most pressing societal issues on a global scale. Improving medical services may be more important in promoting social safety and cooperation in the twenty-first century, even though it is frequently eclipsed by improvements to pensions (ILO, n.d.) The insurance concept, which allows people or families to combine funds with others who face comparable risks to protect themselves against potential losses, is the basis for social insurance, a type of social security that is financed by premiums.

Generally, international players have varying views on social protection, with some prioritizing poverty alleviation (UNDP and FAO) and others associating it with risk management (European Commission) (ECHO, 2017; Loewe & Schüring, 2021). Institutional logic and

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

2.1.2. The Goals of Social Security

Its main goal is interpreted in different ways. Social protection is not a single program but a variety of activities. There is no agreement on the definition and goals of social protection (Midgley, 2012; Loewe & Schüring, 2021). While some associate social protection with income maintenance programs, others argue that it has broader objectives. Social protection aims to safeguard earnings, and a variety of income transfer programs are used, with a preference for social insurance.

Social protection programs aim to prevent poverty and unemployment. Social insurance provides economic support during unforeseen circumstances, but coverage and benefit appropriateness can be problematic. Social assistance programs support low-wage workers and the uninsured but are often limited in scope and underfunded (Midgley, 2012).

The issue of social protection concerns the responsibility of individuals and the government to safeguard income. The World Bank endorsed the marketization of social protection by promoting privately managed retirement plans and limiting direct income transfers. Social funds were created in developing countries to provide emergency relief but were criticized for reducing government spending and social assistance. Politicians may use social protection initiatives to gain support by promising to increase benefits (Midgley, 2012).

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

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

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

Residualism (Anglo-Saxon or Liberal Model)	Slectivitism (Conservative, European Continental Model)	Productivism East Asian Countries (Singapore, South Korea and Japan)	Universalism (Social democratic or Comprehensive) (Scandinavian model)
The idea of personal accountability is connected to means-tested unrestricted funding as well as educational and medical subsidies.	is associated with private insurance, microinsurance, and social security.	Its objective is to link social protection policies with economic productivity and growth. Social protection policies are a way to enhance human capital and economic output. Prioritizes areas like education, skills development, healthcare, and labor market participation.	Through all-encompassing tactics, broad coverage, and fair redistribution, it encourages structural transformation. A universal basic income, public healthcare, child and unemployment benefits, rights-based pensions, and universally available in-kind social services are just a few of the

		Focuses on policies that make workers more employable and competitive.	social benefits that are part of this strategy.
Narrow focus on low-income groups	Need to focus on the entire population.	Focus on managing risks and the resulting contribution system.	It is a non-contributory scheme that focuses on poverty reduction.

Table 2.1 Approaches to prioritization of social protection policies
Source: Own compilation of the author based on Loewe & Schüring (2021).

Varying countries prioritize different social protection functions; less developed countries and nations having middle income are developing their systems. Different countries adopt various approaches based on their economic resources, political ideologies, and social priorities. While universal approaches prioritize broad coverage and equality, productivity and market-oriented models emphasize economic growth and individual responsibility. Every social protection strategy has its goods and challenges, reflecting the complexities of designing effective and sustainable social protection systems.

2.1.3. Social Protection practices in developing countries

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

In India, the Self-employed Women's Association has an integrated social security program for informal sector workers, which includes health, life, and asset insurance. Similar programs exist

in Bangladesh, the Philippines, Colombia, and South Africa, providing asset and life insurance and pensions. Microfinance institutions offer loans and insurance services to informal sector workers, with mixed results. However, social security programs in developing nations suffer from poor governance and low compliance rates, leading to limited financial support for informal sector workers (Canagarajah & Sethuraman, 2001).

Social protection systems differ among nations because of different government objectives, societal conventions, and beliefs. Additionally, historical processes and path dependencies make replacing these systems challenging (Loewe & Schüring, 2021).

Social protection laws are absent in many low- and middle-income nations. 55% of people worldwide do not receive any form of social protection, with 87% of those living in Sub-Saharan Africa and 61% in Asia and the Pacific (ILO, 2017, p.8).

Developing countries have recently recognized social security as a crucial aspect of social and economic policies. Middle-income nations like Brazil, South Africa, and Mauritius have already spent around 3% of their GDP on tax-financed benefits (Kidd, 2014, pp.3-4).

Some low-income nations, such as Bangladesh and Nepal, have developed comprehensive social protection systems at a cost of less than 1% of their GDP. Tax-funded social security plans in developing nations have produced significant outcomes in poverty reduction, human capital development, labour market participation, economic growth, social cohesion, and restoring dignity to disadvantaged members of society (Kidd, 2014, pp.4-9).

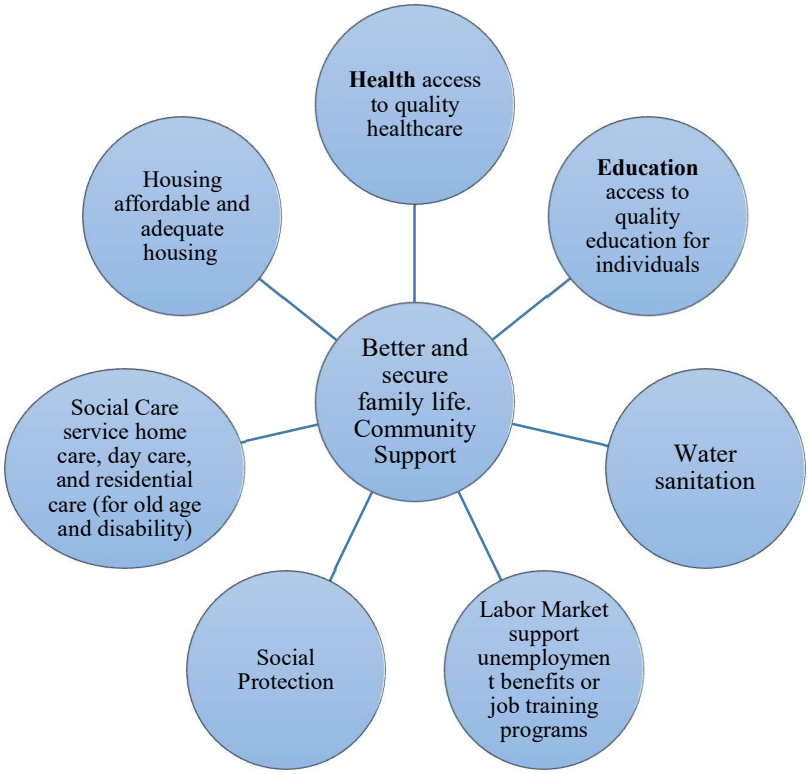


Fig 2.1: Basic social services and its investment

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

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

2.2. Concepts of CBHI

Ethiopia had accomplished six of the eight MDGs, according to the 2014 MDG report. The country had made significant progress on MDG 5, improving maternity health, but did not achieve the target. Now, Ethiopia is implementing the SDG with the Growth and Ten-Year Development

Plan (2021–2030) of the Ethiopian government, all achieved and non-achieved MDG. Health-related goals are part of the 10-year development plan (2021-2030) of the Ethiopian government.

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

Health is becoming more widely acknowledged as a significant factor for growth as well as an objective in and of itself. It is often known that economic growth and health are closely related, particularly in low-income countries. Safeguarding the impoverished from adverse effects becomes a top responsibility as these nations carry out market reforms and global integration. The government still has a crucial role in social sectors like health, even though its position in numerous sectors of the economy has diminished (Ahuja & Jütting, 2004).

In the Alma-Ata Declaration, the World Health Organization (WHO, 1978) stated that everyone has the fundamental human right to health. Around 1.3 billion people worldwide still lack access to basic healthcare services despite this. Even though social security and health care are guaranteed by international law, numerous nations and nonprofit organizations have failed to uphold these rights for millions of people. Developing long-term funding sources to protect this right is a significant challenge in low-income countries (Appiah-Denkyira & Preker, 2007).

Specifically, in numerous affluent countries where out-of-pocket (OOP) payments are the primary source of funding for medical care, poverty and healthcare expenses are closely related. According to the World Health Organization (WHO, 2013), one of the leading causes of financially low-income families falling further into poverty is high medical expenses brought on by accidents or illnesses. Health insurance reduces the strain of excessive medical costs by distributing the monetary risk of fluctuating medical expenses among people through risk pooling (across populations) and prepaid (Tapay & Colombo, 2004).

Community finance programs have developed in accordance with two gaps or inactions by the following organizations:

Ineffective taxation, poor fiscal management, insufficient safety nets for underprivileged groups, and inadequate monitoring of healthcare systems are examples of government failures. On the other hand, market failures result from differences in healthcare needs, consumer demand, and purchasing power, which are exacerbated by the economy's high rate of unofficial, non-cash transactions. Three important factors underlie the effectiveness of community-based health finance, which shows efficacy in resource mobilization and administration in areas where traditional health financing systems fall short:

Social capital is one factor that determines the formal financing mechanisms, and it deals with the fact that for low-income people, neighbourhood, friends, and family are frequently the most important safety net during difficult times. The second reason is the establishment of specific community organizations that provide mutually beneficial agreements, such as micro-insurance, amongst community members. The third element is the connection between local communities and outside organizations dedicated to improving society (Dror & Preker, 2002).

Dror and Preker (2002) define community finance as a variety of healthcare funding strategies, including drug-revolving funds, mutual health organizations, micro-insurance, rural insurance plans, and community-administered user fee systems (Ekman, 2004). Beginning in the late 1990s, numerous low- and middle-income nations have implemented community-based health insurance (CBHI) initiatives as part of a broader shift from user fee systems toward achieving universal health coverage (Mebratie, 2015). Through need-based service allocation and progressive funding (via taxes or income-based premiums), general taxation and social health insurance serve as equitable health financing models that promote universal coverage (WHO, 2003).

Numerous titles, including micro-insurance, mutual health insurance schemes, voluntary, informal sector health insurance, pre-payment insurance companies, mutual health organizations, and community self-financing health organizations, are used to refer to community-based health insurance (CBHI) (Tabor, 2005).

Community-Based Health Insurance (CBHI) is a solidarity-based, non-profit health funding strategy that primarily serves low-income, tiny, and frequently rural groups. The coverage, services, and costs of these programs vary, and many of them target the unorganized sector while operating in rural areas. The mutuelles de santé in Africa are well-known instances. Mutual help,

group risk sharing, and active member involvement in management are the cornerstones of CBHI (Musau, 1999). As a result, CBHI programs are acknowledged for successfully addressing marginalized and low-income groups in both urban and rural areas (WHO, 2013, p.4; Aggarwal, 2010, p.6). Any non-profit health financing strategy that focuses primarily on the unorganized sector and is based on mutual aid and collective risk pooling, including household participation in premium contributions, is referred to as "community-based health insurance" in this dissertation.

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

Table 2.2: Major Types of Health Insurance
Source: Wang, et al. (2012)

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

A common feature of all these programs is the predominant role of collective action in raising, pooling, allocating, purchasing, and supervising the management of the health financing arrangements. Besides this feature, the people covered often have no other financial protection or

collective financing arrangement to pay for their health care, and government-provided services do not reach them. The third feature is the voluntary nature of these schemes and the tradition of self-help and social mobilization that is embraced by people experiencing poverty in many low-income countries (Dror & Preker, 2002).

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

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

Features	**Design characteristics**	
	Supporting effective revenue collection and financial protection	Undermining revenue collection and financial protection
Technical design characteristics	Addressing adverse selection via group membership Accommodating irregular income streams of members (allow in-kind contributions, flexible revenue collection periods) Sliding fees, scales, and exemptions for the poor	Non-compliance, evasion of membership payments Adverse selection Lack of cash income No cash income at collection time

	make schemes more affordable.	
Management characteristics	Community involvement in management can exert social pressure on member compliance with revenue collection rules. Extent of capacity building Information support	Provider capture: the high salary of providers at the expense of service-quality improvement. Weak supervision structures increase the chance of fraud with membership cards. Poor control over providers and members contributes to moral hazard, cost escalation, and undermines the sustainability of the scheme.
Organizational characteristics	Linkages with providers to negotiate preferential rates raise the attractiveness of schemes and contribute to successful membership.	Fragmentation between inpatient and outpatient care leads to inefficiency and waste, ultimately resulting in the loss of membership.
Institutional characteristics	Government and donor support make the schemes more sustainable and pro-poor.	

Table 2.3 Determinants of effective revenue collection and financial protection

Source: Adopted from Jakab et al. (2001)

2.3. Demand for health Insurance and related theories

There are various studies conducted on the rationality of demanding health insurance by the community (Besely, 1989; Grossman, 1972). The willingness to seek health services is derived from the demand for health, and the demand for health insurance is derived from the demand for health services (Grossman, 1971). This implies that people are willing to join health insurance due to seeking health services in their area.

According to Besely (1989), the level of income earned, level of education, current health status, and other determinants such as aversion to receiving health care, availability, and access to health-related information will each influence the demand for health services. The assumption of conventional models of demand, which state that individuals will maximize the expected utility within a budget constraint and based on their preferences, may not work in health services due to individuals' health information being focused on asymmetry; hence, the individuals need to consult a third party (a physician) on the quantity and type of health care needed when they are falling sick (Jowett, 2004).

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

Why are people interested in buying insurance? For this question, scholars such as Besely (1989) designed a theoretical framework according to which the demand for health is modelled much as the demand for any other commodity. Individuals maximize utility, subject to budget constraints. Human health is not good and cannot? Be purchased and sold directly. Unlike other goods, health is produced using inputs to produce health services using healthcare. It points out that health is not a conventional good that can be directly bought or sold in the market. Unlike tangible products, health cannot be exchanged like consumer goods, which complicates the way individuals approach health-related decisions. Health is produced rather than acquired. Individuals must utilize various inputs, including health services and healthcare, to improve or maintain their

health. This perspective shifts the focus from merely purchasing health to recognizing the process of producing health through the consumption of healthcare services.

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

The decision to buy health insurance is influenced by a complex interplay of factors, including the desire to maximize satisfaction within financial constraints, the understanding that health is produced through the consumption of healthcare services and the limitations imposed by available technology. It underscores the importance of theoretical models in understanding the behaviour of individuals in the context of health insurance. Meanwhile, the demand for health insurance is shaped by several factors, including individual risk preferences, income levels, access to healthcare, and governmental policies. Understanding why individuals or groups seek health insurance involves examining both economic and behavioural aspects, particularly in how individuals perceive risks related to health and the financial burden of medical care.

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

For example, an individual may prefer to pay a set amount in insurance premiums rather than risk incurring a significantly larger medical expenditure. The benefits of health insurance, such as peace of mind and financial stability, frequently outweigh the actual cost of the premiums, particularly for risk-averse individuals. The concept of moral hazard emerges once a person purchases health insurance. It refers to the greater likelihood of using medical services when the insured party does not cover the entire cost of care. People who are insured may consume more healthcare services than they would if they had to pay the whole cost out of pocket, resulting in inefficiencies in the health system (Arrow, 2004).

The concept of moral hazard arises when a person acquires health insurance. It refers to the increased chance of using medical services when the insured party does not pay for the total cost of care. People who are insured may use more healthcare services than if they had to pay the entire cost out of pocket, resulting in inefficiencies in the health system (Pauly, 1968). Adverse selection is another important idea that influences health insurance demand. This idea explains why those with higher health risks are more inclined to get insurance, but healthier people may choose not to buy insurance because they believe the benefits are too low in comparison to the expenses. As a result, insurance pools may become skewed toward high-risk individuals, resulting in higher premiums and potentially unsustainable insurance models (Rothschild & Stiglitz, 1976).

In practice, adverse selection has the potential to disrupt insurance markets. If insurers are unable to differentiate between high-risk and low-risk persons, they may increase prices to cover potential losses, preventing healthier individuals from getting insurance and worsening the problem. Income elasticity and price sensitivity both have an impact on health insurance demand. According to studies, health insurance demand rises with income since those with more financial means are more inclined to buy coverage to protect themselves against financial shocks (Cutler & Zeckhauser, 1999). Furthermore, the price of premiums and out-of-pocket payments has a substantial impact on an individual's decision to obtain insurance. When premiums are subsidized, such as in government-sponsored programs, demand for insurance rises.

Understanding the demand for health insurance necessitates an assessment of numerous economic and behavioural variables. Expected utility theory emphasizes the importance of risk aversion, whereas moral hazard and adverse selection expose the intricacies of customer behaviour after an insurance purchase. Furthermore, income and price sensitivity have a substantial impact

on an individual's ability and willingness to buy health insurance. To create health insurance systems that are both accessible and sustainable, policymakers must strike a balance between these elements.

2.3.1. Risk Aversion and Uncertainty

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

2.3.2. Income and Affordability

Income levels have a significant influence on how much people want health insurance. People with higher incomes are willing to have private insurance, while low-income individuals may struggle with the affordability of premiums, even if they understand the benefits of having coverage. The United States Medicaid program addresses this gap by offering low-cost or free health insurance to low-income populations (Cutler & Zeckhauser, 1999). However, where these programs do not exist, the cost of premiums can deter the purchase of insurance, leading to higher rates of uninsured people.

2.3.3. Adverse Selection and Moral Hazard

Adverse selection, which results in a less balanced risk pool, happens when people who are most likely to require healthcare, such as those with chronic conditions, are the ones who are most likely to get insurance, while healthy persons choose not to (Rothschild & Stiglitz, 1976). On the other hand, the demand to be insured is also influenced by moral hazard and adverse selection. The tendency of people with insurance to use more medical treatments than necessary since they do not have to pay the whole cost is a moral hazard (Pauly, 1968). This may result in greater general medical expenses.

2.3.4. The Regulatory and Policy Environment

The demand for health insurance is significantly shaped by laws and regulations from the state. In nations where obligations for health insurance are mandatory, such as Germany, individuals are legally obligated to have insurance, which guarantees a broad risk pool and minimizes adverse selection (Wagstaff et al., 1999). Conversely, in countries like the USA, where health insurance is voluntary mainly except for specific mandates (e.g., the Affordable Care Act), the demand for insurance can fluctuate significantly based on policy changes, subsidies, and penalties for non-coverage.

The demand for health insurance is significantly shaped by laws and regulations from the state. In nations where obligations for health insurance are mandatory, such as Germany, individuals are legally obligated to have insurance, which guarantees a broad risk pool and minimizes adverse selection (Wagstaff et al., 1999). Conversely, in countries like the USA, where health insurance is largely voluntary except for certain mandates (e.g., Affordable Care Act), the demand for insurance can fluctuate significantly based on policy changes, subsidies, and penalties for non-coverage.

2.3.5. Perception of Healthcare Quality and Accessibility

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

2.3.6. Demographic Factors

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

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

2.4. Theoretical Framework

2.4.1. Theory of Social Capital

The term "social capital" describes aspects of social institutions that promote collective action and operate as essential resources for individuals, such as reciprocity standards, mutual aid, and interpersonal trust (Coleman, 1990; Putnam, 1994). It is influenced by civic involvement, shared standards, and the degree of trust in a community (Lochner et al., 1999; Putnam, 1994). Putnam (1993) asserts that generalized reciprocity and community-wide trust are the fundamental components of social capital. Social capital is essential for helping the impoverished manage hazards and weaknesses. As a result, societies with high levels of societal capital are more likely to embrace community-based health insurance (CBHI), which is intended to handle such issues (Woolcock & Narayan, 2000). Altruism and care for the well-being of others are fostered by a strong social capital pool, which makes group action and mutual support easier. In the end, social capital has a favourable impact on the general well-being of the community (Woolcock & Narayan, 2000).

Numerous studies demonstrate the close connection between social capital and the effectiveness of unofficial risk-sharing systems. According to Jowett (2004), these kinds of mechanisms are more likely to appear in social capital-rich communities where reciprocity, trust, and community involvement are common. Similarly, Hsiao (1995) contends that the voluntary formation of health-related risk-sharing schemes can be predicted by a community's amount of social capital. Socially cohesive groups are more likely to pool resources and work together efficiently to ensure that community-based health insurance (CBHI) programs run smoothly

because they understand the benefits of working together. On the other hand, there is a far lower chance of such voluntary arrangements in societies with minimal social cohesiveness.

When applied to extensive, official health insurance programs like Vietnam's, the applicability of community structure arguments is called into question. People are more likely to rely on their participation in calculated rewards; therefore, trust among community members is expected to have less influence due to the scheme's institutional design, which has little local engagement or control. However, even in a centralized organization, enrollment decisions may still be influenced by broader social standards established by the larger societal structure if the program is seen as a sign of national social solidarity. Sociologists may classify national solidarity under the more general heading of social capital, although the two are not interchangeable (Jowett, 2004).

Social capital is generally categorized into two forms: “strong ties” (or “bonding social capital”) and “weak ties” (or “bridging social capital”) (Woolcock & Narayan, 2000). Strong ties describe the close-knit relationships individuals maintain with their family, close friends, and members of their own ethnic or social group, representing connections within a community. In contrast, weak ties refer to more distant or external relationships beyond one’s immediate group, such as with individuals from other communities, institutions like banks, or different social networks (Woolcock & Narayan, 2000).

Strong ties foster solidarity, aiding CBHI, but member similarity can increase risk. Weak ties offer diversity, helping balance risk levels. CBHI may work better in larger, more socially diverse communities (Donfouet & Mahieu, 2012). Grassroots, bottom-up approach to health program planning and decision-making is reflected in community involvement. The significance of active public participation in promoting and protecting their health was underscored in the 1978 WHO Declaration of Alma-Ata (Laverack, 2004). Promoting community member participation in community-based initiatives is essential for several reasons. According to Kreuter, Lezin, and Young (2000), participation is thought to empower people by assisting them in learning how to prioritize problems, recognize needs, and change their environment. Durham (1963) stressed that the most significant transformation happens when programs come from within the community itself, in accordance with the idea of relevance.

Involving community members allows the program to incorporate local values and viewpoints while also utilizing the wisdom of regular people. According to Bracht and Tsouros (1990), this involvement provides access to local leaders, resources, and technical experience that

might not otherwise be available. Additionally, those who participate in such programs develop a sense of ownership, feeling personally accountable for the program's success (Carlaw et al., 1984). People are more likely to believe in the program's advantages and accept it more easily when local opinion leaders support it (Nilsen, 2006).

The performance of health programs and the adoption of insurance can both be enhanced by community involvement. According to the review, healthcare access improved, and OOP costs generally decreased in programs where communities were involved in the planning process. Schemes that did not include the community, however, showed less progress in both areas. Access to healthcare services is enhanced when members participate in administration and supervisory tasks; seven out of seven schemes have favourable outcomes, compared to just nine out of fourteen for schemes without member participation (Mebratie, 2015).

2.4.2. Theory of Social Mobilization

Health promotion has shown success with the social mobilization paradigm, especially when people are reluctant to participate in health programs. Since many people do not immediately recognize the direct benefits of health insurance, CBHI must mobilize people to help them comprehend and accept the program (Habiyonizeye, 2013).

A tried-and-true method that helps people all around the world recognize and address important healthcare issues is community mobilization. In addition to enhancing living circumstances and health, it also makes it easier for the community to work together to accomplish significant objectives. In addition to resolving the present issue, effective community mobilization increases the community's ability to meet future demands and goals (Howard et al., 2003).

The use of organized actions and processes to engage, influence, and involve all relevant stakeholders at national and community levels" is the definition of social mobilization. It seeks to increase awareness, alter behavior, sway laws, call for specific development initiatives, or reallocate funds and services (Russell et al., 2033).

To improve health and meet other needs, community mobilization entails local people, groups, or organizations determining needs, organizing, carrying out, and assessing actions in a sustained and participatory manner, either on their own or with outside assistance (Howard et al.,

2003). There are two types of community mobilization: active mobilization, which involves participatory ways that involve different community members, and passive sensitization, which involves increasing health awareness (Haws et al., 2007; Rosato et al., 2008).

Effective community-based health and insurance program establishment and maintenance are complex tasks that call for long-term resource investment (Cheadle et al., 1997; Turner et al., 2004; Mittelmark, 1993). Numerous strategies for enlisting resource investment are listed by Niel McKee (1992), including beneficiary, corporate, community, political, and governmental mobilization.

Community focus (the community is both the target and the catalyst for change); community member participation (involving members in identifying health or safety issues and solutions); inter-sectorial collaboration (fostering partnerships among community sectors and organizations with shared goals); multifaceted interventions (combining behavioral and structural interventions); and population outcomes (aiming for broad, population-level impacts) are the seven principles that guide community-based health and safety programs (Nilsen, 2006).

3. RESEARCH METHODOLOGY

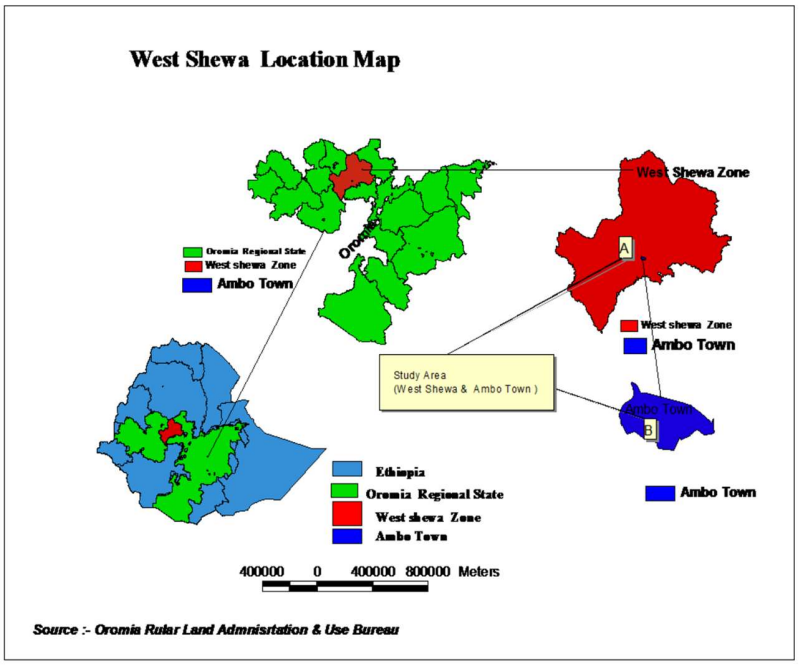
3.1. Description of the study area: West Shewa Zone

In terms of both area and population, the Oromia National Regional State, commonly known as Oromia, is Ethiopia's biggest and most populated regional state. Oromia, which is situated in the country's centre and south, is vital to its politics, economy, and culture (Feyissa, 2011). Located in the centre of the Oromia Region, the West Shewa Zone borders the Amhara Region, Jimma Zone, Horo Guduru, Este Wollega, south-west Shewa Zone, and north-west Shewa Zone. The zone's geographic location makes it simple to reach important market centres like Finfinne and Ambo, which enables local products to be efficiently supplied to the market and satisfies community wants. With 18 districts, one urban local authority, and the capital at Ambo town, the 15185 km2 West Shewa Zone is ideal for the development of livestock and crops (Etefa & Dibaba, 2011). The demographics with 1,028,501 men and 1,030,175 women, the zone has a total population of 2,058,676 according to the Ethiopian CSA (2007) Census; West Shewa has a population density of 139.21 people per square kilometre and occupies 14,788.78 square kilometres. Ambo is the administrative hub of the zone, which is separated into several districts or woredas.

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

In recent years, the West Shewa Zone's infrastructure has been steadily developed. It is connected to Addis Ababa and other locations by major highways, which facilitate trade and the flow of products. Ambo University, located in the zone, is an essential player in higher education and research, contributing to the region's growth (Hassen, 2015).

To summarize, the West Shewa Zone is an essential economic and geographical area in Oromia. Its agricultural output, expanding infrastructure, and strategic location make it a significant contributor to the regional economy and growth.



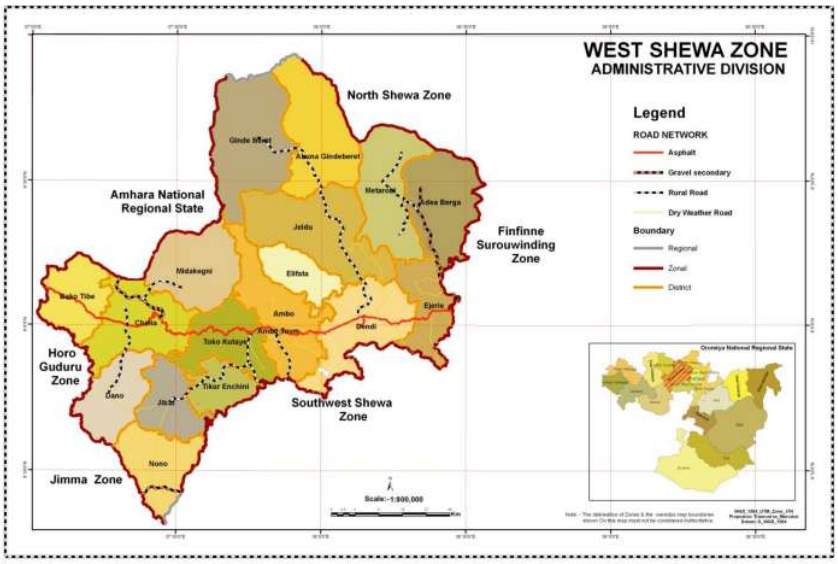


Fig 3.1: Geographical Location of west Shewa zone (Etefa & Dibaba 2011)

The World Health Organization states that health refers to a holistic condition that includes physical, mental, and social well-being rather than simply being free from illness or physical disorders. This state is greatly influenced by a society's degree of economic development and the fair distribution of its resources. The current health policy in the Oromia Region places a high priority on providing integrated primary healthcare services in a decentralized manner with the

goal of improving accessibility by expanding the healthcare infrastructure, human resources, and necessary supplies (Etefa & Dibaba, 2011).

In the West Shewa Zone of Ethiopia, health facilities are essential for controlling chronic illnesses like diabetes and hypertension, as well as for providing services related to mother and child health. Numerous facets of healthcare delivery are highlighted by studies carried out in the area. Maternal satisfaction with delivery services at public health institutions was found to be good, with timing and cleanliness influencing satisfaction levels.

(Etea et al., 2023). Pregnant women's satisfaction with antenatal care services was also not very high, which highlights the need for better patient relations and service quality. In addition, it was observed that a large percentage of diabetes patients visiting local public hospitals had hypertension, which was linked to the illness by family history, age, and obesity (Bekele et al., 2023). It has also been noted that efficient pharmaceutical inventory management is crucial for maximizing healthcare spending and guaranteeing that critical pharmaceuticals are available in medical institutions (Hirpa & Abdisa, 2023).

No.	District	Health Centers	Clinics	Health posts	Drug stores
1	Ambo	1	1	13	_
2	Ambo town	1	12	3	13
3	Adea Berga	3	6	17	4
4	Bako Tibe	2	10	20	2
5	Cheliya	1	4	14	3
6	Dano	3	3	9	2
7	Dendi	2	15	11	5
8	Ejere	1	4	9	1
9	Gindebert	2	5	10	2
10	Jeldu	3	8	12	3
11	Nono	2	15	18	_
12	Meta Robi	1	6	40	_
13	Mida Kegn	1	4	10	_
14	Dirre Inchini	0	3	9	2
15	Jibat	2	6	15	1

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

Table 3.1 Distribution of health institutions in West Shewa zone

3.2. Research Design and Strategy

Setting up the parameters for data collecting and analysis is known as a research design (Kothari & Garg, 2014; McNabb, 2018). To examine pertinent sources and gather information for their study, the researcher employed a descriptive-analytical methodology. Using primary materials, including questionnaires and interviews, the researcher employed both quantitative and qualitative methods. The data was designed and analyzed using Creswell's (2012) principles for scientific research.

Both primary and secondary data would be used in the study, and the data would be analyzed using both qualitative and quantitative techniques. A hybrid research design is employed. Questionnaires and semi-structured interviews are used to gather primary data from CBHI employees and beneficiaries. Officials from the zonal administration offices and CBHI head office would also participate in semi-structured interviews.

The secondary data would be collected from official sources, including national and international health reports, academic literature, Growth and Transformation Plan II (GTP II), CBHI policies and recommendations, and government policies and strategies.

A mixed-methods approach is used because quantitative analysis of the amount of health policy implementation might not be enough to encourage evidence-based policy discussion. Second, as was previously mentioned, the CBHI scheme incorporates several actors whose interests may coincide or diverge, which can affect the development of strategies, the creation of policies, and their execution. The role of many actors in the development and execution of CBHI strategies, as well as the long-term support and demands of various actors, such as beneficiaries and the local community, have not, however, been thoroughly recorded in Ethiopia.

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

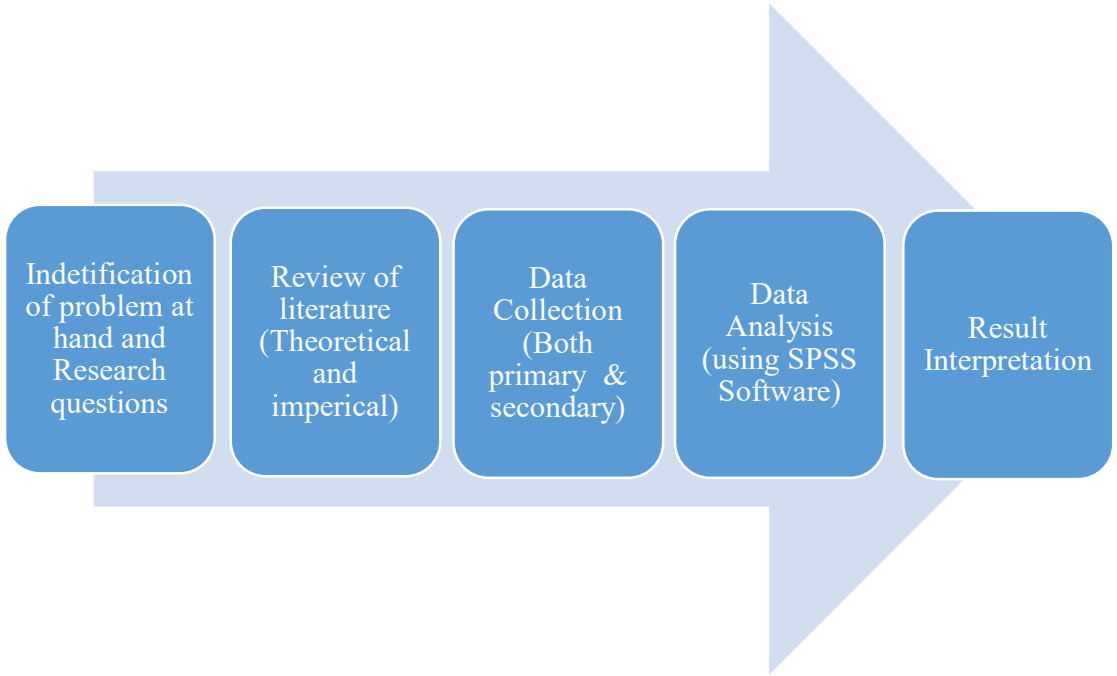


Figure: 3.2 Research Design and steps
Source: Author's own compilation based on research design

3.3. Rational for mixed research methodlogy employeed in this study

Both qualitative and quantitative research methodologies were used in this study's mixed-methods methodology. This approach is well acclaimed for producing comprehensive insights into complex research problems due to its effectiveness and robustness (Creswell & Creswell, 2017). When both methods are combined, the research can benefit from each of their unique strengths:

quantitative methods promote statistical analysis and more generalizations, while qualitative methods offer prosperous, contextual detail (Borrego et al., 2009; Frost, 2011; Castellan, 2010).

The study's central research question: How was the Community-based health insurance (CBHI) strategy developed and executed in the Oromia national and regional state, and what were the implementation challenges that guided the choice of research technique? The need for a mixed-methods approach to guarantee a solid and comprehensive examination was further supported by a careful analysis of the body of current literature and the development of targeted research questions.

Because it enhances the breadth and depth of the findings while compensating for the limits of solitary qualitative or quantitative methodologies, mixed-methods research is especially beneficial (Creswell et al., 2003). Quantitative data was collected using standardized questionnaires to investigate relationships between different factors, while qualitative data was collected through interviews to get detailed opinions from significant stakeholders. More data could be gathered, validity could be improved, and more widely applicable conclusions could be drawn thanks to this two-pronged approach. As shown in Table 3.2, a combination of quantitative and qualitative methodologies was used to address the study issues methodically.

S.No.	Research Questions	Research Method
1	What is the status of CBHI implementation in different parts of West Shewa Zone, Oromiya National Regional State?	Quantitative and qualitative methods
2	What are the primary contents of the CBHI strategy and pitfalls, if any?	Qualitative
3	What is the outcome of community-based health insurance on healthcare access, utilization, and financial protection for vulnerable populations in the West Shewa Zone?	Quantitative and qualitative methods
4	What are the main challenges of CBHI programs in Ethiopia, including issues related to governance, financing, administration, and accountability?	Quantitative and qualitative methods

5	How does the level of community participation and engagement influence the effectiveness of CBHI implementation in different districts of the West Shewa Zone?	Quantitative and qualitative methods
6	How does the regulatory and policy framework in Ethiopia facilitate or hinder the growth and functioning of CBHI schemes?	Qualitative
7	What are the main elements affecting the adoption and enrolment rates of CBHI schemes among various socioeconomic groups in the West Shewa Zone?	Quantitative and Qualitative method

Table 3.2 Research questions and research approach designed to answer them
Source: Authors own compilation based on research question and approach

3.4. Data Source for this study

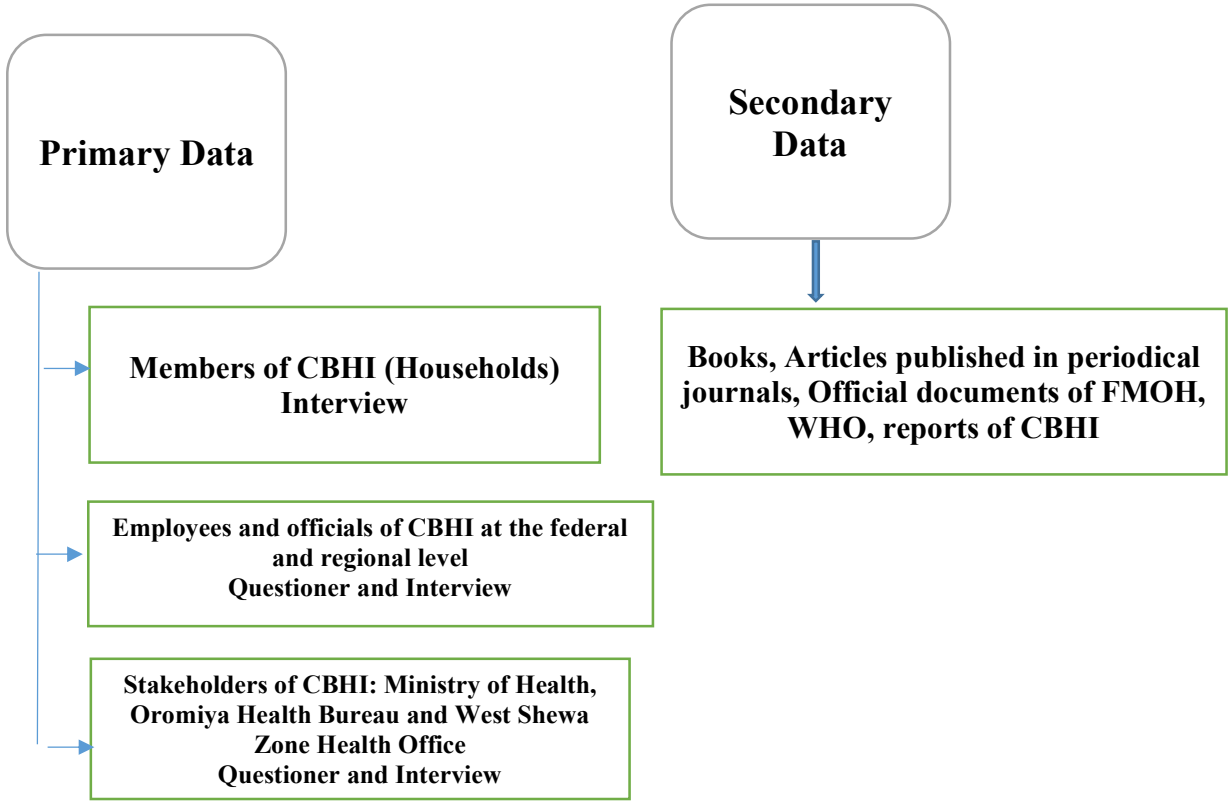


Fig3.3 Source of data

3.5. Data Collection tools

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

3.5.1. Primary data collection instruments

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

3.5.1.1. Questionnaire

Because they enable respondents to freely respond without the researcher interfering, questionnaires are an invaluable tool for gathering objective data from respondents. There are two different versions of the survey questionnaire used in this study: one for CBHI officials and one for CBHI beneficiaries. Both surveys were given out as part of a cross-sectional survey intended to evaluate the difficulties and implementation of Community-Based Health Insurance (CBHI) in Ethiopia's West Shewa Zone. This study's survey questionnaire is divided into four sections, each with a different set of questions.

Three hundred seventy-three households were chosen using the sampling strategy outlined in the research methodology, and they were given a self-administered questionnaire. Fifty workers were also selected to fill out the same kind of survey. Both closed-ended and open-ended items were included in the structured, self-administered questionnaire, and answers were scored on a five-point Likert scale that went from 1 (strongly disagree) to 5 (strongly agree). On December 25,

2023, and March 30, 2024, data was gathered in Ambo town and the neighbouring rural regions (Gandas) in the Ambo district, namely the districts of Bako Tibe and Chaliya. The questionnaire was given to participants directly in printed copies.

3.5.1.2. Survey Methodology

The data for this study were collected using structured questionnaires administered to two main groups: CBHI beneficiaries and relevant officials. To accommodate respondents' accessibility and language preferences, the questionnaires were distributed in paper-based format through face-to-face interactions in selected villages for beneficiaries. At the same time, officials received the surveys via email in a computer-assisted format. All questionnaires were made available in both English and Afaan Oromoo to ensure inclusivity for non-English-speaking participants.

The questionnaire design incorporated both closed-ended and open-ended items to facilitate a mixed-methods approach. Closed-ended questions, including Likert-scale items and multiple-choice formats, supported the quantitative analysis, while open-ended questions allowed for the collection of qualitative insights when appropriate. Likert-scale questions, ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), were primarily employed to assess attitudes and perceptions. In contrast, ordinal scales (e.g., Very Low to Very High) were used to measure levels of engagement and satisfaction.

The questionnaire administered to CBHI beneficiaries consisted of eight sections. Part I gathered demographic information through multiple-choice questions focusing on gender, age, education, marital status, family size, income level, type of CBHI membership, and duration of enrollment. Part II explored the implementation of CBHI, using Likert-scale items to assess perceptions of policy clarity, enrollment efficiency, benefit packages, payment mechanisms, public awareness, and overall satisfaction. Part III examined the challenges encountered in CBHI implementation, with items covering service quality, infrastructure, claims reimbursement, awareness levels, provider networks, and community participation.

Part IV addressed community engagement in CBHI strategy formulation through a combination of ordinal and Likert-scale questions, investigating respondents' views on their level of involvement, transparency in decision-making, the influence of community feedback, and

perceived representativeness. Part V explored the impact of traditional support systems on CBHI by using Likert-scale items to assess the role of elders, local practices, communication channels, and women's participation. Part VI evaluated the contents of CBHI, specifically coverage adequacy for various services, using a single-item Likert scale. Part VII evaluated the financial protection provided by CBHI, including perceptions of affordability, economic security, coverage adequacy, and its impact on household budgets. Finally, Part VIII focused on health outcomes, measuring access to preventive care, disease prevalence, health literacy, and service quality through Likert-scale items.

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

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

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

3.5.1.3. Questionnaire for CBHI Officials

There were four primary sections to the questionnaire created for CBHI officials. In Part I, respondents' background information was gathered using multiple-choice, closed-ended questions. Gender, age, education, current position, and years of work experience were essential subjects.

Using a five-point Likert scale, Part II examined the difficulties faced during the implementation of the CBHI. These difficulties included those pertaining to administrative capacity, public awareness, financial resources, infrastructure constraints, and political or bureaucratic obstacles. The impact of different stakeholders on the CBHI program was examined in Part III. This section employed Likert-scale items to evaluate dimensions such as inter-institutional collaboration, resource distribution, levels of community engagement, and the alignment of stakeholder actions with national health policies. Part IV concentrated on administrative capacity and resource-related challenges. The respondents were asked to assess the distribution and adequacy of resources, including funding sufficiency, workforce shortages, district-level disparities, and the equity of resource allocation procedures.

Both the beneficiary and official questionnaires were pilot-tested and subsequently refined based on feedback from key stakeholders, including the West Shewa Zone Health Bureau and Ambo Hospital. Data collection among beneficiaries was conducted face-to-face in selected villages, namely Ambo, Bako Tibe, and Chaliya. To encourage broader participation, the official questionnaires, on the other hand, were sent out electronically through email. Ordinal scales were used to rank the degree of community engagement, while Likert-scale items were primarily used to measure attitudinal responses. This methodical and inclusive approach was adopted to ensure clarity, consistency, and the comprehensive collection of data relevant to the study's objectives.

S.No.	**Questionnaires**	**Number of questions**
1	Background of the respondents	Part I (Q1-Q5)
2	Challenges of CBHI Implementation	Part II (Q1-Q13)
3	Influence of Stakeholders on the Success of CBHI Strategy Implementation	Part III (Q1-Q17)
4	Effect of administrative capacity, workforce, and resources on CBHI implementation	Part IV (Q1-Q12)

Table 3.4 Items of the questioner for the CBHI Officials (See Appendix ‘’B’’)
Author’s Table made according to the research questions made for the officials of CBHI

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

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

To accommodate respondents who could not speak English, the questionnaire was created in English and translated into regional tongues. The West Shewa Zone Health Bureau, Ambo Hospital, Gedo Referral Hospital, Bako Referral Hospital, Oromia Health Bureau, and Ethiopian Health Insurance Service played a significant role in distributing the questionnaire among respondents (Beneficiaries and Employees), and Prior to deployment, pilot testing was used to examine and improve it.

3.5.1.4. Semi-structured interview

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

Among the different methods of interview, researchers preferred the face-to-face method because of its ability to allow respondents to provide the depth of information they want and the researcher's ability to follow up questions in the form of investigative questions. Open-format questions are likely the most frequently used interview format in research studies (Turner, 2010).

Interviews were conducted with five people within the district, the main branch (EHIS), for triangulation purposes and to answer some other questions that were not addressed by the questionnaire. The people who were recruited in the in-depth interview were chosen purposefully based on their closeness to the implementation (enrolment) of CBHI. The interviews took place at the EHIS in Addis on June 3, 2024, and in Ambo town on December 28, 2023. Participants were

interviewed in person at their workplace, with a duration of approximately 40 minutes. The researcher followed a protocol for conducting the interviews, which included contacting the interviewees, explaining the objective of the interview, ensuring confidentiality, and recording the interviews (or taking manual notes if the recording was refused). The interviews were conducted in English or Afaan Oromo and Amharic, transcribed, and analysed thematically.

CBHI beneficiaries residing in the West Shewa zone are the study's target demographic. Federal CBHI authorities, as well as Oromiya national and regional state/zonal CBHI officials, were interviewed a simple random selection process for the households for the interview. In contrast, purposive sampling was used to select the interview subjects based on their expertise, responsibility, and familiarity with the topics being discussed.

3.6. Sampling methodology and the target population

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

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

The following sample formula would be used to calculate the sample size:

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

Sample Size Formula (Srivastav, 2022)

Where,

Population size, N=22,667

Critical value at 95% confidence level, Z=1.96

The margin of error, e= 5% or 0.05

Sample of proportion (Uncertain) (p) =0.5

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

$= 22,667*384.16/ 23,050.16$

$=377.78 \approx 378$ (members of CBHI)

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

Plus, 50 employees of CBHI were selected.

3.7. Method of data analysis

Within this study, data measured through nominal and ordinal are employed to measure the implementation and challenges of CBHI in the west Shewa district.

3.7.1. Quantitative data analysis

The researcher used quantitative analysis to evaluate hypotheses and estimate unknown parameters. Version 26 of the SPSS program was utilized to examine data obtained from a questionnaire. Finding the relationship between the research variable and controllable variables is made easy by this analysis, which is crucial for interpreting the raw data and turning it into a form that can be easily understood and controlled. The sampled population's community-based health insurance implementation and related challenge scores were assessed using descriptive statistics, and the study's results were interpreted using a variety of statistical methods, including standardized regression and Cronbach's alpha.

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

Table 3.5. The mean score and standard values
Author's work based on the research methods.

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

The regression equation is

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

Whereby: **Y:** CBHI implementation

X_1: Financial protection

X_2: Improve health outcome

Whereas β and β_2 stand for the coefficient of determination

β_0 = is the intercept term, a constant that, if all slope coefficients are zero, will equal the mean.

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

3.7.2. Analysis of Qualitative Data

The final phase of the process for interview design involves analyzing and interpreting qualitatively by categorizing and interpreting the gathered information and establishing correlations between different attitudes and common themes. To comprehend attitudes, find common themes, and create connections between various attitudes and topics, the researcher manually transcribed and analyzed the interviews using thematic analysis.

As a further interpretation of quantitative data, the qualitative information obtained from key informant interviews is transcribed, analyzed, and interpreted into descriptions and narratives. Quantitative dominant data analysis is used in the mixed data analysis process. Data was gathered using several data collection tools to supplement the information. The standard deviation and mean are used to analyze the quantitative data obtained from closed-ended questionnaires, while the narrative approach is used to analyze the quantitative data.

3.8. Reliability and validity

Although validity and reliability are commonly employed in quantitative research, their application is currently being reexamined by the qualitative research paradigm (Golafshani, 2003). According to Joppe (2000), a trustworthy research instrument yields reproducible results under a similar technique. Reliability is defined as the correctness of outcomes in representing the entire population and their consistency over time. As suggested by Joppe (2000) and referenced by Golafshani (2003), How well a study reflects the idea or phenomenon it seeks to explore is referred to as validity in research. Researchers examine previous research and create questions that support the objectives of the study to evaluate validity.

To increase the reliability of the study, a Pilot test was taken to test the questionnaire, and the respondents answered the questions with their willingness. Cronbach's alpha was calculated to assess the consistency and reliability of the response. The instrument sub-scales Cronbach's alpha ranged from 0.89 to 0.76, demonstrating excellent consistency and dependability.

Thirty participants in a pilot study validated the questionnaire, confirming its suitability for measuring CBHI implementation and associated challenges.

The interview protocol was refined and updated multiple times, and five semi-structured interviews were conducted to ensure validity and reliability, which many scholars consider enough. However, there is no consensus on the ideal number of interviews. Some academics, such as Morse (1994), argue that six interviews are necessary for credible results. In contrast, Mason (2010) suggests that using multiple methods and conducting in-depth interviews with the same participants may require fewer participants.

3.9. Ethical Consideration

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

In this study, the researchers obtained informed consent from participants before involving them in the study. This was done by providing participants with details regarding the study purpose, methods, benefits and risks and ensuring that respondents voluntarily agreed to participate. The process of getting approval from an ethics committee or review board prior to starting a research study with human subjects is known as ethical clearance (Farin et al., 2022; Therese, 2013; Cleaton-Jones & Curzon, 2012; Rizka et al., 2022). To ensure this, an ethical clearance letter was written from the Oromiya Health Bureau. To assure participants' confidentiality, protect the confidentiality of respondents' information by ensuring that data is stored securely and anonymized. Participants received guarantees that their data would not be shared or revealed without their permission. To verify that the respondents' involvement is voluntary and private, a consent letter was written in Afaan oromoo and given to them. In the letter, those who responded were reassured that their privacy would be guaranteed and that the data obtained would be kept private. The researcher prioritized participant privacy, anonymity, and confidentiality when disseminating the study's findings, ensuring secure data storage and limited use of participant data.

4. COMMUNITY BASED HEALTH INSURANCE PROGRAMS IN ETHIOPIAN CONTEXT

4.1.Public Service Delivery in Ethiopia

Ethiopia elected subnational politicians at the regional and district (or "woreda") levels to implement political decentralization. An essential step towards decentralization in Ethiopia was administrative decentralization, which involved the transfer of planning and administrative duties to regions of expenditure. The main decentralization measures were the transfers of spending in large social service sectors, including healthcare, education, and agriculture. A sizeable amount of the national budget was redistributed to several regions beginning in 1992 and reaching the woreda level in 2001 (Lee, 2013). In Ethiopia, decentralization seeks to improve accountability at the regional, state and local levels, encourage citizen participation, and guarantee efficient and responsive public service delivery (MOI, 2004).

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

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

To enhance the provision of public services, Ethiopia has instituted extensive public sector capacity-building initiatives, such as the Public Sector Capacity Building Programme Support Project (PSCAP) (World Bank); besides this, a number of tools for public service reform have been implemented by the Ethiopian government, including provision, fast wins, management by objective, BPR, BSC, Public service change army, and the Citizens Charter (Debela, 2009).

However, Ethiopia's public service delivery is hampered by ineffective accountability, responsiveness, and transparency mechanisms, as well as the incapacity of public agencies (Teshome et al., 2012). When we see how practical community-based approaches to public service delivery are in improving access and efficiency in Ethiopia,

In Ethiopia, community-based initiatives like Community-Based Newborn Care (CBNC) and the Program for Health Extension have shown promise in improving the effectiveness and accessibility of public services. The HEP used Health Extension Workers (HEWs) to successfully implement evidence-based interventions, resulting in considerably increased under-5 mortality intervention coverage (Drown et al., 2024, p.5). However, issues such as low intervention fidelity in CBNC implementation have been discovered, pointing to limitations in effective intervention delivery (Molla et al., 2023, p.10). On the other hand, efforts such as the TESFA program have established long-term and scalable approaches for delivering reproductive health programs through peer-based solidarity groups, resulting in improved health outcomes and participant empowerment (Chowdhary et al., 2022, p.7). Additionally, the adoption of CBHI has demonstrated encouraging outcomes in reducing gaps in modern health service consumption, underscoring the relevance of such community-based programs in improving healthcare access and equity (Geta et al., 2023, p.12). Efforts to address barriers to HEW service consumption, such as demand- and supply-side problems, are critical for increasing the effectiveness of community-based approaches in Ethiopia (Miller et al., 2021, p.15).

In general, Ethiopia's public sector faces a wide range of obstacles to providing effective and efficient services. The primary issues of public service delivery were a need for more accountability, a readiness to give service as requested, a sense of belonging, discrepancies in rules and regulations, and a lack of integration among various government service providers. (Hailu & Shifare, 2019, pp.24-26). Furthermore, concerns such as a lack of professional leadership, corruption, infrequent consultation with stakeholders, and poor automation impede service delivery in public enterprises (Seyoum, 2021, pp.44-46). Furthermore, issues in pharmaceutical procurement processes, such as lengthy procurement procedures, a lack of employee competency, and inadequate procurement planning, influence service delivery at health institutions such as Jimma University Specialized Hospital (Gadisa & Zhou, 2021, pp.117-118). Addressing these

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

Specifically, the effectiveness of rendering public service in Ethiopian health institutions is influenced by maternal age, educational levels of mothers and partners, household affluence, exposure to mass media, antenatal care visits, and contraceptive use (Gebrekrstos et al., 2023, p.8). Factors influencing the acceptance of delivery services include the mother's residency and the number of antenatal care visits (Tafere et al., 2023, p.11). Delivery of maternal satisfaction is influenced by factors such as education level, monthly income, prenatal care, fetal outcome, birth location, and admission duration (Argawu & Erena, 2023, p.6).

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

4.2. Health policy in Ethiopia

Ethiopia established modern medicine in the 16th century, with a focus on giving prompt primary healthcare to citizens injured in accidents. Later, in 1886, Swedish doctors served as medical staff in western Ethiopia, offering primary healthcare as charity work. Ethiopia adopted its first comprehensive health strategy in 1993, with a focus on democratization, decentralization, inter-sectoral collaboration, and the development of preventive and promotional healthcare components (Barnabas & Zwi, 1997, pp.12-15).

Ethiopia's health strategy includes establishing a national Health Technology Assessment (HTA) system, community-based health policies, maternal, newborn, and child health (MNCH) policies, and implementing private sector health policies in public hospitals. The country has underlined the significance of institutionalizing HTA and increasing national capability for HTA (Ararso, 2022, p.8). Furthermore, community-based health strategies have been implemented to improve primary health care in rural regions through grassroots mobilization (Tefera, 2022, p.5). While progress has been made in MNCH policies, there are persisting imbalances that must be

addressed to achieve health equity (Rono et al., 2022, p.73). Furthermore, the implementation of private-wing health programs confronts obstacles such as inadequate collaboration among units, emphasizing the need for greater policy formation procedures and coordination structures (Dessie & Getinet, 2023, pp.10-12).

This subtopic's primary goal is to provide answers to the following queries: What health policies does Ethiopia currently have in place? How have Ethiopia's health policies evolved over the past decade? Moreover, what challenges does Ethiopia face in implementing effective health policies?

Ethiopia is currently pursuing several health policies aimed at various elements of healthcare. The country has implemented innovative community-based health initiatives to improve basic health care at the grassroots level (Tefera, 2022). Efforts are being undertaken to enhance maternal, newborn, and child health (MNCH) through strategic frameworks and policies that prioritize equity (Rono et al., 2022). Other initiatives that emphasize multifaceted approaches and stakeholder involvement are designed to integrate mental health and substance abuse (MH/SA) services into primary care. (Gebremedhin et al., 2021). Public health measures, including promoting hand washing and social distancing, have been put into place in relation to the COVID-19 pandemic, especially in rural areas where resources may be few (Baye, 2020). These programs seek to improve health outcomes, reduce inequities, and strengthen Ethiopia's entire healthcare system.

Ethiopia's health policy has improved over the last decade, with a focus on maternal, newborn, and child health (MNCH) equity (Rono et al., 2022, pp.6-8). Adolescent and youth health (AYH) issues have been addressed, with initiatives focusing on SRH (Admassu et al., 2022, p.130). The country has also sought to incorporate comprehensive SRHR services into the UHC benefit package (Berhan et al., 2022, p.5). Furthermore, efforts have been made to build a national Health Technology Assessment (HTA) framework, highlighting the significance of HTA in health decision-making (Höstlund, 2022, pp.10-11; Ararso, 2022, p.8). To address the complex health needs of young people and advance equity in health policies for long-term development, more coordinated, evidence-based, and well-funded national solutions are required, notwithstanding these advancements. Even if Ethiopia has been showing robust progress in the past decades, the following challenges have been faced in the execution of formulated health policies: Challenges

such as gaps in digitalizing healthcare systems (Biru et al., 2022, p.78), insufficient training and supervision of health workers, particularly in non-communicable disease services (Tesema et al., 2022, p.6), and obstacles to implementing electronic community health information systems (e-CHIS) due to heavy workloads and limited resources (Namomsa, 2023, p.3). Potential solutions include strengthening ICT infrastructure, boosting health worker training quality, implementing supportive supervisory methods, streamlining performance reviews, and ensuring consistent supply and service availability (Tesfahun et al., 2023, p.12; Mengistu et al., 2021, p.4). In Ethiopia, effective policy implementation and healthcare system development require increased government commitment, resource allocation, capacity building, and community engagement.

Ethiopia's health strategy prioritizes enhancing access to healthcare and health outcomes in line with global equitable objectives. Geographic access to healthcare is a problem for the nation, especially in rural and low-income areas (Assebe & Norheim, 2023, p.5). Initiatives like the Ethiopian Essential Health Service Package (EHSP) have improved financial security and health equity (Nathaniel et al., 2023, p.7). There are still disparities, though, as common childhood illnesses are not evenly distributed throughout the nation, which affects service use (Daraje, 2023). While Ethiopian policies encourage equity in maternal, newborn, and child health (MNCH), interventions' implementation and monitoring might be improved (Defar, 2023, p.11). Ethiopia's emphasis on equity and access to healthcare stands out among low-income countries. However, more work is needed to reduce spatial disparities and ensure effective policy implementation for better health outcomes.

Ethiopia's healthcare system has serious issues with accessibility, affordability, and coverage. Donor contributions, CBHI, government aid, and out-of-pocket costs make up Ethiopia's health funding structure. All citizens do not automatically have the right to free health care under this tax-based system. Here are significant facts concerning Ethiopia's healthcare system: In Ethiopia, healthcare finance is generally derived from four sources: government spending (including taxes), out-of-pocket payments by people, external donors, and CBHI programs. Considerable contributions from donors, such as the World Bank, USAID, and the Global Fund, complement government subsidies for public medical services. In 2019, government spending on health as a proportion of GDP was approximately 3.3%, lower than the Sub-Saharan Africa average of 5% (World Bank, 2022). This shows that there are minimal domestic resources available for

health. OOP contributes to around 31% of financing, putting a strain on individuals, particularly in rural areas (WHO, 2021).

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

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

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

The amount paid out of pocket for medical services in Ethiopia varies depending on the kind of care received. Primary care services at government facilities are significantly subsidized or free for specific categories (e.g., children and pregnant women). However, more advanced services usually demand payment. CBHI members pay a yearly premium of roughly 240-360 ETB (about USD 2-3), whereas those who are not enrolled must fund the entire cost of care (Ministry of Health, Ethiopia, 2022).

In summary, Ethiopia's health care system does not provide universal free access to treatments and is not tax-funded. Instead, it depends on a combination of out-of-pocket expenses, community-based health insurance (CBHI), donor support, and government funding. Even while

some low-income groups now have better access thanks to CBHI, there are still significant obstacles in the way of attaining universal health coverage, particularly in rural areas.

4.2.1. Health Care reform In Ethiopia

Ethiopia has made healthcare reform a top priority in recent years. The government has strengthened its healthcare system in several ways. One approach is the expansion of primary healthcare, which has been hailed as a model in Sub-Saharan Africa (World Bank, 2019). Among this reform work in Ethiopia is the training and deployment of health extension workers, as well as the construction of health clinics and village-level health posts (World Bank, 2017). The Ethiopian government initiated this community-based healthcare reform implementation. This program has increased access to health care while decreasing out-of-pocket expenses. Nonetheless, obstacles remain, such as fragmented healthcare systems in public hospitals and limited effects on specific metrics of health system performance. Overall, the Ethiopian healthcare reform has improved access to care, but there is still potential for improvement. This section discusses the healthcare reforms implemented in Ethiopia under various regimes.

4.2.2. Pre-revolution, Haile Sellasie period to 1974

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

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

During Libne Dingel's rule, Ethiopia began to strengthen its links with the Portuguese, particularly with the entry of Portuguese envoys and missionaries. These exchanges created the framework for Western influence in Ethiopia, particularly in medicine and healthcare. The Portuguese dispatched medical missionaries, some of whom introduced early European medical procedures to the Ethiopian court. Although these early contacts did not result in widespread healthcare modernization during Libne Dingel's reign, they did mark the start of Ethiopia's engagement with Western medicine, which would grow significantly over centuries, particularly under later emperors such as Menelik II and Haile Selassie (Pankhurst, 1990).

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

The goal of the fourth Five-Year Plan (1974-78) was to formalize community contributions to developing health stations and clinics. However, due to the revolution that occurred during this period, the plan could not be implemented. Between the late 1960s and 1974, an estimated 15-20% of Ethiopia's population was served by basic basic health care (Kloos, 1998, p. 510).

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

the healthcare system was overburdened, and the population's access to adequate care remained limited (Kloos, 1998, p. 515).

4.2.3. Derg Regime (1974-1991)

Even though Ethiopia's national literacy drive raised health awareness and consumption of health services, family planning visits and rural health care remained low during this socialist rule. In Ethiopia, accessibility and affordability were significant hurdles to healthcare access, with high costs deterring a substantial proportion of sick people from seeking treatment. The worsening of primary healthcare facilities throughout the conflict resulted in poorer child immunization rates, tuberculosis cases, and child nutrition, while bureaucratic and authoritarian tendencies inhibited people's empowerment and participation (Kloos, 1998, p. 513).

4.2.4. Post Derg (EPRDEF)

Poor immunization rates and the need for repair and restoration resulted from the 1991 power outage that damaged Ethiopia's health facilities. Decentralization, collaborations with the private sector and non-governmental organizations, and reducing infant and under-5 mortality were given top priority in the new government's health policy. Future enhancements to the healthcare system will be made possible by Ethiopia's healthcare reform (Manyazewal & Matlakala, 2018). However, the closure of private clinics, bureaucratic bottlenecks, and a strained relationship between the government and non-governmental organizations hindered the health program's implementation.

Significant components of health care reform during the EPRDF regime were Equity, efficiency, quality, finance, and sustainability are all components of health sector reform that are essential in identifying and correcting problems within the health system in a way that policymakers can easily understand (Darling, 2010).

4.2.5. Current Regime (Prosperity Party)

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

The under-five mortality rate, or the chance of dying before turning five per 1000 live births, decreased from 123.2 in 2005 to 46.8 in 2019, according to World Bank data (World Bank, 2020). The likelihood of dying before becoming one year old per 1000 live births, or the infant mortality rate, decreased from 77.1 in 2005 to 29.5 in 2019 (World Bank, 2020). Even though they are still higher than the global standards of 38.6 and 28.8 in 2019, these are significant improvements. By combining data from multiple international organizations, such as WHO, UNICEF, the World Bank, the Global Burden of Diseases (GBD) study, and the nation's Demographic and Health Survey, the global norms for calculating mortality rates can be established.

Maternal education, birth order, birth interval, place of delivery, antenatal care, and immunization are some of Ethiopia's under-five mortality factors (Kitila et al., 2021, p.3). Ethiopia's government has launched several actions to minimize child mortality, including building health facilities, educating health professionals, encouraging community-based health services, and increasing immunization coverage (Indicators, 2019, p.10).

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

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

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

Less developed countries frequently focus on the content of health sector reform, risking equating it with specific measures such as market mechanisms, user charges, and public sector reduction while ignoring the feasibility of implementation, emphasizing the importance of

understanding reform processes alongside reform content for effective strategies and planning (WHO, 2000, p.9).

Ethiopia has been implementing a variety of healthcare changes to improve access and quality. Initiatives such as CBHI and the PHSP have sought to solve issues in the healthcare system (Zarepour et al., 2023; Israel et al., 2023). The implementation of mandatory Social Health Insurance (SHI) for formal sector employees is a suggested reform to increase healthcare access (Ali et al., 2022). Health insurance plans have been proven in studies to have a good influence on universal health coverage, lowering catastrophic health expenditures and enhancing health service quality (Bayked et al., 2023). Despite these efforts, difficulties like underfunding, high out-of-pocket payments, and variations in service quality continue (Debie et al., 2022). Ethiopia should think about growing national health insurance systems, fortifying public-private partnerships, and boosting funding to attain universal health coverage and enhance health care outcomes. Ethiopia's healthcare system has made improvements thanks to efforts such as CBHI and planned SHI, which target the informal and formal sectors, respectively. Despite the government's goal of covering 80% of the population, by 2021, 32.2 million people have enrolled in the CBHI program, which may represent around 36% of the overall population working in the unorganized sector.

This program is critical for persons in the informal economy, which includes non-government-regulated economic activity (EHIA, 2021). Due to its high cost and restricted availability, just about 4% of people have private health insurance (Debie et al., 2022). The informal sector encompasses economic operations that are unregulated by the government and frequently lack formal contracts or legal protections. Workers in this sector typically do not have access to benefits such as health insurance unless they participate in initiatives like CBHI.

4.3. Overview of health status in Ethiopia

Over the years, Ethiopia has made significant advancements in healthcare. Strong leadership and political commitment are evident in the nation's primary healthcare expansion plan, which was initiated in 2004 and includes the construction of numerous health facilities and the training of over 30,000 health extension workers (Croke, 2020). Moreover, the establishment of CBHI schemes and the projected SHI program for formal sector employees are intended to improve healthcare access and utilization (Zarepour et al., 2023).

Furthermore, public-private partnership has been critical in tackling public health priorities, with the Private Health Sector Programme emphasizing leadership, governance, access to pharmaceuticals, human resources, and funding in private health facilities (Ali et al., 2022). It has been demonstrated that the decentralization of health system responsibilities to local levels, along with effective governing boards, improves health centre performance in comparison to reform standards, highlighting the importance of continuous capacity building (Rono et al., 2022). Lastly, initiatives like the Primary Healthcare Transformation Initiative have demonstrated increases in managerial capability at the district and health centre levels, highlighting the significance of comprehensive instruction and mentoring in reform initiatives (Tefera, 2022).

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

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

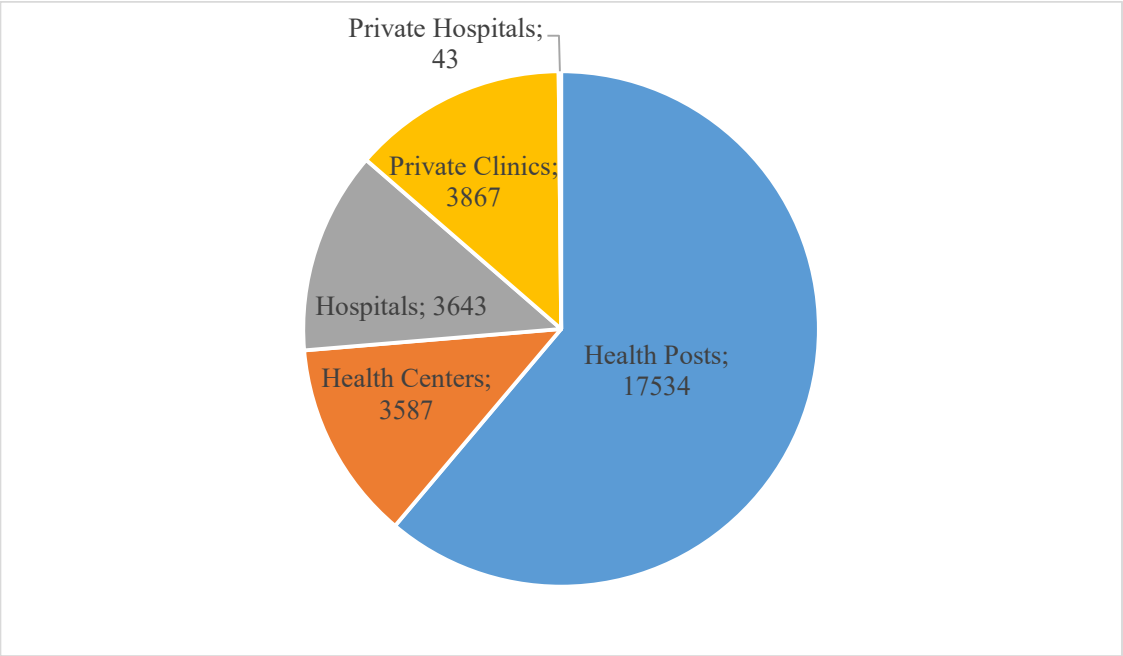


Fig4.1: Health care facilities available in Ethiopia
Source: Compiled by the Author (2024)

Ethiopia now has 89 health centres, 77 health posts, and 57 hospitals under construction. With seven hospitals, Ambo University Referral Hospital, Ambo General Hospital, Ginchi Hospital, Gedo Hospital, Guder Hospital, Jaldu Hospital, and Ejere Hospital, with a population of almost 2.5 million, West Shewa Zone (Federal Ministry of Health [FMOH], 2017). Ethiopia has limited access to affordable healthcare, especially in rural areas. The government is heavily dependent on outside funding and out-of-pocket medical expenses (OOPHE); around 34% of overall health spending comes from donor sources, and 31% comes from OOPHE (Alebachew et al., 2023, p.3). This implies that a significant section of the populace is responsible for covering their medical expenses, which can be extremely costly.

The average cost of primary healthcare per capita is much lower than the standard cost required to deliver high-quality services. For instance, the normative cost is determined to be $38.5, while the actual cost per capita ranges from $4.7 to $20.2 (Alebachew et al., 2023, pp. 5-6). This financial deficit raises the possibility that many people will find it difficult to pay for necessary medical care.

4.3.1. Plans I and II for the Transformation of the Health Sector

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

Building on the achievements of the HSTP-I phase (July 2015–June 2020), the HSTP-II 2020/21–2024/25 incorporates lessons learned after its execution. The Woreda Transformation, the Information Revolution, the Quality and Equity Transformation, and the Compassionate, Respectful, and Caring Health Workers agendas were the four transformation agendas that were put into practice during HSTP-I (Federal Ministry of Health [FMOH], 2020). The Health Sector Transformation Plan I in Ethiopia sought to improve the accuracy and utilization of Health Management Information System (HMIS) data at the point of service delivery. Key tactics included the Connected Woreda concept, capacity building, performance monitoring teams, and motivational rewards (Tilahun et al., 2022, p. S18). Improving equity in maternal, newborn, and child health (MNCH) policy was the plan's primary goal, with the Ethiopia Health Sector Transformation Plan (2016–2020) being the most comprehensive in addressing health equity issues (Rono et al., 2022 p.5). The plan also underlined the necessity of eliminating data falsification in healthcare facilities to enable accurate reporting and decision-making (Estifanos et al., 2022, p.4). Furthermore, the Private Health Sector Program (PHSP) worked with private facilities to strengthen the health system by addressing leadership, access to pharmaceuticals, human resources, service delivery, and financial issues (Ali et al., 2022). Overall, these programs sought to improve healthcare delivery, management methods, and performance across multiple levels of Ethiopia's health system.

HSTP I significantly improved the health of mothers and children. Ethiopia has achieved notable strides in lowering the rates of infant and maternal mortality. According to MOH (2020), Ethiopia's maternal mortality ratio (MMR) declined from 412 to 401 deaths per 100,000 live births between 2016 and 2020. Additionally, at the end of the plan, the under-five mortality rate has dropped from 67 deaths per 1,000 live births in 2016 to 55 (MoH, 2020). The leading causes of these improvements were improved access to prenatal care, skilled birth attendance, and vaccination campaigns.

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

Ethiopia has achieved great success in communicable disease control, specifically HIV, tuberculosis (TB), and malaria. The HIV prevalence rate stayed constant at 0.9%, but TB treatment success rates increased to 90% by 2020 (Federal Ministry of Health [FMOH], 2019). Malaria morbidity and fatality rates have also decreased due to increased availability of insecticide-treated bed nets and improved diagnostic services. A significant turning point in HSTP I was the creation and deployment of the District Health Information Software (DHIS-2) and electronic Health Management Information System (eHMIS). These technologies improved the quality of data and its application to service-level decision-making. Data accuracy improved, with report completion rates rising from 83% in 2016 to 94% by 2020, and data use in district and facility planning improved significantly (Teklegiorgis et al., 2014).

Health financing also made advances. The introduction and expansion of CBHI has helped lower payment at the time of falling sick, with enrollment increasing from 3.5 million in 2016 to 9.2 million by 2020 (MoH, 2020, p.27). This expansion helped low-income people get more financial protection and access to healthcare services.

4.4. Barriers to Healthcare Access in Ethiopia and the Role of the Transformation Plan

In Ethiopia, challenges to accessing healthcare services include limited spatial access, staffing shortages, inadequate infrastructure, and poor data quality (Derso et al., 2022; Hendrix et al., 2023; Tilahun et al., 2022). The country's Health Sector Transformation Plan seeks to solve these issues by emphasizing data quality and utilization at the point of care delivery through initiatives such as Connected Woreda, capacity building, and performance monitoring teams (Bogale et al., 2023). Furthermore, the plan stresses investments in new health facilities, staffing, and equitable expansion of the healthcare system to decrease gaps between rural and urban areas, with the ultimate objectives of improving healthcare facilities and lowering poverty (Tsegaye, 2022). To provide the public with higher-quality health services, the transformation strategy must include efforts to enhance data-use practices, boost capacity, and get past infrastructure limitations.

4.4.1. The challenges of HSTP I

Ethiopia's HSTP experienced several problems. One significant concern was the purposeful falsification of maternal and newborn health data by healthcare practitioners, which was driven by a system that promoted service quantity over accuracy (Tilahun et al., 2022, p. S12). Furthermore, the plan experienced challenges such as duplicate data gathering tools, insufficient health information system infrastructure, staffing shortages, and negative attitudes among health workers toward data (Estifanos et al., 2022). Additionally, Ethiopia's digitalization of health sectors—a crucial component of the transformation plan—was impeded by issues like inadequate ICT infrastructure, a lack of computer skills, budget constraints, and management concerns (Tsegaye et al., 2022). The complexity and diversity of Ethiopia's Health Sector Transformation Plan I challenges are reflected in these issues.

4.4.2. Elements of Health Sector Transformation plan I

Ethiopia's HSTP I aimed to advance the quality of Health management information system (HMIS) data and its application at the point of rendering health services. The Connected Woreda strategy, capacity building, performance monitoring teams, and motivational rewards were among

the key initiatives for improving data quality and utilization (Tilahun et al., 2022). Furthermore, the plan sought to address equity in Maternal, Newborn, and Child Health (MNCH) policies, highlighting Ethiopia's Health Sector Transformation Plan (2016–2020) for its high ranking in enforcing equity principles (Rano et al., 2022). Moreover, the plan acknowledged the significance of eliminating data falsification in maternal and newborn health (MNH) statistics by separating rewards and punishments based on normal HMIS data (Estifanos et al., 2022). Along with highlighting the nation's growing non-communicable disease (NCD) burden, the strategy set aggressive goals to reduce the prevalence of key risk factors like alcohol and tobacco use (Marquez et al., 2018).

The Health Policy and Systems Research Initiative (HTSP-I) identified important priorities related to the SDG. These priorities include increasing the utilization of healthcare through social security programs, encouraging cross-sectorial collaborations for health, and establishing more participatory and accountable institutions (Sachs & Sachs, 2021). The framework's convention on tobacco control is also essential for addressing the tobacco pandemic under SDG 3, emphasizing the value of multi-sectoral collaboration to bolster tobacco control efforts (Qiu, 2018). The geographic locations and income levels of nations are critical factors in the overall attainment of the SDGs, and the SDGs emphasize the importance of prioritizing and strengthening co-beneficial targets for successful attainment (Bennett, 2020). These priorities highlight the connections between social protection, health, and sustainable development within the framework of the SDGs.

As part of the Health Transformation and Social Protection Initiative (HTSP-I), Ethiopia has improved access to healthcare through social protection systems. Through the integration of community-based health insurance and health extension programs, this initiative has dramatically improved the delivery of health services, especially for vulnerable populations. CBHI was established in 2011 with the goal of reaching 80% of districts and people by 2020. It has mobilized community resources, improved access to health services, and provided financial protection, particularly empowering women (Mulat et al., 2022). Early pilots and strong political support facilitated its scale-up, demonstrating the importance of community engagement in health financing (Mulat et al., 2022).

Since 2003, the Health Extension Program (HEP) has significantly improved maternal and child health, communicable diseases, and health-seeking behaviours (Assefa et al., 2019). The

program adapts to community needs, enhancing local ownership and participation in health initiatives (Assefa et al., 2019). Despite achievements, there are still issues, such as health extension workers' (HEWP) productivity and health posts' capacity (Assefa et al., 2019).

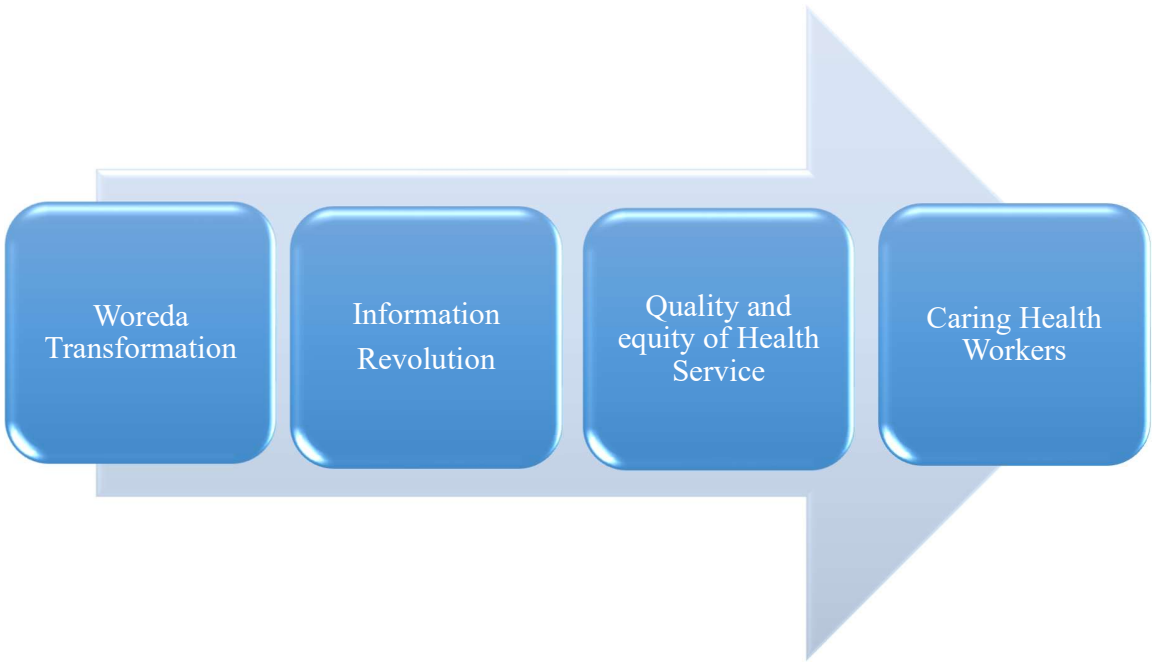


Fig 4.2: Four Priorities of HTSP-I
Compiled by Researcher (2024)

1. Woreda Transformation

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

Ethiopia's democratic representation is significantly impacted by the Prosperity Party's (PP) control over local and constituency-level government institutions. The concentration of power, which jeopardizes local autonomy and accountability, two essential components of successful democratic governance, is an example of this dominance. The PP's transition from a coalition to a more unified party structure has led to increased centralization, diminishing the autonomy of regional and local governments (Gemechu, 2023). Local governments often function as extensions

of the party rather than independent entities, limiting their ability to represent local interests (Fiseha, 2020) (Fessha & Debela, 2023). Local councils stifle grassroots representation because they lack actual authority and accountability and frequently put party interests ahead of community needs (Fiseha, 2020; Fessha & Debela, 2023). A new framework for local governance is required, with a focus on inclusive decision-making procedures to improve democratic representation (Fiseha, 2020). Ethiopia's Woreda Transformation plans centre on critical areas such as increasing competitiveness, improving resilience, decreasing vulnerabilities, and promoting long-term economic growth, all of which are in line with the country's development goals. These plans are part of Ethiopia's larger Growth and Transformation Plans (GTPs), which seek to promote innovation, infrastructure development, and poverty reduction (Kuriakose et al., 2016; Gizaw, 2017). The GTPs' emphasis on green and climate-resilient structural change demonstrates Ethiopia's commitment to sustainable development (Medhin & Mokonnen, 2019). Furthermore, infrastructure expenditures are critical to enabling economic growth and poverty reduction and have made significant contributions to Ethiopia's economic trajectory during the 1990s (Nuru, 2019). This study concentrated on local health facilities. Considering Ethiopia's healthcare system, on average, woreda has 20 health posts, one primary hospital, and four health centres.

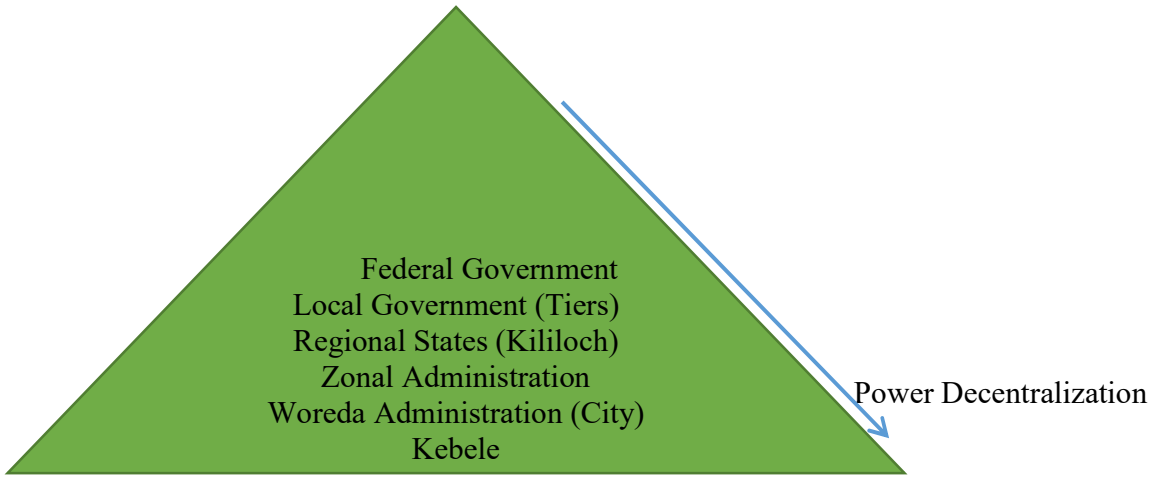


Fig4.3: Government Structure of EFDR
Source: Compiled by the researcher (2024)

In Ethiopia, zonal administration is the administrative system that connects the regional and district (woreda) levels. Zones are subregional subdivisions in charge of organizing and guaranteeing the implementation of regional government policies and directives at the woreda

level. Each zone is administered by a zonal council and administration, which oversees managing local public services like as health, education, and infrastructure (Bach, 2011).

A kebele is Ethiopia's lowest administrative unit, serving as a neighbourhood or village council. It oversees executing policies and programs at the grassroots level, as well as dealing with local governance concerns like community mobilization, basic service delivery, and local security (Vaughan & Tronvoll, 2003). Kebele administrations are crucial in facilitating communication between the general populace and higher governmental levels.

The Ethiopian decentralized system makes the woreda central to development efforts. According to regional state constitutions, woredas are governed by locally elected governance structures and district councils. Planning, allocating resources, carrying out, and overseeing and assessing primary health care services, as well as other social services, are their primary duties. Woreda is the most comprehensive political and administrative unit accountable for the delivery of fundamental social services, including health services. That is why woreda transformation was included as part of HSTP.

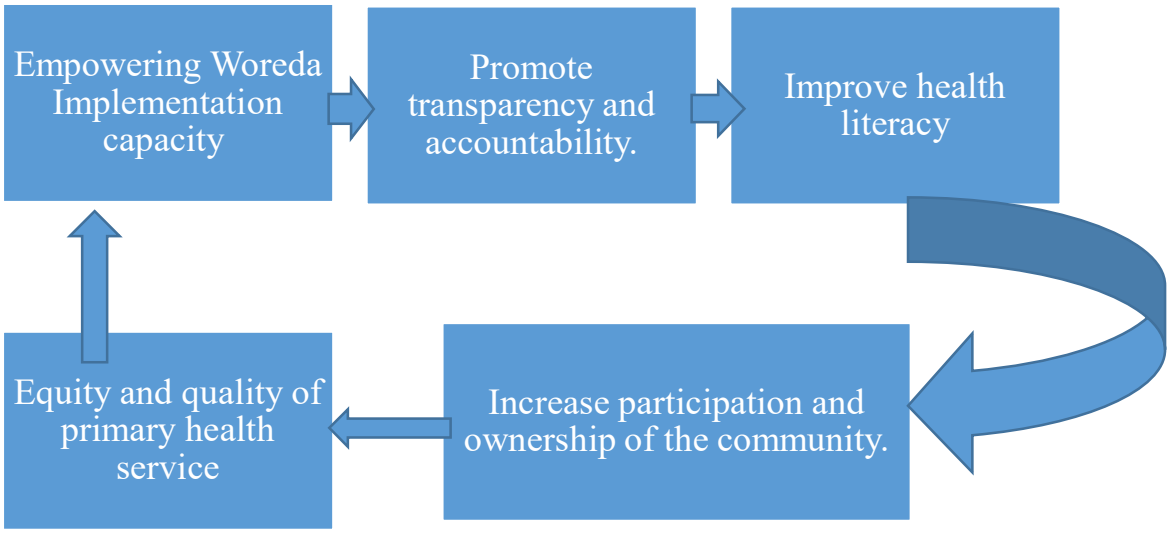


Fig4.4: Objectives of Woreda transformational
Source: compiled by the researcher (2024)

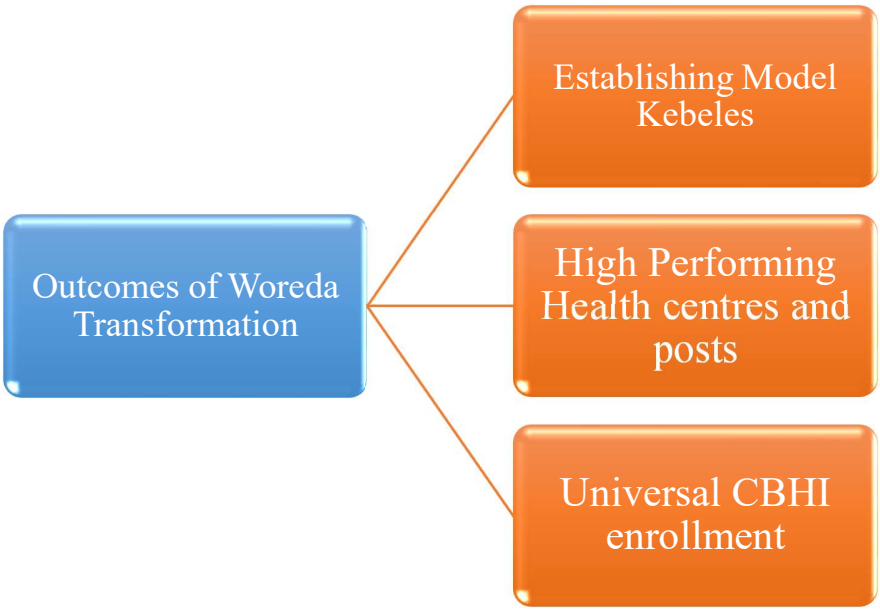


Fig4.5: Consequences of woreda Transformation
Source: Compiled by the researcher (2024)

i. Model Kebeles

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

The scale-up plan promotes women's participation in the health development army (HAD), which has increased the construction of model families at the kebele stage while also addressing training and implementation shortages. The main criteria used for selecting this model kebeles are

that more than 85% of the households in the community have achieved model family status, home delivery-free kebeles, open defection-free kebele and complete coverage of CBHI.

In Ethiopia, a kebele is the lowest administrative unit that operates at the local level. Kebeles are essential local governance organisations in charge of carrying out government policies and programs, such as those pertaining to development, education, and health. They are essential in addressing local problems and encouraging community involvement. By enabling grassroots participation in decision-making, the kebele system gives communities a say in how they are governed. It is easier for local leaders to interact with residents and promote programs like the Health Development Army (HDA) and the model family concept, which aim to improve health outcomes because each kebele is usually composed of multiple neighbourhoods or groups of households (Ethiopian Ministry of Health [MoH], 2018, p. 22)

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

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

Table4.1. Woreda Transformation Indicators and measurements

Source: Compiled by the researcher from MOH (2018)

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

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

Table4.2. Woredas Transformation performance

Source: Compiled by the researcher from MOH (2017)

ii. Establishing high performing PHCUs

Primary Health Care Units (PHCUs) are established at the woreda level to ensure that communities have access to a basic range of healthcare services. Each PHCU is composed of a health centre and associated health posts with the aim of offering complete primary health services to meet the needs of the local population (Admasu, 2016). With an emphasis on attaining high satisfaction within the served populations, these units aim to enhance community participation in health efforts in addition to providing vital health services (Erku et al., 2023).

iii. Community Bbased Health Insurance

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

CBHI is a volunteer initiative in Ethiopia designed to improve healthcare affordability and accessibility (Daraje, 2022). Families must pay for healthcare services, and the government is considering making SHI for workers in the formal sector mandatory (Zarepour et al., 2023). By promoting risk-sharing between affluent and underprivileged households, CBHI lowers the cost of healthcare (Getahun et al., 2023). Age, educational attainment, land ownership, and scheme awareness all affect CBHI utilization (Belayneh & Tamiru, 2025, p5). CBHI is more affordable for low-income individuals since, in contrast to traditional models, it places a higher priority on cost-sharing, community involvement, and risk-sharing (Zepre, 2023). The success of the plan hinges on factors like home contentment, comprehension of the advantages of CBHI, and backing for the initiative's management.

As part of Ethiopia’s efforts to achieve universal health coverage, the CBHI scheme intends to offer cheap health care to most Ethiopians who work in the informal sector. Nearly every district in the nation is now covered by the program, which charges a nominal premium to members in

exchange for a notable rise in medical consultations. CBHI beneficiaries are served by a vast number of hospitals and health centres under contract; some of these institutions collaborate with outside suppliers to guarantee the supply of necessary medications (World Health Organization [WHO], 2022).

Ethiopia is getting closer to attaining universal health care by implementing a community-based health insurance program to protect its citizens from monetary hardship and ensure access to necessary services without pushing them into poverty. To guarantee the effective execution of the CBHI program in the country, the Ministry of Health and EHIS have received assistance and training from the WHO (WHO, 2022).

Policies and laws have a significant influence on how CBHI systems are developed and run in Ethiopia. To address the low health-seeking behaviour observed in rural areas, the government implemented voluntary CBHI (Zarepour et al., 2023; Daraje, 2022). Increased coverage and improved healthcare utilization are the goals of policies like the Social Health Insurance (SHI) program that are required for workers in the formal sector (Getahun et al., 2023). Studies indicate that being a part of the CBHI positively influences the behaviour of people seeking medical attention, especially those from vulnerable households, encouraging them to use healthcare facilities (Mussa et al., 2023). These rules aim to ensure fair access to healthcare, reduce out-of-pocket costs, and help Ethiopia meet its goals for universal health coverage (Tefera & Ayele, 2022). These steps can enhance CBHI support and improve health outcomes by proactively integrating private healthcare facilities and addressing quality issues in public facilities. In addition, there is resistance to the introduction of a SHI program for workers in the formal sector because of worries about the affordability of premiums and the restricted coverage provided by contracted institutions. Efforts aimed at increasing awareness, improving service quality (including that of private healthcare providers), and addressing the concerns of different income levels should be made to generate broader acceptance and support for these initiatives to increase sustainability and scalability.

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

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

Ethiopia has improved the health of its people in significant ways. Despite limited implementation capacity, low enrolment in CBHI, shortages and insufficient distribution of personnel, and lack thereof, performance gaps across states, woredas, and health infrastructures make it difficult to provide equitable and quality basic health services for all segments of the community (MoH, 2017).

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

Ethiopia's per capita health service consumption in 2017 was 0.48 visits annually, well below the World Health Organization's target of 2.5 visits annually due to user fees or high out-of-pocket medical expenses. In 2008, the Ethiopian government unveiled a new Health Care Financing Strategy (HCFS) based on other nations' experiences and backed by important partners like USAID and the ABT Association. SHI, a payroll-based, mandatory program for government and private sector workers that has not yet been implemented, and CBHI, which is intended for people in the informal sector and has been in place since 2013, are the two forms of health insurance that are part of this strategy. The main aim of introducing this new HCF is to mobilize revenue and protect vulnerable groups in the community from catastrophic health expenditures. Within this

reform, Ethiopia is planning to achieve universal health coverage (UHC). According to USAID (2017), by guaranteeing fair access to medical care and offering financial risk protection, nations can take steps toward attaining Universal Health Coverage (UHC). This means that everybody, regardless of their level of income, is freed from financial catastrophic spending while getting medical services. The CBHI scale-up significantly increased the quality of modern healthcare services and reduced disparities in utilization across wealth status and family size (Geta et al., 2023). The execution of CBHI is a vital part of the Woreda transformation, increasing enrolment, having a transparent and easily understood process, and ensuring the financial and institutional sustainability of the scheme (Ministry of Health [MoH], 2017).

Priorities of HSTP-II

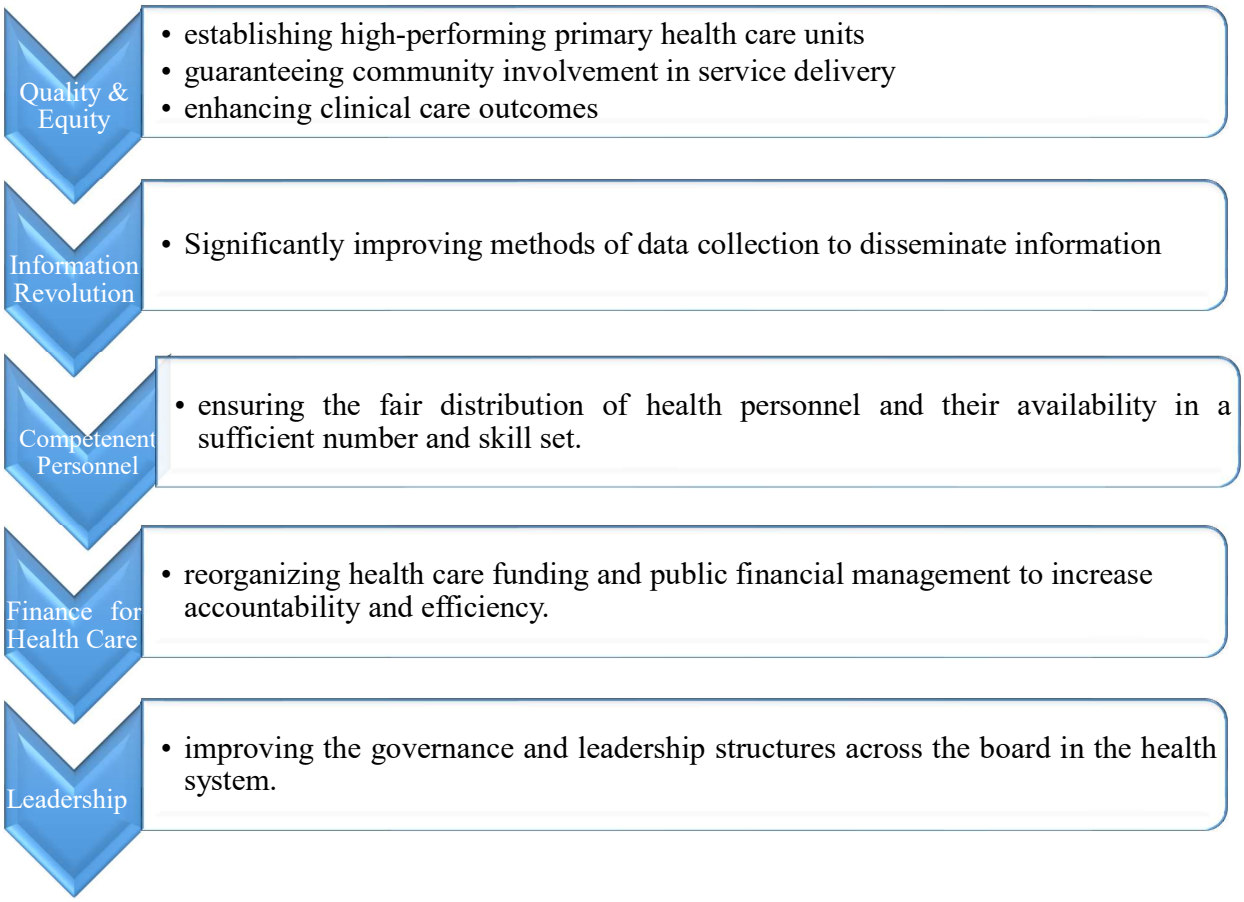


Fig4.6: Elements of HSTP-II Source

Compiled by the researcher (2024)

4.4.4. Impact of CBHI Adoption on the Effectiveness of HSTP-II

The implementation of CBHI significantly advances the goals of Ethiopia's Health Sector Transformation Plan II. According to studies conducted in Ethiopia and Vietnam, membership in the CBHI enhances health outcomes, reduces financial stress, and boosts health service utilization. Compared to non-members, CBHI members in Ethiopia reported fewer catastrophic health expenditures, fewer out-of-pocket costs, and more frequent outpatient visits (Alemayehu et al., 2023; Edosa et al., 2023; Pardoel et al., 2023). Similarly, in Vietnam, the establishment of Intergenerational Self-Help Clubs (ISHCs) resulted in improved health outcomes and high member satisfaction, demonstrating the beneficial effect of community-based support for promoting wellness (Alemayehu et al., 2023). Those findings imply that combining CBHI and community-based support models can improve the efficacy of health sector transformation initiatives by encouraging healthcare consumption and financial risk management.

Implementing CBHI coincides with the goals of HSTP (II) by improving health outcomes and lowering healthcare expenditures (Eze 20203; Ntube, 2023; Kassa, 2023; Mussa et al., 2023; Edosa et al., 2023). In low- and middle-income nations, CBHI programs reduce out-of-pocket and catastrophic medical expenses, so reducing financial risk while simultaneously increasing healthcare use, especially for outpatient treatments. CBHI enrolment also improves the use of curative care and health professional services, which helps to attain UHC and health equity. Additionally, households with insurance have a higher likelihood of utilizing contemporary health services, indicating a reduction in disparities and improved access to medical care. Therefore, CBHI supports the objective of enhancing health outcomes while reducing healthcare costs by promoting healthcare utilization and financial protection.

4.4.5. Best Practices for CBHI Implementation under HSTP-II

CBHI programs have demonstrated potential for providing inexpensive and accessible healthcare to underserved communities in low- and middle-income nations. Several approaches, including cooperative healthcare (CH) (Eze et al., 2023), have proven effective in boosting healthcare utilization and financial risk protection (Edosa et al., 2023). Studies in Ethiopia have shown that CBHI has a positive influence on lowering gaps in contemporary health service

consumption among families (Hsiao & Yip, 2024). Furthermore, research in South Central Ethiopia shows that households are willing to enrol on CBHI schemes, highlighting the significance of modifying contribution amounts to ensure affordability (Kaso et al., 2022). According to a study done in Addis Ababa, community-based health insurance, or CBHI, had a favourable impact on people's decisions to seek medical attention. Living conditions and family size were found to be essential factors in this. According to Getahun et al. (2024), these results imply that CBHI initiatives can contribute to bettering underprivileged communities' access to healthcare in low- and middle-income nations.

Designing and executing successful community-based health insurance (CBHI) programs necessitates careful consideration of a variety of issues. For starters, significant national support is required to secure funds and ensure long-term viability (Donessouné et al., 2023). Second, incorporating CBHI into existing organizational systems and aligning aims with host structures is critical to long-term success (Namyalo et al., 2023). Addressing financial difficulties, such as insufficient reserves and reinsurance, is crucial for financial viability (Kakama et al., 2022; Hussien et al., 2022). Educating and engaging communities through door-to-door visits and promotional programs can increase population coverage while also combating difficulties such as adverse selection and moral hazards (Nurnabi et al., 2022). The long-term sustainability and fairness of CBHI programs can be significantly increased by involving community leaders in their design and execution while honouring regional customs, values, and social norms.

4.4.6. Challenges and Constraints of CBHI Implementation in Achieving HSTP-II Objectives

Several obstacles prevent Ethiopia's community-based health insurance (CBHI) program from achieving the objectives outlined in the Health Sector Transformation Plan II (HSTP-II). These include low enrollment brought on by a lack of public awareness, budgetary limitations, and discontent with the standard of medical care (Gutama, 2023). Financial viability is a major worry, with schemes reporting negative net income and substantial losses, limiting their ability to protect members against out-of-pocket payments (Tefera & Ayele, 2022). Moral risk, unfavourable selection, and insufficient population coverage behaviours all complicate CBHI implementation (Sheikh et al., 2022). Furthermore, impediments such as inadequate ICT infrastructure, a lack of computer skills, financial constraints, and management styles impede the successful integration of

ICT into the Ethiopian healthcare system, hurting CBHI operations (Hussien et al., 2022). Addressing these problems is critical for CBHI to effectively contribute to meeting the Health Sector Transformation Plan II objectives.

The government and stakeholders should give priority to several crucial methods to increase the efficacy and sustainability of Ethiopia's community-based health insurance (CBHI) programs. To begin, addressing poor health-seeking behaviour among formal sector employees by enhancing healthcare quality and aggressively incorporating private health facilities into the system is critical (Daraje, 2022). Second, improving beneficiary satisfaction through higher service quality and coverage can enhance overall plan performance (Bayked et al., 2023). Furthermore, measures to increase household awareness of CBHI advantages, encourage role modelling for rural health extension programs and assure the availability of prescribed medications are critical for boosting scheme satisfaction and sustainability (Zarepour et al., 2023). One important way to support the long-term success of CBHI in Ethiopia is by ensuring that premium structures are fair and affordable while also building trust so that people are more willing to pay. Just as crucial is the active participation of different stakeholders, from local communities to government agencies, since their involvement plays a key role in making the program both effective and sustainable. CBHI in Ethiopia is dependent on stakeholders for their sustainability (Daraje, 2022; Getahun et al., 2023). Increasing household knowledge of the CBHI program, helping them act as role models for rural health extension programs, and ensuring the fulfilment of the CBHI promised package are ways to boost their engagement (Geta et al., 2023). Moreover, enhancing the financial viability of CBHI schemes requires addressing problems such as moral hazard behaviours, medicine shortages, adverse selection, delays in service provider claims payment, and low insurance premiums (Zepre, 2023). The CBHI plan should be improved, with a focus on the location and educational attainment of households, to advance the use of contemporary medical facilities and eradicate disparities (Mohammed et al., 2022). To surmount financial barriers and improve the healthcare-seeking behaviour of households involved in CBHI schemes, stakeholders must work together.

4.5. Impact of International Organizations on Healthcare Reform and Policy in Ethiopia

International organizations and foreign aid have a considerable impact on healthcare reform policies and practices in Ethiopia (Vernaelde, 2022; Teshome & Hoebink, 2018; Disha et al., 2022; Le Mat, 2020). For example, the United States government has been a significant donor to Ethiopia's healthcare sector, particularly in sexual and reproductive health (Heyi, 2022). The Private Health Sector Program (PHSP), backed by USAID, has helped bring the public and private sectors together to tackle a range of health issues across Ethiopia. By doing so, it has contributed to improvements in different areas of the health system, such as leadership, access to medication, staffing, and how services are delivered. Furthermore, the quality of primary healthcare services in Ethiopia has improved because of the implementation of performance management innovations, as demonstrated by programs like USAID's Transform: Primary Health Care project.

International organizations have greatly influenced Ethiopian healthcare changes and regulations. USAID-funded Private Health Sector Program (PHSP) has played a significant role in fostering public-private partnerships that aim to advance public health goals while fortifying governance, leadership, and service delivery systems (Ali et al., 2022). Furthermore, the United States' Global Gag Rule influences Ethiopian sexual and reproductive health services, hurting non-governmental organizations and service delivery (Kebede et al., 2023). Moreover, initiatives implemented by the Federal Ministry of Health in collaboration with international partners have incorporated Integrating mental health and drug addiction services into primary care, leading to enhanced service quality and better health outcomes (Vernaelde, 2022). Collaborations like these have clearly influenced how healthcare is practised and shaped in Ethiopia affecting everything from policies to everyday services. They also underscore how vital long-term partnerships with international organizations are when it comes to reaching meaningful public health goals.

4.6. Stakeholders involved in the CBHI in Ethiopia

In Ethiopia, governing boards, families, and healthcare practitioners are usually the prominent participants in CBHI initiatives (Daraje, 2023; Zepre, 2023). As CBHI scheme participants, households are vital, and their satisfaction levels have a direct bearing on the program's performance (Belayneh, 2023; Asfaw et al., 2023). Healthcare providers are essential in

implementing the services offered through the CBHI scheme and have a direct influence on the standard of care that beneficiaries receive" (Bayked et al., 2023). At the same time, governing boards play a key role in guiding how CBHI programs are managed and how important decisions are made. Their involvement helps ensure that operations are carried out transparently and responsibly, fostering trust among beneficiaries and supporting the smooth and sustainable functioning of the program. Through collaboration, these stakeholders contribute significantly to the overall success of CBHI programs in Ethiopia. Their collective efforts help more people gain access to the healthcare they need while also reducing the financial strain that frequently accompanies medical expenses. The key stakeholders involved in Ethiopia's community-based health insurance (CBHI) system include:

1. Government: The Ethiopian government plays a key role in the implementation of CBHI by offering policy guidance, regulatory oversight, and, at times, financial support. Government bodies such as the Ministry of Health are responsible for designing and implementing strategies aimed at increasing health insurance coverage across the country.
2. Community Members (CBHI members): One of the main CBHI stakeholders is the community itself. They take part in the planning, execution, and administration of CBHI programs. In addition to making monetary contributions through premiums, community members frequently donate their time to help with the scheme's management.
3. Healthcare Providers: Clinics, hospitals, and other healthcare establishments are crucial CBHI stakeholders. They supply enrolled members with healthcare services, and the CBHI schemes reimburse them for those services. Practical cooperation between healthcare providers and CBHI initiatives is essential for their success.
4. Non-Governmental Organizations (NGOs): NGOs are frequently helpful in putting CBHI into practice. For community-based organizations and government agencies taking part in CBHI projects might offer financial support, technical help, and capacity building.
5. International Development Partners: To support the creation and execution of CBHI programs in Ethiopia, the World Bank, World Health Organization and bilateral aid agencies may offer money, technical help, and experience.
6. Research Institutions: To improve program efficacy, inform policy decisions, and produce evidence-based recommendations for scaling up CBHI projects, academic and research institutions participate in CBHI by conducting studies, evaluations, and assessments.

7. Insurance Companies: Private insurance providers may occasionally participate in CBHI programs by offering their technical know-how in insurance administration private management. In Ethiopia, private insurance firms may participate in Community-Based Health Insurance (CBHI) initiatives, frequently by offering important technical assistance in fields such as insurance management and administration. Particularly in putting in place efficient financial management systems and guaranteeing effective premium collection and claims processing, this collaboration can support the CBHI programs (Worku, 2023).
8. Civil Society Organizations (CSOs): CSOs can represent marginalized groups' and vulnerable populations' interests during the planning and execution of CBHI programs. To encourage enrolment and involvement in CBHI programs, they could also take part in community mobilization and awareness-raising initiatives.
9. Financial Institutions (Payor): Payers oversee enrolling patients as beneficiaries and carrying out the policy framework's financial components. Payers purchase medical services from providers on behalf of these beneficiaries. They are also actuarially responsible for guaranteeing the healthcare program's economic viability. Policymakers receive their reports from them. It entails the analysis and compilation of data on healthcare expenses, service utilization, and program performance by payers, including insurance companies and financial entities. These studies help policymakers understand the present status of healthcare programs, including areas that require improvement, access to care, and financial sustainability. By consistently providing this data, payers encourage strategic planning and evidence-based policy modifications, assisting in the development of future health policies that can better serve the requirements of the populace, increase cost-effectiveness, and improve health outcomes.

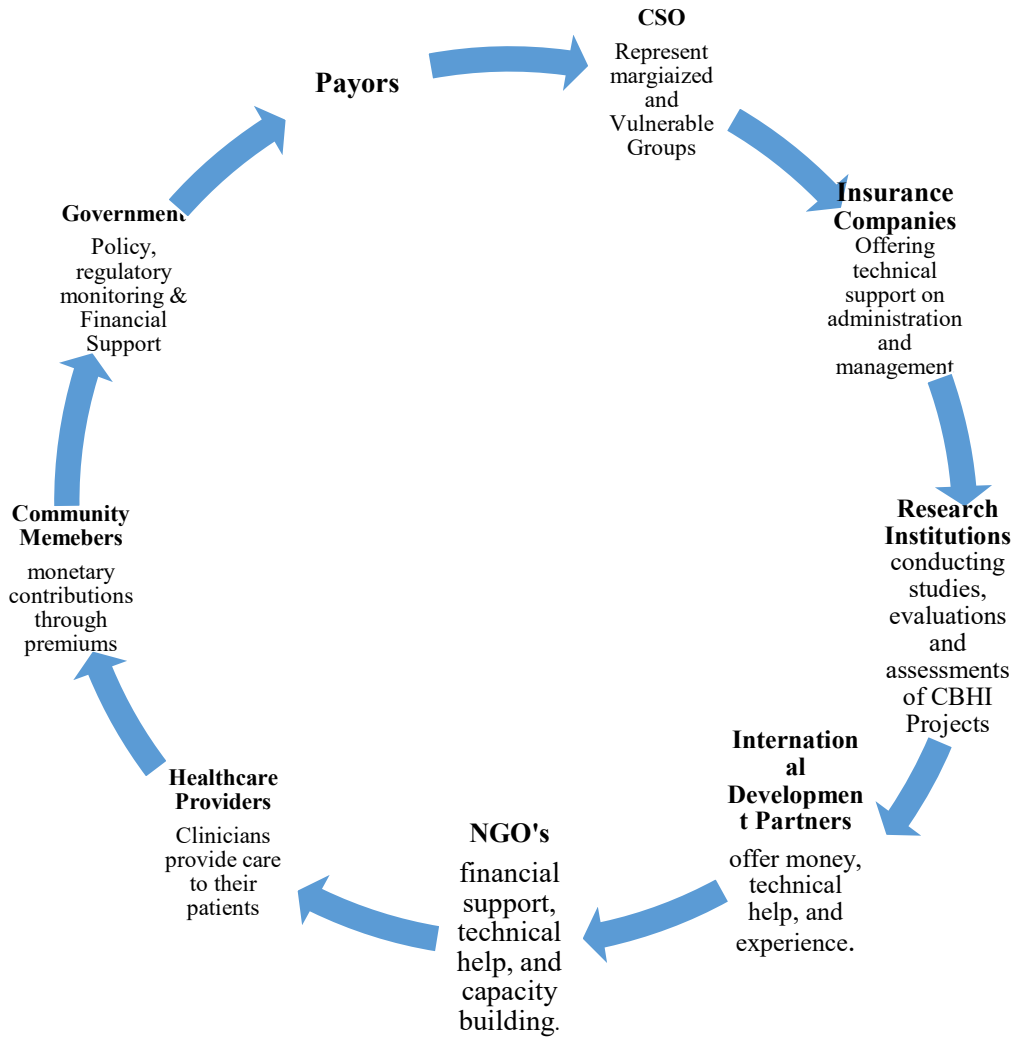


Fig4.7: Stakeholders Involved in the Ethiopian CBHI

4.6.1. The role of CBHI stakeholders

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

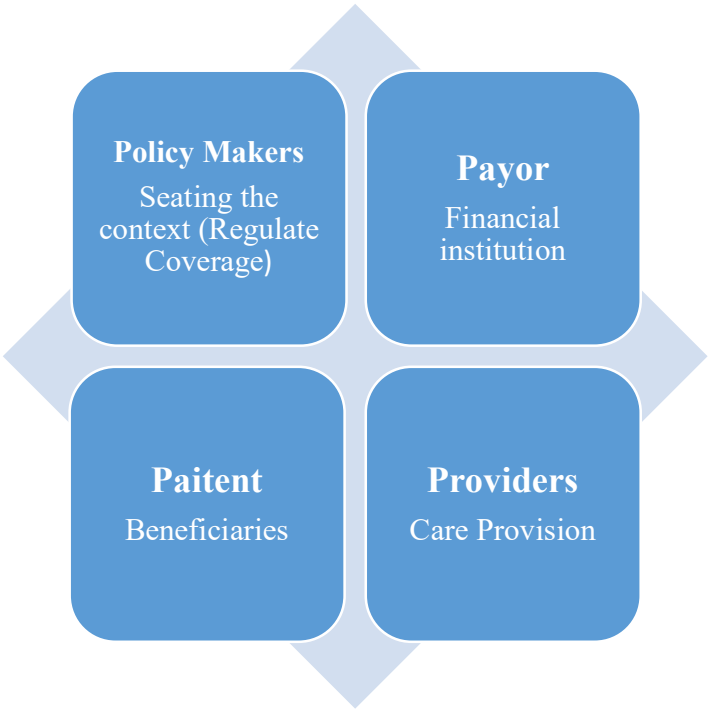


Fig4.8: The relationship between the 4ps of CBHI
Source: Adopted from Data (2014)

4.6.2. Policy Makers (Federal ministry of health)

Policymakers create the framework within which the health care system operates. They adhere to these policies, which regulate the behaviour of payors and providers. Ideally, the policies are designed to maximize population health within the constraints of the country's finances and resources. The following diagram shows the relationship between the primary stakeholders of CBHI from the perspective of policymakers.

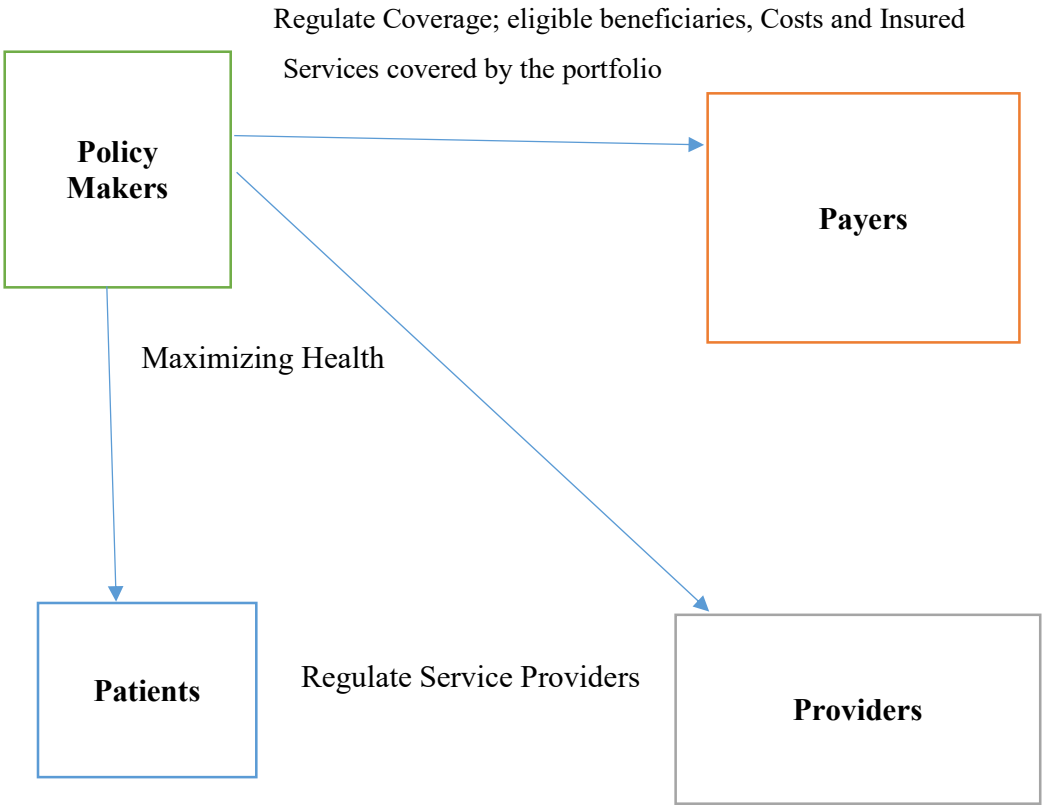


Fig4.9: The relationship between primary stakeholders in health insurance from Policy maker's perspectives
Source: Compiled by the researcher (2024)

As shown in the above fig4.9, Payers and policymakers, like the Ethiopian Health Insurance Service, have a cooperative and regulated relationship. Legislators create rules and policies that specify the extent of coverage, including the covered healthcare services that must be provided, service fees, and qualified beneficiaries to ensure that beneficiaries receive the services to which they are entitled at predetermined, reasonable rates, payers, in turn, implement these guidelines when overseeing health insurance coverage. A more cohesive system that supports the nation's larger health priorities while striking a balance between reliable service delivery and long-term financial viability is made possible by this concerted effort.

Maximizing health outcomes and guaranteeing fair access to healthcare services are the main goals of the partnership between patients (users) and policymakers, such as the Ethiopian Health Insurance Service: to improve population health and well-being, policymakers create frameworks and policies that put patients' needs first. This entails establishing eligibility requirements, choosing benefit plans, and making sure that everyone can access and afford healthcare services. Policymakers govern service delivery with respect to providers (hospitals)

through agreements they have made with these organizations. By following this rule, hospitals are guaranteed to provide the services that were agreed upon, uphold quality standards, and stay within the budgetary parameters specified in their contracts. To ensure that patients receive the care they need while effectively allocating funds and resources, policymakers monitor performance and compliance to maintain the integrity of the healthcare system. Ultimately, the overall sustainability and effectiveness of Ethiopia's healthcare system are supported by this triadic link.

4.7. Insured Service Covered by CBHI in Ethiopia

At the health centre level, CBHI typically provides fundamental health service packages. The coverage covers both inpatient and outpatient services. CBHI schemes cover all kinds of necessary medical services that would be paid for out of pocket in the event of illness (Ethiopia Scales Up CBHI | HFG, n.d.).

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

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

7. **Essential Medicines**: A lot of CBHI plans cover essential medicines, guaranteeing that participants have access to the drugs they need to address a range of illnesses.
8. **Emergency Care**: Ambulance services, ER visits, and urgent care may all be covered under this type of coverage.
9. **Rehabilitation Services**: For people recuperating from injuries or managing chronic ailments, coverage.
10. **Mental health treatments**: A few CBHI plans cover psychiatric drugs, psychotherapy, and counselling, among other mental health treatments.

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

Cosmetic procedures: Plastic surgery and other elective cosmetic procedures are typically not covered because they are primarily performed for aesthetic reasons.

Non-essential therapies: You might not be paid for services or treatments regarded as experimental or exploratory or not judged medically necessary.

Expensive treatments: Certain CBHI plans may restrict coverage of costly procedures or treatments that cost more than a predetermined amount.

Pre-existing conditions: Certain plans may not cover pre-existing conditions for a set amount of time following enrolment.

Alternative medicine: Some services, like homoeopathy or acupuncture, may not be covered because they are classified as complementary or alternative medicine.

Over-the-counter medications without a prescription: Some OTC medications may not be covered.

Long-term care: Long-term care and nursing home care services may not be covered by CBHI insurance.

Dental and vision care: more comprehensive or specialist services might not be covered, but certain fundamental dental and vision care services might (Teklehaimanot et al., 2016).

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

Community-based health insurance (CBHI) programs are currently the primary source of funding for medical treatment in many developing countries. Donations from social insurance groups or general tax revenue frequently finance these initiatives (Carrin, 2003). The CBHI program was established in Ethiopia as a community-based health project that collects member fees into a fund to pay for essential medical expenses. As a result, members have access to nearby medical facilities whenever they become ill (Ethiopia Scales Up Community-Based Health Insurance | HFG, n.d.).

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

4.9. USA Health care Insurance model Vis-à-vis Ethiopian CBHI model

Ethiopian and American healthcare systems differ significantly from one another. Ethiopia's Community-Based Health Insurance (CBHI) program aims to make health care more accessible, lower out-of-pocket costs, raise funds and raise the standard of care (Tefera et al., 2021; Shigute et al., 2020). Without significantly increasing wait times, the CBHI program in Ethiopia has demonstrated favourable effects on outpatient visits, patient satisfaction, quality of care, and health facility revenues (Shigute et al., 2020). However, the United States has multiple healthcare systems that cater to various demographic groups rather than one. Although most Americans have private health insurance, seniors, some people with disabilities, and members of the low-income and near-poor populations can obtain coverage through Medicare and Medicaid, two critical federal programs. About 10% of Americans do not have health insurance, which is a remarkably high

percentage when compared to other high-income nations, even though coverage has dramatically expanded since the Affordable Care Act was passed in 2014, bringing the uninsured rate down from 17% (Rice et al., 2020). In contrast to the diversified and multi-payer system in the US, the Ethiopian CBHI program places a strong emphasis on community engagement, financial security, and improving the standard of medical care. The researcher used funding mechanisms, scheme contents/health service coverage, scheme management/administration equity, accessibility, challenges, and opportunities as yardsticks to compare the USA health insurance model with the Ethiopian CBHI model.

1. Source of Finance for health coverage

USA Model: The primary sources of funding for healthcare in the US are out-of-pocket expenses, employer-sponsored insurance, government initiatives like Medicare and Medicaid, as well as private health coverage. The Affordable Care Act (ACA) made insurance much more accessible by expanding Medicaid eligibility and establishing health insurance exchanges, even if it did not create a universal healthcare system (Davis et al., 2014). Enacted in March 2010, the Affordable Treatment Act (ACA), also referred to as Obamacare, aims to lower healthcare costs in the US, improve treatment quality, and increase access to healthcare. By 2014, many of the ACA's key provisions had taken effect, fundamentally changing the US healthcare system (Duston, 2016). By the end of 2014, the number of Americans with health insurance had increased significantly. Medicaid expansion and the health insurance markets helped an estimated ten million people get coverage (Garfield et al., 2019). The Affordable Care Act also improved health outcomes by reducing the number of people without insurance and increasing access to preventive care. **Ethiopian CBHI:** The nation's healthcare system primarily relies on out-of-pocket expenses because a sizable portion of the populace lacks access to formal health insurance. A sizable section of Ethiopia's population, according to current estimates, does not have access to government health insurance. As of 2020, about 86% of Ethiopians lacked health insurance, according to the Ethiopian Health Insurance Agency. This indicates that most healthcare treatments for around 90 million Ethiopians were paid for out of pocket. By combining resources from member contributions and, in certain situations, additional government funding, the programs seek to offer financial security (Federal Ministry of Health [FMOH], 2016a).

Ethiopia's CBHI programs have considerably decreased the proportion of the population without medical insurance, albeit the results may vary depending on the region and demographic conditions. Although it can be challenging to determine specific numbers about the percentage decrease in uninsured rates brought on by CBHI, the following important elements shed light on how successful these initiatives are:

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

Concerning the decrease in uncertain rates Before CBHI, almost 86% of Ethiopians did not have health insurance. The percentage of people without insurance has dropped by roughly 10% to 12% since the implementation of CBHI, particularly in rural regions, as CBHI programs gained popularity (World Bank, 2017). Compared to households without insurance, insured households are four times more likely to use contemporary health services (Geta et al., 2023). CBHI members reported an average of 2.09 outpatient visits per capita annually, significantly higher than non-members (Alemayehu et al., 2023). The overall CBHI enrollment in Ethiopia stands at approximately 45.5%, with rural areas showing higher engagement (Tahir et al., 2022; Habte et al., 2022).

1. The Scheme Contents

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

Ethiopian CBHI: Primary care, maternity and child health services, and certain outpatient services are among the fundamental healthcare services that are usually the focus of CBHI programs in Ethiopia. Depending on the scheme and its resources, coverage may change (Federal Ministry of Health [FMOH], 2016a). Financial resources, administrative effectiveness, community involvement, policy support, and the makeup of the covered population are some of the interrelated

factors that affect CBHI coverage in Ethiopia (The scheme depends on). For Ethiopia's rural and low-income inhabitants to have complete health coverage and financial security, these areas must be strengthened to increase the extent and calibre of CBHI services.

2. Scheme Management/Administration equity

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

Ethiopian CBHI: Community-based health initiative programs in Ethiopia are often run by regional associations or cooperatives. Volunteers from the community may assist with administration, with assistance from NGOs and government organizations. The administration of the program oversees payments to healthcare providers (Federal Ministry of Health [FMOH], 2016a).

3. Equity and accessibility of health services

USA Model: Several factors, including insurance coverage, income, geography, and institutional disparities, affect access to healthcare in the United States. Inequalities in health outcomes and access continue, especially for marginalized communities (Baciu et al., 2017). Socioeconomic barriers and racial minorities are the two major factors contributing to institutional disparities. Institutional inequities have a significant impact on access to healthcare in the United States, especially for low-income and racial minority communities. Socioeconomic position, health insurance coverage, and institutional racism are some of the systemic barriers that contribute to these discrepancies and prevent equitable access to healthcare. According to a study, over 14% of Americans have limited access to healthcare facilities because of income differences, and low-income individuals frequently reside farther away from these services (Guo et al., 2022).

Minorities have higher percentages of uninsured people due to economic restrictions; minority groups account for 62.3% of uninsured nonelderly adults (Pollock, 2024).

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

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

4. Challenges and Opportunity

USA Model: Deep inequalities, exorbitant costs, and a complex web of administrative obstacles are just a few of the major problems currently plaguing the American healthcare system. Although solving these issues will not be simple, significant change is achievable. What is needed are reforms that not only cut costs but also expand access and help people get better care. Important areas for improvement are outlined in the sections that follow (Squires & Anderson, 2015). Despite having the largest per capita spending in the world, the US healthcare system faces challenges with

high out-of-pocket expenses and inefficiencies (Rice et al., 2020). Innovative strategies, such as Methodist Le Bonheur Healthcare's "Power of One Idea" program, have shown promise for significant cost reductions through operational improvements and employee engagement, resulting in $17 million in savings (Wharton & Jacobs, 2023). Many Americans now have much better coverage thanks to the Affordable Care Act, but there are still gaps, especially for low-income groups (Rice et al., 2020). Since vulnerable groups are disproportionately affected by severe cost-sharing requirements, ongoing efforts are required to lower the uninsured rate (Rice et al., 2020).

Health disparities are exacerbated by healthcare delivery fragmentation, which calls for improved communication and integration between the public and private sectors (Lu & Young, 2023). To increase access and lower avoidable hospitalizations, reforms should give priority to primary care and preventive services, especially for low-income households (Goujard & Kergozou, 2023). These reforms could pave the way for a fairer healthcare system, but how well they work often comes down to politics. That is why ongoing advocacy and teamwork across different fields are not just helpful. They are essential.

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

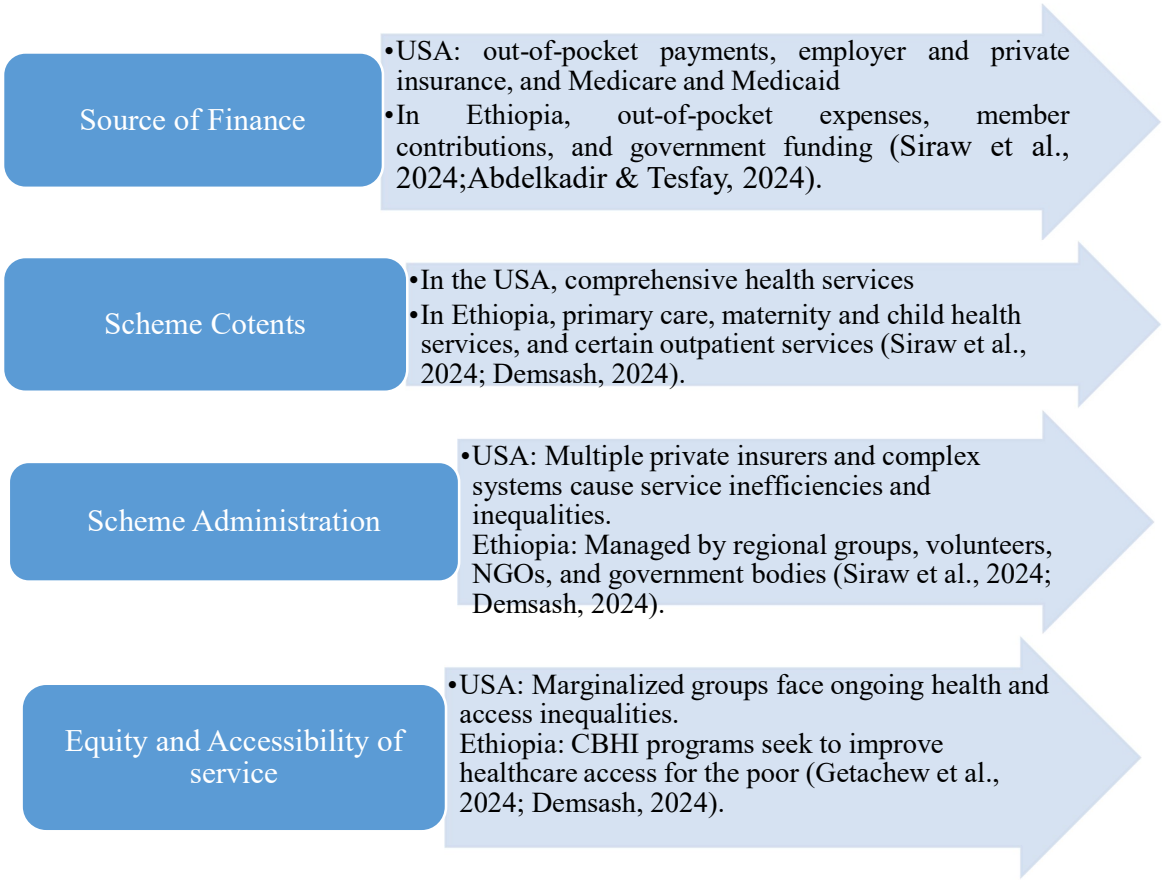


Fig4.10 USA model of insurance Vis-à-vis Ethiopian CBHI
Source: Compiled by the researcher (2024)

4.10. Comparative Analysis of Healthcare Systems in Ghana, Ethiopia, Rwanda, and Thailand

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

Ghana: Despite the National Health Insurance Scheme's (NHIS) objective of reducing financial barriers, research indicates that insurance status has no discernible impact on healthcare-seeking behaviour in rural areas (Kumah et al., 2024).

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

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

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

The attainment of UHC is hampered by issues that all four nations face, including fragmented insurance plans and inadequate coverage among disadvantaged people (Fenny et al., 2021).

Finding best practices and lessons learnt through comparative analysis can help other low- and middle-income nations improve their policies. The complexity of healthcare access and utilization shows that insurance alone is insufficient to provide fair health outcomes, even though various nations' health insurance systems show differing degrees of success. The interaction between sociocultural elements and healthcare delivery systems in these settings requires more investigation.

There are differences between Ethiopia's Community-Based Health Insurance (CBHI) program and health insurance programs in Ghana, Rwanda, Thailand, and other nations. The Universal Health Coverage (UHC) program in Thailand provides all citizens with comprehensive coverage, ensuring both financial stability and availability of first-rate medical care (Shigute et al., 2020).

Although there are problems with service sustainability and quality, Ghana's National Health Insurance Scheme (NHIS) aims to expand access to healthcare and reduce financial obstacles (Tefera et al., 2021). The Mutuelles de Santé program in Rwanda emphasizes fairness and financial risk protection through community-based insurance (Mulat et al., 2022). However, in contrast to previous systems in Sub-Saharan Africa, Ethiopia's CBHI scheme has demonstrated success in improving health facility income, quality of care, and patient satisfaction (Geta et al., 2023). Every nation has a different model that shows how it plans to solve healthcare issues and attain universal health coverage.

1. Funding Mechanisms

Thailand's: The healthcare system is largely tax-funded and organized around three main insurance programs: The Universal Coverage Scheme (UCS), which covers most of the population; the Civil Servant Medical Benefit Scheme (CSMBS), which covers government employees; and the Formal sector employees are covered by the Social Security Scheme (SSS) (Tangcharoensathien et al., 2018).

Ghana: A combination of government subsidies, certain levies, and payments from formal sector workers fund the nation's National Health Insurance Scheme (NHIS). Premiums are not mandatory for people living in poverty or working in the unorganized sector (Agyepong & Adjei, 2008).

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

Ethiopia: The nation's healthcare system mainly relies on out-of-pocket payments because a sizable portion of the populace lacks access to formal health insurance. By pooling resources from member contributions, which are occasionally supplemented by government subsidies, community-based health insurance (CBHI) programs aim to provide financial security (FMOH, 2016b).

2. Coverage

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

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

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

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

3. Scheme Administration

Thailand: The nation's healthcare system is run by a mix of public and private entities under the direction of the Ministry of Public Health. Insurance schemes are managed by a variety of government agencies and ministries (Tangcharoensathien et al., 2018).

Ghana: Ghana's NHIS is managed by the National Health Insurance Authority (NHIA), which oversees enrollment, premium collecting, claims processing, and provider payment. Implementation also involves regional and district offices (Agyepong & Adjei, 2008).

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

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

4. Accessibility and Equity

Thailand: Because of the nation's universal healthcare program, all Thai people should have equitable access to healthcare treatments, irrespective of their financial status or geographic location wealth. However, disparities in availability and quality of care persist, particularly for underprivileged populations (Tangcharoensathien et al., 2018).

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

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

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

5. Challenges and Opportunities

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

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

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

Ethiopia's healthcare system has difficulties due to a high prevalence of communicable diseases, inadequate infrastructure, and scarce resources. Although CBHI offers a chance to increase healthcare access and mobilize community resources to fortify the health system, scalability and sustainability continue to be significant obstacles (FMOH, 2016a).

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

1. Source of Funding

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

Ethiopian Model: Ethiopia's healthcare system mainly relies on out-of-pocket costs because most of its citizens lack access to government health insurance. CBHI programs pool

resources through member payments and, in certain situations, add government subsidies to give communities financial protection. Funded through premiums paid by community members, often supplemented by government support, which can limit financial sustainability (Abdelkadir & Tesfay, 2024).

2. Reportage of the service

European Model: Primary care, hospital care, prescription medication, and occasionally dental and eye care are among the many services that are covered by healthcare in European nations. In general, coverage varies in depth and is available to all citizens and residents.

Ethiopian Model: Primary care, maternity and child health services, and specific outpatient treatments are among the fundamental healthcare services that are typically the focus of CBHI programs in Ethiopia. Depending on the scheme and its resources, coverage may change (Getachew et al.,2024).

3. Health Care/ Scheme Administration

European Model: Managed by national or regional health authorities, ensuring standardized care across regions. In Europe, the administration of health insurance is typically centralized or semi-centralized, and state regulatory frameworks frequently assure the rendering of better and equitable health care services. For example, the National Health Service (NHS) in the United Kingdom operates under a single national system, but Germany's statutory health insurance funds are dispersed (Thomson et al., 2013).

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

4. Equity and Accessibility of health service

European Model: To promote equity and solidarity, European healthcare systems typically seek to offer Medical care for every citizen. The goal of the egalitarian European health systems is

to provide universal coverage with low out-of-pocket costs. Subsidies for low-income people are one way to guarantee access for vulnerable groups (Thomson et al., 2013).

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

5. Challenges and Opportunities

European Model: Potential problems for European healthcare systems include ageing populations, disparities in access to and quality of care, and rising healthcare costs. Some countries also struggle to provide timely care due to lengthy wait times (Thomson et al., 2013). To solve these issues, opportunities exist to utilize technology, enhance productivity, and encourage preventive care. Enhancing productivity (Reducing expenses) and lessening the effects of healthcare worker shortages can be achieved by increasing personnel productivity through automation, training, and optimized workflows. To maximize service delivery, this also entails effective resource allocation (ibid).

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

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

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

There are several issues and potential areas for development with the West Shewa Zone's healthcare system in Ethiopia. Research conducted in the region has brought attention to several topics, including preconception care, medication inventory management, and maternal satisfaction with labour and delivery services. Preconception care refers to a series of prenatal health interventions given to women and couples to enhance the health of both mothers and unborn

children. Risk factors that may affect subsequent pregnancies are evaluated, counselled, and managed as part of this care. Preconception care covers a range of topics, such as mental health, chronic disease management, dietary status, lifestyle choices, and physical health (World Health Organization [WHO], 2013). Improving preconception care is crucial for bettering the health of mothers and children. Low awareness, insufficient prenatal testing, and a lack of reproductive health education are among the current issues. By filling these gaps, community health initiatives can enhance family planning methods and prevent difficulties for mothers and newborns (Bekele et al., 2020).

Around 60.8% of mothers were said to be satisfied with the delivery services, with issues including support during childbirth, accessibility, and cleanliness (Bulto et al., 2020; Deressa et al., 2022). A review of pharmaceutical inventory management showed that goods accounted for the bulk of all pharmaceutical expenditures, underscoring the need for improved control and management (Fekene et al., 2020). Furthermore, only 14.5% of women used preconception care, showing a deficiency in the promotion of health and well-being before pregnancy (Argawu & Erana, 2023). All these results point to the necessity of extensive upgrades to the West Shewa Zone's healthcare system and service provision. The West Shewa Zone's health outcomes are significantly influenced by the quantity and calibre of its medical facilities. In public health facilities, maternal satisfaction with service delivery is crucial, and factors such as service availability and cleanliness affect overall satisfaction (Etea et al., 2023)

Furthermore, empowered pregnant women exhibit better nutritional status during pregnancy, which is another important factor in enhancing maternal nutrition outcomes (Argawu & Erana, 2023). Additionally, given that the degree of dissatisfaction with antenatal care services was found to be relatively high, it is imperative that pregnant women feel satisfied with these services. This underscores the need for enhanced communication and care quality in healthcare facilities (Bekele et al., 2023). To guarantee that necessary pharmaceuticals are available for the population's medical needs, effective pharmaceutical inventory management in these healthcare facilities is also vital (Deressa et al., 2022).

In the West Shewa Zone, several initiatives have been put in place to improve access to healthcare services. Different aspects have been the focus of both government and non-governmental organizations. The government has addressed issues including cleanliness and the

availability of facilities to increase mother satisfaction with delivery services (Argawu & Erana, 2023). Furthermore, efforts have been undertaken to safeguard healthcare personnel at public hospitals by offering PPE and assistance (Chaka et al., 2022). Initiatives have also been made to support the provision of respectful maternity care throughout labour and delivery, with a focus on elements such as informed consent and decision-making engagement (Etea et al., 2023). Additionally, there are several obstacles to maternal healthcare use in rural locations, including a lack of knowledge, false information, and transportation issues (Bulto et al., 2020). The goal of these concerted efforts is to improve healthcare services' overall delivery and accessibility in the West Shewa Zone.

5. DATA PRESENTATION AND ANALYSIS

5.1. Demographic characteristics of the respondents

A total of 378 participants answered the survey questions for this study. According to the sample distribution, out of the 378 CBHI members, 197 were men, making up 52.12% of the sample, and 181 were women, making up 47.88%. One can calculate that the family's membership and involvement in the CBHI are nearly identical to those of the male based on the proportion shown in Table 5.1. Women and other marginalized community groups find it extremely difficult to get healthcare services in most underdeveloped nations. However, in the majority of emerging countries, including Ethiopia, the CBHI is reversing this tendency. The Mini Ethiopian Health and Demographic Survey for 2019 states that improving access to healthcare for Ethiopian women of reproductive age requires community-based health insurance (Handebo et al., 2023).

Community-based health insurance (CBHI) significantly improves women's access to financial security and healthcare services (Handebo et al., 2023; Thomas et al., 2022; Getahun et al., 2023; Musa et al., 2022; Koch, 2022). Research from Ethiopia and India highlights that women have unique obstacles when it comes to obtaining health insurance, and community engagement initiatives can increase their use of health insurance. In Ethiopia, a woman's decision to enrol in a health insurance program can be influenced by several factors, including the size of her family, whether she lives with her family, and whether a man or woman manages the household. Community-based health insurance, or CBHI, has become a vital instrument for helping women feel financially secure and get the healthcare they need. CBHI makes it easier for women, particularly those who struggle financially and frequently require more medical care, to afford services by distributing the costs among numerous people. It brings quality healthcare within reach and advances the nation's goal of universal health coverage with reduced premiums and extensive coverage. About the respondents' ages, 67 of the 378 respondents were older than 61, making up 17.72% of the sample. At the same time, 57 of them were found between 51 and 60 years old, which represents 15.08 per cent of the sample. While 94 of them and 116 of them were between 41 and 50 and 31 and 40 years old, respectively, the rest of the percentage is held by respondents ages 18–30 years old. This implies that as people get older, they are more inclined to enrol in the CBHI.

Age is a significant factor when applying for and using CBHI. Research conducted in Ethiopia indicates that older people are more likely to sign up for CBHI, especially those who are 35 years of age or older (Belayneh & Tamiru, 2025; Handebo et al.). Age groups between 35 and 54, 55 and 74, and 75 and older are linked to greater rates of CBHI utilization (Musa et al., 2022). Furthermore, those over 60 who are exposed to the media are more likely to sign up for health insurance (Moyehodie et al., 2022). These results imply that age has a role in the decision to participate in CBHI, as older people have higher participation rates. Understanding the influence of age on enrolment is essential in formulating focused tactics to enhance CBHI coverage, particularly in the elderly demographic. The adoption of CBHI is influenced by age. Research indicates that people aged 30 to 49 years old are more likely to follow health insurance plans (Ntube et al., 2023). Younger spouses who are under 60 years old are also more likely to sign up for CBHI for senior family members (Archibong et al., 2023).

On the other hand, reproductive-age women in Ethiopia who are in the age range of 20 to 34 years old are less likely to enrol in health insurance than younger women (Handebo et al., 2023). Furthermore, the average age of homes with CBHI enrolled was greater than that of those without CBHI in Katsina State, Nigeria, indicating a potential correlation between age and CBHI utilization (Achibong et al., 2023). These findings highlight how important it is to take age demographics into account while promoting and carrying out CBHI programs.

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

Table 5.1 Sample distribution by Gender and Age

Source: Own survey data (2024)

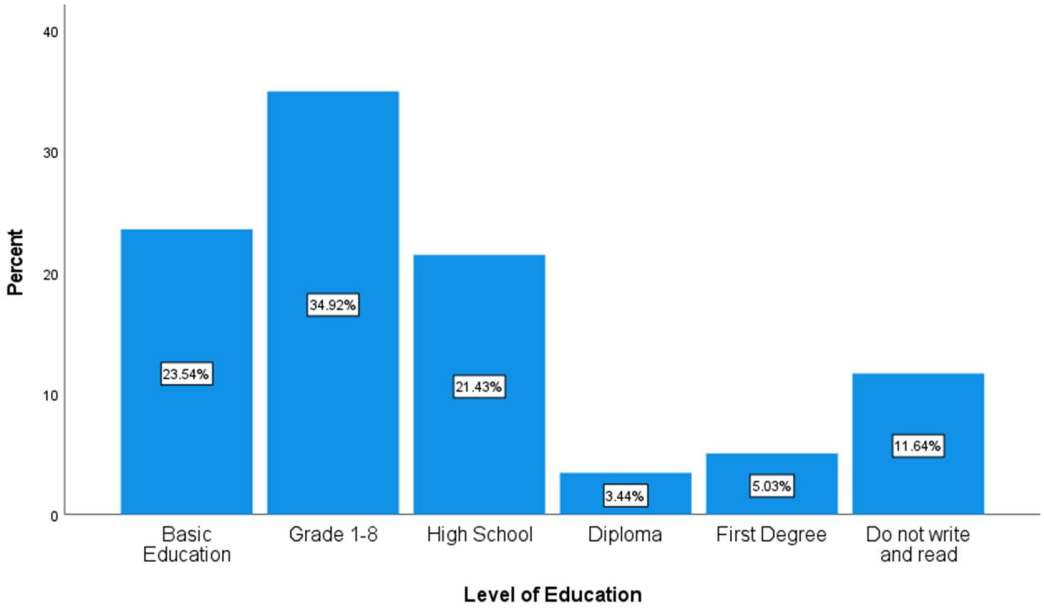


Fig 5.1 Sample distribution by Level of education
Source: Own survey data (2024)

In terms of level of education, most respondents (56.35%) completed primary and secondary school, whereas only 44 (11.6%) of them were not able to write or read. Having formal education is very important for CBHI enrolment and to have high knowledge levels and awareness of CBHI. Additional research from Ethiopia and Indonesia supports this conclusion.

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

Additionally, higher education levels are linked to a greater understanding of CBHI programs, which increases the enrolment and use of health services (Odima et al., 2023). A family's history of illness, understanding of the program, and opinion of the insurance system all have an

impact on how effective CBHI is (Elegbede et al., 2022). Education plays a critical role in determining how adequate community-based health insurance (CBHI) is by raising people's awareness, knowledge, and engagement levels, which in turn helps these programs succeed.

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

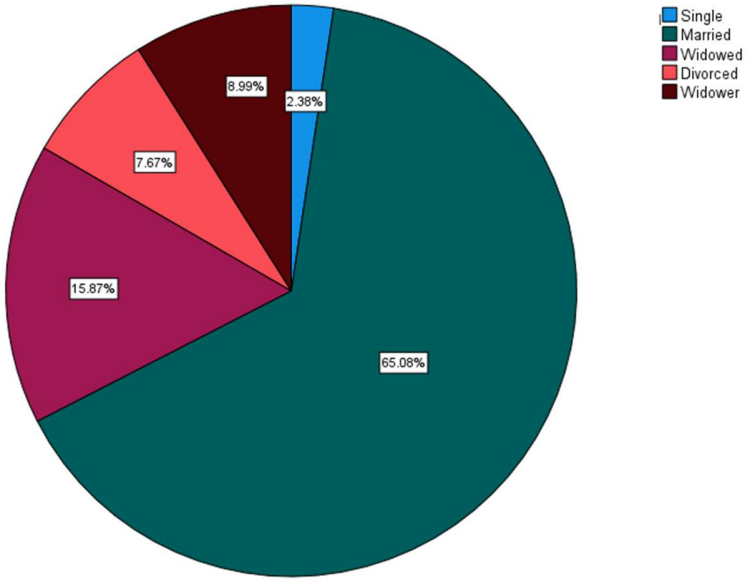


Fig 5.2 Sample distribution by Martial status
Source: Own survey data (2024)

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

When discussing Community-Based Health Insurance (CBHI), one important factor is marital status. Research indicates that those who are married experience greater health and well-being than single people do. Marriage is linked to better survival rates for several diseases, including colorectal neuroendocrine neoplasms and cervical cancer (Mastekaasa, 1993). Furthermore, studies show that hospitalization patterns are influenced by marital status, with married women with insurance having higher hospitalization rates than women without insurance, even when their morbidity patterns are similar (Xiao et al., 2020). The complex relationship between marital status and health in the context of community-based health insurance (CBHI), which includes elements like social support networks, treatment accessibility, and healthcare

services, highlights how crucial it is to consider marital status when developing health policies and intervention plans (Patel et al., 2010). A significant factor in community-based health insurance programs is marital status. Marital status is a predictor of when people will leave these schemes, according to research (Hussien et al., 2022), with married people adhering to these programs for longer. This research implies that a person's marital status affects how long these insurance programs can last.

Additionally, compared to families without insurance, individuals with insurance, regardless of marital status, have better access to medical care and are less prone to experiencing financial disaster (Bodhisane & Pongpanich, 2019). Even while it might result in shorter participation durations in community-based health insurance (CBHI) schemes, this demonstrates that insurance offers both improved healthcare access and financial security. To protect people and families against unforeseen medical costs, which may be financially ruinous for those without insurance, health insurance is essential. By distributing risk among participants, CBHI programs provide a safety net against medical expenses and can lessen such financial shocks (Habib et al., 2016).

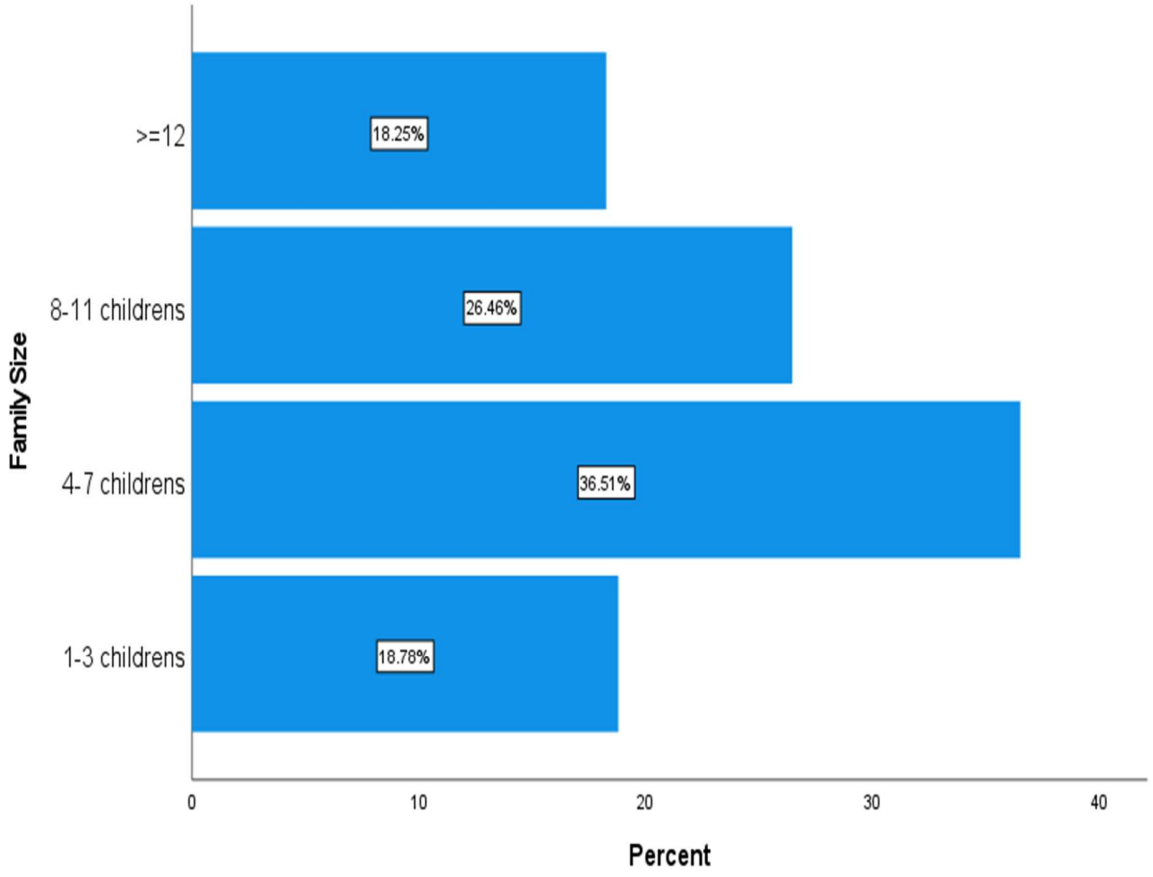


Fig 5.3 Sample distribution by family size
Source: Own survey data (2024)

In terms of the respondents' family size, every participant stated that they had children, with 307 respondents (or 81.5% of the sample) having four or more children. Enrollment and renewal of community-based health insurance (CBHI) membership are significantly correlated with family size. It has a significant impact on the level of household involvement in CBHI initiatives.

Participation in community-based health insurance (CBHI) is significantly correlated with the number of children living in a family. Larger families are more likely to use CBHI services (Geta et al., 2023), renew their memberships (Gashaw et al., 2022), and exhibit more suitable healthcare-seeking behaviours (Belayneh, 2023), according to studies. Families with four or more people are more likely to depend on CBHI programs for medical care. The reason for this tendency is that larger families have greater healthcare needs, which encourages them to sign up for and keep CBHI coverage. To improve healthcare access and utilization across a range of family sizes, CBHI

initiatives must consider the requirements of bigger families. According to research, families with more dependents have a higher need for health insurance (Moyehodie et al., 2022), and they frequently give priority to CBHI to protect themselves from future medical expenses. This preference makes CBHI programs easier to obtain and more affordable for households with more people (Daraje, 2022). Family size must, therefore, be a key consideration in the development and application of CBHI policies to guarantee that they are inclusive and prosperous in providing comprehensive healthcare coverage.

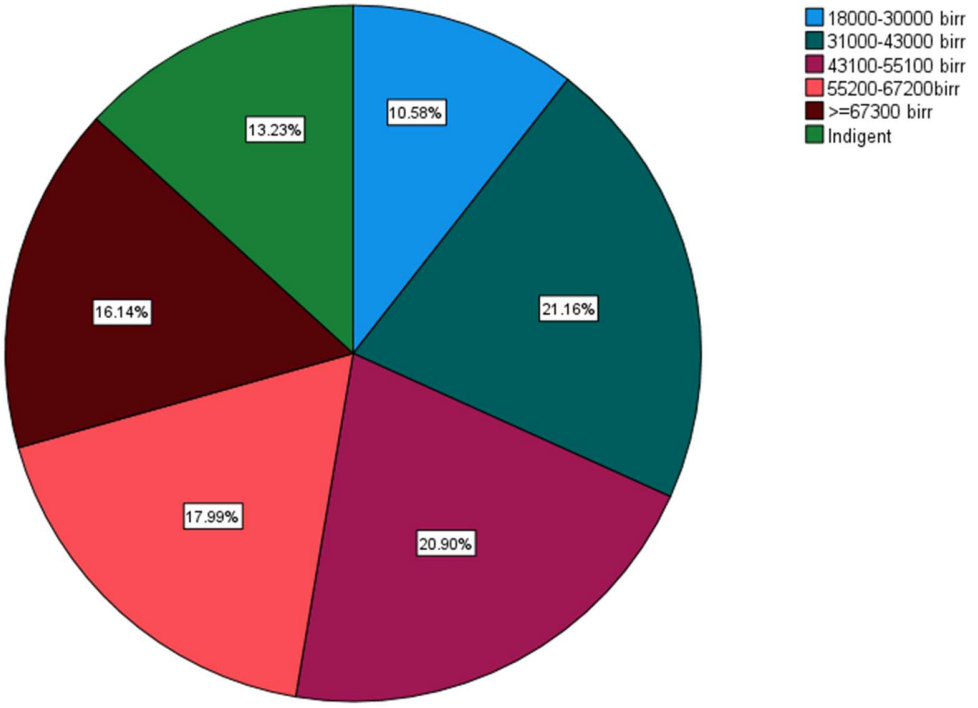


Fig 5.4 Sample distribution by income Level per year
Source: Own survey data (2024)

Concerning the income level of the sample respondents, 318 of them have their income, which accounts for 86.8% of the sample of respondents, whereas 50 (13.23%) of them do not have their own monthly or yearly income. They are living with the aid and SafetyNet program of the government, and they are non-paying members of CBHI; hence, they are assessing the health service freely without paying the health insurance premium. This implies that there are high income disparities among CBHI members.

There is a substantial correlation between income level and the willingness to pay (WTP) for community-based health insurance (CBHI). Studies in Lahore and Ethiopia revealed that

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

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

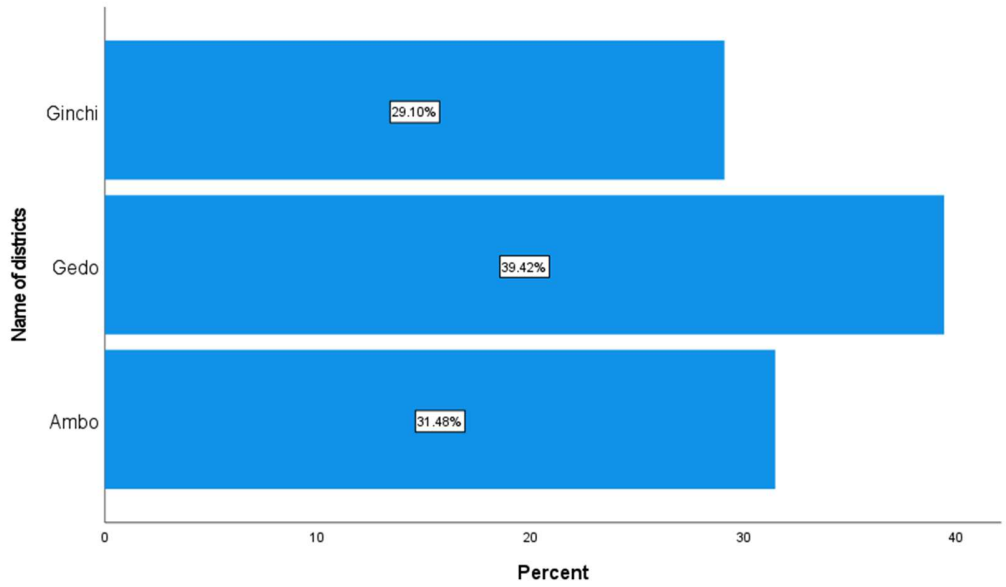


Fig 5.5 Sample distribution by Districts where the respondents are living
Source: Own survey data (2024)

This data was collected from households living in Oromiya National Regional State, West Show Zone, and three districts were selected randomly. As the data in Fig. 5.5 shows, among the total respondents, 119 were from Ambo, which accounts for 31.48% of the sample, and 149 were from Gedo, which represents 39.42% of the sample, whereas 110 were from Ginchi, which represents 29.10. Since 2013, the Ethiopian government has been working on scaling up CBHI to expand the scheme to different parts of the region. According to Mussa et al. (2023, p.5), the use of healthcare services in Ethiopia rose dramatically once CBHI was extended to 770 districts. Most of the respondents considered in this research live in rural parts of the districts. Low-income and rural individuals who might not have access to formal health insurance programs are the primary populations that CBHI programs in Ethiopia seek to serve (Tahir et al., 2022; Tefera & Ayele, 2022; Mulat et al., 2022; Kaso et al., 2022).

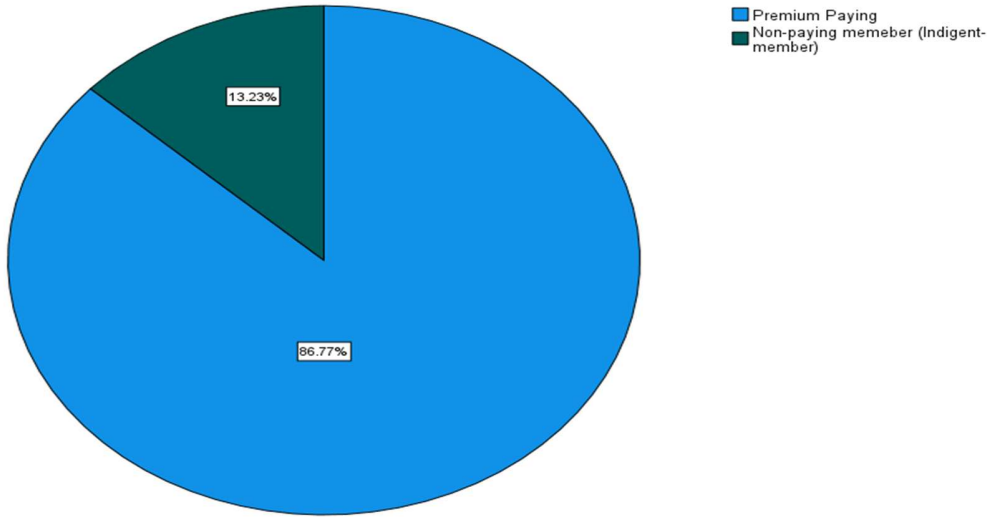


Fig 5.6 Sample distribution by CBHI membership type
Source: Own survey data (2024)

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

The type of CBHI membership, whether paying or non-paying (poor), has a significant influence on Ethiopians' use of healthcare services and financial security. Better health, lower catastrophic health costs, and more outpatient department visits are all experienced by paying members, which improves their financial security against medical expenses (Daraje, 2022; Degefa et al., 2023; Zepre, 2023). However, non-paying members of the CBHI also gain from it because it protects them from unforeseen medical expenses, improves their health, and provides insurance for their families, all of which lessen dropout rates and increase the scheme's sustainability (Alemayehu et al., 2023). Promoting universal health coverage and lowering the prevalence of catastrophic health expenditures among households, especially those with chronic conditions, require both kinds of membership to be very effective (Mussa et al., 2023).

One of the non-paying members of CBHI in the open-ended questionnaire stated that

I am a non-paying member of CBHI (Ultra-Poor). I have admitted one of my 2-year-old babies here at Ambo General Hospital. They are treating her by giving her medication; they saved

her life. The main challenge is that there is a shortage of medicines within the hospital, so they usually tell me to buy from a private pharmacy. I am asking for help from the people to buy medicines for the baby, and ultimately, when I ask the CBHI authority to refund the money, they do not give me back (CBHI beneficiaries at Ambo Hospital).

Differential access to healthcare services between paying and non-paying members can lead to variations in health outcomes. To guarantee that each member experiences equitable health outcomes, it is critical to track and resolve any disparities. According to Mussa et al. (2023), both kinds of membership are essential for advancing universal health coverage and lowering the prevalence of catastrophic health expenses among households, especially those with chronic diseases.

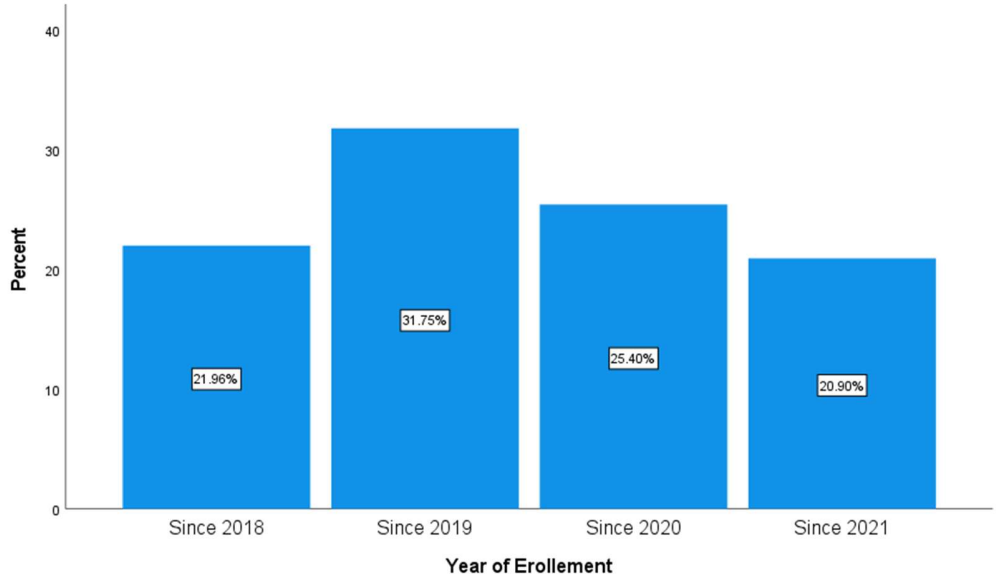


Fig 5.7 Sample distribution by enrolment year in CBHI
Source: Own survey data (2024)

Regarding the year of membership enrolment, of the total respondents, 83 of them have been members of CBHI since 2018, which accounts for 22% of the sample. Whereas 120 (31.7%) have been enrolled in CBHI since 2019, 96 (25.4%) and 79 (20.9%) of them have been enrolled since 2020 and 2021, respectively. The year of enrolment varies across each district. This implies that respondents have experience and know how to provide genuine information for this study.

5.2. Implementation of CBHI and challenges hindering it

Descriptive Statistics

		Min	Max	Mean	Std. Deviation
Members may not always be satisfied with the quality of healthcare services covered by CBHI.	78	1	5	4.06	1.107
Inadequate infrastructure and healthcare facilities in certain regions impact the effectiveness of CBHI.	78	1	5	4.15	1.056
The process of claims reimbursement within CBHI systems can be complex and time-consuming.	78	1	5	4.40	1.177
Lack of awareness about CBHI options hinders enrolment among community members.	78	1	5	4.35	1.124
Limited healthcare provider networks are hindering access to quality services under CBHI.	78	1	5	4.39	.936
CBHI programs struggle to accommodate the diverse healthcare needs of the community.	78	1	5	4.03	1.268
Limited understanding of insurance concepts and procedures has made it difficult for the community to engage with CBHI.	78	1	5	4.05	1.111
Valid N (listwise)	78				

Table 5.2 Challenges facing CBHI implementation

Source: Own survey data (2024)

Beneficiaries were asked to reply to the statement that member discontent may result from variable healthcare service quality under CBHI coverage in Table 5.2 above. Therefore, the information below reflects feedback from beneficiaries about the difficulties posed by CBHI. The weight given to each essential element and the score given to each significant element within the factor were considered when calculating the point for each key component. If you receive a perfect score of 5, you strongly agree with the component; if you receive a score of 4, you agree with it; if you receive a score of 3, you are neutral; if you receive a score of 2, you disagree; and if you receive a score of 1, you strongly disagree and receive one mark.

Most respondents firmly feel that the quality of healthcare services offered under CBHI is inconsistent, which causes member discontent, according to the average value (n) for healthcare service quality of 4.06. Member dissatisfaction is a result of these disparities in service quality. The result reveals that members of CBHI's satisfaction with the insurance plan are affected by uneven service quality as the result of various service delivery standards used by CBHI, uneven resource distribution, and differences in healthcare provider performance. Hence, that problem should be fixed to improve member satisfaction and increase the efficacy of the CBHI program.

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

Various findings support this finding, among them:

Community-based health insurance (CBHI) programs may be severely impacted by inconsistent quality of care (Hussien et al., 2022; Tefera et al., 2021). Research has demonstrated that CBHI enrolment and retention are significantly influenced by healthcare quality (Lakew et al., 2023). The introduction of CBHI is intended to increase access to healthcare and decrease out-of-pocket expenses; nevertheless, several localities have reported difficulties, including low diagnostic test capacity, insufficient drug supply, and inadequate service quality standards (Gashaw et al., 2022). Additionally, it has been discovered that there are notable differences between CBHI and non-CBHI districts in terms of elements like provider-client communication and client satisfaction (Bayked et al., 2023). Hence, addressing those problems facing CBHI on service quality is so important to ensure the satisfaction of members and meet universal health coverage.

The study articles cite several causes for the inconsistent service quality in community-based health insurance plans. Issues with healthcare quality, insurance holders' claim reimbursement, governance processes, acceptance, and community awareness all contribute to this challenge (Hussien et al., 2022). Furthermore, low community engagement, poor infrastructure, low awareness, limited benefit packages, high premiums, poor healthcare services, supply shortages, and a lack of incentives for healthcare providers are some of the factors that have been found to affect the consistency and quality of services in community-based health insurance schemes (Odima et al., 2023; Gashaw et al., 2022). Addressing these problems with targeted interventions and better policies is necessary to raise the calibre and sustainability of community-based health insurance schemes.

Regarding the availability of infrastructure, Table 5.1 shows a mean response value of 4.15, stating that most of them strongly agreed that the efficacy of community-based health insurance (CBHI) in the West Shewa Zone is negatively impacted by inadequate infrastructure. According to this conclusion, basic utilities, medical equipment, transportation services, and healthcare facilities are examples of essential infrastructure components that are either nonexistent or of low quality. These flaws significantly impair the delivery of high-quality healthcare services, which also lowers the operational efficacy of CBHI programs and their ability to meet member needs. Due to this provision of reliable and accessible medical services to the members of CBHI will be difficult, and they will be dissatisfied. Hence, to bolster the CBHI system's legitimacy, performance, and functionality in the area, improving infrastructure is essential.

The following previously conducted studies support the result of my findings:

The efficacy of Community-Based Health Insurance (CBHI) programs is greatly impacted by inadequate infrastructure and healthcare facilities. Studies conducted in Uttarakhand, India, Nigeria, and Zambia show how inadequate infrastructure affects healthcare delivery. Patients with mental illnesses in Zambia have suffered, as has society at large, from a lack of adequate health facilities (Chilufya, 2022). Like this, insufficient infrastructure in Nigeria, such as a lack of hospital beds and a variable electrical supply, makes it difficult to successfully execute healthcare programs, including CBHI initiatives (Joshi et al., 2020). Furthermore, studies of Uttarakhand's susceptibility highlight the necessity of building healthcare facilities that are earthquake-resistant to reduce service interruptions after seismic events, which could otherwise jeopardize CBHI operations

(James et al., 2008). Therefore, it is essential to strengthen this infrastructure to guarantee the dependability and accessibility of CBHI programs in various geographical areas.

Poor infrastructure, such as poor internet connections, limited funds and antiquated management practices, hinders the implementation of CBHI efficiently in Ethiopia (Namomsa, 2023). The report also emphasizes how healthcare facilities lack the infrastructure to set up local area networks that work and the personnel to maintain digital technologies (Mekonen & Tedla, 2022). This insufficient infrastructure affects the calibre of services offered under CBHI by causing ancillary issues such as medication shortages, drawn-out reimbursement procedures, and a high patient volume (Getachew et al., 2022). The inadequate infrastructure in healthcare institutions undermines the efficacy of the CBHI program, even while it improves access to healthcare and lowers out-of-pocket costs (Tefera et al., 2021).

The information in Table 5.1 shows that respondents consider the Community-Based Health Insurance (CBHI) system's claim reimbursement procedure to be time-consuming and complicated. Although some difficulties and delays are recognized, the process is not particularly troublesome. While there are important problems that could be fixed to increase efficiency, like drawn-out approval processes, administrative bottlenecks, or an overwhelming amount of paperwork, the moderate score indicates that these difficulties are not insurmountable. This implies that even though the system is still primarily functional, there is still room for improvement to boost productivity and streamline the process. Simplifying and streamlining the reimbursement process may increase member satisfaction and the overall effectiveness of CBHI services. This conclusion is supported by numerous investigations carried out in various nations, including:

Community-based health insurance (CBHI) program members may suffer adverse effects from intricate and drawn-out claims reimbursement procedures (Mussa et al., 2023). Healthcare facilities may experience financial strain because of reimbursement delays, which could compromise their long-term viability and efficiency (Asfaw et al., 2022). Accordingly, these problems could jeopardize the standard and accessibility of vital medical care for CBHI recipients (Ranson et al., 2007). Delays in reimbursements can also put a burden on the system and jeopardize the financial stability of healthcare facilities (Nasage, 2020). These problems must be resolved for CBHI programs to continue offering universal and equitable access to healthcare, particularly by ensuring that claims are handled efficiently and quickly (Nshakira-Rukundo et al., 2019).

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

In terms of how lack of awareness about CBHI options hinders enrolment among community members, the average value of the respondents was 4.35. This shows that lack of awareness about CBHI options is a significant factor contributing to low enrolment rates in the West Shewa Zone. This suggests that a significant number of potential enrollees are either unaware that CBHI programs exist or do not fully understand their benefits, operations, or enrollment requirements. People are discouraged from using CBHI programs because of this ignorance. Improving outreach and educational efforts to raise awareness about CBHI options could help increase enrolment and ensure that more people can benefit from the insurance and the health services it provides. This conclusion is supported by several studies that have been done in many nations on the impact of a lack of awareness of not enrolling in the CBHI.

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

Enrolment in CBHI is greatly impacted by a lack of knowledge about available options (Daraje, 2022; Khuwaia et al., 2021). Low enrolment rates are caused by several factors, including inadequate knowledge of the program, unaffordable premiums, and deceptive marketing by dropouts (Archibong et al., 2023). Furthermore, the significance of financial literacy and awareness in augmenting the real payments for CBHI is underscored, underscoring the necessity of enhancing community comprehension of the program (Preker & Dror, 2002). Additionally, the study conducted in Northwest Ethiopia highlights the favourable correlation between awareness and enrolment rates. It identifies knowledge and information (awareness) on CBHI as critical elements

determining enrolment (Atafu & Know, 2018). Therefore, to increase CBHI participation rates and guarantee greater access to healthcare services, raising awareness through efficient communication tactics and community engagement is crucial.

Regarding CBHI's healthcare provider networks, the study's findings show that a sizable majority of participants, with a mean score of 4.29 on a scale (presumably out of 5), believe that a limited healthcare provider network is a significant hindrance to accessing quality services under the Community-Based Health Insurance (CBHI) scheme in their areas. The respondents' strong agreement that their ability to obtain timely and appropriate medical care is hampered by the lack of healthcare providers in the CBHI network is reflected in the high mean score. In the end, this restriction would make it more difficult for the CBHI program to give the community the benefits it was intended to by causing longer travel times, longer wait times, and potentially worse care. Expanding the network of healthcare providers participating in CBHI could significantly improve insured members' access to high-quality healthcare services. Research conducted in the United States and Uganda supports this conclusion.

Access to high-quality treatments may be impacted by narrow healthcare provider networks, such as those seen in CBHI programs. Studies on CBHI programs, such as Uganda's Kisiizi Hospital CBHI, show that although these initiatives lower out-of-pocket costs and increase access to healthcare, there are still obstacles because of small networks (Vargas et al., 2015). Comparably, research on limited network plans in the US reveals that although they can reduce costs by shifting money from downstream to primary care, they may limit patient access to specialists and hospital care (Schleicher et al., 2016; Gruber & Mcknight, 2016). This suggests that although limited networks are more cost-effective, they also lower the standard of services offered by CBHI programs and make it more challenging for patients to get specialized care.

Concerning the respondent's response rate to CBHI programs on accommodating the diverse healthcare needs of the community, the data found in 5.1 shows that the respondents agreed that the services covered by the scheme are not comprehensive. The primary causes of the CBHI program's inability to meet the community's varied healthcare needs are conflicting social demands. Most of the services covered by the scheme are not comprehensive health services, limited coverage, a poor health system, a failure to ensure financial sustainability and a lack of quality of health care services.

Few studies support the result of these findings; Ethiopian CBHI systems struggle to provide for the wide range of healthcare demands of the populace. The willingness to pay for CBHI programs is high, but many households would find it challenging to cover the premiums (Kaso et al., 2022). Ethiopia's overall CBHI enrolment coverage is just about 45%, which is less than the 80% national target (Tefera & Ayele, 2022).

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

Regarding the level of understanding of insurance concepts and engagement with CBHI, the data in the above table 5.1 shows that most respondents agree that a limited understanding of the concepts and procedures of CBHI contributes to low community engagement in the CBHI program. This implies that many community members are not sufficiently informed about the functions of CBHI, its advantages, and the procedures needed to sign up for and make use of the services. People may feel uncertain, sceptical, or uninterested in joining the CBHI scheme because of this knowledge gap, which lowers participation and involvement. To ensure that more people can take advantage of the insurance program and the healthcare services it offers, addressing this issue through focused education and awareness campaigns may help boost community involvement. A lack of awareness of insurance ideas and procedures negatively impacts community engagement with CBHI schemes. Research indicates that insufficient understanding of CBHI results in reduced enrolment rates (Odima et al., 2023; Desalegn et al., 2023).

The CBHI faced several major obstacles, such as differences in the calibre of medical care, poor facilities and infrastructure, a complicated and drawn-out claim reimbursement process, and a lack of knowledge about CBHI alternatives that deterred enrollment. CBHI programs fail to meet the population's varied healthcare needs due to a limited network of healthcare providers; a lack of knowledge about insurance ideas and procedures has hampered community involvement in CBHI.

5.3. Person correlation between awareness campaign and CBHI implementation

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

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

Table 5.3. The Relationship Between Community Awareness and CBHI Implementation correlations

Source: Own survey data (2024)

The Person correlation between CBHI implementation, the community's awareness and knowledge of CBHI is 0.51, which implies that positive and moderate correlation. The sig. (2-tailed) value is less than 0.05, and CBHI implementation and, community awareness and knowledge creation are significantly correlated. The research results indicate that there is a Pearson correlation coefficient of 0.51 between the implementation of Community-Based Health Insurance (CBHI) and the community's awareness and knowledge of CBHI. This value implies a positive and moderate correlation. Practically speaking, this means that the effectiveness of CBHI implementation tends to increase when community awareness and comprehension of CBHI programs grow, and vice versa.

The moderate correlation, however, suggests that although there is a significant association, other factors also play a considerable role in the implementation success of CBHI. Among the crucial components that are necessary for the implementation of CBHI are the infrastructure, administrative effectiveness, and the calibre of healthcare services provided under the program. Together with community awareness, these factors influence member satisfaction and the program's capacity to achieve its goals, which in turn influences the program's overall efficacy and sustainability. Although raising community awareness and knowledge of CBHI is likely to have a positive effect on its implementation, other influencing factors may require the use of additional strategies.

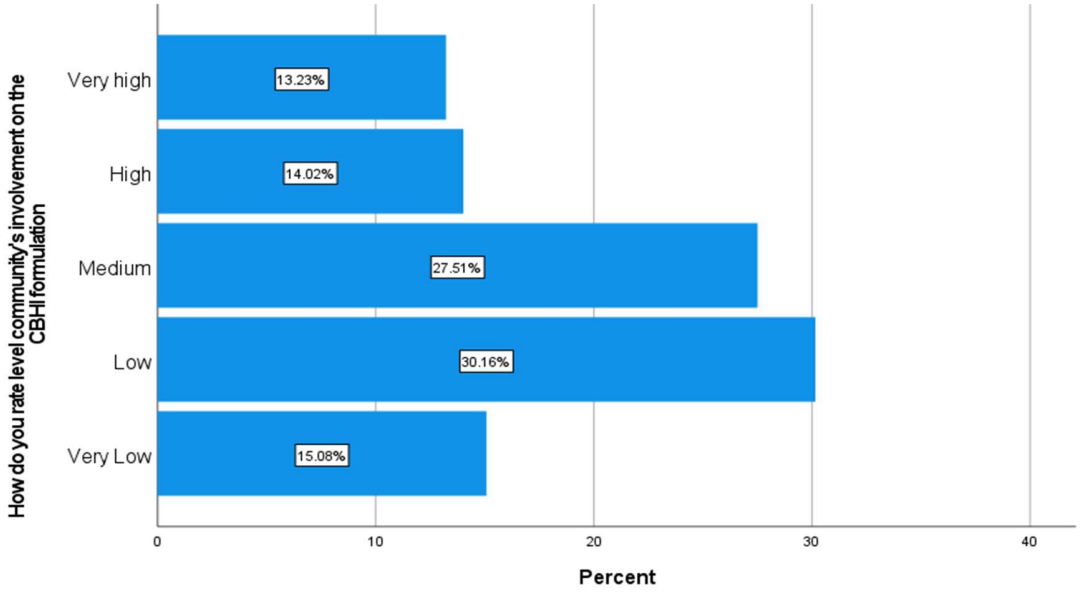


Fig 5.8 Sample distribution by involvement level of the community in the CBHI formulation
Source: Own survey data (2024)

The research findings, which show variations in the level of community involvement in the development of CBHI policies, are depicted in Figure 5.8. This indicates that there are wide variations in the degree to which various community members or groups take part in the creation and planning of CBHI. Some people might be actively involved, like providing input and supporting shaping the CBHI policies, whereas others are less engaged or entirely exempted from the process. Because of these differences, uneven representation of the community needs and priorities in CBHI policies potentially affects the effectiveness and equity of the scheme.

To create a more effective and balanced policy that represents the many demands of the community, all pertinent stakeholders must participate inclusively. All members of the community may find CBHI policies more relevant and acceptable if these disparities are addressed by encouraging more inclusive and participatory approaches. This is due to the CBHI settings in which strategy formulation is a top-down approach, in which the target population or members of the CBHI may not get an opportunity to participate in the process of its strategy formulation directly.

This conclusion is supported by numerous investigations carried out in various nations, including:

Depending on the situation, different levels of community involvement were involved in the creation of Community-Based Health Insurance (CBHI). In Nigeria, CBHI programs have faced difficulties due to low participation rates and inadequate community involvement (Odima et al., 2023). A lack of public awareness and active participation can occasionally compromise the efficacy of user associations in Colombia that seek to encourage citizen participation in healthcare organizations (Bolivar-Vargas et al., 2022).

Other studies identified that both demand- and supply-side challenges are responsible for varying the level of the community's involvement in CBHI. The level of community involvement in designing Community-Based Health Insurance (CBHI) schemes varies across different contexts. Research indicates that although there is a desire to engage in CBHI (Bolivar-Vargas et al., 2022; Sana et al., 2020), there are obstacles such as low awareness (Mebratie et al., 2013), the exclusion of the inferior (Ebrahim et al., 2019), and the restricted efficacy of user associations (Mebratie et al., 2013). Several factors, such as health, income, education, and awareness of the advantages of CBHI, influence community participation in CBHI programs. Public awareness of these advantages must be increased to encourage greater community involvement. The target population must also be actively involved in the planning and implementation phases of CBHI projects for them to be pertinent, well-received, and long-lasting. Overall, even though the community is willing to participate, ensuring inclusivity and closing awareness gaps will be necessary to increase community involvement in CBHI design.

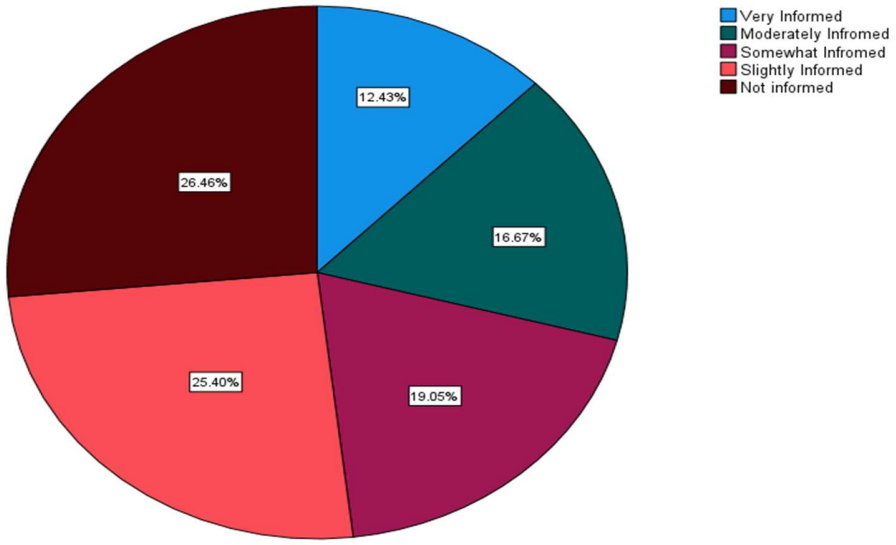


Fig5.9 Sample distribution on the level of community's awareness of decisions made during the formulation of the CBHI strategy
Source: Own survey data (2024)

Concerning respondents' awareness of decisions made during the formulation of the CBHI strategy, as shown in Fig. 5.9, The research results indicate significant disparities in the community's awareness about the decisions made during the formulation of the Community-Based Health Insurance (CBHI) strategy. 26.46% of the respondents are totally ignorant of these decisions, whereas 44.45% of them are only dimly aware of them. This indicates that more than 70% of the community does not know enough about the formulation process of the CBHI and the decisions that have been made.

Such a high level of unawareness suggests a communication gap between policymakers and community members. Because community members may feel left out or unaware of significant developments that impact them, this gap may cause mistrust, decreased engagement, and even opposition to the CBHI program. A more inclusive and knowledgeable community can be created by addressing these inequities through better information sharing, increased transparency, and active community involvement in the decision-making process. In addition to providing people with the information they need to make wise decisions; such initiatives would increase system trust and a sense of ownership. In the end, this would result in Community-Based Health Insurance (CBHI) initiatives being implemented more successfully and fairly. There are various studies

conducted in different countries, like Nigeria, Cameroon, and Ethiopia that support this finding. Various regions have various levels of community awareness regarding decisions made during the development of Community-Based Health Insurance (CBHI) programs. Studies from Ethiopia (Wortley et al., 2016), Nigeria (Noubiap et al., 2014), and Cameroon (Odima et al., 2023) indicate that awareness of Community-Based Health Insurance (CBHI) programs varies significantly across countries and populations. In Cameroon, for example, only 1.2% of informal sector workers were enrolled in a CBHI scheme, suggesting a low level of awareness among this group (Workneh et al., 2017). Conversely, despite limited awareness in Nigeria, a considerable proportion of traders demonstrated a good understanding of CBHI, indicating that membership could increase with better outreach efforts (Sujarwoto & Maharani, 2020). In Ethiopia, the relatively high level of compliance with CBHI policies suggests that many community members possess both awareness of and adherence to the program.

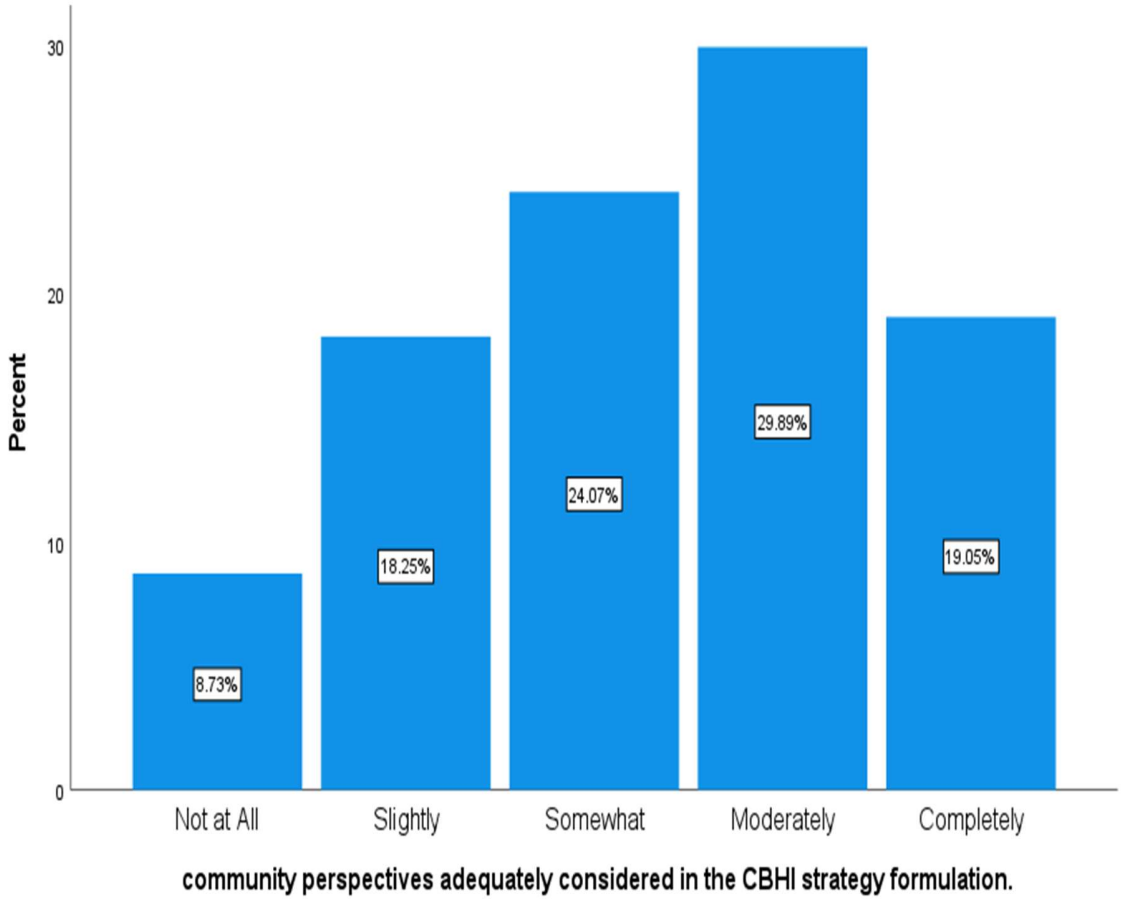


Fig5.10 Sample distribution on the extent to which CBHI considered the community's perspectives
Source: Own survey data (2024)

Concerning the respondent's feedback on the extent to which CBHI considered the community's perspectives, the result in Fig. 5.10 shows that there is a disparity of responses on the community's perspectives that is adequately considered in the CBHI strategy formulation. Of the total respondents, 42.32% of them stated that there is a poor level of community perspective consideration in CBHI strategy formulation; only 19.05% of them responded that CBHI has considered the community's perspectives. CBHI targets the informal groups of the community, primarily those living in rural parts of the country; however, the design and formulation of the policy in Ethiopia are not initiated at the grass-roots level; rather, it is from the top (designed) to the community. The national health insurance policy of Thailand was created with the direct participation of the target community, so it was initiated at the gross root level.

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

The opinions of the community are critical in determining health insurance policies. Taking community opinions into account while developing community-based health insurance (CBHI) initiatives is a significant difficulty. Research reveals several challenges, including high rates of membership dropout brought on by issues like perceived service quality, knowledge gaps, and pricing (Kaso et al., 2022). CBHI implementation in Bangladesh is further hampered by issues such as low population coverage, ignorance of health insurance, and poor outside support (Sheikh et al., 2022). Another issue with schemes in Ethiopia is their financial viability; they struggle to shield members from out-of-pocket costs and have negative net income (Hussien et al., 2022). The operational sustainability of CBHI programs in Ethiopia is further threatened by persistent issues with community awareness, governance frameworks, claims reimbursement processes, and healthcare service quality, in addition to irregular enrollment patterns (Hussien et al., 2022). Resolving these problems successfully is essential to enhancing public opinion, building trust, and guaranteeing the long-term viability and operational effectiveness of CBHI programs.

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

have a big impact on how health insurance policies are created, implemented, and performed.

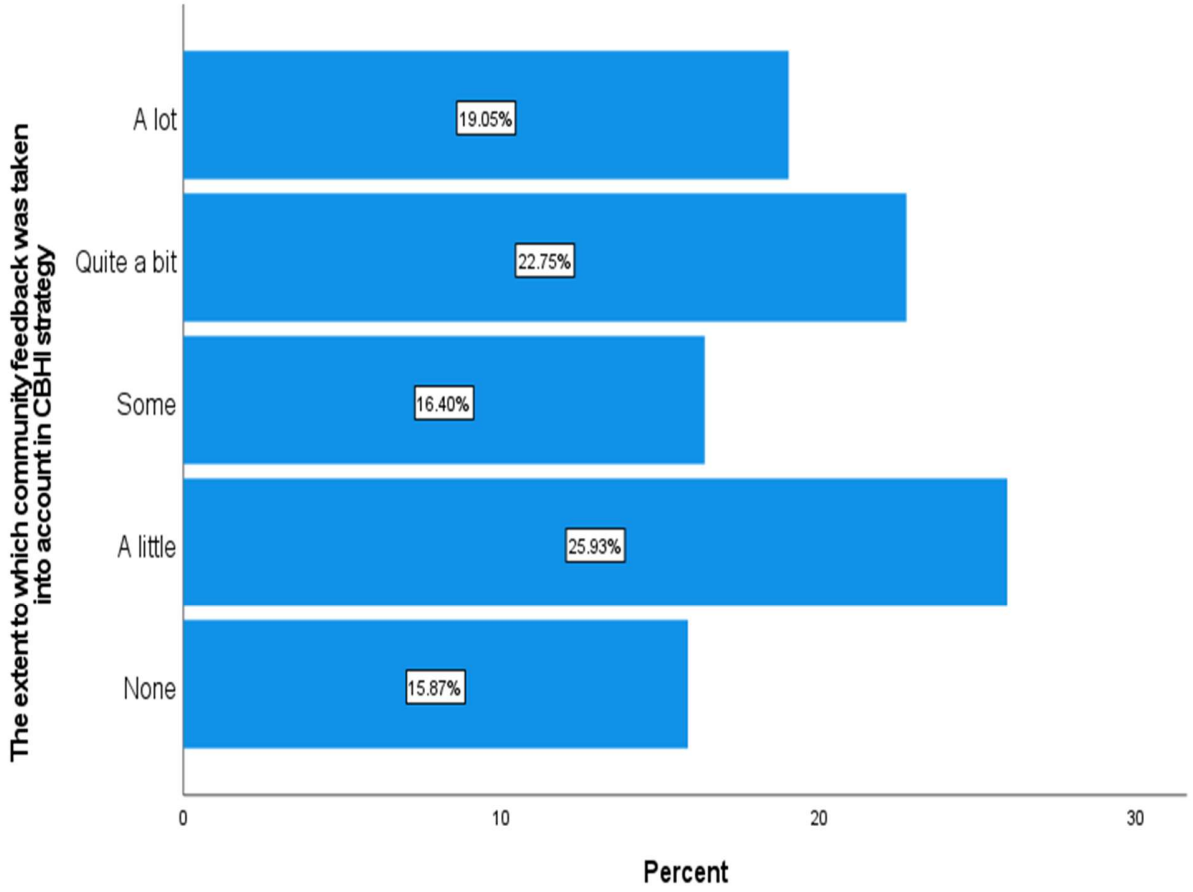


Fig5.11 Sample distribution on the level to which community feedback was taken into consideration in CBHI strategy

Source: Own survey data (2024)

In the above Fig 5.11, the research result indicates that a significant portion of respondents, specifically 246 out of the total sample, believe that community feedback was not considered during the formulation of the CBHI strategy. This 246 represents 65.1% of the entire sample, suggesting that most of the surveyed individuals feel that their input or the input of the community was not considered when developing the CBHI strategy. This disregard for community input is a clear indication of the need for change. With improved community involvement, the CBHI program can better address the needs and preferences of the community it is meant to serve, enhancing its efficacy and acceptability. The disparities and low involvement of community feedback in CBHI policy formulation in Ethiopia have the same results as the research conducted in different nations.

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

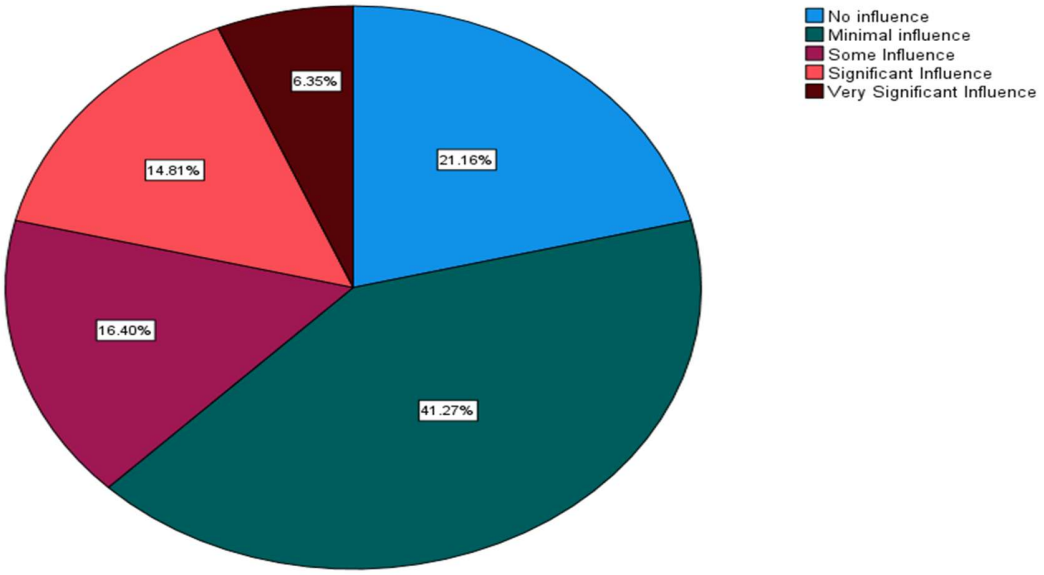


Fig5.12 Sample distribution on the level of community influence on shaping the key components of CBHI strategy
Source: Own survey data (2024)

The research result indicates that 218 respondents, which represent 57.7% of the sample, believe that the influence of community feedback on finalizing the Community-Based Health Insurance (CBHI) strategy is poor. This perception is attributed to power dynamics among the

target population. In other words, because of power and influence disparities within the community, most respondents believe that community input was not sufficiently incorporated into the final CBHI strategy. In the process of developing a CBHI strategy, these power dynamics may make it difficult for groups or individuals to have their opinions heard or their needs sufficiently met. This could lead to a strategy that does not fully reflect or serve the interests of the entire community. This conclusion is supported by several studies carried out in different countries, and it is summarized in this interpretation for triangulation purposes.

The effectiveness of CBHI schemes depends on community involvement in their finalization (Odima et al., 2023; Franz et al., 2018; Diop & Butera, 2005; Uzochukwu et al., 2015). Research indicates that significant investment in community-based healthcare systems is essential to the success of Community-Based Health Insurance (CBHI) programs. CBHI initiatives require clear policies, dependable institutional support, and shared objectives to continue to be successful over time. These essential elements promote cooperation among stakeholders, maintain program operations, and build trust, all of which are required to increase access to healthcare and lessen inequities in marginalized areas. CBHI programs in Rwanda were founded on the principles of community solidarity and mutual aid, and actors were mobilized by high-level leadership to support the programs' national execution. Community support, power dynamics among community actors, and health personnel's views toward the program are some of the factors influencing the execution of the CBHI. Thus, completing successful CBHI plans requires including communities in decision-making processes, guaranteeing broad support, and clearly communicating policy requirements.

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

Correlations

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

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

Table 5.4 The relationship between Community Engagement and Participation in the implementation of CBHI

Source: Own survey data (2024)

The Pearson correlation coefficient between CBHI implementation and community engagement and participation is 0.25. This indicates a positive but weak correlation between the two variables. In practical terms, as community engagement and participation in CBHI increase, the implementation of CBHI also increases, but the relationship is not strong. Although community involvement improves the performance of CBHI initiatives, it is insufficient on its own. The success of these programs is also greatly influenced by other factors. Involving communities is crucial, but a more comprehensive strategy that addresses several issues is necessary for success.

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

5.5. Analyzing the third study hypothesis (H3)

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

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

The success and long-term viability of Oromia National Regional State's Community-Based Health Insurance (CBHI) program are greatly dependent on your community involvement and engagement. Research from Southern Ethiopia (Zepre, 2023), Gudeya Bila (Asfaw et al., 2023), and Basona Worena District (Tefera & Ayele, 2022) emphasize the importance of elements that affect household satisfaction and CBHI scheme enrolment, such as attending CBHI-related meetings, healthcare providers' respect, knowledge of CBHI, and illness experience. More people can access healthcare services, more funding becomes accessible, and families get financial security when communities join involved, according to recent studies on Ethiopia's CBHI program (Getahun et al., 2024). For CBHI to function effectively and keep assisting people in Oromia in the long run, more individuals must sign up for the program. This can be achieved through your active community involvement, awareness campaigns, and guaranteeing high-quality healthcare services.

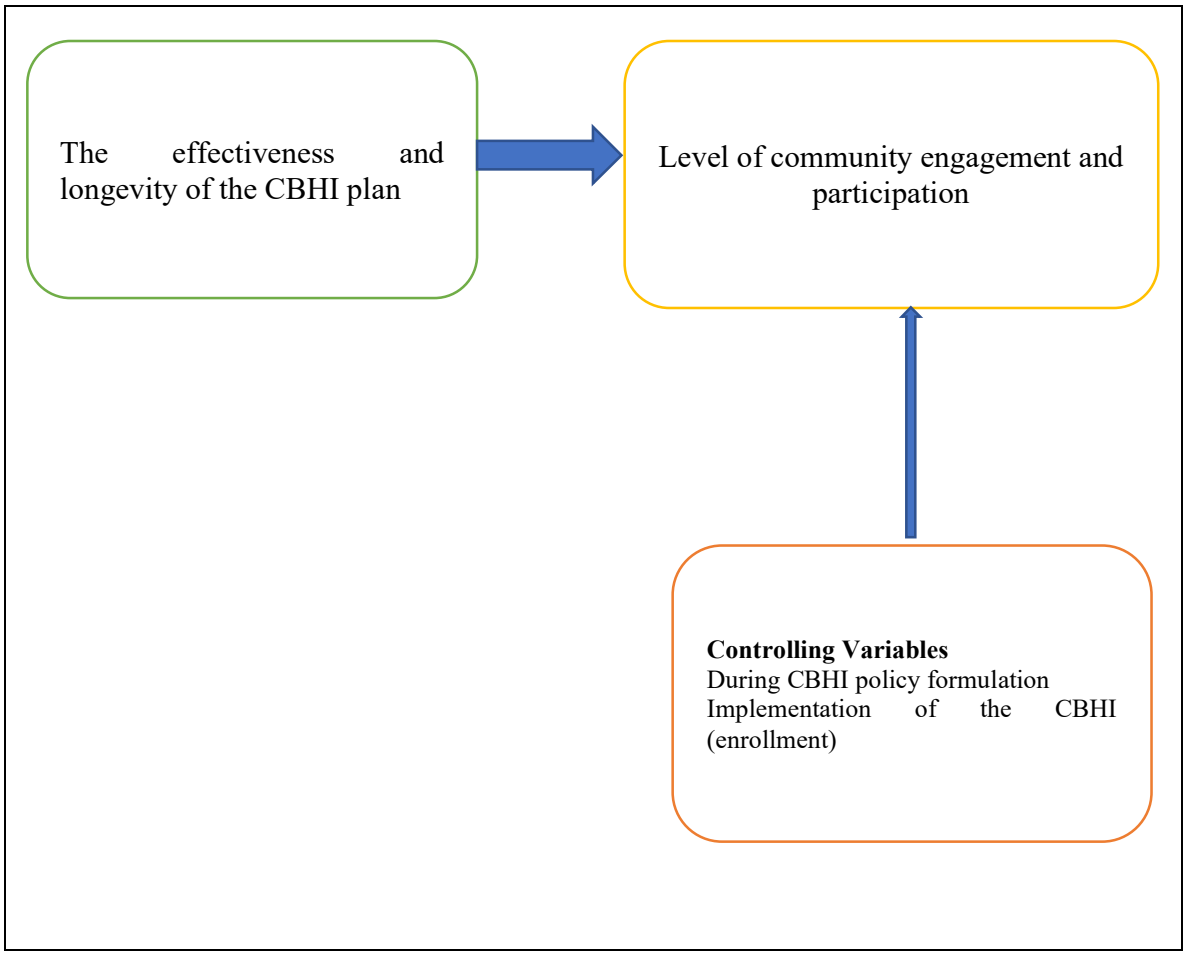


Figure5.13 Conceptual Model

Source: Own compilation based on research methods.

Descriptive Statistics

	N	Min.	Max.	Mean	Std. Deviation
The CBHI strategy development process effectively engaged community members.	378	1	5	2.51	1.143
Community participation and ownership are adequately ensured in CBHI schemes.	378	1	5	2.61	1.135
Community members were given meaningful opportunities to contribute to the CBHI strategy.	378	1	5	2.89	1.252
Enough efforts were made to raise awareness and educate community members about CBHI.	378	1	5	4.20	1.072

Community input played a crucial role in shaping the key elements of the CBHI strategy.	378	1	5	4.29	.908
Community leaders actively participated in the CBHI strategy formulation process.	378	1	5	4.33	.906
Community engagement significantly contributes to the success of the CBHI programs.	378	1	5	4.14	.978
The CBHI strategy genuinely represents the needs and preferences of our community regarding accessing health services.	378	1	5	4.17	.950
Community members were well-informed about the progress and decisions related to the CBHI strategy.	378	1	5	4.12	1.101
The CBHI strategy demonstrates a collaborative effort between community representatives and policymakers.	378	1	5	4.26	1.007
The CBHI strategy will contribute positively to the overall health and well-being of our community.	378	1	5	4.09	1.050
The CBHI strategy was developed in a way that encourages ongoing community involvement.	378	1	5	4.32	.975
The CBHI strategy demonstrates a commitment to addressing the unique challenges of our community.	378	1	5	4.34	.939
Community members were actively engaged in discussions about the long-term goals of the CBHI strategy.	378	1	5	4.23	1.065
Community members developed a sense of pride and ownership because of the CBHI plan creation process.	378	1	5	4.07	1.010
Community perspectives were given equal importance to expert opinions in the CBHI strategy formulation.	378	1	5	4.32	1.006
The CBHI strategy reflects the collective aspirations of our community for better healthcare.	378	1	5	4.06	.982
Community engagement in the CBHI strategy was characterized by transparent communication.	378	1	5	4.05	.978

The CBHI strategy showcases a strong partnership between local institutions and the community.	378	1	5	4.36	.965
Valid N (listwise)	378				

Table5.5 Degree of community involvement and engagement in the development of the CBHI strategy

Source: Own survey data (2024)

The data in Table 5.5, which represents beneficiary input on community engagement and participation, is significant. It provides valuable insights into the beneficiaries' perspectives on their level of community engagement and participation in the development of the CBHI plan.

To calculate scores for each key component, two factors were considered: (1) the weight given to each core element and (2) the rating assigned to each critical element within that factor. The rating system used a 5-point scale:

The first three questions in the above table attempted to gauge community involvement and engagement during the program's invitation to the west Shewa zone, and the respondents' answers were unfavourable in this respect; this implies that the level of community engagement and participation in the west Shewa zone at the time of scheme formulation was negative. However, various strategies have been used to increase the awareness of the community. The interview data revealed that community engagement is male keystone in the implementation of CBHI. The community is the primary stakeholder of CBHI and is participating in the scheme management and implementation (CBHI, senior expert in Oromia Health Bureau). Therefore, we can accept the hypothesis (H3) that the degree of community involvement and engagement in formulating the CBHI plan in the Oromia National Regional State determines its efficacy and lifespan.

The statement that the CBHI strategy creation process successfully engages community members has a mean value (n) of 2.51. According to this mean value, most respondents disagree with the statement, indicating that they do not think community people were adequately involved during the CBHI strategy formulation process; this implies that community members were not sufficiently engaged during the CBHI policy formulation stage. Numerous investigations were out in different countries to support this finding:

Programs for community-based health insurance have demonstrated differing degrees of success in including the community. Due to a lack of public knowledge, user associations in Colombia were found to be weak and inactive, which made it difficult for them to empower subscribers and improve the responsiveness of health insurance (Bolivar-Vargas et al.,2022). While

increasing health insurance membership, particularly among the previously uninsured, improved technical quality of healthcare services did not significantly increase households' subjective judgments of healthcare quality in Ghana (Opoku et al.,2022). Ethiopia's CBHI program successfully increased the use of outpatient services, promoting health equity and universal health coverage. However, because these services are freely available at public facilities, the program had no discernible effect on the utilization of medical services by mothers and their children (McNeish et al.,2022). Maximizing the effectiveness of community-based health insurance programs requires the implementation of effective community engagement measures, such as enlisting the help of community leaders and establishing trust (Mussa et al.,2023).

According to the data in Table 5.5, the CBHI plan does not sufficiently guarantee the target population's ownership and involvement in terms of community engagement and ownership.

The experience of different countries shows that the CBHI scheme is not adequately ensuring the ownership and participation of CBHI members. Various challenges have contributed to the low infectiveness of CBHI in ensuring the ownership and participation of the target population. There have been obstacles to ownership and participation in Community-Based Health Insurance (CBHI) programs in Bangladesh, Ethiopia, Senegal, Nigeria, and other nations. Stakeholders in Bangladesh emphasized the value of public-private partnerships, comprehensive benefit packages, and outside aid in boosting coverage and confidence (Shiekh et al., 2022). Similarly, low knowledge, financial constraints, and dissatisfaction with services were cited as reasons for Ethiopia's low attendance (Tefera & Ayele, 2022). Senegalese research has emphasized the significance of power dynamics, societal values, and sustainable governance systems in expanding the reach of CBHI (Mirach et al., 2023). According to Nigeria's experience, low uptake was caused by things like regressive finance, low beneficiary involvement, and a lack of awareness of and trust in the programs (Mladovsky et al., 2015). It is essential to address these issues through specialized approaches, stakeholder involvement, and legislative changes to guarantee ownership and active participation in CBHI programs.

According to the respondents, community members were given meaningful opportunities to contribute to the CBHI strategy. However, the statistics in Table 5.5 tell a different story, suggesting that community members were not provided meaningful opportunities to contribute to the CBHI approach. This discrepancy can be attributed to power dynamics among the CBHI target population, which may lead to specific groups within the community being marginalized or

excluded from the decision-making process. These power dynamics influence whose opinions are heard and whose input is valued, potentially leading to a strategy that does not accurately represent the wants and needs of the entire community.

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

"In Ethiopia, community involvement in the formulation and execution of community-based health insurance (CBHI) initiatives has been a dynamic process. At the same time, the CBHI strategies were initially developed by the government of Ethiopia with the support of other international non-governmental organizations with minimal involvement of the community. The important development at this stage was the development of a strategy known as community conversation (CC). Community Conversations (CCs) are planned discussions designed to help communities identify their health needs, set priorities, and investigate possible solutions. Feedback on the design and implementation of health insurance programs like CBHI is the specific objective of these discussions. Meaningful community involvement in CBHI is still hampered, however. These include a lack of understanding of insurance principles, power imbalances that exclude marginalized groups, and the need for increased community capacity to enable effective participation. To overcome these obstacles and improve community involvement in CBHI initiatives in Ethiopia, sustained efforts are required" (EHIS, provider affairs and quality assurance senior officer).

The average response from respondents to the question of whether sufficient efforts were made to inform and educate the community about CBHI was 4.20, indicating that most respondents agreed that the community was informed and educated about the CBHI initiative. The CBHI scheme. The following four conclusions can be drawn from this finding:

Positive Perception: Most respondents said that much work was done to inform and educate the public about CBHI.

Awareness Campaigns: This shows that effective public education programs, awareness campaigns, or informational sessions are in place to alert people about CBHI.

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

Impact on Implementation: Increased knowledge and awareness can result in improved comprehension and possibly increased rates of CBHI program enrollment and participation.

In conclusion, the respondents believe that enough attempts were made to inform and educate the community about CBHI, which is a good thing about the way the program was implemented. This suggests that while there may be areas needing improvement, such as community involvement in strategy formulation, the efforts to inform and educate the community have been successful.

The commitment and support of the government at different levels are significant for the effectiveness of the CBHI scheme. The Ethiopian government has been providing crucial support to the implementation of the scheme, ensuring that local community members have a say in decision-making processes, scheme contents, and premium and fund management. This strategy seeks to guarantee that the requirements and preferences of the community are considered while designing and implementing the plans, thereby enhancing the effectiveness and relevance of the CBHI scheme.

The Ethiopian government has made great efforts to raise awareness of the CBHI program and encourage community enrollment in it. Expanding the use of CBHI is one of these methods to address low enrollment issues such as limited knowledge, financial limitations, and discontent with health care (Daraje, 2022). Despite efforts to incorporate communities, such as town hall meetings and community mobilization initiatives, the study discovered that the actual impact of community participation on decision-making was little. Things like inadequate literacy and ignorance about health insurance were noted as obstacles to meaningful engagement. Furthermore, a commitment to expanding CBHI coverage is shown by the government's 2020 goal to reach 80% of districts and 80% of the population (Tahir et al., 2022). Studies have demonstrated that successful pilot initiatives and strong government support have promoted community engagement, improved access to healthcare, and empowered women, all of which have increased awareness and enrollment in CBHI (Tefera & Ayele, 2022). Moreover, continuous efforts to improve awareness and enrolment in the CBHI scheme are highlighted by the government's focus on strengthening regional growth and resolving bottlenecks within implementing regions (Mulat et al., 2022).

Apropos, questions related to Community input played a crucial role in shaping the key elements of the CBHI strategy. Respondents believe that community input (community participation) played a crucial role in changing the CBHI strategy. Community input includes

premium contributions, timely membership renewals, and CBHI enrolment. Respondents stated that community participation has a significant role in changing the CBHI strategy. Community participation in the areas of being a member, premium contribution and renewing their membership. This implies that respondents believed that community input was instrumental in forming the key elements of the CBHI strategy. As a result, community members' contributions and feedback were basic tools in influencing and modifying the CBHI, ensuring it aligns better with the community's needs and preferences.

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

Positive impact: The degree of community participation had a significant impact on the CBHI strategy

Responsive system: It makes the CBHI strategy more effective since it is adjusted based on feedback and input from the community.

Positive result: The community inputs within CBHI suggest a collaborative system for strategy development, fostering optimism among the audience.

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

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

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

Community leaders, as active members of the CBHI community, play a crucial role in the strategy formulation process. They represent the target population in the general counsel of the CBHI, thereby becoming the voice of the community in the decision-making processes. The significance of their involvement can be deduced from the following points:

Active Participation of Leaders: The strong agreement among respondents, with a mean value of 4.1, underscores the active role played by community leaders in the formulation of the CBHI strategy. This level of involvement reassures the audience about the legitimacy of the strategy.

Community leaders' influence is evident in the CBHI strategy formulation. Their participation implies that decisions are guided by community needs and values, ensuring the strategy is in line with the community's best interests.

Community leaders often serve as a vital bridge between the public and decision-makers. Their involvement in the CBHI strategy formulation process gives the community a sense of representation and ensures their voices are heard.

Enhanced Legitimacy: The perceived legitimacy of CBHI initiatives is increased when esteemed community leaders participate in decision-making. Residents are more inclined to accept decisions as valid and deserving of support when trusted community members make them.

According to the study's findings, most respondents have a favourable opinion of community leaders' participation in CBHI planning. This inclusive approach has produced a strategy that is more legitimate and accepted by the community while also better reflecting local demands.

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

Respondents' responses to community engagement significantly contribute to the success of the CBHI programs. As shown in Table 5.2 above, the mean value for this question is 4.14, which implies that community engagement significantly contributes to the success of the CBHI programs in the west show zone. From this, one can infer that community engagement is one of the important factors determining the effectiveness of CBHI schemes in the west show zone. From this, the involvement of community members in the CBHI programs might include activities such

as decision-making processes, awareness campaigns, feedback mechanisms, and participatory planning.

Significantly contributes boldly indicates how community involvement is so crucial for the successful implementation of the CBHI. The strategy may not meet its goal if the local community is not engaged and supports it. Hence, community involvement is crucial to the success of CBHI programs. Research indicates that the main goals of community engagement initiatives are to mobilize difficult-to-reach populations, address disinformation, develop community ownership, and establish trust (Agrawal et al., 2023, 2023; Berrett-Abebebe et al., 2023). Collaborating among institutions, professions, and stakeholders is essential for effective community involvement. It also highlights the value of deliberate leadership and places the community at the heart of efforts to promote health equity (Schlechter et al., 2021). Moreover, community-engaged dissemination and implementation research (CEDI) emphasizes how important it is to include stakeholders from a variety of backgrounds to incorporate local knowledge and, eventually, improve health disparities (Cory et al., 2021). The relevance of enhanced awareness and factors impacting engagement in community-based health education (CBHI) programs is underscored by primary healthcare professionals' favourable attitudes and increasing awareness towards CBHI (Miskeen & Al-Shahrani, 2023). The respondent's view of the CBHI strategy genuinely represents the needs and preferences of our community in accessing health services. Services. Respondents agreed that the CBHI strategy genuinely represents the needs and preferences of our community in accessing health services. We can infer this result using the following points:

Alignment with Community Needs and Preferences: The scheme emphasizes the community's unique medical care needs and preferences; this implies that the CBHU formulation and implementation consider the local community's needs for the services, cultural considerations and regional health priorities.

Positive Perception: Respondents agreed that they do have a favourable view of the CBHI. This suggested that CBHI is important, appropriate and responsive to the community.

Community Representation response: Participants feel that their ideas, concerns, and unique circumstances were taken into consideration during the development and execution of the CBHI program, indicating that the approach accurately represents community opinions.

Accessing Health Services: The emphasis on obtaining health services indicates how well the CBHI approach works to make healthcare more widely available, reasonably priced, and suited

to the needs of the community. This could cover things like service quality, financial security, and service availability.

In general, most of those surveyed thought that the scheme effectively answers their local healthcare preferences and needs. This implies how the community-centred and stakeholders' implementation significantly aligns with contextual requirements.

There are different studies conducted in various nations that support these results:

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

The statement "Respondents agreed that community members were well-informed about the progress and decisions related to the CBHI strategy" indicates that the individuals surveyed believe there is effective communication and transparency regarding the Community-Based Health Insurance (CBHI) strategy. CBHI communication channels are successful in updating the program's developments, modifications and decisions. Members' continued knowledge is important for fostering the CBHI and trust building and showing strong transparency.

Respondents agree that different stakeholders, like community representatives and policymakers, were engaged in the CBHI strategy formulation because the program is inclusive.

Stakeholder Involvement: According to the consensus of respondents, the CBHI strategy was developed by means of inclusive stakeholder engagement, considering a range of viewpoints and interests. This participatory approach recommends that various points of view be thoroughly considered when designing policies.

Community Representatives: The community was not directly represented in CBHI during the policy formulation, but there were indirect representations by community leaders. That is why community representatives are those directly impacted by the CBHI. Such engagement ensures that CBHI aligns with the needs of the household and wants.

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

Collaborative Effort: There are various collaborative mechanisms between the scheme and the community. Among those are joint meetings, consultations, workshops or other forms of participatory planning where various stakeholders could disseminate their opinions and contribute to the strategy.

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

The research result indicating that respondents agreed with the contribution of community-based health insurance to the overall health and well-being of the community suggests that the respondents agreed with the positive impact of CBHI on their lives. Respondents likely perceive that CBHI has enhanced their access to essential healthcare services. Improved Access to and Results from Healthcare

Most survey participants agree that the Community-Based Health Insurance (CBHI) program has increased access to healthcare by lowering financial barriers and allowing more people to receive medical care, treatments, and prescription drugs. The noted increases in the accessibility

of healthcare services might significantly improve public health. Such improved access, according to empirical data, may mediate decreased frequency of treatment hold-ups and related issues, Lower cause-specific death rates and better population-level aggregate health metrics. Additionally, the positive response from respondents shows greater institutional confidence in the framework of CBHI, and increased beneficiary satisfaction has favourable effects on long-term retention rates as well as initial enrollment uptake. This kind of community trust supports the program's long-term viability and success. The sense of shared benefit from CBHI can strengthen community bonds as members recognize that the scheme contributes to collective well-being and supports each other in times of health crises.

CBHI program has improved people's health and well-being. According to studies, being a member of the CBHI increases the use of health services, lowers out-of-pocket costs, and lowers catastrophic health expenditures, which benefits the community at large as well as insured households (Daraje, 2022; Lakew et al., 2023; Alemyehu et al., 2023). CBHI has effectively improved members' quality of life; insured people have a higher quality of life than their uninsured counterparts (Get et al., 2023). Additionally, CBHI has contributed significantly to reducing disparities in how households use modern health services, improving access to healthcare services and fostering equity in communities (Kassa, 2023). Overall, the data point to the CBHI strategy's critical role in advancing financial protection, advancing universal health care and improving community health and well-being in Ethiopia.

Respondents' responses to the CBHI strategy were developed in a way that encourages ongoing community involvement. The respondents (n = 4.32) believed that the current CBHI strategy promotes ongoing community engagement and involvement in the CBHI scheme activities. This implies that the CBHI scheme includes mechanisms that encourage participation, feedback, and collaboration from community members. Respondents feel that the CBHI strategy not only engages them but also involves them in various activities and decision-making processes. Regular meetings, community forums, or participatory planning sessions are a few examples of how members can express their thoughts and help shape and enhance the CBHI program. Continuous community involvement and engagement are essential to the CBHI scheme's viability. The respondents' perception of this element implies that the approach successfully cultivates in community members a sense of accountability and ownership, which is critical to the program's long-term sustainability. The positive response implies that the current CBHI strategy promotes

trust and transparency. Community members are more inclined to trust the program and believe it to be open and accountable when they are actively involved on a regular basis. Programs for education and awareness that educate the public about the advantages, protocols, and significance of the CBHI system are part of the plan.

This knowledge empowers them to participate actively, make informed decisions, and shape the future of their community's health care.

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

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

The research result indicating that the mean (n) value is 4.34 implies that respondents believe the CBHI strategy demonstrates a commitment to addressing the unique challenges of their community, such as [specific health issues or financial constraints]. This high mean value on a Likert scale (typically ranging from one to five) suggests strong agreement among respondents, and it has several key implications:

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

The high mean value indicates that the CBHI strategy is not a one-size-fits-all approach but a tailored method that ensures the interventions and solutions provided are suitable for the community's context, meeting their unique needs.

Community-Specific Solutions: The consensus among the respondents indicates that the CBHI plan includes ideas meant to solve problems unique to their neighbourhood, such as (specific diseases, healthcare facilities, or social obstacles). These answers could be tackling common diseases, improving access to healthcare facilities, offering reasonably priced healthcare, or removing social obstacles to health.

The mean value of 4.34 reflects a perception of the CBHI strategy as committed and responsive to the community's needs, building trust and confidence among community members in the scheme's ability to support them.

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

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

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

In summary, the mean value of 4.34 implies a strong belief among respondents that the CBHI strategy is successfully addressing their community's unique challenges. This implies that the program promotes confidence, contentment, and continued support by being efficient, pertinent, and sensitive to the unique requirements of the community.

The CBHI plan shows a devoted approach to tackling the difficulties encountered by communities (Sanjib, 2020). By combining their resources, CBHI programs seek to safeguard low-income populations financially against unforeseen medical costs in the future (Haldar et al., 2021, 2021). Although CBHI can aid in reaching underprivileged groups, government-built health infrastructure cannot be replaced by it (Aggarwal, 2011). The tactic is pooling assets to pay for medical costs, especially for individuals who are not eligible for regular health insurance benefits,

including workers in the unorganized sector (Sniezek, 2012). It is clear from examining package prices and contrasting them with hospital expenditures that CBHI plans would not always provide enough coverage, which could result in operating losses for healthcare facilities (Hayes et al., 2021). Notwithstanding obstacles, CBHI continues to be an essential instrument for improving community health needs and access to healthcare services.

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

The findings suggest a collaborative approach to managing and evolving the CBHI program. Members' input is considered valuable in shaping the program's direction and addressing its main concerns. The active involvement of members could indicate a sense of empowerment within the community. The CBHI program is not only providing health insurance but also fostering a participatory environment where members can voice their opinions and influence decisions. According to Vértesy & Namomsa (2023), Due to their lack of access to social security, health insurance, and financial independence, women were often unable to get healthcare on their own. Because of CBHI's goal, things are beginning to change for Ethiopian women and their families.

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

Discussions concerning the long-term objectives of the CBHI program were actively taking place among Ethiopian community members (Yonas et al., 2022; Mulat et al., 2022). The CBHI program sought to lower out-of-pocket costs, guarantee access to necessary medical care, and raise funds (Tahir et al., 2022). Despite early obstacles, including low knowledge, misunderstandings,

financial limitations, and discontent with health services impeding enrolment (Shigute et al., 2020), the program attracted much interest from the community, particularly from those with chronic illnesses and those who believed their family's health status was compromised (Mirach et al., 2023). For the CBHI to be implemented and decision-making to be successful, stakeholders stressed the significance of progressively raising risk pooling, enhancing operational staff training and health information system, engaging different stakeholders, and improving the service quality.

Does the CBHI approach, in the opinion of the respondents, encourage a feeling of pride and ownership among community members? The research results that respondents agree that current Community-Based Health Insurance (CBHI) nurtures a feeling of ownership and trust among the members of their community indicates several significant implications. The viability of the program is positively impacted by the trust that the majority of CBHI members have in the organization. CBHI members feel a sense of ownership over the program. This feeling likely arises from their active involvement in discussions and decision-making processes, contributing to a perception that the program belongs to them and serves their interests.

Members' trust in the program has been successfully increased. Any community-based project needs trust to be successful because it promotes involvement, following rules, and support among participants. Building trust and ownership improves ties within the community. A stronger, more cohesive community is created when participants trust the program's operations and feel invested in it. The sustainability of the CBHI program depends on trust and a feeling of ownership. The program's stability and long-term success are influenced by the likelihood that dependable and engaged participants will stick with it.

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

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

The Community-Based Health Insurance (CBHI) program's introduction in Ethiopia has improved the sense of pride and ownership among residents. According to research, community involvement in the creation and oversight of health services, such as through CBHI programs, improves financial security and the utilization of essential medical care (Tefera & Ayele, 2022; Kaso et al., 2022). Households' interests and attitudes have also improved because of the CBHI's successful implementation; a large majority of them have good opinions about the program (Jembere, 2018). Furthermore, positive attitudes regarding the program, a sense of ownership and commitment among participants, and a thorough understanding of the CBHI program all have a substantial impact on membership renewal rates (Tiruneh et al., 2020). CBHI has been extremely important in helping Ethiopian communities develop a sense of pride and ownership.

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

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

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

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

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

Enhanced Relevance and Effectiveness: Strategies developed with input from both the community and experts are likely more relevant and practical. While specialists offer technical knowledge and evidence-based procedures, community people can offer insights into local problems and workable solutions.

Sustainable Development: Through encouraging a sense of dedication and ownership among community members, this strategy promotes sustainable development. When people see their perspectives influencing policy and strategy, they are more likely to remain engaged and supportive over the long term.

The results highlight how crucial it is to develop CBHI strategies through collaborative and participatory methods, which will result in programs that are better suited to the needs and realities of the communities they serve.

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

The CBHI strategy, a community-based health insurance initiative, reflects the collective aspirations of our community for better healthcare. Respondents believed that the collective aspirations of the community were included in the CBHI strategy, which is designed to provide affordable and accessible healthcare to all members. From this, one can infer that the insured services covered by CBHI, such as primary care, hospitalization, and emergency services, fulfil the community's desire for better health care. The research result indicating that respondents believe the CBHI strategy reflects the collective aspirations of the community for better healthcare suggests several key points:

1. **Community-Centered Strategy:** The CBHI strategy is designed with a strong focus on the community's needs and desires. Because of this congruence, the program is guaranteed to be pertinent and sensitive to the community members' unique health issues and objectives.

2. **Reflecting Collective Aspirations:** The strategy incorporates the collective aspirations of the community, such as improved access to healthcare, financial stability, and better health outcomes. This means that the shared hopes and goals for improved healthcare are considered in its formulation. This collective approach helps to unify the community around common objectives.
3. **Enhanced Support and Engagement:** When community members see their collective aspirations reflected in the CBHI strategy, it can enhance their support and engagement with the program. They are more likely to participate actively and contribute to the program's success when they feel their goals and needs are being addressed.
4. By aligning the CBHI strategy with the community's aspirations, the program is poised to achieve positive health outcomes. Strategies that are rooted in the genuine aspirations of the community have the potential to effectively address specific health issues and elevate overall health standards, instilling a sense of optimism about the program's potential.
5. **Building Trust and Ownership:** Members' trust and sense of ownership are increased when the CBHI approach considers the community's goals. Increased community cohesion and dedication to the program's long-term objectives may result from this.
6. **Responsive and Adaptive Strategy:** A strategy that reflects collective aspirations is more likely to be adaptive and responsive to changing community needs. This dynamic approach ensures that the program can evolve and remain effective over time.

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

The community's overall goals for better access to healthcare and financial stability are in line with Ethiopia's CBHI plan. Through CBHI, disparities in the use of contemporary health services have decreased, households have been shielded from excessive medical costs, and health service utilization has dramatically improved. Rural families are particularly willing to pay for CBHI initiatives, according to research, underscoring the region's need for affordable and easily accessible healthcare (Geta et al., 2023; Kaso et al., 2022; Kassa, 2023).

The study's findings, which showed that respondents agreed with a mean score of 4.05, demonstrate that open communication was a key component of community involvement in the CBHI plan:

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

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

Effective Engagement: An essential component of successful community engagement is open and honest communication. More active and meaningful engagement may result from ensuring that community members are educated about the plan, their responsibilities, and the results of their contributions.

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

Positive Perception: The fact that the respondents agreed with the statement indicates that they had a favourable opinion of the engagement process. This favourable opinion is essential to the CBHI program's long-term viability and success since it promotes community involvement and support.

In summary, the mean value of 4.05, indicating agreement that community engagement in the CBHI strategy was characterized by transparent communication, reflects a strong endorsement of openness and clarity in how the strategy was communicated. This transparency is essential for building trust, fostering effective participation, and ensuring the success of the CBHI program.

Transparent communication was a defining feature of community engagement in Ethiopia's CBHI strategy (Adebisi et al., 2021). The study underscored the crucial role of the research community in planning, sharing evidence, regulating procedures, and distributing findings in health research (Carvalho & Capurro, 2016). It also highlighted the importance of community involvement in ensuring community ownership of research results (Chantler et al., 2018). Open communication and transparency are essential components of successful community involvement

programs, as they foster shared accountability and constructive dialogue about health issues among community members (Schlechter et al., 2021). This emphasis on community involvement underscores the audience's value and integral role in the success of the CBHI program.

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

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

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

Integrated Health Services: The collaboration with hospitals and pharmacies indicates an integrated approach to healthcare delivery. This integration ensures that when government hospitals lack certain medicines, patients can still obtain their prescribed medications from agreed-upon pharmacies, minimizing disruptions in their treatment.

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

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

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

Resource Optimization: Collaboration with local hospitals and pharmacies helps optimize resources. It ensures that members have access to necessary treatments and medications even when

specific resources are unavailable at one location, demonstrating a practical and flexible approach to healthcare provision.

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

Ethiopia's CBHI program is an example of strong collaboration between community members and local organizations (Geta et al., 2023; Mulat et al., 2022; Kassa, 2023; Daraje, 2022; Alemayehu et al., 2023). The CBHI implementation bolstered domestic resource mobilization and international efforts towards universal health care with strong political support and the utilization of early pilots to guide scaling up. This tactic encouraged community involvement, enhanced accessibility to healthcare, offered financial security, and gave women more influence. Furthermore, among enrolled households, CBHI dramatically decreased catastrophic health expenses, demonstrating its efficacy in health service consumption and financial protection. In addition to improving health outcomes, community and local institution participation in the CBHI scheme adds to the program's success and sustainability in Ethiopia.

5.6. Traditional community-support institution and CBHI implementation

5.6.1. ***Analysis of hypothesis number five (H5)***

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

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

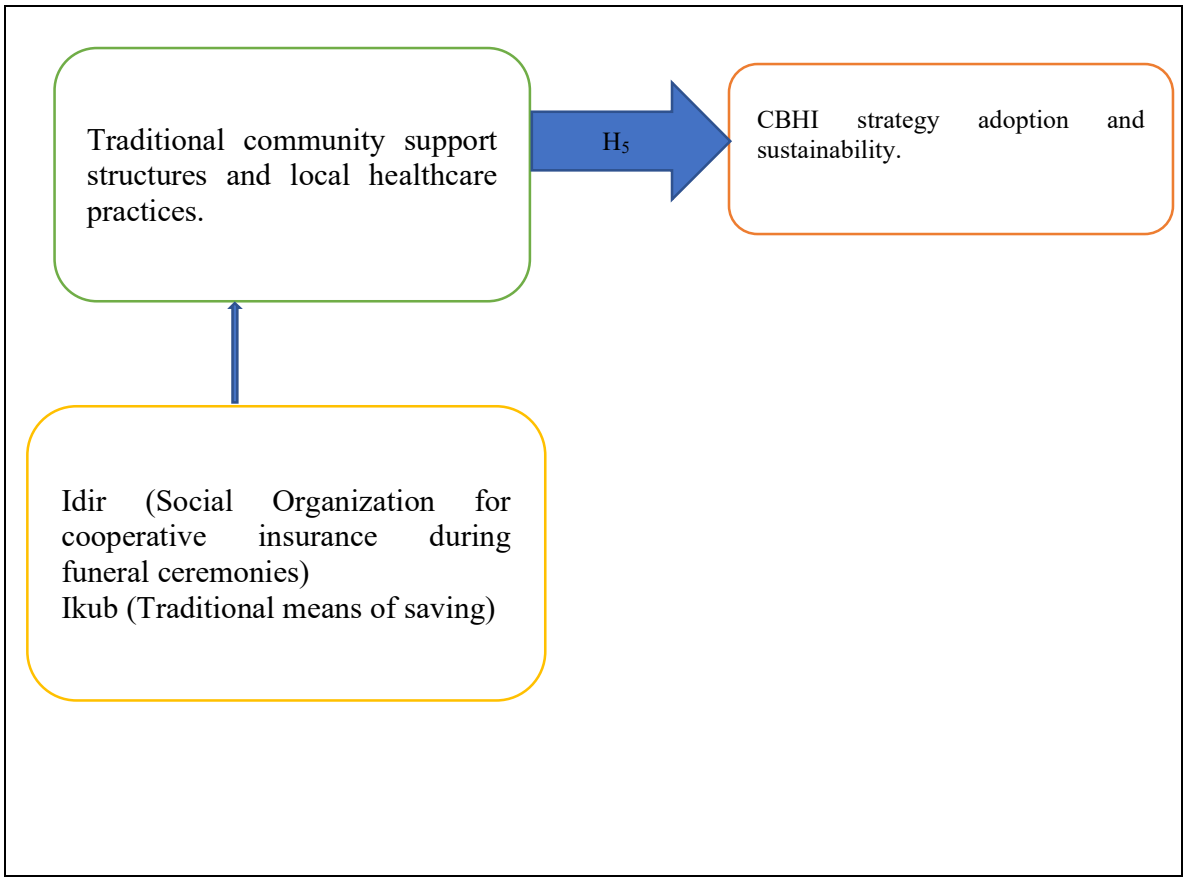


Fig 5.14 Conceptual Model

Source: Author's compilation based on research methods.

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

Correlations

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

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

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

Source: Own survey data (2024)

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

There is a significant correlation between the deployment of CBHI and traditional community support networks, as indicated by the sig. (2-tailed) the value is less than 0.05.

Ethiopia has a variety of traditional community-support structures that are ingrained in the nation's social and cultural fabric. These systems frequently offer community members various sorts of assistance, social solidarity, and mutual aid. The following are some well-known traditional community-support systems in Ethiopia: Mahber (a religious or social organization that regularly hosts meetings for social, spiritual, or financial reasons), Ikub (a traditional rotating savings and credit association where members contribute a set amount of money on a regular basis), and Edir (a community-based mutual aid association primarily formed to provide financial and social support during times of bereavement).

The relationship between the implementation of a CBHI system and traditional community support systems can be understood in several dimensions:

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

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

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

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

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

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

Communication and Information Dissemination: Conventional community support networks are essential for information sharing and communication. They can help spread awareness about the CBHI, its benefits, and how to enrol, ensuring that the information reaches all community members, including those who might find it harder to get through formal channels.

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

Descriptive Statistics

	N	Range	Min	Max	Mean	Std. Deviation	Variance
The involvement of respected community elders in endorsing healthcare programs positively impacts community members' willingness to participate.	378	4	1	5	4.09	.985	.971
The accessibility of healthcare programs within the community positively influences community members' acceptance of such programs.	378	4	1	5	4.03	1.064	1.132
The level of integration of local healthcare practices into modern healthcare programs impacts the community's perception of the program's relevance.	378	4	1	5	4.13	1.002	1.004
The current healthcare programs gain acceptance among community members because they prioritize community input and feedback.	378	4	1	5	4.03	1.090	1.187
The presence of effective communication channels between healthcare providers and community members facilitates program acceptance.	378	4	1	5	4.05	1.038	1.077
Traditional rituals and ceremonies that incorporate healthcare messages contribute to the community's openness to healthcare programs in my area.	378	4	1	5	4.08	.994	.988

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

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

Source: own survey data (2024)

The beneficiaries were asked about the impact of local healthcare practices and conventional community support networks on CBHI implementation in Table 5.7 above. Therefore, the information below shows what the beneficiaries think about the effect of traditional community support systems and local healthcare practices on CBHI implementation. The two factors taken into consideration to determine the point for each key component were the weight assigned to each central element and the score assigned to each significant element inside the factor. A perfect score of five would denote strong agreement; a score of four would denote agreement; a score of three would denote neutrality; a score of two would denote disagreement; and a final score of one would yield one mark (strongly disagree).

The willingness of community members to participate is positively impacted when esteemed community elders endorse health care programs. The decision to enrol in the CBHI was

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

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

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

CBHI programs benefit from the availability of medical services in the local area (James et al., 2008; Chen & Wu, 2022; Simiene et al., 2021). Increasing the geographic reach of healthcare

facilities improves healthcare service equity, which is advantageous for CBHI initiatives (Donfouet & Mahieu, 2012). Furthermore, studies show that CBHI programs have improved members' access to healthcare services, highlighting the significance of these initiatives in enhancing healthcare access for the intended population (Yu et al., 2018). CBHI members have greater rates of healthcare-seeking behaviour than non-members, demonstrating the substantial influence of the organization on healthcare-seeking behaviour for pediatric illnesses. For this reason, improving community access to healthcare services is essential to the efficacy and success of CBHI initiatives.

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

How relevant CBHI is in Ethiopia depends on how much local medical traditions are incorporated into modern healthcare programs. Studies show that CBHI initiatives have raised healthcare utilization, reduced catastrophic health spending, and enhanced the public's view of the quality of healthcare services (Bayked et al., 2023; Geta et al., 2023). However, variations in healthcare utilization persist across numerous sociodemographic factors, indicating that the CBHI program needs to be especially enhanced to tackle these variations (Bayked et al., 2023; Musa et al., 2023). Although beneficiary satisfaction with CBHI in Ethiopia is moderate, some signs of improving population coverage and healthcare quality are necessary to achieve universal health coverage effectively (Geta et al., 2023). Therefore, the community's opinion of the CBHI scheme's relevance and its overall influence on healthcare services in Ethiopia can be improved by skillfully incorporating traditional medical practices with contemporary healthcare initiatives.

Regarding the types of communication channels between healthcare providers and users, the research result indicates that respondents believe the existing communication channels between healthcare providers and users are effective. An essential factor in promoting the adoption of CBHI programs is communication effectiveness. More individuals are likely to take part in and benefit

from CBHI activities when there is clear and effective communication because it helps spread knowledge, resolve issues, and foster trust.

Research indicates that the use of effective communication channels between the community and healthcare practitioners impacts the acceptance of healthcare initiatives in Ethiopia.

In Ethiopia, health program adoption is greatly influenced by the availability of efficient channels of communication between healthcare personnel and the community (Wolka et al., 2022). Research on Mobile Health and Nutrition Teams (MHNTs) in Ethiopia emphasizes the significance of government ownership and community involvement as sustainability drivers (Tsegaye et al., 2022; Abamecha et al., 2021). Furthermore, the perceived quality, utility, and accessibility of health education resources are factors that impact their use during pandemics such as COVID-19, underscoring the importance of communication tools in healthcare environments (Debele et al., 2022). As demonstrated by the school-engaged SBCC strategy for malaria prevention, putting techniques that improve communication into practice, such as behaviour change communication interventions, can have a substantial influence on program acceptability and viability. Thus, promoting efficient channels of communication between communities and healthcare practitioners is crucial to guaranteeing program acceptability and success in Ethiopia.

Like other health care programs, CBHI schemes are influenced by the efficient channels of communication between employees of health care and the user.

Traditional rituals and ceremonies that incorporate healthcare messages contribute to the community's openness to healthcare programs in Ethiopia. The research result suggests that traditional rituals and ceremonies incorporating healthcare messages significantly contribute to the community's openness to healthcare programs, including Community-Based Health Insurance (CBHI). Respondents agreed that receiving information and awareness about CBHI from trusted figures such as religious leaders, local administrators, and CBHI officials has effectively increased their understanding and acceptance of these programs. This approach leverages established social structures and trusted community leaders to enhance communication and trust, thereby fostering greater engagement and participation in healthcare initiatives.

In Ethiopia, traditional rituals and ceremonies like coffee ceremonies held after childbirth and gatherings for community discussions during coffee ceremonies are significant in spreading health-related information and raising community involvement in healthcare initiatives (Limperg

et al., 2021; de Fouw et al., 1999). These cultural traditions facilitate the acceptance and adoption of healthcare services, such as screening for cardiovascular disease and cervical cancer, in addition to acting as platforms for the dissemination of health-related information (Kedir et al., 2022; Aragaw et al., 2020). Furthermore, the community's deeply ingrained knowledge and behaviours are reflected in traditional medicine, which is extensively practised in Ethiopia, and this influences the community's attitudes regarding healthcare treatments (Levene et al., 2016). Comprehending and integrating these customary beliefs and practices into healthcare initiatives helps cultivate community trust, acceptance, and involvement, ultimately leading to enhanced healthcare results in Ethiopia.

According to the study's findings, community people have a much higher feeling of confidence and trust when traditional community leaders support healthcare initiatives. The community's trust and impression of CBHI initiatives are positively impacted by the support of community leaders, as indicated by the mean value of 4.05. This support contributes to the legitimacy of the CBHI programs, promoting more community acceptance and involvement. There are various studies conducted in Ethiopia that support this conclusion.

Traditional community leaders in Ethiopia play a crucial role in bolstering healthcare programs and establishing the legitimacy and trust of the local populace. Research carried out in rural Ethiopia shows the importance of Health Extension Workers (HEWs) and the Health Development Army (HDA) as trustworthy health communicators who effectively spread knowledge about maternal health (Akafu et al., 2023). Additionally, involving a variety of actors in the promotion of mother and child health services, including religious leaders, health extension workers, and community members, increases community trust and involvement (Asfaw et al., 2019). Additionally, trust levels are significantly impacted by household heads' support of community-based health insurance programs and members' favourable opinions of the program, highlighting the significance of trust-building elements in healthcare initiatives (Mamo et al., 2019; Akafu et al., 2023). Overall, the support of traditional community leaders enhances credibility and confidence, which in turn increases the efficacy of Ethiopia's healthcare programs.

The data found in Table 5.6 above revealed that the availability of healthcare information in the local language, mainly Afaan Oromo, has a significant positive effect on the acceptance of CBHI within the community. Respondents agreed that being able to access healthcare services and information in their mother tongue enhances their understanding and trust in the CBHI scheme,

thereby increasing its acceptance and effectiveness within the community. This highlights the importance of culturally and linguistically appropriate communication in promoting public health initiatives.

The community's adoption of the program in Ethiopia is greatly influenced by the accessibility of healthcare information in their native tongues. Research indicates that the utilization of the Health Extension Program (HEP) as a service delivery platform facilitated the effective execution and expansion of evidence-based interventions (EBIs) across the country, hence enhancing the viability and coverage of healthcare initiatives (Tadele et al., 2023). In addition, the electronic Community Health Information System (eCHIS) program emphasized the significance of community-wide activities to integrate health structures and promote community health, with a focus on strengthening the standard of medical care data and service supply (Hailemariam et al., 2023). The need to provide health education through a range of learning tools was also highlighted by the finding that healthcare providers employed printed Information, Education, and Communication (IEC) materials quite frequently (Drown et al., 2024). As a result, in Ethiopia, providing healthcare information in the native tongue improves community participation and program acceptance.

Apropos respondents' responses on the involvement of women and mothers in healthcare decisions positively influence the community's acceptance of healthcare initiatives. The data found in Table 5.6 above show that respondents believe the engagement of mothers and women in healthcare decisions has a positive effect on the acceptance of CBHI schemes by the community. This involvement empowers women, who often play key roles in family health and decision-making, thereby fostering greater trust and participation in the CBHI schemes. Their active participation helps ensure that the healthcare needs and preferences of families are better understood and addressed, contributing to the overall success and acceptance of the program.

The community's acceptance of healthcare initiatives is significantly impacted by the participation of mothers and women in healthcare decision-making. Decisions around maternity healthcare, vaccination programs, and reproductive health are heavily influenced by women, which affects how acceptable these practices are in the community (Meier et al., 2023; Jaya et al., 2019; Batura et al., 2022).

In Ethiopia, women's participation in healthcare decision-making has a significant effect on healthcare acceptability efforts by the community. Research indicates that the autonomy of women

in making decisions about their maternity healthcare has a positive effect on the use of services (Kebede et al., 2023; Getu et al., 2023). Furthermore, including women in the decision-making processes for maternal health services improves the continuum of care, enabling continued access to treatments from early pregnancy to postpartum (Ayele et al., 2022). Gender-based norms, power dynamics, and social support all play important roles in moulding women's decisions about childbirth and postnatal care services, eventually influencing community attitudes and acceptance of healthcare initiatives (Kassahun & Zewdie, 2022). It is stressed that gender intersectionality, more especially men's support of women's healthcare choices, is essential to expanding access to and utilization of maternity, child, and reproductive health services in Ethiopia (Tiruneh et al., 2021).

The study's findings show that the presence of community-based healthcare professionals, such as health extension workers, positively impacts the community's comprehension and acceptance of CBHI. To increase the acceptance of CBHI, respondents concurred that these health professionals are essential in spreading knowledge and highlighting its advantages. Their direct engagement with the community helps in effectively disseminating information, addressing concerns, and building trust in the CBHI schemes. Healthcare professionals who work in the community are essential to the public health system. They serve as vital conduits between formal healthcare institutions and communities, advancing community-clinical ties, culturally competent care, and health fairness (Mashauri, 2023; Rodriguez et al., 2023).

Community-based healthcare providers have a substantial impact on informal workers' acceptance of health insurance. Research indicates that elements like professionalism, secrecy, and trust affect how well-liked community health workers (CHWs) are when they perform home visits to provide maternity and child health services (Ahmed et al., 2018). Enrolment rates are also significantly impacted by the knowledge and attitudes of informal workers toward community-based health insurance (Bantie et al., 2020). Additionally, it has been discovered that the introduction of CBHI programs increases the number of insured informal workers who use healthcare services from medically qualified providers, underscoring the beneficial effects of such programs on the acceptance and use of health insurance (Mussa et al., 2023). The existence and efficacy of CHWs can improve the populations of informal workers' acceptance and use of CBHI healthcare workers influence medical insurance uptake through a variety of approaches. Studies show that because CHWs receive adequate training, are trained to recognize warning signs, and

possess essential mother-care skills, they significantly influence the usage of maternal health services (Eric et al., 2023).

Furthermore, CHWs help to raise awareness and enrolment in community-based health insurance schemes by providing frequent supervision, transportation, refresher training, and motivation, all of which have been linked to improved maternal healthcare uptake (Boyer et al., 2021). Several factors, including geographic distance, personal risk preferences, wealth, education, and community involvement, influence health insurance adoption. This highlights the varied roles that CHWs play in fostering access to critical healthcare services and financial risk protection (Ntube et al., 2023; Bantie et al., 2020; Bayked et al., 2021).

Correlations

		CBHI implementation	Financial Hard ship	Community health outcome
CBHI implementation	Pearson Correlation	1	.221**	.246**
	Sig. (2-tailed)		.000	.000
	N	378	378	378
Financial Hard ship	Pearson Correlation	.221**	1	.582**
	Sig. (2-tailed)	.000		.000
	N	378	378	378
Community health outcome	Pearson Correlation	.246**	.582**	1
	Sig. (2-tailed)	.000	.000	
	N	378	378	378

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

Table 5.8 The correlations between DV and IV

Source: Own survey data (2024)

5.7. Analyzing the initial study hypothesis (H1)

This sub-section of this chapter examines the first research hypothesis, which asserts that: *CBHI programs in Ethiopia cover outpatient and inpatient care, critical drugs, maternity and child health services, and specific diagnostic tests. However, specialized and high-cost medical procedures have limited coverage, requiring beneficiaries to seek additional financial assistance.*

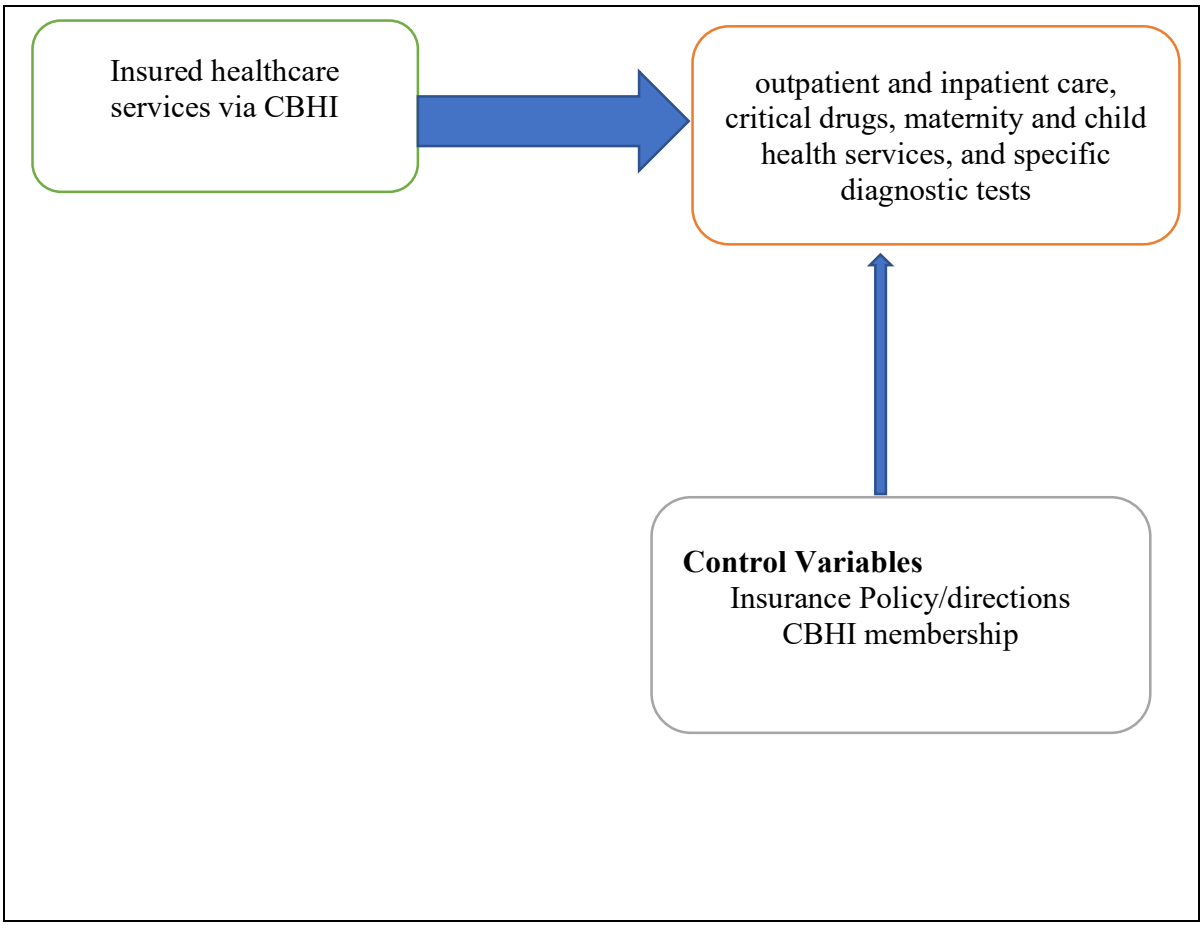


Fig5.15 Conceptual Model 1
Source: compiled by the authors using the research methodology

This hypothesis looks at essential aspects of healthcare services for CBHI members, as seen in Figure 5.15, which may directly and significantly impact community satisfaction with the

sachem's coverage. Therefore, the first hypothesis investigates the comprehensiveness of the insured healthcare services.

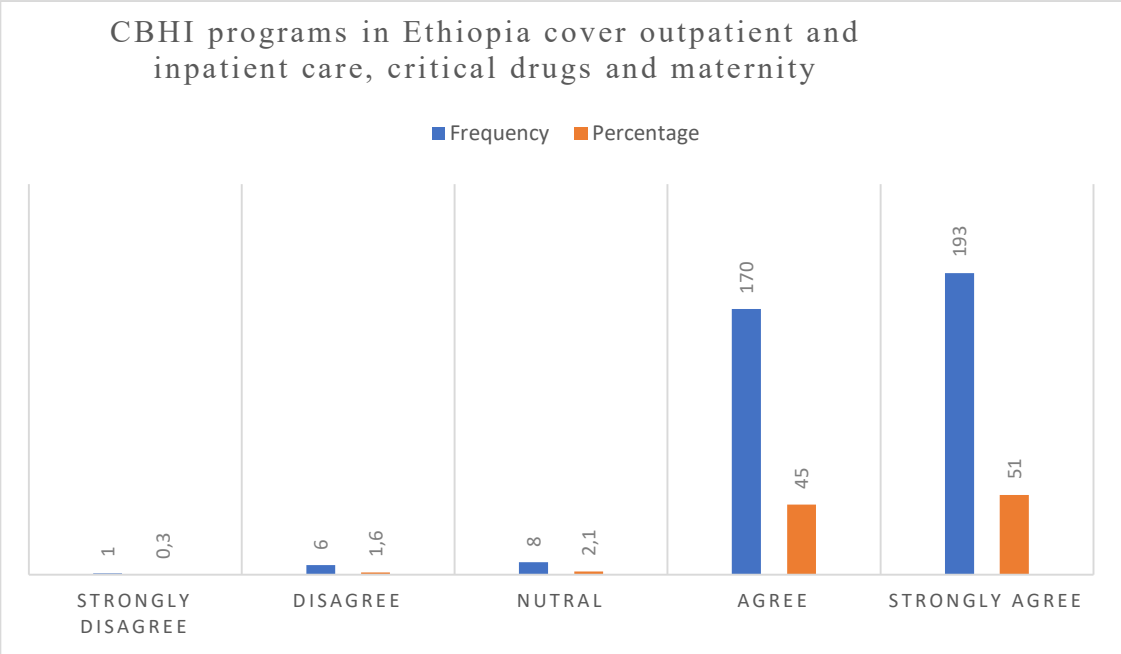


Fig5.16 Insured healthcare services covered by CBHI
Source: Own survey data (2024)

The findings show that most respondents (96%) think that critical medications, maternity and child health services, outpatient and inpatient care, and specific diagnostic tests are covered by Ethiopia's Community-Based Health Insurance (CBHI) programs. However, the coverage is not comprehensive when it comes to more costly and specialized medical procedures. Those serves are

1. Expensive and Specialized Medical Procedures:
2. Complex surgeries
3. Specialized treatments (e.g., cancer treatment, kidney dialysis)
4. Advanced diagnostic tests (e.g., MRIs, CT scans)
5. High-Cost Medications:
6. Drugs for chronic or life-threatening conditions that are expensive and require long-term use.
7. Specialized Consultations and Treatments:

8. Care is provided by specialist doctors, particularly in private hospitals.
9. Specialized therapies, such as physiotherapy or rehabilitation services.
10. Cosmetic and non-essential treatments:
11. Procedures deemed non-essential, such as cosmetic surgeries,
12. Private Healthcare Services:
13. Services provided in private health facilities are often not covered or are partially covered.
14. International Treatment:
15. Treatments sought outside of Ethiopia are generally not covered.
16. The exclusions highlight areas where CBHI coverage is limited, and beneficiaries may need to pay out-of-pocket or seek alternative funding for these services.

This gap means that beneficiaries who require such services often need to seek alternative financial support, as the CBHI program does not fully cover these more expensive treatments. This could highlight a potential area for improvement in the CBHI programs to better meet the healthcare needs of beneficiaries, especially for critical and specialized therapies. The initial research hypothesis (H1) was thus approved.

Pearson Correlation Coefficient of the absolute magnitude of the observed	Interpretation
+/- 0.00-0.10	Positive/Negative Negligible correlation
+/- 0.10-0.39	Positive/Negative Weak correlation
+/- 0.40-0.69	Positive/Negative Moderate Correlation
+/- 0.70-0.89	Positive/Negative Strong Correlation
+/-90-1.00	Positive/Negative Robust Correlation

Table 5.9 Correlation Coefficient and Interpretation

Source: Schober et al. (2018)

Based on the above table 5.9, we can interpret the data found in the above table 5.8. A positive and weak association is implied by the 0.221 Pearson correlation between CBHI implementation and shielding CBHI users from financial difficulty. People are more protected against catastrophic healthcare expenditures when they seek medical attention when they are registered in CBHI.

When we come to its sig. (2-tailed), as we can see in the above table 5.8, since the value is less than 0.05, it is significant. CBHI implementation and protecting the CBHI user from financial

hardship are significantly correlated. The Pearson correlation between CBHI implementation and community health outcomes is 0.246; this implies that there is a positive correlation between them, but they have a negative correlation. When we see the sig. (2-tailed) value in the above table, 5.8, is less than 0.05, which means the correlation is significant. Implementation of CBHI and community health outcomes are significantly correlated.

One Way MONOVA Analysis

	Implementation	Mean	Std. Deviation	N
Financial Hard ship	1.46	3.8571	.	1
	1.54	3.6429	.10102	2
	1.77	3.7143	.	1
	2.31	3.1429	.	1
	2.54	4.7143	.00000	2
	2.62	3.8571	.	1
	3.15	4.7143	.00000	2
	3.23	4.5714	.00000	2
	3.31	4.8571	.00000	2
	3.38	3.6429	1.65985	4
	3.46	3.3810	1.57359	3
	3.54	3.7714	1.31940	5
	3.62	4.3929	.47201	4
	3.69	3.9107	1.02715	8
	3.77	4.3482	.75226	16
	3.85	4.4762	.71344	18
	3.92	3.9929	.93904	20
	4.00	4.4089	.31187	29
	4.08	4.3247	.39739	44
	4.15	4.3547	.53673	29
	4.23	4.0045	.92474	32

	4.31	4.3401	.38986	21
	4.38	4.4041	.73621	35
	4.46	4.4929	.31256	20
	4.54	4.4762	.34300	18
	4.62	4.5714	.44416	19
	4.69	4.6939	.17357	7
	4.77	4.5238	.11121	12
	4.85	4.7857	.08248	4
	4.92	4.6190	.14754	6
	5.00	4.7429	.17561	10
	Total	4.3348	.65293	378
Community health	1.46	3.5385	.	1
outcome	1.54	3.6154	.10879	2
	1.77	3.6923	.	1
	2.31	4.0769	.	1
	2.54	4.5385	.00000	2
	2.62	4.0000	.	1
	3.15	4.3077	.00000	2
	3.23	4.3846	.00000	2
	3.31	4.3077	.00000	2
	3.38	3.5000	1.29709	4
	3.46	3.2308	1.70103	3
	3.54	3.8308	1.03832	5
	3.62	4.0192	.19231	4
	3.69	4.0769	.40076	8
	3.77	4.0769	.73514	16
	3.85	4.3120	.39881	18
	3.92	4.0038	.85055	20
	4.00	4.2467	.25043	29

	4.08	4.1993	.29552	44
	4.15	4.2626	.24283	29
	4.23	4.0144	.82767	32
	4.31	4.0293	.66461	21
	4.38	4.3209	.55171	35
	4.46	4.3923	.34210	20
	4.54	4.4060	.22820	18
	4.62	4.3401	.20723	19
	4.69	4.3846	.28782	7
	4.77	4.5385	.10372	12
	4.85	4.7692	.08882	4
	4.92	4.4103	.14322	6
	5.00	4.5538	.13950	10
	Total	4.2163	.54178	378

Table 5.10 Descriptive Statistics

Note. This table presents descriptive statistics for two dependent variables Financial Hardship and Community Health Outcome across different levels of CBHI implementation.

Source: Own survey data (2024)

Box's Test of Equality of Covariance Matrices[a]

Box's M	431.068
F	6.399
df1	60
df2	4760.662
Sig.	.000

Note. Box's M test assesses the assumption of homogeneity of covariance matrices.

Tests the null hypothesis that the observed covariance matrices of the dependent variables are equal across groups.

a. Design: Intercept + Implementation

Based on the above result:

The covariance matrices of financial hardship and community health outcomes are equal across the group.

As we can see from the sig. Values of Box's test of equality of covariance matrices it is significant, so we will reject the null hypothesis, which states that:

- The implementation of CBHI does not significantly protect the community from financial hardship at the time of seeking health services.
- The implementation of CBHI is significantly improving the community's health outcomes.

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	Pillai's Trace	.958	3914.875[b]	2.000	346.000	.000	.958
	Wilks' Lambda	.042	3914.875[b]	2.000	346.000	.000	.958
	Hotelling's Trace	22.629	3914.875[b]	2.000	346.000	.000	.958
	Roy's Largest Root	22.629	3914.875[b]	2.000	346.000	.000	.958
CBHI Implementation	Pillai's Trace	.232	1.515	60.000	694.000	.009	.116
	Wilks' Lambda	.777	1.550[b]	60.000	692.000	.006	.118
	Hotelling's Trace	.276	1.585	60.000	690.000	.004	.121
	Roy's Largest Root	.226	2.615[c]	30.000	347.000	.000	.184

a. Design: Intercept + Implementation

b. Exact statistic

c. The statistic is an upper bound on F that yields a lower bound on the significance level.

Table 5.11 Multivariate Tests[a]

All four tests (Pillai's, Wilks', Hotelling's, Roy's) yield statistically significant p-values (< .01). This indicates that CBHI Implementation has a significant multivariate effect on the combined dependent variables. The Partial Eta Squared values suggest a moderate effect size, with Roy's Largest Root indicating a relatively stronger individual dimension ($\eta^2 = 0.184$).

The multivariate test of CBHI implementation, the Wilks-Lambda test, is used to test whether CBHI implementation is significant in reducing financial hardship for the community at the time of seeking health services or not. As well as whether CBHI is significantly improving the community's health outcome or not.

As the value of the Wilks-Lamda test is 0.006, it is significant since it is less than 0.05, so we will reject the null hypothesis and accept the following hypothesis:

The implementation of CBHI is significantly protecting the community from financial hardship when seeking health services.

The implementation of CBHI is significantly improving the community's health outcomes. We tested whether the **independent variable** (CBHI Implementation) has a significant **combined effect** on **dependent variables**. Based on the multivariate tests:

Test	**P-Value**	**Interpretation**
Pillai's Trace	.009	Significant
Wilks' Lambda	.006	Significant
Hotelling's Trace	.004	Significant
Roy's Largest Root	.000	Significant

Table 5.12. Is the Model a good fit?

Hence, all four tests are **statistically significant** ($p < 0.05$), which **supports the overall fit of the model**.

		Levene Statistic	df1	df2	Sig.
Financial hardship	Based on Mean	3.072	26	347	.000
	Based on Median	1.797	26	347	.011
	Based on Median and with adjusted df	1.797	26	154.165	.016
	Based on trimmed mean	2.648	26	347	.000
Community health outcome	Based on Mean	3.614	26	347	.000
	Based on Median	1.906	26	347	.006
	Based on Median and with adjusted df	1.906	26	124.955	.010
	Based on trimmed mean	2.966	26	347	.000

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.

b. Design: Intercept + Implementation

Table 5.13 Levene's Test of Equality of Error Variances[a]

Since the values of financial hardship based on the mean are significant, we will reject the null hypothesis that the error variance of the dependent variable is equal across groups.

If the value of the community health outcome based on the mean is significant, we will reject the null hypothesis.

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	FH	24.892[a]	30	.830	2.120	.001	.155
	CHO	17.331[b]	30	.578	2.148	.001	.157
Intercept	FH	1943.955	1	1943.955	4966.207	.000	.935
	CHO	1846.332	1	1846.332	6864.698	.000	.952
Implementation	FH	24.892	30	.830	2.120	.001	.155
	CHO	17.331	30	.578	2.148	.001	.157
Error	FH	135.828	347	.391			
	CHO	93.329	347	.269			
Total	FH	7263.673	378				
	CHO	6830.503	378				
Corrected Total	FH	160.720	377				
	CHO	110.661	377				

a. R Squared = .155 (Adjusted R Squared = .082)

Table 5.14 Tests of Between-Subjects Effects

- The implementation of CBHI is significantly protecting the community from financial hardship when seeking health services.
- The implementation of CBHI is significantly improving the community's health outcomes.

5.8. Analyzing the fourth study hypothesis (H4)

This section looks at the fourth research hypothesis, which says that the West Shewa Zone of Ethiopia will gain better access to healthcare and financial security by implementing community-based health insurance (CBHI). Low enrollment and participation rates, poor

infrastructure, a lack of funding, and a lack of knowledge among the target population about the benefits of health insurance are some of the issues that need to be resolved.

The Wilks-Lamda test value of 0.006 suggests significance because it is less than 0.05, as Tables 5.11 and 5.14 demonstrate. Consequently, the hypothesis above is supported, and the null hypothesis is rejected. The community is being considerably shielded from financial difficulties when seeking medical care thanks to the adoption of CBHI. Health outcomes in the community are significantly improving because of the application of CBHI. The CBHI scheme's implementation in the West Show Zone is being hampered by several issues, including the uneven quality of healthcare services covered by the program, a lack of infrastructure and medical facilities, the problematic and drawn-out claims reimbursement process in CBHI systems, and a small network of healthcare providers that restrict access to high-quality CBHI services (Table 5.2).

6. CBHI IMPLEMENTATION AND CHALLENGES FROM CBHI EMPLOYEES' PERSPECTIVES

6.1. Introduction

This unit deals with the feedback of employees of CBHI at the federal, state, and local levels. This includes the background of the respondents, The relationship between administrative capacity, level of education, and work experience Challenges of CBHI Implementation, Influence of stakeholders on the success of CBHI strategy implementation in the study area, The effect of administrative capacity and workforce on CBHI implementation in the West Shewa zone, the effect of resource allocation on CBHI implementation in the West Shewa zone, and the relationship between administrative capacity, level of education, and work experience. Randomly selected 50 participants were chosen to provide their responses, and interviews were also conducted with higher officials of CBHI.

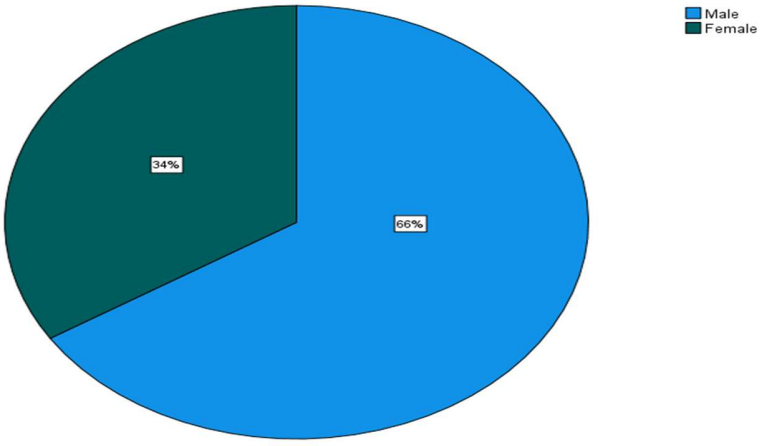


Fig 6.1 Sample distribution based on Gender
Source: Own survey data (2024)

Thirty of the total responses were men, making up 66% of the sample, while the remaining twenty were female CBHI employees, making up 34% of the sample. The result suggests that male CBHI employees made up most of the respondents.

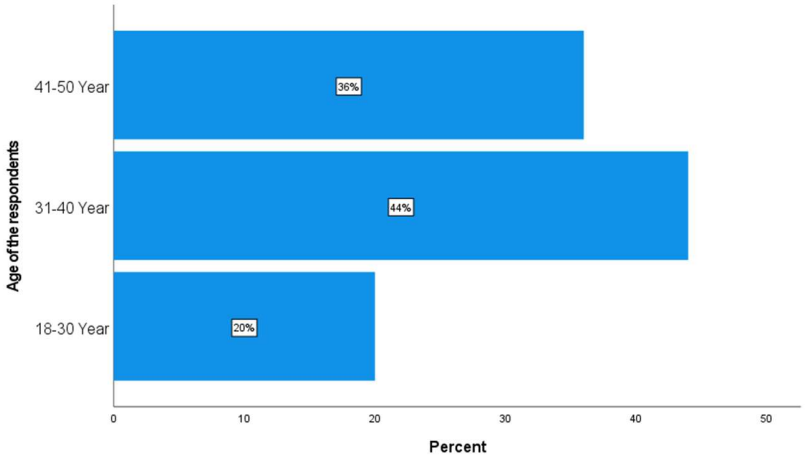


Fig 6.2 Age of the respondents
Source: Own survey data (2024)

The age distribution of the respondents showed that 10 respondents, or 20% of the sample, were between the ages of 18 and 30. A larger group of 22 respondents, making up 44% of the sample, fell within the 31–40 age range. Finally, 18 respondents, accounting for 36% of the sample, were aged between 41 and 50 years old.

This distribution implies that most of the respondents (64%) are in the younger to middle-aged workforce, particularly those between 31 and 50 years old. The significant representation of younger individuals suggests that the CBHI workforce is composed mainly of people in their prime working years, which could indicate a dynamic and active workforce capable of implementing and managing the program effectively.

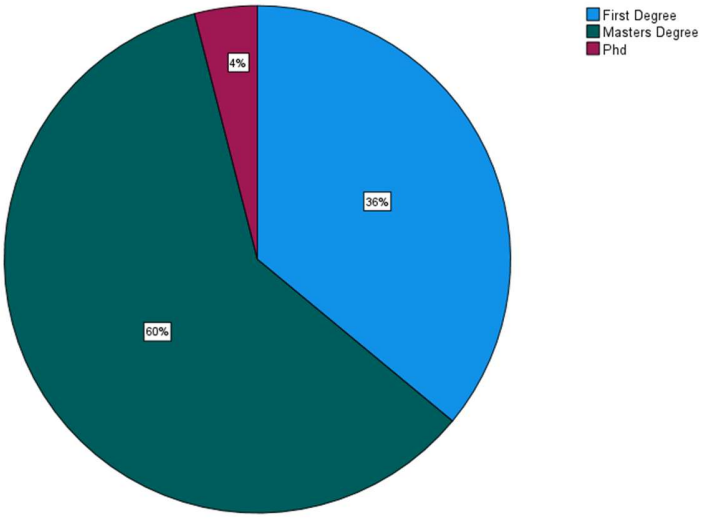


Fig 6.3 Sample distribution by Level of Education
Source: Own survey data (2024)

In terms of educational level, the data shows that 18 respondents, or 36% of the sample, hold a first degree (bachelor's degree). A larger portion of the 30 respondents, or 60% of the sample, have a master's degree. Additionally, two respondents, accounting for 4% of the sample, are PhD holders. This result suggests that most of the respondents (64%) have an advanced level of education (a master's degree or higher). The high level of education among the respondents likely contributes positively to their productivity and the overall effectiveness of the CBHI program. A staff with a high level of education can help the CBHI program be implemented, managed, and successful because these people are better able to handle complicated problems and provide better services.

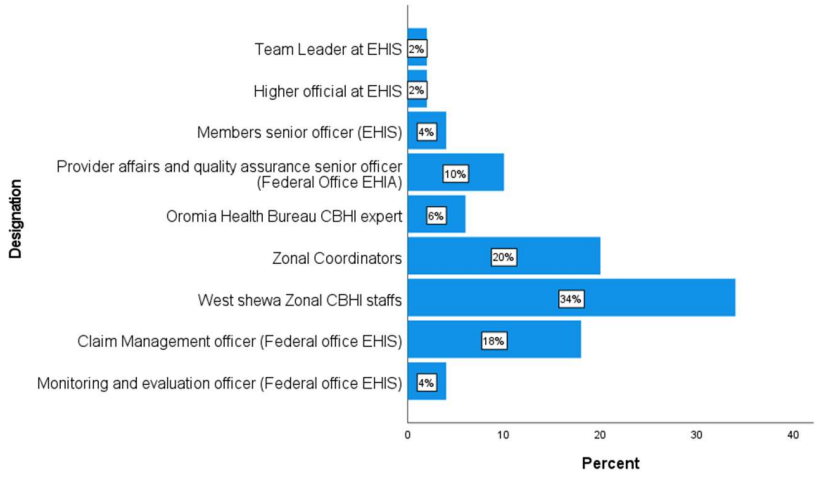


Fig 6.4 Sample distribution by Work positions
Source: Own survey data (2024)

The research included respondents from various key positions within the Community-Based Health Insurance (CBHI) framework, such as team leaders, senior officers in membership and provider affairs, quality assurance officers, officials from the Oromia Health Bureau and West Shewa Zone CBHI, as well as claim management and monitoring evaluation officers.

This broad representation suggests that the research engaged the main stakeholders of CBHI, including the Ethiopian Health Insurance Service, the Oromia Health Bureau, and the West Shewa Health Bureau. By involving employees from different departments and levels of the CBHI structure, the study was able to gather diverse perspectives and insights on the implementation and challenges of CBHI in Ethiopia. The reliability and validity of the research data are improved by this inclusivity, which also increases the comprehensiveness of the comments and opinions gathered. The involvement of various stakeholders and departments ensures that the findings are more representative and reflective of the actual conditions and experiences within the CBHI program.

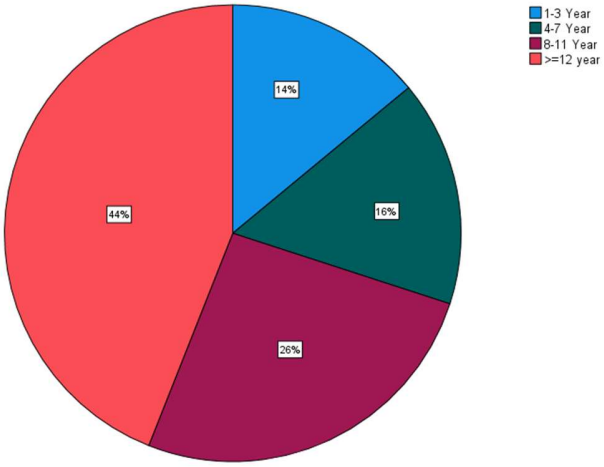


Fig. 6.5: Sample distribution by work experience
Source: Own survey data (2024)

The work experience distribution among the respondents indicates that seven individuals, or 14% of the sample, have 1-3 years of service. Eight respondents, accounting for 16%, have worked for 4–7 years. A larger group of 13 respondents, representing 26% of the sample, have 8–11 years of experience, while 22 respondents, or 44%, have more than 12 years of experience.

This distribution suggests that all respondents have relevant work experience, with a significant majority (70%) having over eight years of experience. This high level of expertise among the respondents implies that they are likely well-versed in their roles and knowledgeable about the Community-Based Health Insurance (CBHI) system. Their extensive experience can contribute to more informed and credible feedback, enhancing the depth and accuracy of the study's findings on the implementation and challenges of CBHI in Ethiopia.

6.2. Challenges related to CBHI implementation in the West Shewa Zone

Descriptive Statistics

	N	Min	Max	Mean	Std. Deviation
Limited financial resources are a significant challenge.	50	1	5	4.02	1.317
Inadequate healthcare infrastructure poses a challenge.	50	1	5	4.28	1.031
A lack of awareness about HI Benefits hinders CBHI enrolment.	50	1	5	4.40	.990
Socioeconomic disparities affect the enrolment rates.	50	1	5	4.10	1.147
Inconsistent administrative capacity across districts.	50	1	5	4.20	1.161
Difficulties in recruiting and training local healthcare workers.	50	1	5	4.12	1.304
Challenges in reaching remote and underserved areas.	50	1	5	4.00	1.443
Inadequate coordination among stakeholders.	50	1	5	4.16	1.113
Challenges in building trust and credibility.	50	1	5	2.46	1.417
Difficulties in negotiating agreements with providers.	50	1	5	4.34	1.099
Political and bureaucratic processes challenges.	50	1	5	4.48	.931
External factors (e.g., economic instability).	50	1	5	4.28	1.051
Financial sustainability challenge.	50	1	5	4.06	1.252
Complex claims reimbursement process.	50	1	5	4.28	1.031
Valid N (listwise)	50				

Table 6.1: Challenges of CBHI Implementation

Source: Own survey data (2024)

In Table 6.1, CBHI personnel were asked to share their feedback on the challenges facing CBHI implementation. As a result, the data shown below represents employees' feedback on the difficulties confronting CBHI. The point for each key component was determined by considering two factors: the weight assigned to each central element and the score provided to each significant element within the factor. Strong agreement is indicated by a perfect score of 5, agreement by a score of 4, neutrality by a score of 3, disagreement by a score of 2, and one mark is awarded for a total score of 1 (strongly disagree).

According to Table 6.1, the mean response value for the respondents' opinions regarding the effect of insufficient funding on the implementation of CBHI was 4.02. According to this mean

value, most respondents either strongly agree or agree that a lack of funding is considerably hampering the West Shewa zone's implementation of CBHI.

The high mean score reflects a consensus among employees that the lack of enough financial resources is a critical issue hindering the effective operation and expansion of the CBHI program. This result emphasizes how crucial it is to handle budgetary limitations to increase the program's efficacy and guarantee that it satisfies the community's healthcare needs.

There have been various studies conducted that support the conclusion of this finding.

In Ethiopia, insufficient financial resources are limiting the adoption of community-based health insurance (CBHI) (Daraje, 2022; Namomsa, 2023; Zepre, 2023). The current trend in developing countries, including Ethiopia, demonstrates that people frequently rely on out-of-pocket expenditures for healthcare, resulting in financial vulnerability and limiting access to critical services (Zarepour et al., 2023). According to studies, difficulties include limited government healthcare funding, significant reliance on out-of-pocket expenses, and poor resource utilization (Moyehodie et al., 2022). Furthermore, the execution of a mandatory SHI program faces opposition due to public employees' refusal to pay the planned premium. These financial constraints influence CBHI enrolment rates, with differences reported between regions based on wealth status and other individual and community-level characteristics. For CBHI to be implemented successfully and remain sustainable in Ethiopia, these financial obstacles must be removed.

The adoption of community-based health insurance (CBHI) strategies is significantly hampered by a lack of funding (Sheikh et al., 2022). The CBHI programs are intended to reduce out-of-pocket costs and enhance healthcare access; however, budgetary constraints limit their usefulness (Adsul et al., 2022). In resource-constrained environments such as Bangladesh, financial hurdles such as insufficient external support and competing financial priorities at the family level hamper the expansion of CBHI programs (Kakama et al., 2020). Furthermore, the success of CBHI implementation is dependent on reasonable premiums and extensive benefits packages, which can be challenging to maintain without adequate financial resources (Barriga et al., 2023). Overcoming these financial barriers is critical for the effective growth of CBHI schemes and for reaching universal healthcare goals in countries with limited resources (Manyazewal et al., 2016).

Based on the feedback that the respondents gave, one major obstacle to the implementation of Community-Based Health Insurance (CBHI) is the lack of suitable healthcare infrastructure. They concurred that insufficient healthcare infrastructure has a detrimental influence on the

standard of healthcare services offered, in addition to impeding the successful implementation of CBHI.

The researcher's observation supports this view, noting a severe shortage of medicines, which forces patients to purchase drugs from private vendors. This situation exacerbates the challenges faced by CBHI, as it underscores the gap in infrastructure and resource availability that affects the program's ability to deliver comprehensive and quality healthcare services. Addressing these infrastructure issues is crucial for improving CBHI effectiveness and ensuring that beneficiaries receive the necessary care.

The CBHI plan's implementation is significantly hampered by inadequate healthcare infrastructure. The quality of treatment provided in accordance with CBHI regulations is reduced when medical care services are unable to function correctly due to a lack of infrastructure, personnel, and resources (Sheikh et al., 2022).

Inadequate healthcare infrastructure reduces Community-Based Health Insurance (CBHI) membership. Poor care quality, the lack of laboratory services, and a perceived lack of respectful treatment are some of the reasons for lower CBHI enrollment rates (Desalegn et al., 2023; Daraje, 2022). Furthermore, the lack of basic logistics and supplies in healthcare facilities serves as a barrier to CBHI enrollment (Gashaw et al., 2022). According to studies, trust in the CBHI system, perceived quality of service, and premium affordability are all important factors in determining membership rates (Habte et al., 2022). Furthermore, strengthening community education, improving healthcare service quality, and guaranteeing transparent management are proposed measures for overcoming hurdles to CBHI enrolment caused by insufficient healthcare infrastructure (Abdilwohab et al., 2021).

Inadequate healthcare infrastructure (mainly lack of available medicines) is among the supply-side challenges affecting CBHI effectiveness and leading to low CBHI membership enrolment.

The respondents concurred that one significant barrier to enrollment in the CBHI program is a lack of knowledge about the advantages of health insurance. This suggests that members of the community who are not enrolled in CBHI may lack enough knowledge about the program's advantages, which affects their willingness to participate.

Despite efforts to raise awareness through various channels, there remains a knowledge gap among potential enrollees. This indicates that more effective strategies may be needed to educate

and inform the community about the benefits of CBHI to increase participation and ensure that more individuals can benefit from the program. Addressing this awareness gap is crucial for improving enrolment rates and the overall success of the CBHI initiative.

There are studies conducted in Ethiopia regarding the effect of a lack of awareness on CBHI enrolment.

Ignorance of the benefits of health insurance hinders the efficacy of CBHI in Ethiopia. Research indicates that low awareness levels are a factor in both high dropout rates and low enrolment (Daraje, 2022). Furthermore, community members' comprehension and impression of the program, particularly those who have chronic illnesses, are critical to the success of CBHI in Ethiopia (Mussa et al., 2023). The CBHI scheme's awareness, trustworthiness, and benefits knowledge have been found to be important elements that favourably impact membership renewal rates (Gashaw et al., 2022). Therefore, to improve the acceptance and sustainability of CBHI in Ethiopia, addressing the lack of awareness through focused awareness campaigns and educational activities is crucial.

The respondents agreed that socioeconomic disparities significantly impact enrolment rates in CBHI programs. Specifically, income levels and education levels among community members are key contributing factors.

Income Levels: Individuals with lower incomes may struggle to afford the premiums or contributions required for CBHI enrolment, reducing their participation in the program.

Education Levels: People's willingness to enrol may be impacted by lower educational attainment since they may not fully comprehend the significance and advantages of CBHI.

The necessity for focused initiatives to overcome these discrepancies and make CBHI more accessible to all facets of the community is highlighted by the barriers to enrollment created by these socioeconomic characteristics. This could involve offering financial assistance, improving educational outreach, and designing programs that cater to diverse socioeconomic backgrounds.

The necessity for focused initiatives to overcome these discrepancies and make CBHI more accessible to all facets of the community is highlighted by the barriers to enrollment created by these socioeconomic characteristics (Archibong et al., 2023).

Additionally, socioeconomic status affects participation in CBHI programs; the rich are more inclined to pay for CBHI than the poor, and actual involvement is strongly correlated with socioeconomic status (Chirwa et al., 2021). Gender discrepancies also exist, with female-headed

families making lesser contributions to CBHI expenditure than male-headed ones (Asante et al., 2016). To increase equality and encourage enrollment among disadvantaged populations, these findings highlight the significance of tailored approaches to CBHI design, such as flexible payment plans, subsidized premiums for people experiencing poverty, and the removal of co-pays.

The mean value of 4.20 for the question regarding the effect of inconsistent administrative capacity on CBHI implementation indicates a strong agreement among respondents that varying levels of administrative capacity across different regions contribute to disparities in CBHI implementation.

This high mean score suggests that respondents believe the inconsistency in administrative resources, skills, and processes between regions significantly affects how well CBHI is implemented. Regions with more substantial administrative capacity are likely to manage and deliver CBHI services more effectively, while those with weaker administrative support face greater challenges. Addressing these inconsistencies and strengthening administrative capacity uniformly across regions could help reduce disparities and improve the overall effectiveness of the CBHI program.

Inconsistent administrative capacity impedes the effective implementation of CBHI strategies (Sheikh et al., 2022; Hussien et al., 2022; Tefera & Ayele, 2022). Implementation challenges include poor population coverage, adverse selection, and a lack of external assistance (Vroom et al., 2022). Furthermore, a study in Ethiopia found that CBHI schemes have negative growth ratios due to governance methods, healthcare quality, and community awareness issues (Kühler, 2019). Furthermore, a lack of administrative capacity within the health system, as witnessed in Romania, hampers the practical implementation of EU-driven changes, reducing the efficacy of CBHI policies. To address these capacity issues and increase the profitability and successful execution of CBHI projects in low- and middle-income countries, strategies, expert administrative assistance, and political will are needed.

The respondents agreed that the CBHI strategy encounters difficulties in both recruiting and training local healthcare workers. This feedback highlights two main challenges:

1. **Recruitment:** CBHI is struggling to attract and hire new healthcare workers, which can impact the program's ability to expand and provide services effectively.

2. **Training:** There are challenges in providing adequate training for existing and new healthcare workers, which affects their preparedness and ability to deliver quality care within the CBHI framework.

These difficulties in staffing and training can hinder the successful implementation of CBHI and the quality of services provided. Addressing these issues may require developing more robust recruitment strategies and investing in comprehensive training programs to ensure that healthcare workers are well-equipped to support the goals of the CBHI program.

Lack of budget and existing CBHI procedures responsible for recruiting new employees and providing training and development (CBHI zonal experts).

CBHI approach confronts issues in recruiting and educating local healthcare workers. These problems include the perception that paying clients receive preferential care over insurance enrollees, which leads to a preference for private health facilities (Kang & Kang, 2023). Furthermore, the practice of health professional licensing is poorly administered in Ethiopia, with many professionals working without a license, lowering the quality of healthcare (Mekonen & Tedla, 2022). Additionally, there are insufficient training and supervision methods for health extension workers (HEWs) in the delivery of noncommunicable diseases (NCDs), with disparities in training quality and supervision practices that negatively affect employee motivation and service delivery (Tesema et al., 2022). Addressing these difficulties through better licensing standards, fair treatment of insurance enrolees, and greater training and supervision for healthcare personnel is critical to the CBHI strategy's success in Ethiopia.

The respondents agreed that the Community-Based Health Insurance (CBHI) strategy faces significant challenges in reaching remote and underserved areas. The difficulties in implementation in these regions are attributed to several factors:

Political Situation: Unstable or unfavourable political conditions can obstruct the effective deployment of CBHI services, impacting outreach and operations.

Poor Infrastructure: Inadequate infrastructure, such as a lack of roads, transportation, and healthcare facilities, hampers the ability to deliver CBHI services to remote areas.

These factors contribute to the limited implementation of CBHI in these regions, affecting the program's reach and effectiveness. Addressing these challenges might involve improving infrastructure, developing strategies to navigate political issues, and creating targeted outreach programs to enhance the accessibility of CBHI services in remote and underserved areas.

The CBHI plan in Ethiopia has unique problems reaching remote and neglected communities. Problems include the perception that paying customers receive preferential care, medicine shortages that lead to stockouts, excessive patient volume that overwhelms public health facilities, needless price increases by private pharmacies, and misunderstandings regarding yearly renewal payments without service consumption. (Mekonen & Tedla, 2022). Furthermore, Ethiopia's low total CBHI enrolment coverage, which is concentrated in large regions, makes it challenging to reach outlying communities (Mulat et al., 2022). Furthermore, inadequate ICT infrastructure, a lack of computer skills, budget constraints, and management styles impede the use of ICT in the healthcare system, limiting CBHI access to underserved regions (Daraje, 2022). Addressing these obstacles is critical to expanding CBHI access in Ethiopia's distant and underserved communities.

The mean value of 2.46 for the question regarding the CBHI strategy's challenges in building trust and credibility suggests that respondents generally do not perceive a significant issue with trust and credibility within the communities.

This relatively low mean value indicates that the CBHI strategy is not losing trust or credibility among its members. On the contrary, it implies that CBHI has successfully established and maintained trust and credibility within the communities it serves.

The positive perception of trust and credibility is beneficial for the sustainability of the CBHI scheme, as it indicates that members are likely to continue their participation and support, contributing to the long-term success and stability of the program.

Various mechanisms, like community leaders, religious leaders, and other influencers within the community, improve the quality of healthcare services, address client satisfaction, reduce waiting time for healthcare services, conduct regular promotional and educational campaigns, provide benefit packages, and establish public-private partnerships, were used to build the trust and credibility of CBHI schemes with the insured communities (Woreda CBHI officials).

Various studies support the conclusion of these findings:

There are several efficient ways to establish credibility and confidence in communities during the community-based health insurance (CBHI) rollout. These include raising the standard of healthcare, attending to client satisfaction, making sure that providers are viewed favourably, cutting down on wait times, holding frequent awareness and education campaigns, engaging community leaders, offering complete benefit packages, and creating public-private partnerships

(Akafu et al., 2023; Sheikh et al., 2022; Gashaw et al., 2022). Building and sustaining trust in communities also requires providing training, raising awareness of CBHI concepts, and guaranteeing confidence in the CBHI program (Odima et al., 2022). Enhancing confidence and credibility can be achieved through utilizing community involvement, eliminating implementation challenges, and methodically including key stakeholders. These actions will ultimately result in the successful implementation of the CBHI and greater population coverage (Tefera & Ayele, 2022).

The respondents indicated that the Community-Based Health Insurance (CBHI) strategy encounters difficulties in negotiating agreements with healthcare providers, including hospitals, health centres, health posts, and public pharmacies. The data suggests that these difficulties are affecting the effectiveness of the CBHI scheme.

Key challenges identified include:

Stock Out of Medicines: Providers experiencing shortages of essential medications can impact the ability of the CBHI to deliver comprehensive and reliable services to its members.

Claim Settlement Issues: Issues with resolving claims for services delivered may cause conflict between CBHI and healthcare providers, which may influence the providers' desire to take part in the program.

These challenges in negotiating and maintaining agreements with healthcare providers can hinder the overall implementation and effectiveness of the CBHI program. Addressing these issues may involve improving the supply chain for medicines and streamlining the claims process to ensure smoother operations and better cooperation with healthcare providers.

Negotiating contracts with healthcare providers presents difficulties for Ethiopia's CBHI programs, which affects their capacity to pay for services and maintain their financial stability (Getahun et al., 2023). These schemes' financial reports show that it is challenging to keep claims costs and revenue in balance, which results in negative net incomes and significant losses (Hussien et al., 2022). The schemes' inability to pay service providers' claims on time also makes it more difficult for them to be financially viable (Namomsa, 2023). These difficulties underline the necessity of interventions to deal with problems like moral hazard, adverse selection, and medication stockouts to improve the bargaining process with healthcare providers and guarantee the sustainability of the schemes (Terefe et al., 2022). For Ethiopia's CBHI schemes to operate effectively, these agreements must be improved (Tefera & Ayele, 2022).

The respondents agreed that political and bureaucratic processes significantly affect the implementation of the CBHI program. The data from Table 6.1 highlights two main issues:

Lack of Political Commitment: Insufficient support and commitment from middle-level officials can impede the effective implementation of CBHI. This lack of engagement may result in inadequate policy support and resource allocation, impacting the program's success.

Bureaucratic Processes: The complexity and time-consuming nature of the bureaucratic processes involved in claims reimbursement within CBHI systems create inefficiencies. These cumbersome procedures can delay payments and frustrate both service providers and beneficiaries, affecting overall program performance.

These difficulties imply that removing bureaucratic and political obstacles is essential to raising the CBHI program's efficacy and efficiency. Ensuring stronger political support and streamlining bureaucratic processes could enhance implementation and service delivery.

However, political and administrative procedures have an impact on the Community-Based Health Insurance (CBHI) program's implementation. The CBHI agenda has significantly benefited from political support, and the scheme's early experiments provided valuable insights for its expansion (Tefera & Ayele, 2022). Strong political support and community engagement made possible by CBHI have been credited with helping to negotiate obstacles, including subpar care (Mulat et al., 2022). successfully. Furthermore, the perception of receiving preferential treatment for paying clients over insurance beneficiaries has brought attention to problems with the service delivery process, highlighting the need for measures aimed at raising awareness and improving public health facilities (Shigute et al., 2020).

Political concerns offer hurdles to the CBHI plan. The successful execution and extension of CBHI are dependent on political support, as evidenced by the scheme's strong governmental backing in Ethiopia (Tefera & Ayele, 2022). However, difficulties such as perceived preferential treatment for paying clients in healthcare facilities have been recognized as potential deterrents to CBHI enrolment (Mulat et al., 2022). Furthermore, inadequate government spending in the health sector and inefficient resource utilization impede the effective operation of health insurance programs such as CBHI in Ethiopia (Daraje, 2022). Overcoming these political hurdles is critical to the long-term viability and effectiveness of CBHI in Ethiopia, and it will necessitate enhanced policy frameworks and stakeholder engagement (Mekonen & Tedla, 2022).

Ethiopia's Community-Based Health Insurance (CBHI) implementation faces significant obstacles due to bureaucratic procedures. These difficulties include low program awareness and misconceptions, financial limitations that prevent premium payments, discontent with health services, the perception that paying patients receive preferential treatment, drug shortages that lead to stockouts, high patient volume that overwhelms public health facilities, and misunderstandings regarding yearly renewal payments in the absence of service utilization (Tefera & Ayele, 2022; Mekonen & Tedla, 2022; Namomsa, 2023). Furthermore, insufficient ICT infrastructure, a lack of computer skills, financial constraints, management style challenges, and the absence of enabling legislation all limit the efficient implementation of CBHI in Ethiopia (Mulat et al., 2022; Lott et al., 2021). To increase the CBHI plan's success and sustainability throughout the nation, several administrative obstacles must be removed.

The respondents agreed that external factors, such as economic instability, have a significant impact on the sustainability of CBHI programs. Specifically, they pointed out that the current high levels of inflation are driving up the costs of health infrastructure. This economic pressure is leading to shortages in the availability of medicines, which directly affects the ability of CBHI programs to provide adequate healthcare services.

The increase in costs due to inflation can strain the financial resources of CBHI programs, making it more challenging to maintain a steady supply of essential medicines and other healthcare resources. This circumstance may jeopardize the calibre and dependability of the services rendered under CBHI, which would be problematic for the program's long-term viability. To maintain the efficacy and sustainability of CBHI programs, these economic issues must be addressed.

The respondent's response towards financial sustainability is a significant challenge faced by some CBHI programs in Ethiopia. The mean value of 4.06 implies that the respondents agreed that financial sustainability is a significant challenge faced by some CBHI programs in Ethiopia: low CBHI enrolment, low membership renewal, and low general and target subsidies from the government.

There is financial fragmentation among the CBHI schemes, which is a challenge for CBHI implementation and efficient use of the finances. This is since the fact that the collected membership premium is handled at the district level by the provident and quality assurance officer of EHIS.

Financial sustainability is a serious concern for several CBHI systems in Ethiopia. Low government spending in the health sector, reliance on out-of-pocket costs, inefficient use of resources, and erratic donor funding all threaten the financial viability of CBHI programs (Daraje, 2022; Mulat et al., 2022). Additionally, the financial sustainability of Ethiopian health initiatives is impacted by budgetary restrictions, poor infrastructure, and a lack of enabling regulations that hinder Information and communication technology (ICT) integration in the healthcare system (Tefera & Ayele, 2022). Despite attempting to provide financial security and improve health-seeking behaviour, CBHI schemes encounter obstacles such as perceived preferential treatment for paying customers, drug shortages, and high patient flow, which jeopardize their financial viability (Namomsa, 2023). Efforts to resolve these difficulties are critical to ensuring the long-term financial viability of CBHI projects in Ethiopia.

The respondents agreed that socioeconomic disparities significantly impact enrolment rates in CBHI programs. Specifically, income levels and education levels among community members are key contributing factors.

Income Levels: Individuals with lower incomes may struggle to afford the premiums or contributions required for CBHI enrolment, reducing their participation in the program.

Education Levels: People's willingness to enrol may be impacted by lower educational attainment since they may not fully comprehend the significance and advantages of CBHI.

The necessity for focused initiatives to overcome these discrepancies and make CBHI more accessible to all facets of the community is highlighted by the barriers to enrollment created by these socioeconomic characteristics. This could involve offering financial assistance, improving educational outreach, and designing programs that cater to diverse socioeconomic backgrounds.

The necessity for focused initiatives to overcome these discrepancies and make CBHI more accessible to all facets of the community is highlighted by the barriers to enrollment created by these socioeconomic characteristics (Archibong et al., 2023).

Additionally, socioeconomic status affects participation in CBHI programs; the rich are more inclined to pay for CBHI than the poor, and actual involvement is strongly correlated with socioeconomic status (Chirwa et al., 2021). Gender discrepancies also exist, with female-headed families making lesser contributions to CBHI expenditure than male-headed ones (Asante et al., 2016). To increase equality and encourage enrollment among disadvantaged populations, these

findings highlight the significance of tailored approaches to CBHI design, such as flexible payment plans, subsidized premiums for people experiencing poverty, and the removal of co-pays.

The mean value of 4.20 for the question regarding the effect of inconsistent administrative capacity on CBHI implementation indicates a strong agreement among respondents that varying levels of administrative capacity across different regions contribute to disparities in CBHI implementation.

This high mean score suggests that respondents believe the inconsistency in administrative resources, skills, and processes between regions significantly affects how well CBHI is implemented. Regions with more substantial administrative capacity are likely to manage and deliver CBHI services more effectively, while those with weaker administrative support face greater challenges. Addressing these inconsistencies and strengthening administrative capacity uniformly across regions could help reduce disparities and improve the overall effectiveness of the CBHI program.

Inconsistent administrative capacity impedes the effective implementation of CBHI strategies (Sheikh et al., 2022; Hussien et al., 2022; Tefera & Ayele, 2022). Implementation challenges include poor population coverage, adverse selection, and a lack of external assistance (Vroom et al., 2022). Furthermore, a study in Ethiopia found that CBHI schemes have negative growth ratios due to governance methods, healthcare quality, and community awareness issues (Kühler, 2019). Furthermore, a lack of administrative capacity within the health system, as witnessed in Romania, hampers the practical implementation of EU-driven changes, reducing the efficacy of CBHI policies. To address these capacity issues and increase the profitability and successful execution of CBHI projects in low- and middle-income countries, strategies, expert administrative assistance, and political will are needed.

The respondents agreed that the CBHI strategy encounters difficulties in both recruiting and training local healthcare workers. This feedback highlights two main challenges:

Recruitment: CBHI is struggling to attract and hire new healthcare workers, which can impact the program's ability to expand and provide services effectively.

Training: There are challenges in providing adequate training for existing and new healthcare workers, which affects their preparedness and ability to deliver quality care within the CBHI framework.

These difficulties in staffing and training can hinder the successful implementation of CBHI and the quality of services provided. Addressing these issues may require developing more robust recruitment strategies and investing in comprehensive training programs to ensure that healthcare workers are well-equipped to support the goals of the CBHI program.

Lack of budget and existing CBHI procedures responsible for recruiting new employees and providing training and development (CBHI zonal experts).

CBHI approach confronts issues in recruiting and educating local healthcare workers. These problems include the perception that paying clients receive preferential care over insurance enrollees, which leads to a preference for private health facilities (Kang & Kang, 2023). Furthermore, the practice of health professional licensing is poorly administered in Ethiopia, with many professionals working without a license, lowering the quality of healthcare (Mekonen & Tedla, 2022). Additionally, there are insufficient training and supervision methods for health extension workers (HEWs) in the delivery of noncommunicable diseases (NCDs), with disparities in training quality and supervision practices that negatively affect employee motivation and service delivery (Tesema et al., 2022). Addressing these difficulties through better licensing standards, fair treatment of insurance enrolees, and greater training and supervision for healthcare personnel is critical to the CBHI strategy's success in Ethiopia.

The respondents agreed that the Community-Based Health Insurance (CBHI) strategy faces significant challenges in reaching remote and underserved areas. The difficulties in implementation in these regions are attributed to several factors:

Political Situation: Unstable or unfavourable political conditions can obstruct the effective deployment of CBHI services, impacting outreach and operations.

Poor Infrastructure: Inadequate infrastructure, such as a lack of roads, transportation, and healthcare facilities, hampers the ability to deliver CBHI services to remote areas.

These factors contribute to the limited implementation of CBHI in these regions, affecting the program's reach and effectiveness. Addressing these challenges might involve improving infrastructure, developing strategies to navigate political issues, and creating targeted outreach programs to enhance the accessibility of CBHI services in remote and underserved areas.

The CBHI plan in Ethiopia has unique problems reaching remote and neglected communities. Problems include the perception that paying customers receive preferential care, medicine shortages that lead to stockouts, excessive patient volume that overwhelms public health

facilities, needless price increases by private pharmacies, and misunderstandings regarding yearly renewal payments without service consumption. (Mekonen & Tedla, 2022). Furthermore, Ethiopia's low total CBHI enrolment coverage, which is concentrated in large regions, makes it challenging to reach outlying communities (Mulat et al., 2022). Furthermore, inadequate ICT infrastructure, a lack of computer skills, budget constraints, and management styles impede the use of ICT in the healthcare system, limiting CBHI access to underserved regions (Daraje, 2022). Addressing these obstacles is critical to expanding CBHI access in Ethiopia's distant and underserved communities.

The mean value of 2.46 for the question regarding the CBHI strategy's challenges in building trust and credibility suggests that respondents generally do not perceive a significant issue with trust and credibility within the communities.

This relatively low mean value indicates that the CBHI strategy is not losing trust or credibility among its members. On the contrary, it implies that CBHI has successfully established and maintained trust and credibility within the communities it serves.

The positive perception of trust and credibility is beneficial for the sustainability of the CBHI scheme, as it indicates that members are likely to continue their participation and support, contributing to the long-term success and stability of the program.

Various mechanisms, like community leaders, religious leaders, and other influencers within the community, improve the quality of healthcare services, address client satisfaction, reduce waiting time for healthcare services, conduct regular promotional and educational campaigns, provide benefit packages, and establish public-private partnerships, were used to build the trust and credibility of CBHI schemes with the insured communities (Woreda CBHI officials).

Various studies support the conclusion of these findings:

There are several efficient ways to establish credibility and confidence in communities during the community-based health insurance (CBHI) rollout. These include raising the standard of healthcare, attending to client satisfaction, making sure that providers are viewed favourably, cutting down on wait times, holding frequent awareness and education campaigns, engaging community leaders, offering complete benefit packages, and creating public-private partnerships (Akafu et al., 2023; Sheikh et al., 2022; Gashaw et al., 2022). Building and sustaining trust in communities also requires providing training, raising awareness of CBHI concepts, and guaranteeing confidence in the CBHI program (Odima et al., 2022). Enhancing confidence and

credibility can be achieved through utilizing community involvement, eliminating implementation challenges, and methodically including key stakeholders. These actions will ultimately result in the successful implementation of the CBHI and greater population coverage (Tefera & Ayele, 2022).

The respondents indicated that the Community-Based Health Insurance (CBHI) strategy encounters difficulties in negotiating agreements with healthcare providers, including hospitals, health centres, health posts, and public pharmacies. The data suggests that these difficulties are affecting the effectiveness of the CBHI scheme.

Key challenges identified include:

Stock Out of Medicines: Providers experiencing shortages of essential medications can impact the ability of the CBHI to deliver comprehensive and reliable services to its members.

Claim Settlement Issues: Issues with resolving claims for services delivered may cause conflict between CBHI and healthcare providers, which may influence the providers' desire to take part in the program.

These challenges in negotiating and maintaining agreements with healthcare providers can hinder the overall implementation and effectiveness of the CBHI program. Addressing these issues may involve improving the supply chain for medicines and streamlining the claims process to ensure smoother operations and better cooperation with healthcare providers.

Negotiating contracts with healthcare providers presents difficulties for Ethiopia's CBHI programs, which affects their capacity to pay for services and maintain their financial stability (Getahun et al., 2023). These schemes' financial reports show that it is challenging to keep claims costs and revenue in balance, which results in negative net incomes and significant losses (Hussien et al., 2022). The schemes' inability to pay service providers' claims on time also makes it more difficult for them to be financially viable (Namomsa, 2023). These difficulties underline the necessity of interventions to deal with problems like moral hazard, adverse selection, and medication stockouts to improve the bargaining process with healthcare providers and guarantee the sustainability of the schemes (Terefe et al., 2022). For Ethiopia's CBHI schemes to operate effectively, these agreements must be improved (Tefera & Ayele, 2022).

The respondents agreed that political and bureaucratic processes significantly affect the implementation of the CBHI program. The data from Table 6.1 highlights two main issues:

Lack of Political Commitment: Insufficient support and commitment from middle-level officials can impede the effective implementation of CBHI. This lack of engagement may result in inadequate policy support and resource allocation, impacting the program's success.

Bureaucratic Processes: The complexity and time-consuming nature of the bureaucratic processes involved in claims reimbursement within CBHI systems create inefficiencies. These cumbersome procedures can delay payments and frustrate both service providers and beneficiaries, affecting overall program performance.

These difficulties imply that removing bureaucratic and political obstacles is essential to raising the CBHI program's efficacy and efficiency. Ensuring stronger political support and streamlining bureaucratic processes could enhance implementation and service delivery.

However, political and administrative procedures have an impact on the Community-Based Health Insurance (CBHI) program's implementation. The CBHI agenda has significantly benefited from political support, and the scheme's early experiments provided valuable insights for its expansion (Tefera & Ayele, 2022). Strong political support and community engagement made possible by CBHI have been credited with helping to negotiate obstacles, including subpar care (Mulat et al., 2022). successfully. Furthermore, the perception of receiving preferential treatment for paying clients over insurance beneficiaries has brought attention to problems with the service delivery process, highlighting the need for measures aimed at raising awareness and improving public health facilities (Shigute et al., 2020).

Political concerns offer hurdles to the CBHI plan. The successful execution and extension of CBHI are dependent on political support, as evidenced by the scheme's strong governmental backing in Ethiopia (Tefera & Ayele, 2022). However, difficulties such as perceived preferential treatment for paying clients in healthcare facilities have been recognized as potential deterrents to CBHI enrolment (Mulat et al., 2022). Furthermore, inadequate government spending in the health sector and inefficient resource utilization impede the effective operation of health insurance programs such as CBHI in Ethiopia (Daraje, 2022). Overcoming these political hurdles is critical to the long-term viability and effectiveness of CBHI in Ethiopia, and it will necessitate enhanced policy frameworks and stakeholder engagement (Mekonen & Tedla, 2022).

Ethiopia's Community-Based Health Insurance (CBHI) implementation faces significant obstacles due to bureaucratic procedures. These difficulties include low program awareness and misconceptions, financial limitations that prevent premium payments, discontent with health

services, the perception that paying patients receive preferential treatment, drug shortages that lead to stockouts, high patient volume that overwhelms public health facilities, and misunderstandings regarding yearly renewal payments in the absence of service utilization (Tefera & Ayele, 2022; Mekonen & Tedla, 2022; Namomsa, 2023). Furthermore, insufficient ICT infrastructure, a lack of computer skills, financial constraints, management style challenges, and the absence of enabling legislation all limit the efficient implementation of CBHI in Ethiopia (Mulat et al., 2022; Lott et al., 2021). To increase the CBHI plan's success and sustainability throughout the nation, several administrative obstacles must be removed.

The respondents agreed that external factors, such as economic instability, have a significant impact on the sustainability of CBHI programs. Specifically, they pointed out that the current high levels of inflation are driving up the costs of health infrastructure. This economic pressure is leading to shortages in the availability of medicines, which directly affects the ability of CBHI programs to provide adequate healthcare services.

The increase in costs due to inflation can strain the financial resources of CBHI programs, making it more challenging to maintain a steady supply of essential medicines and other healthcare resources. This circumstance may jeopardize the calibre and dependability of the services rendered under CBHI, which would be problematic for the program's long-term viability. To maintain the efficacy and sustainability of CBHI programs, these economic issues must be addressed.

The respondent's response towards financial sustainability is a significant challenge faced by some CBHI programs in Ethiopia. The mean value of 4.06 implies that the respondents agreed that financial sustainability is a significant challenge faced by some CBHI programs in Ethiopia: low CBHI enrolment, low membership renewal, and low general and target subsidies from the government.

There is financial fragmentation among the CBHI schemes, which is a challenge for CBHI implementation and efficient use of the finances. This is since the fact that the collected membership premium is handled at the district level by the provident and quality assurance officer of EHIS.

Financial sustainability is a serious concern for several CBHI systems in Ethiopia. Low government spending in the health sector, reliance on out-of-pocket costs, inefficient use of resources, and erratic donor funding all threaten the financial viability of CBHI programs (Daraje, 2022; Mulat et al., 2022). Additionally, the financial sustainability of Ethiopian health initiatives

is impacted by budgetary restrictions, poor infrastructure, and a lack of enabling regulations that hinder Information and communication technology (ICT) integration in the healthcare system (Tefera & Ayele, 2022). Despite attempting to provide financial security and improve health-seeking behaviour, CBHI schemes encounter obstacles such as perceived preferential treatment for paying customers, drug shortages, and high patient flow, which jeopardize their financial viability (Namomsa, 2023). Efforts to resolve these difficulties are critical to ensuring the long-term financial viability of CBHI projects in Ethiopia.

6.3. The role of stakeholders in CBHI implementation

Descriptive Statistics

	N	Min	Max	Mean	Std. Deviation
There is Strong Gov-Ngo collaboration.	50	2	5	4.66	.688
Multiple stakeholder's involvement improves CBHI design.	50	1	5	4.40	.808
Collaboration expands CBHI coverage.	50	2	5	4.40	.670
Gov-Ngo-community engagement drives success.	50	2	5	4.54	.646
Shared Responsibility for CBHI goals.	50	3	5	4.40	.571
Coordination mitigates implementation challenges.	50	3	5	4.52	.646
Gov-Ngo collaboration ensures fair resource allocation.	50	2	5	4.66	.593
Diverse expertise enhances healthcare quality.	50	2	5	4.08	.944
Improved community engagement through coordination.	50	3	5	4.46	.613
Collaborative decision-making adapts CBHI to the local context	50	3	5	4.20	.700
CBHI's responsiveness to involving health care needs.	50	2	5	4.04	.925
Stakeholder coordination enhances accountability.	50	1	5	4.32	.819
Identification/utilization of local resources for sustainability.	50	1	5	4.16	.889
Stakeholder involvement boosts Community awareness.	50	2	5	4.12	.799
Government-Ngo collaboration improves enrollment rates.	50	3	5	4.38	.697
Capacity-building opportunities through collaboration.	50	3	5	4.32	.653

Alignment of CBHI with broader health policies.	50	2	5	4.20	.881
Valid N (listwise)	50				

Table 6.2: Influence of stakeholders on the success of CBHI strategy implementation in the study area

Source: Own survey data (2024)

CBHI staff members were requested to provide input on how stakeholders affected the implementation of the CBHI strategy in the research area, as shown in Table 6.2. Employee opinions regarding the influence of stakeholders on the implementation of CBHI are thus represented in the statistics below. The weight given to each main element and the score given to each significant element within the factor were taken into consideration while determining the point for each key component. Strong agreement is indicated by a perfect score of 5, agreement by a score of 4, neutrality by a score of 3, disagreement by a score of 2, and one mark is awarded for a total score of 1 (strongly disagree). The participants said that the CBHI initiative in Ethiopia has developed a solid working relationship with a variety of stakeholders, including NGOs and government institutions. The data in Table 6.2 highlight these meaningful collaborations:

Government Agencies: The Ministry of Health, health bureaus, local health bureaus, regional and zonal administrations, and financial institutions are just a few of the government organizations with which CBHI works closely. Because they supply the required institutional support and resources, these partnerships are crucial to the CBHI scheme's implementation, supervision, and growth.

Non-Governmental Organizations (NGOs): The program also partners with NGOs like Abt Global, which operates via USAID-funded projects. According to Ethiopia Abt Global (2024), the organization's primary role involves the implementation and scaling up of the CBHI program, as well as supporting the institutionalization of the scheme. This partnership helps enhance the program's capacity to reach more communities and improve its operational efficiency.

Practical cooperation with these parties is essential to the CBHI program's success and long-term viability. Government agencies provide necessary policy and infrastructural support, while NGOs contribute through expertise, funding, and programmatic support, ensuring that CBHI can effectively serve its target populations.

According to the respondents, involving a variety of stakeholders promotes a more thorough and integrated approach to the CBHI strategy's implementation in the West Shewa Zone. This

consensus implies that the participation of various stakeholders, such as government agencies, NGOs, community leaders, and financial institutions, is beneficial for the CBHI program.

The participation of these diverse stakeholders contributes to the development of an all-encompassing implementation strategy by integrating different perspectives, resources, and areas of expertise. This cooperative approach ensures that the program is formulated to achieve the healthcare needs of the community by more successfully addressing the many implementation challenges of CBHI. Thus, the successful and long-term execution of CBHI programs in the West Shewa Zone depends heavily on the participation of numerous stakeholders.

The participation of numerous stakeholders significantly impacts Ethiopia's implementation of CBHI. According to research, households have a significant impact on enrollment rates and satisfaction levels as important stakeholders in CBHI initiatives (Zarepour et al., 2023; Zepre et al., 2023). Stakeholder engagement is crucial because it can influence program execution, as can the willingness of formal sector employees to pay premiums and their opinions toward it (Alemayehu et al., 2023). Furthermore, supportive factors that positively affect stakeholder satisfaction and program sustainability include the availability of prescribed medication, trust in leadership, and a comprehensive understanding of the CBHI scheme (Degefa et al., 2023). A range of stakeholders, including the government, healthcare facilities, and the community, must be involved to guarantee the efficacy and financial protections offered by CBHI programs in Ethiopia (Daraje, 2022).

6.4. Analysis of research hypothesis number five (H5)

This section aims to examine the fifth research hypothesis, which states that *the collaboration and coordination of multiple stakeholders, including local authorities, non-governmental organizations, and government agencies, are crucial to the successful implementation of the CBHI plan in the West Shewa Zone.*

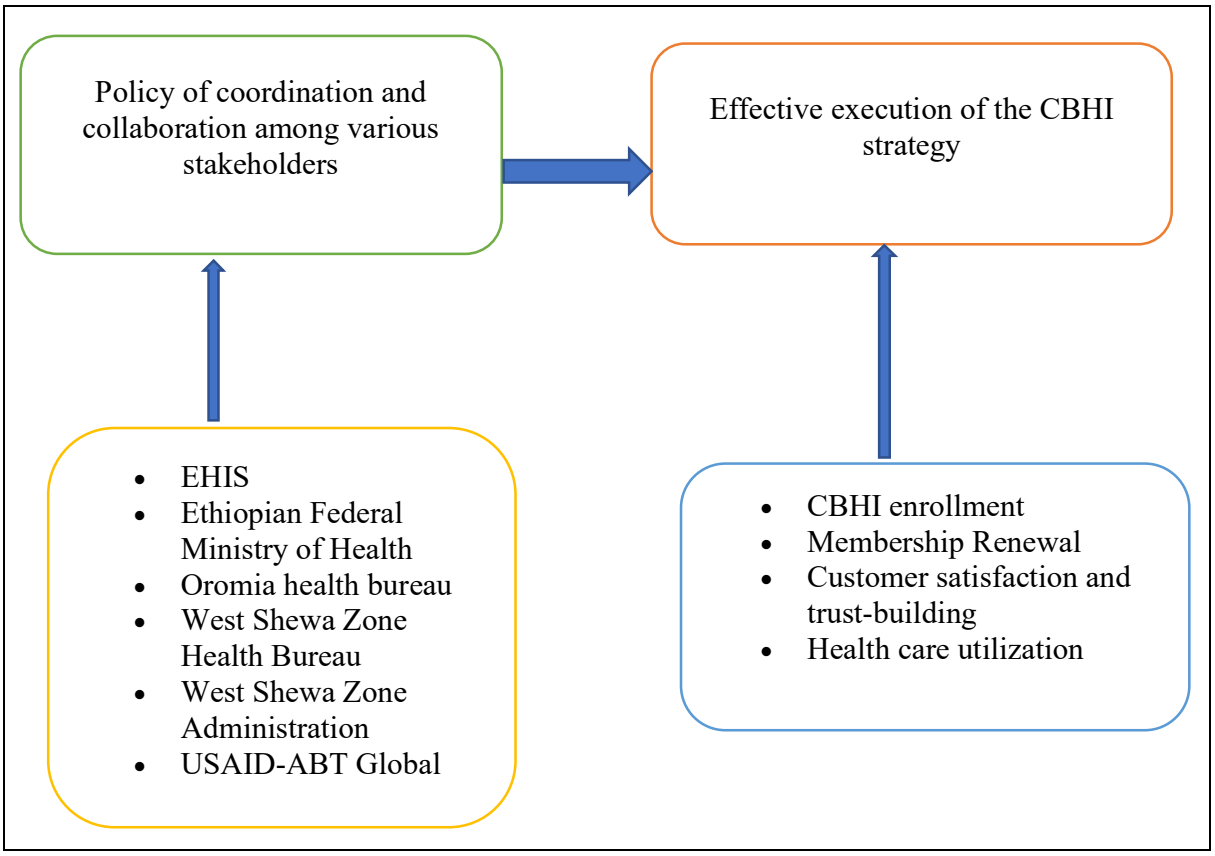


Fig. 6.6: Conceptual Model on Coordination and Collaboration among Various Stakeholders Vis-à-vis Effective execution of the CBHI strategy

Source: A compilation created by the author using research methodology

This hypothesis investigates how the coordination and cooperation of various stakeholders impact the successful implementation of the CBHI strategy. The data in the above table demonstrates that effective CBHI implementation depends on collaboration amongst the different CBHI stakeholders. Hypothesis 5 was thus accepted. Respondents concurred that the coverage and reach of the Community-Based Health Insurance (CBHI) program within West Shewa Zone communities are positively impacted by the cooperation of various stakeholders. According to this input, the growth and efficacy of CBHI are being facilitated by the combined efforts of stakeholders, including governmental organizations, non-governmental organizations, community organizations, and financial institutions.

The positive outcomes of this partnership are likely responsible for the program's more expansive reach, which increases the number of people who can access CBHI. By working together to share resources, expertise, and problem-solving techniques, these stakeholders can improve the

program's capacity to address the community's healthcare requirements community. This cooperative strategy is essential to CBHI's sustained expansion and prosperity in the area.

Collaboration among stakeholders is crucial to the success of CBHI initiatives. Numerous stakeholders, including local communities, governmental bodies, and organizations, must be included in program implementation, according to research (Nugrahaini, 2022; Darwis et al., 2019; Agbanu, 2010). Effective collaboration improves program performance by increasing skills, healthcare quality, and stakeholder trust (Hanida et al., 2017). Furthermore, successful CBHI initiatives rely on strong stakeholder connections, shared decision-making, and frequent communication to achieve improved results and sustainability (Awotunde et al., 2020).

The findings show that the successful implementation of the Community-Based Health Insurance (CBHI) strategy in the West Shewa Zone is mainly due to the active participation and efficient channels of communication among government agencies, non-governmental organizations (NGOs), and community leaders. Coordination and efficiency in putting the CBHI plan into practice are improved by this active participation, which guarantees that all important stakeholders are on the same page and cooperating to achieve shared objectives. Effective communication is very significant for solving the challenges and adapting the program to the needs of the community because it enables the prompt exchange of information, the solution of issues, and the dissemination of knowledge.

The strong interaction among these stakeholders fosters a more integrated and responsive approach to CBHI implementation, ensuring that the program is well-supported and better positioned to achieve its objectives of improving healthcare access and coverage in the West Shewa Zone.

Only through active engagement and communication between government agencies, non-governmental organizations (NGOs), and community leaders can the CBHI model in Ethiopia be successful (Hailemariam et al., 2023; Tefera & Ayele, 2022). These partnerships aid in dispelling myths, raising awareness of the CBHI program, and raising enrolment rates all around. Involving community leaders also guarantees improved community mobilization and support for the program, which improves trust and participation (Tiruneh et al., 2022). In addition, the involvement of multiple stakeholders' aids in the recognition of obstacles, such as budgetary limitations and discontent with medical care. It permits the creation of focused approaches to surmount these

difficulties, ultimately supporting the successful execution and long-term viability of the CBHI initiative in Ethiopia.

The respondents concurred that a favourable environment for sharing responsibility in accomplishing the objectives of the CBHI program in the West Shewa Zone had been established by the cooperative efforts of various stakeholders. This implies that the involvement of many stakeholders, including governmental and non-governmental organizations, community leaders, and medical professionals, has led to a shared sense of ownership and accountability for the CBHI scheme's success.

By working together, these stakeholders can distribute tasks and responsibilities effectively, ensuring that all aspects of the CBHI program are addressed. The implementation of the schemes can be enhanced via shared responsibility. As a result, no single entity bears the entire burden, and it enhances a more cooperative and coordinated system to solve the challenges. The long-term viability and efficacy of the scheme in the area rely on this cooperative atmosphere.

Working together is essential to creating a sense of shared accountability for accomplishing the objectives of the CBHI program. Many stakeholders cooperating toward a single goal have been credited with the successful implementation and scale-up of CBHI (Tefera & Ayele, 2022; Mulat et al., 2022). Because it involves healthcare professionals, policymakers, and the commercial sector, involving a variety of stakeholders is essential for resource mobilization and sustaining the sustainable development of CBHI (Tahir et al., 2022). Participation in the program has also been demonstrated to raise health facilities' accountability since it emphasizes the shared duty of providing high-quality healthcare services. Health facilities are obligated to provide quality services using the premiums collected from registered households (Simieneh et al., 2021). All things considered, cooperative efforts foster a positive atmosphere that increases CBHI's effectiveness and influence in Ethiopia.

Respondents agreed that stakeholder coordination significantly facilitates the identification and mitigation of challenges encountered during the implementation of the CBHI strategy in the West Shewa Zone. This agreement emphasizes how crucial it is for stakeholders, including governmental organizations, non-governmental organizations, community leaders, and healthcare providers, to work together effectively to resolve problems that come up while the program is being implemented.

The coordination among these various entities helps in:

1. **Identifying Challenges:** Collaborative efforts enable stakeholders to share insights and data, leading to a clearer understanding of the problems affecting CBHI implementation.
2. **Mitigating Issues:** With a coordinated approach, stakeholders can develop and implement solutions more efficiently, addressing challenges in a timely and effective manner.

This effective stakeholder coordination is crucial for the smooth operation and success of the CBHI program, as it ensures that challenges are addressed comprehensively and collaboratively, enhancing the overall impact and sustainability of the scheme.

Stakeholder coordination facilitates the identification and mitigation of challenges faced during the implementation of the CBHI strategy in the West Shewa Zone. In this regard, respondents agreed that the coordination among the stakeholders is supporting the sorting of the challenges facing them and working on solving those challenges.

To detect and mitigate difficulties throughout the implementation of CBHI in Ethiopia, collaboration among stakeholders is essential. (Mekonen & Tedla, 2022). Research has indicated that several issues are common to Ethiopian health insurance programs, including the perception of preferential care for paying patients, a lack of medications, a high patient volume in public health facilities, and uncertainty around annual renewal payments (Hordofa et al., 2019). Similar problems, such as a lack of shared plans, insufficient organizational structures, and a lack of ongoing capacity-building mechanisms, arise when interested stakeholders in adult literacy initiatives fail to coordinate with one another (Nigussie, 2021). To solve these problems and guarantee the successful implementation of health insurance and literacy initiatives in Ethiopia, practical cooperation among stakeholders is important.

The respondents indicated that the diverse expertise of different stakeholders significantly enhances the overall quality of healthcare services provided to CBHI members. According to the data in Table 6.2, various types of expertise, such as healthcare, health policy, and other specialized knowledge contributed by stakeholders, are improving the quality of services within the CBHI program.

Here is how the diverse expertise impacts the CBHI program:

1. **Healthcare Expertise:** Experts in medicine and healthcare make sure that the services are of the highest calibre, adhere to clinical guidelines, and suit the covered community's health needs.

2. **Health Policy Expertise:** Experts in health policy contribute to designing effective policies and strategies that enhance the program's structure, governance, and operational efficiency.
3. **Specialized Knowledge:** Other forms of expertise, such as financial, administrative, and logistical knowledge, help in managing resources effectively, optimizing processes, and ensuring that the program runs smoothly.

A more comprehensive approach to healthcare service delivery results from the cooperation of stakeholders with different specialities, which eventually raises the standard of care and guarantees that CBHI members receive better medical treatment.

The success of CBHI programs in Ethiopia depends on the knowledge of various stakeholders. Through resource mobilization, service quality improvement, and increased community engagement, stakeholders like lawmakers, healthcare providers, and the commercial sector contribute to the program's success (Tefera & Ayele, 2022).

To solve issues like low premium rates, claim settlement delays, and adverse selection, stakeholder participation is crucial to the financial sustainability of CBHI schemes (Hussien et al., 2022). For CBHI projects in Ethiopia to be effective and sustainable, a wide range of stakeholders must work together.

Respondents agreed that effective stakeholder coordination plays a crucial role in enhancing community engagement and participation in the CBHI program. According to the feedback:

1. **Improved Community Engagement:** Effective coordination among stakeholders helps in mobilizing community members, raising awareness about CBHI, and fostering active participation. When stakeholders work together seamlessly, they can create more impactful outreach efforts and educational programs.
2. **Enhanced Participation:** Higher levels of enrolment and engagement result from community people being more active in the CBHI programme thanks to coordinated efforts. When different stakeholders coordinate their activities, improved communication and support are made possible, which promotes community involvement.
3. **Current State:** The coordination among stakeholders is reported to be better in most parts of Ethiopia, contributing positively to the levels of community engagement and participation.

Overall, effective stakeholder coordination helps create a supportive environment that encourages greater involvement from the community, which is essential for the success and sustainability of the CBHI program.

Effective community participation is greatly enhanced by stakeholder collaboration. A cooperative strategy to address community issues and guarantee active participation in research activities can be formed by involving a variety of stakeholders, including people in the community, healthcare experts, and local government representatives (Siew, 2023; Silberberg & Martinez-Bianchi, 2019). Key components of stakeholder engagement include dedication, respect, and power-sharing (Poger et al., 2021). Community involvement can be further strengthened by including stakeholders through innovative educational approaches and bidirectional learning (Chabukswar et al., 2022). Including a variety of stakeholders can also result in better trial design, execution, and dissemination plans, including payers, pharmacists, patient partners, and guidelines experts (Barger et al., 2019). In general, good stakeholder coordination increases community ownership, rapport, and trust, all of which improve community involvement in research projects.

CBHI officials agreed that the collaborative decision-making processes among stakeholders have significantly contributed to the adaptability of the CBHI strategy to the local contexts in the West Shewa Zone. This means that:

1. **Local Context Adaptation:** Incorporating local knowledge and insights through collaborative decision-making guarantees that the CBHI plan is customized to satisfy the unique requirements and conditions of the West Shewa Zone. This flexibility contributes to the program's increased effectiveness and relevance in the local setting.
2. **Stakeholder Involvement:** Diverse viewpoints and skills are brought to the decision-making process by the participation of several stakeholders, which improves the capacity to adjust and react to local opportunities and difficulties.
3. **Enhanced Effectiveness:** The program can better satisfy community needs, improve service delivery, and accomplish its objectives by modifying the CBHI strategy to fit the local environment through cooperative efforts.

Cooperative decision-making procedures are essential to maintaining the CBHI strategy's adaptability and responsiveness to the unique circumstances of the West Shewa Zone, which will result in a more effective and significant implementation.

Enhancing the CBHI strategy's ability to adjust to Ethiopian local conditions requires stakeholder participation in decision-making. Involving stakeholders in healthcare initiatives has been found to be beneficial for identifying challenges, choosing implementation strategies, and resolving implementation-related problems (Tiruneh et al., 2022). Facilitators for effective data-

driven decision-making (DDM) techniques were identified as including external change agents, internal change leaders, and encouraging team-based reflection (Baynes et al., 2022). Strong governmental backing, community mobilization, and early pilot programs that guided the scaling-up process were also credited with the CBHI's successful expansion in Ethiopia, underscoring the significance of stakeholder participation in policy implementation (Tefera & Ayele, 2022). To successfully execute healthcare initiatives in Ethiopia and to ensure that they are tailored to local circumstances, collaborative decision-making processes are important.

Involving stakeholders is crucial to guaranteeing that the CBHI program successfully meets the evolving healthcare needs of the local community in the West Shewa Zone, according to respondents (mean value = 4.04). This suggests that:

1. **Adaptability to Healthcare Needs:** The collaborative efforts among stakeholders help the CBHI program remain responsive to evolving healthcare requirements, ensuring that the services provided meet the current and emerging needs of the community.
2. **Positive Impact:** The high degree of agreement suggests that the cooperation of stakeholders enhances the CBHI scheme's efficacy and capacity to meet the healthcare demands of the insured population.
3. **Ongoing Adjustment:** The active involvement of various stakeholders allows for continuous assessment and adjustment of the program, making sure that it continues to be applicable and efficient in meeting the community's healthcare needs.

In conclusion, cooperation between stakeholders is necessary for the CBHI program to adjust and successfully address the community's healthcare requirements, which will ultimately contribute to the scheme's overall success and sustainability.

The consensus among respondents was that well-organized coordination among stakeholders can significantly enhance the transparency and accountability of the CBHI program. This implies that:

1. **Improved Transparency:** Effective stakeholder coordination ensures that processes and decisions related to the CBHI program are clear and visible to all parties involved, including the community. This transparency helps build trust and ensures that stakeholders are aware of how resources are allocated and used.
2. **Enhanced Accountability:** Coordination among stakeholders facilitates better oversight and accountability mechanisms. Stakeholders can hold one another accountable for their

contributions and performance when roles and responsibilities are clearly defined, and communication is effective. This ensures that the CBHI program runs as planned.

3. **Strengthened Trust:** Enhancing accountability and transparency through stakeholder coordination contributes to the development of community and stakeholder trust, which is essential for the CBHI program's effective execution and long-term viability.

Overall, organized and collaborative efforts among stakeholders are essential for ensuring that the CBHI program remains transparent and accountable, thereby enhancing its effectiveness and credibility within the community.

The respondents indicated that collaboration with community elders, religious institutions, and the target community significantly supports the sustainability of the CBHI program in the area. Specifically:

1. **Awareness Creation:** Collaboration with community elders and religious institutions helps in creating awareness about the benefits of CBHI, which encourages more community members to enrol in the scheme.
2. **Increased Engagement and Participation:** The involvement of these stakeholders enhances community engagement and participation by leveraging their influence and trust within the community. This leads to higher enrolment rates and active involvement in the CBHI program.
3. **Resource Mobilization:** Engaging local stakeholders helps in mobilizing resources and convincing members of the community to participate in CBHI. Their support and endorsement can facilitate resource acquisition and program sustainability.

Overall, the collaborative efforts of local stakeholders play a crucial role in promoting CBHI enrolment, increasing community engagement, and mobilizing resources, all of which contribute to the program's long-term sustainability and effectiveness.

One of the objectives of IDIR is to offer its members economic and social insurance in the event of an accident, death, or property loss, among other things (Emana, 2009).

Respondents noted that effective collaboration between government entities, such as the Ethiopian Health Insurance Service (EHIS), and non-governmental organizations (NGOs) like USAID has a positive impact on the enrolment rates and membership retention of the CBHI program. Specifically:

1. **Increased Enrolment Rates:** The partnership between EHIS and NGOs helps to promote the CBHI program more effectively, leading to higher enrolment rates. The support from NGOs can enhance outreach efforts and provide additional resources for expanding coverage.
2. **Improved Membership Retention:** Effective collaboration ensures that the CBHI program is better managed and supported, which can lead to higher satisfaction among members and improved retention rates. The combined efforts of the government and NGOs contribute to maintaining the quality of services and addressing any issues that might affect membership continuity.
3. **Coverage for Non-Paying Members:** The government plays a crucial role in covering non-paying members of the CBHI, ensuring that even those who cannot afford to contribute are still included in the program. This support helps in maintaining a broader membership base and ensuring that the program reaches underserved populations.

Overall, the collaboration between government and NGOs enhances the effectiveness of the CBHI program, leading to better enrolment and retention outcomes by leveraging the strengths and resources of both sectors.

CBHI program in Ethiopia has seen a notable increase in enrolment and membership retention because of practical cooperation between government and non-governmental organizations. Enrolment in participating districts has reached 50%, indicating that the government's efforts to increase CBHI coverage are yielding encouraging results (Daraje, 2022). According to studies, enrolling in the CBHI program lowers catastrophic health costs by 79.4% and boosts universal health coverage by 24.8% (Mussa et al., 2023). Additionally, research has shown that CBHI participation is linked to higher use of health services, protection from financial risk, and lower out-of-pocket medical expenses. These findings demonstrate the program's beneficial effects on households' financial stability and healthcare-seeking behaviour (Bayked et al., 2023). This emphasizes how crucial it is for government and non-government organizations to work together to advance the efficacy and sustainability of CBHI in Ethiopia.

Respondents agreed that collaborative efforts with various NGOs are creating valuable opportunities for capacity building and knowledge sharing among stakeholders involved in the CBHI program. Specifically:

1. **Capacity Building:** Collaboration with NGOs facilitates training and development programs that enhance the skills and capabilities of stakeholders involved in the CBHI program. This improves the overall effectiveness and efficiency of program implementation.
2. **Knowledge Sharing:** NGOs often bring expertise and best practices that are shared with local stakeholders, including government agencies and community organizations. This exchange of knowledge helps in improving strategies, addressing challenges, and implementing innovative solutions.
3. **Enhanced Stakeholder Competence:** The joint efforts in capacity building and knowledge transfer contribute to a more competent and well-informed group of stakeholders, which positively impacts the management and sustainability of the CBHI program.

Overall, the collaboration with NGOs in capacity building and knowledge sharing strengthens the ability of stakeholders to effectively contribute to the CBHI program, leading to improved outcomes and more successful implementation.

As the interview data reveal, USAID-funded projects, Abt Global Works, and UNICEF (Supporting on Social Programs, or PSP) play a crucial role in offering support, technical help, and training to local stakeholders, such as administrators, healthcare professionals, and members of the community. These issues have been addressed by collaborative efforts inside quality improvement collaboratives, which have improved teamwork skills, encouraged system-level changes, and fostered collaboration through learning sessions, experience sharing, and peer support. Moreover, data quality and utilization have improved because of a health information systems capacity-building and mentorship program, highlighting the need to enlist professionals from other fields to improve the health information system (West Shewa Zone CBHI expert).

Cooperation among participants in Ethiopia's CBHI scheme has several benefits. First off, these kinds of partnerships have the potential to strengthen women's empowerment, increase community involvement, enhance access to healthcare, and offer financial security (Belay et al., 2022). Second, the quality and application of health data can be improved through a cooperative capacity-building and mentorship program involving professionals from diverse sectors, resulting in data-driven decision-making in the healthcare industry (Friman et al., 2023). As evidenced by a case study from Sweden about cooperative academic and non-academic cooperation (Mulat et al., 2022), collaborative capacity-building techniques can also facilitate the transfer of knowledge, encourage innovation, and aid in the shift to sustainable mobility. In general, cooperative efforts in

knowledge-sharing and capacity-building can improve the sustainability, resource mobilization, and service delivery of healthcare initiatives such as the CBHI in Ethiopia.

Stakeholder coordination, according to the respondents, is essential to ensuring that the CBHI program is in line with more general health policies and objectives. Specifically:

1. **Alignment with Health Policies:** Effective cooperation among stakeholders ensures that the CBHI program is in harmony with broader health policies, such as achieving universal health coverage (UHC). This alignment helps the program contribute to national and global health objectives.
2. **Increasing Healthcare Utilization:** By working together, stakeholders can ensure that the CBHI program encourages greater utilization of healthcare services within the community. This helps in improving overall health outcomes and reducing preventable diseases.
3. **Reducing Out-of-Pocket Payments:** By offering complete coverage and lowering financial obstacles to accessing healthcare services, coordinated initiatives help people pay less out of pocket.
4. **Enhancing Quality and Equity:** Working together ensures that all participants, irrespective of their financial situation, receive the proper care and contributes to raising the standard and fairness of healthcare services provided by the CBHI program.
5. **Meeting Sustainable Development Goals (SDGs):** Coordinated stakeholder efforts align the CBHI program with goals for Sustainable Development, especially those pertaining to health and well-being, ensuring that the program supports long-term global health objectives.

Overall, stakeholder coordination ensures that the CBHI program effectively supports and integrates with broader health policies and goals, contributing to improved healthcare outcomes and sustainability.

Stakeholder coordination is critical for connecting Community-Based Health Insurance (CBHI) initiatives with Ethiopia's broader health policies and goals. Stakeholder cooperation ensures the successful deployment and long-term viability of CBHI schemes (Tahir et al., 2022). It contributes to addressing issues such as perceived preferential treatment for paying clients, medicine shortages, and quality of care concerns (Mekonen & Tedla, 2022; Shigute et al., 2020). Furthermore, stakeholder participation increases awareness, enrolment, and sustainability of CBHI initiatives, resulting in better health outcomes and financial protection for households (Daraje, 2022). The government's role as a strong coordinator of foreign aid in the health sector highlights

the need for stakeholder alignment in meeting national health goals (Teshome & Hoebink, 2018). Effective coordination promotes stakeholder synergy, allowing for more efficient resource usage and the attainment of Ethiopia's health policy goals.

Generally, the following results of the coordination and cooperation among CBHI stakeholders are being observed: It promotes a more comprehensive and all-encompassing method of the implementation of the CBHI strategy, influences the program's coverage and reach within communities in West Shewa Zone, significantly contributes to the strategy's implementation success in West Shewa Zone, fosters a sense of shared responsibility for achieving the program's goals, makes it easier to identify and mitigate difficulties encountered during the strategy's implementation, ensures a more equitable distribution of resources to support CBHI implementation, enhances the general standard of healthcare services provided through the CBHI program, and is improving community engagement and participation in the CBHI program. Please contribute to the CBHI strategy's adaptability to local contexts, guarantee that the program is responsive to the population's changing healthcare needs, improve the program's accountability and transparency, make it easier to find and use local resources to support the program's sustainability, raise community understanding and awareness of the CBHI program, have a positive impact on the program's enrolments rates and membership retention, and provide opportunities for capacity-building and knowledge-sharing among various stakeholders.

6.5. The effect of administrative capacity and workforce on CBHI implementation in the West Shewa Zone

Descriptive Statistics

	N	Min	Max	Mean	Std. Deviation
Employees at Woreda CBHI lack the administrative skills necessary to do their jobs well.	50	3	5	4.40	.606
There is a lack of workforce to carry out membership renewal, cash reimbursement, and other activities of CBHI.	50	2	5	4.32	.653
The differences in administrative capacity among districts within the West Shewa Zone significantly impact the success of CBHI implementation.	50	1	5	4.36	.985
The level of administrative expertise in each district affects the efficiency of CBHI enrolment processes.	50	1	5	4.26	1.046
Variations in the number of trained personnel in different districts contribute to differences in CBHI service quality.	50	2	5	4.34	.798
Districts with more substantial administrative capacity are better equipped to adapt CBHI programs to local community needs.	50	2	5	4.36	.851
The effectiveness of CBHI awareness campaigns varies based on the administrative capacity of each district.	50	4	5	4.50	.505
Valid N (listwise)	50				

Table 6.3: The effect of administrative capacity and workforce on CBHI implementation in the West Shewa Zone

Source: Own survey data (2024)

Employees of CBHI were asked to provide input on the impact of administrative capability and workforce on CBHI implementation in the western zone (Table 6.3). Consequently, the information below displays employee opinions regarding the degree of CBHI implementation capability.

Two criteria were taken into consideration to determine the point value for each key component: the weight assigned to each central element and the score given to each significant element within the factor. Strong agreement is indicated by a perfect score of 5, disagreement is shown by a score of 2, neutrality is indicated by a score of 3, and strong disagreement is indicated by a final score of 1 (strongly disagree), which carries one mark.

Respondents agreed that there is a significant lack of administrative capacity among Woreda (district) employees and a shortage of CBHI staff, especially in rural areas. Specifically:

Administrative Capacity Issues: The mean value of 4.40 indicates a strong agreement that administrative capacity is deficient among district employees. This suggests that administrative structures and processes may be insufficiently developed or supported.

Shortage of Manpower: The consensus that there is a staffing deficit, especially in rural regions, is reflected in the mean score of 4.32. This shortage of staff exacerbates the administrative burden on existing employees and affects the efficiency of CBHI program implementation.

Training and Development Needs: The lack of administrative capacity and workforce highlights the need for more comprehensive training and development programs to build the skills and capabilities of employees. This will help address administrative challenges and improve program management.

Administrative Burden: The quality of service delivery and the overall efficacy of the CBHI program may be impacted by the increased workloads and administrative pressures that current workers may experience because of the staffing deficit and inadequate administrative capacity.

In summary, addressing these issues through targeted training, capacity building, and recruitment efforts is crucial for enhancing the administrative efficiency and effectiveness of the CBHI program.

As the interview data reveal, there are various factors causing disparities in administrative capacities among the CBHI employees of the West Show Zone: inadequate management, restricted decision-making authority, poor intergovernmental connections, financial capabilities, and insufficient financial and human resources, all of which impede the effective implementation of decentralization projects (District CBHI Coordinator).

There are various studies conducted in Ethiopia concerning the capacity of employees for CBHI implementation, and their results support the conclusion of the above findings.

According to Negash et al. (2019), the lack of competence among Woreda community-based health insurance (CBHI) staff is primarily due to weak management, strategic planning, and financial capacities. Furthermore, Agegnehu's (2014) study identifies issues such as a shortage of health staff (midwifery, lab technician, and pharmacy technician), insufficient funding for duty service and per diem payments, and drug shortages. These challenges not only reduce the quality of health care available to people in Woreda but also strain the overall capacity of the CBHI system. It is essential to invest in capacity-building efforts, provide adequate financial support, and strengthen strategic planning to improve the effectiveness and long-term success of the program.

Respondents agreed that differences in administrative capacity among CBHI employees impact the success of the scheme's implementation, leading to performance variations across districts. Specifically:

Impact on Implementation Success: Variations in administrative capacity among CBHI employees affect the overall success of the scheme. Areas with more substantial administrative capacity tend to have more effective implementation and better outcomes compared to those with weaker administrative support.

Performance Variation: The differences in administrative capacity result in inconsistent performance across districts. This means that some districts may experience more successful implementation and service delivery while others may struggle due to insufficient administrative support.

Need for Standardization: To address these disparities, it may be necessary to standardize administrative practices and support systems across districts. This could involve enhancing training, increasing resources, and improving overall administrative infrastructure.

Equity in Implementation: Ensuring that all districts have adequate administrative capacity is crucial for achieving uniform success in the CBHI program. This will help reduce performance gaps and ensure that the benefits of the program are distributed more equitably.

In general, improving the efficacy and uniformity of CBHI program execution across all districts requires addressing the disparities in administrative capacity.

Adequate management capacity, technical support, and cooperation with formal health financing networks, all essential for improving the sustainability and reach of CBHI schemes, led to variations in administrative capacity, according to an interview response from a higher EHIS official.

Ethiopian CBHI implementation varies depending on administrative capacity. Ethiopia's pooled coverage of CBHI enrolments was found to be 45 per cent, which is less than the 85 per cent national target set for 2020 (Tahir et al., 2022). CBHI coverage is influenced by variables such as living in a rural area, the gender of the household head, educational attainment, wealth index, and availability of financial resources (Alemayehu et al., 2023). Furthermore, there are regional differences in the readiness to pay for CBHI; the Oromia region is less eager to pay than the Amhara region (Gizaw & Weldeslassie, 2021). These differences emphasize how crucial it is to deal with administrative issues, raise awareness, and improve financial accessibility to guarantee the fair and efficient implementation of CBHI throughout Ethiopia's many areas.

The feedback from respondents, with a mean value of 4.26, indicates a strong agreement that the level of administrative expertise in each district significantly impacts the efficiency of the CBHI enrolment processes. Specifically:

Impact on Enrolment Efficiency: The high mean value suggests that differences in administrative expertise are a key factor affecting the efficiency of the CBHI enrolment process. Districts with higher levels of administrative expertise are likely to have smoother and more efficient enrollment procedures.

Variation in Enrolment Performance: The variation in administrative expertise across districts leads to differing enrolment performance. Districts with more experienced and skilled administrators are better equipped to handle enrollment processes effectively, while those with less expertise may face challenges that hinder their performance.

Implications for Program Success: The efficiency of enrolments is crucial for the overall success of the CBHI program. Inconsistent administrative expertise can result in uneven coverage, with some districts achieving higher enrolment rates than others, which could undermine the program's effectiveness.

Need for Capacity Building: To address these disparities, there may be a need for targeted capacity-building initiatives aimed at improving the administrative expertise in districts that are lagging.

This could involve additional training, mentorship, and resource allocation to ensure that all districts can manage the enrollment process efficiently.

In conclusion, the level of administrative experience has a significant impact on the efficacy of CBHI enrollment methods, leading to variations in district performance. These disparities need to be addressed to ensure consistent and effective enrollments throughout the program.

To optimize resources, boost productivity, and ultimately expand the number of people who have health insurance, it is imperative to have knowledgeable administrators who understand the complexities of health systems and insurance programs. Since CBHI is volunteer-run, we must raise awareness and persuade the community to sign up. In this instance, the degree of administrative expertise required to create an efficient CBHI performance among the various districts of the West Shewa Zone must possess the qualities of communication skills, emotional intelligence, commitment, organizational skills, problem-solving abilities, technology proficiency, customer service skill (West Shewa Zone CBHI expert).

Respondents reached a consensus that variations in the number of trained personnel across different districts contribute to differences in the quality of CBHI services. Specifically:

Impact on Service Quality: The availability of qualified staff directly impacts the calibre of services offered by the CBHI program. While districts with fewer trained employees could find it challenging to achieve service standards, those with more trained workers are better able to provide high-quality services.

Variation Across Districts: The differences in the number of trained personnel across districts lead to inconsistencies in the quality of CBHI services. This results in some districts offering better services than others, depending on the availability and expertise of their staff.

Implications for Program Effectiveness: A key component of the CBHI program's effectiveness is service quality. A lack of skilled staff in some regions may result in lower-quality services, which could damage the program's reputation and overall efficacy.

Need for Uniform Training and Resources: It might be essential to establish standardized training programs and distribute funds more fairly among districts to overcome these discrepancies. CBHI services will be more consistent and of higher quality if all districts have access to enough trained staff.

In summary, the number of trained personnel in each district is a key determinant of the quality of CBHI services. Addressing the disparities in staff training and availability is essential for enhancing service quality and ensuring the success of the CBHI program across all districts.

Variations in the number of trained personnel across different districts significantly impact the quality of Ethiopia's CBHI services. Research indicates that several elements are significant predictors of users' satisfaction, including the availability of laboratory services (Getaneh et al., 2023), prompt care at medical institutions (Geta et al., 2023), and referral services (Baykedet al., 2023).

All the respondents agreed that administrative capability and the ability to modify CBHI programs to suit the needs of the local community are positively correlated. Specifically:

Positive Relationship: A district or region's ability to modify and personalize CBHI initiatives to meet the unique requirements of the community improves with its administrative capability. This implies that adjusting the program to local health issues and preferences requires efficient administration.

Adapting to Community Needs: Districts with robust administrative systems are more likely to successfully implement CBHI programs that are responsive to the unique demands and circumstances of their local communities. This adaptability is crucial for ensuring that the program is relevant and practical in different contexts.

Implications for Program Success: The ability to align CBHI programs with local community needs is essential for the program's success and sustainability. When programs are well-adapted to local conditions, they are more likely to be accepted and utilized by the community, leading to higher enrolments and satisfaction rates.

Need for Capacity Building: Strengthening administrative capacity in districts where it is lacking could enhance the ability of those districts to adapt CBHI programs to serve their communities better. This might involve training, resource allocation, and the development of localized administrative strategies.

In summary, a strong administrative capacity is crucial for adapting CBHI programs to meet local community needs effectively. Enhancing administrative capabilities will improve the program's relevance and success across diverse communities.

In Ethiopia, districts with stronger administrative capacities are better equipped to tailor community-based health insurance (CBHI) plans to address the unique requirements of their local populations. The successful implementation of CBHI depends on several factors, including adequate resource mobilization, active community participation, and consistent governmental support (Mulat et al., 2022). Evidence suggests that involvement in CBHI strengthens the

accountability of health facilities by promoting the consistent delivery of quality healthcare services, an important factor in encouraging both enrolment and continued participation (Tefera et al., 2021). Additionally, studies have demonstrated that CBHI dramatically lowers insured households' catastrophic medical costs, enhancing access to care and fortifying financial security (Kassa, 2023). District-level preparedness is crucial for the sustainable implementation of new health services, such as the Community-Based Newborn Care program, which calls for thorough planning and evaluation of the health system's capacity to accept the service (Daraje, 2022).

The data from Table 6.3 indicates that administrative capacity has a significant impact on the effectiveness of CBHI awareness campaigns. Specifically:

Key Determinants: The effectiveness of awareness campaigns is closely linked to administrative capacity, which includes factors such as the number of experts, availability of workforce, and enough budget. These resources are essential for planning, executing, and sustaining effective awareness campaigns.

Impact on Awareness and Knowledge: When administrative capacity is strong, awareness campaigns are more effective in increasing community knowledge and understanding of CBHI. This, in turn, can lead to higher enrolment rates and better participation in the CBHI program.

Challenges in Low-Capacity Areas: In districts with lower administrative capacity, awareness campaigns may be less effective. A limited workforce, insufficient expertise, and budget constraints can hinder the ability to reach and educate the community effectively about the benefits of CBHI.

Implications for Program Success: The success of CBHI programs depends not only on their design but also on their ability to communicate their benefits to the community. Strong administrative capacity is therefore crucial for ensuring that awareness campaigns are impactful and lead to increased community engagement.

Need for Resource Allocation: To improve the effectiveness of CBHI awareness campaigns, allocate more resources to districts with weaker administrative capacity. This could involve training additional personnel, increasing budget allocations, and providing the necessary tools and materials for successful campaign execution.

In conclusion, one of the most important factors influencing the success of CBHI awareness initiatives is administrative capability. Increasing administrative resources will probably result in

more effective community awareness-raising and program enrollment campaigns. Data from the interview reveals that tailored techniques have been used to implement CBHI awareness campaigns in the West Shewa zone. Moreover, we notice that the best way to maximize CBHI adoption and sustainability in our districts is to collaborate with local leaders like the Health Development Army and Women's Development Army, customize awareness campaigns to suit community needs and issues, and make use of already-existing community institutions (West Shewa Zone CBHI expert).

CBHI awareness programs in Ethiopia are greatly influenced by the administrative capabilities of Ethiopian districts (Mirach et al., 2023; Kaso et al., 2022; Tefra & Ayele, 2022). Strong district-level management capabilities can improve CBHI program implementation and outreach, guaranteeing increased household knowledge and participation (Liu et al., 2022). The performance of CBHI awareness programs is influenced by district-level decentralization, which in turn affects important characteristics of local government responsiveness, accountability, and transparency (Tefera & Ayele, 2022). By enhancing awareness campaigns and boosting community involvement, district-level management techniques like training and mentoring can hasten the advancement of healthcare initiatives like CBHI.

6.6. The effect of resource allocation on CBHI implementation in west Shewa

Descriptive Statistics

	N	Min	Max	Mean	Std. Deviation
Differences in resource allocation among districts in the west Shewa zone contribute to varying challenges during CBHI implementation.	50	2	5	4.30	.763
The availability of adequate funding influences the success of CBHI enrolments and service delivery efforts.	50	1	5	4.48	.789
Resource constraints in certain districts hinder the implementation of CBHI outreach and education initiatives.	50	2	5	4.46	.646
Equitable allocation of resources among districts is essential for consistent CBHI implementation outcomes.	50	2	5	4.54	.613
Resource availability aligned with population needs is crucial for the success of CBHI service delivery.	50	3	5	4.52	.544

Valid N (listwise)	50				

Table 6.4 The effect of resource Allocation on CBHI implementation in west Shewa zone

Source: Own survey data (2024)

Regarding the impact of resource allocation on CBHI implementation in the west show zone, Table 6.4 surveyed CBHI employees for their opinions. As a result, employee opinions regarding the impact of resources on CBHI are displayed in the information below. To determine the point value for each major component, two key factors were considered: the individual scores assigned to each significant element within the factor and the weight attributed to each principal component. A score of 1 (strongly disagree), carrying one point, reflects strong disagreement, while a score of 5 signifies strong agreement. Different levels of disagreement, neutrality, and agreement are represented by scores of 2, 3, and 4, respectively. According to the respondents, there is general agreement that disparities in resource distribution among districts significantly influence the effectiveness of CBHI program implementation. Specifically:

1. **Impact on Implementation:** Differences in resource allocation are leading to variations in how CBHI programs are implemented across different districts. Districts with more resources are better equipped to effectively implement the program, while those with fewer resources may struggle with aspects such as enrolments, service provision, and resource mobilization.
2. **Variation in Membership enrolment:** Districts receiving more resources tend to have higher membership enrolment rates. Adequate funding allows these districts to conduct more effective awareness campaigns, streamline the enrolment process, and provide better services, making the CBHI program more attractive to potential members.
3. **Differences in Service Provision:** Resource-rich districts are likely to offer better quality and more comprehensive health services under the CBHI scheme. In contrast, districts with limited resources may face challenges in maintaining service quality, which could lead to dissatisfaction among members and lower retention rates.
4. **Resource Mobilization:** Districts with more resources can more effectively mobilize additional resources from within the community and external partners. This capability helps to sustain and expand the CBHI program, while districts with less resource allocation may find it challenging to achieve the same level of success.

5. **Implications for Equity:** The differences in resource distribution raise concerns regarding equity within the CBHI program. Reviewing and modifying resource distribution procedures may be required to guarantee that districts with higher needs receive adequate assistance and that all communities gain equitably from the program.

In summary, differences in resource allocation among districts are creating significant variations in CBHI implementation, affecting membership enrolment, service provision, and resource mobilization. Addressing these disparities is crucial for ensuring a more equitable and effective CBHI program across all districts.

The available resources influence the effectiveness of CBHI projects in the West Shewa Zone. According to research, several vital variables influence CBHI enrolment, including knowledge, courteous treatment, laboratory services, when premium payments are due, education level, and financial standing (Lin et al., 2023; Desalegn et al.,2023). In addition, the availability of resources such as technological assistance, social and emotional support, and stakeholder and user involvement is critical to building trust, motivation, and sustainability at various stages of implementation (Mekuria & Chaka, 2019).

The respondents' feedback, with a mean value of 4.48, indicates a strong consensus that the allocation of adequate funding significantly influences both CBHI enrolment and the quality of service delivery.

1. **Impact of Adequate Funding:**

Quality of Service Delivery: Districts that receive enough funds are better positioned to deliver higher quality services under the CBHI scheme. This includes being able to provide essential healthcare services, maintain a steady supply of medicines, and support efficient healthcare infrastructure.

CBHI enrolment: Adequate funding enables more effective outreach and education initiatives, which in turn drive higher enrolment rates in the CBHI program. Well-funded districts can implement comprehensive awareness campaigns, streamline the enrolment process, and ensure that members renew their participation, leading to sustained and growing membership.

2. **Challenges in Resource-Constrained Districts:**

Hindered Implementation: In districts where resources are limited, the implementation of CBHI outreach and education initiatives is negatively impacted. This can result in lower enrolment rates, challenges in membership renewal, and poorer service delivery quality.

Variation Across Districts: The variation in CBHI performance across different districts is influenced by the level of resource allocation. Districts with better funding see higher enrolment and better service delivery, while those with less funding struggle to achieve similar results.

3. Factors Contributing to Variation:

Enrolment and Membership Renewal: Districts that receive more funding tend to have higher enrolment rates and better membership renewal rates, as they can provide better services and effectively communicate the benefits of the CBHI program.

Administrative Capacity: The effectiveness of the CBHI program is also influenced by district administrators' capacity to manage and use funds that have been allotted effectively. Stronger administrative capacities increase the likelihood that districts will spend their resources efficiently, improving enrollment and service delivery even more.

In summary, the allocation of adequate funds is a critical factor that influences the success of CBHI enrolment and service delivery efforts. Resource constraints in certain districts are creating significant challenges, leading to variations in program performance, which are further exacerbated by differences in enrolment rates, membership renewal, and administrative capacity. Addressing these disparities in funding and resource allocation is essential for improving the overall effectiveness of the CBHI program.

For CBHI to succeed in Ethiopia, financial resources are essential. Studies show that CBHI participation reduces catastrophic health costs and out-of-pocket expenditures while increasing financial protection and health service utilization (Musa et al.,2023). Furthermore, enrolment in CBHI improves health-seeking behaviour among vulnerable households, boosting the usage of healthcare services, particularly outpatient treatment (Alemayehu et al.,2023). Furthermore, households engaged in CBHI benefit from increased well-being, including lower per-capita health spending and higher consumption of necessary goods and services (Daraje, 2022). Despite these encouraging outcomes, problems remain, such as the need for expanded national coverage to attain universal health coverage for the entire population (Asfaw et al.,2022). Thus, substantial financial resources are required to maintain and enhance the benefits of CBHI in Ethiopia.

Resource constraints in some Ethiopian areas make it difficult to undertake community-based health insurance (CBHI) outreach and education activities (Daraje, 2022; Mussa et al., 2023; Namomsa, 2023). These limitations include a significant reliance on out-of-pocket costs,

inefficient resource use, limited government spending in the health sector, and inconsistent donor support (Belayneh, 2023). Furthermore, obstacles such as inadequate ICT infrastructure, a lack of computer skills, budget constraints, and insufficient policies impede the successful implementation of CBHI programs (Bayked, 2023). Despite efforts to increase CBHI coverage, enrolment rates are influenced by age, education level, land ownership, involvement in safety net programs, and awareness of CBHI. Strengthening the effectiveness and expanding the reach of CBHI initiatives in Ethiopia requires tackling current resource limitations. This involves not only increasing financial support but also investing in capacity-building and reinforcing policy frameworks to support sustainable implementation.

Respondents in the study expressed strong agreement, reflected by a mean score of 4.54, that fair and balanced distribution of resources among districts is key to achieving more consistent outcomes in the implementation of CBHI programs.

1. **Importance of Equitable Resource Allocation:**

Consistency in Implementation: Regardless of their present ability or financial situation, all districts will have the resources and assistance they need to execute the CBHI program if resources are distributed successfully. This reduces differences in service quality and enrollment rates and produces more consistent results across regions.

Enhanced Program Effectiveness: A more balanced approach to outreach, education, and service delivery is made possible by the equitable allocation of resources. This increases the overall efficacy of the CBHI program by guaranteeing that communities in all districts have access to comparable levels of healthcare services and benefits.

2. **Addressing Disparities:**

Mitigating Variations: The current disparities in resource allocation have led to inconsistent CBHI implementation outcomes, with some districts performing better than others. Equitable resource distribution is seen as a solution to these variations, enabling districts with fewer resources to catch up and perform on par with better-resourced areas.

Improving Equity: Equitable allocation of resources not only improves the quality of services provided but also ensures that all members of the community, regardless of their location, have equal access to the benefits of the CBHI program. This promotes a fairer and more just healthcare system across the regions.

- **Impact on Overall Program Success:**

Sustaining Membership: Equitable resources help in sustaining high enrolment and renewal rates by ensuring that all districts can offer a similar quality of service, thus maintaining trust and satisfaction among CBHI members.

Strengthening Administrative Capacity: By distributing resources more evenly, districts with weaker administrative capacities can be supported to improve, leading to a more consistent and reliable administration of the CBHI program across all regions.

In summary, respondents believe that equitable allocation of resources among districts is vital for ensuring consistent and effective implementation of the CBHI program. By addressing current disparities, this approach would lead to more uniform outcomes, improving service delivery, enrolment rates, and overall program success across all regions.

Achieving CBHI implementation results in Ethiopia requires equitable resource distribution among districts (Daraje, 2023). Decision-making mechanisms for equitable infrastructure resource allocation are critical for addressing infrastructure imbalance and social injustice in the country (Desalegn & Solomon, 20230). The CBHI plan in Ethiopia has had a good impact, including more community engagement, improved access to health care, and financial protection (Mulat et al.,2022). However, overall CBHI enrolment in Ethiopia remains low at 45%, falling short of the national target of 80% (Tahir et al.,2022). Factors including premium affordability, scheme comprehension, perceived service quality, trust in the program, and the presence of a chronic illness in the home all affect CBHI enrollment (Habte et al.,2022). If CBHI programs are to succeed, the uneven distribution of resources across districts needs to be addressed. Without fair allocation, it is difficult to guarantee that everyone, irrespective of their residence, can access healthcare and be protected from financial hardship.

The data in Table 6.4 highlights the significance of aligning resource mobilization with population needs for the success of the CBHI scheme in providing services to insured members.

1. **Alignment with Population Needs:**

Importance of Resource Mobilization: The CBHI scheme's effectiveness depends on resource mobilization that is in line with the unique needs of the populace. The program may more successfully address the healthcare needs of the insured community when resources are allocated to areas of highest need, which improves results and increases member satisfaction.

Tailored Services: The services offered are guaranteed to be pertinent and sensitive to the local context when resources are matched with population requirements. This strategy improves the efficacy of the CBHI program by addressing the distinct healthcare issues that various communities encounter.

2. Local Resource Mobilization:

Community Involvement: The CBHI program promotes the mobilization of resources from local communities, which not only supports the financial sustainability of the scheme but also encourages community ownership and participation. When communities are involved in resource mobilization, they are more likely to engage with and support the program.

Revenue Generation: Local resource mobilization is one of the key strategies for generating revenue for healthcare financing in Ethiopia. By tapping into local resources, the CBHI program can supplement government funding and donor support, making the scheme more resilient and less dependent on external sources of finance.

3. Impact on Service Provision:

Enhanced Service Delivery: Aligning resource mobilization with population needs helps ensure that the CBHI scheme can provide essential healthcare services effectively. This alignment allows the program to allocate funds and resources where they are most needed, improving the quality and availability of services for insured members.

Sustainability: By focusing on local resource mobilization, the CBHI program can build a more sustainable financial model. This strategy lessens the need for outside funding and contributes to the development of a more autonomous healthcare system that is better able to address the population's changing requirements. Generally, ensuring that resource mobilization responds to the actual healthcare needs of the population is central to the success of the CBHI scheme in Ethiopia. When resources are allocated based on need, they are more likely to support meaningful service improvements, make the program more sustainable, and help deliver better care to those who rely on it. The success of CBHI service delivery depends on the availability of resources in accordance with population demands. Studies have identified factors that influence CBHI membership renewal rates, such as affordability, knowledge, and perceived quality of health services (Kaso et al.,2022; Kim & Kang, 2022). Additionally, variables including awareness-raising, accessibility issues, and distance from medical facilities affect the utilization of Micro

Health Insurance (MHI) schemes in less developing nations. (Durovich & Roberts, 2018). Residence, education level, family size, chronic sickness presence, and household attitude are all factors that influence CBHI scheme utilization in Ethiopia (Cheema et al., 2020). These results emphasize how important it is to match the population's specific needs with the resources that are available to preserve the effectiveness and sustainability of CBHI service delivery.

7. CONCLUSION AND POLICY IMPLICATIONS

7.1. Conclusion

Male and female participants in a CBHI program were almost equally represented, according to research with 378 respondents. Thanks to CBHI, women and underprivileged groups have better access to healthcare in underdeveloped nations like Ethiopia. In countries like Ethiopia and India, CBHI is essential to improving women's access to healthcare and financial security. A range of factors, such as whether the household is headed by a woman, the number of family members, and where the household is located, can influence a woman's likelihood of participating in a health insurance program. However, research shows that when women are meaningfully involved in local, community-based health efforts, they are often better able to overcome the practical and social challenges that stand in the way of enrolling in health insurance. This points to the critical role that CBHI can play in supporting women's financial security and improving their access to reliable, quality healthcare, both of which are necessary steps toward universal health coverage.

Enrolment in Community-Based Health Insurance (CBHI) is significantly influenced by age, with older people having greater participation rates. The likelihood of enrolment in CBHI is higher among older people, especially those over 60, especially if they are exposed to media. This suggests that age should be taken into consideration when developing measures to improve CBHI coverage. The CBHI is more likely to be enrolled by younger couples and those between the ages of 30 and 49, which highlights the importance of considering age demographics when developing and implementing CBHI programs.

Given that most respondents have finished their elementary and secondary education, formal education is crucial for CBHI enrolment and knowledge levels. Research from Ethiopia and Indonesia bolsters the idea that involvement in CBHI initiatives is correlated with education and awareness. Education has a significant influence on the efficacy and acceptability of CBHI programs, according to research from Ethiopia and Indonesia. The success of these programs is ultimately attributed to higher education levels, which also boost enrolment and utilization of health services and improve awareness of CBHI.

The Ethiopian government has been expanding CBHI since 2013 to offer healthcare services to rural and low-income populations. The majority of CBHI members pay fees, which

helps to ensure the scheme's long-term viability while also providing improved health results and financial security. CBHI members, both paying and non-paying, benefit from lower catastrophic health expenses and improved health outcomes, which help to achieve universal health care. Disparities in healthcare access between paying and non-paying members must be addressed to promote equitable health outcomes for all CBHI members. CBHI is critical in lowering catastrophic healthcare costs and supporting universal health coverage, particularly among households with chronic diseases. Testimonials from non-paying CBHI members emphasize the scheme's value in providing healthcare services and financial security despite problems such as a lack of drugs.

According to the beneficiaries of CBHI, the significant challenges facing the scheme were slow claim reimbursement steps, including Claim submission, claim review and adjudication, payment processing reconciliation and reporting and dispute resolution, and high patient volume, reducing the efficacy of CBHI initiatives. Delays in reimbursement can put financial pressure on healthcare facilities, jeopardizing their long-term survival and patient access to important health services. Lack of awareness of CBHI choices impedes enrolment, resulting in poor participation rates and financial hardship for patients. CBHI programs' limited healthcare provider networks can make it challenging to receive high-quality services and specialized care. CBHI programs struggle to meet different healthcare demands due to restricted coverage, inadequate health systems, and a lack of financial sustainability. Insufficient grasp of insurance principles and procedures contributes to limited community participation in CBHI systems. Overall, CBHI has challenges such as inconsistent healthcare service quality, inadequate infrastructure, complex reimbursement systems, a lack of understanding of CBHI alternatives, and restricted healthcare provider networks.

Due to a top-down approach, there are differences in the community's involvement in creating CBHI. Research from Nigeria and Colombia highlights issues such as low engagement rates and insufficient community involvement. Because of low awareness, the poor's exclusion, and the limited effectiveness of user associations, research indicates that different levels of the community are involved in creating CBHIs. Gaining public awareness of the advantages of CBHI is essential to enhancing community involvement. Health, income, education, and knowledge of CBHI benefits are some of the elements that affect community involvement in CBHI initiatives. Improving public awareness and inclusivity are crucial for boosting community involvement in CBHI design.

The decisions made throughout the development of CBHI programs are not widely known in the community. Respondents' opinions were divided regarding the consideration of community perspectives in the creation of CBHI strategies, with 42.32% indicating inadequate consideration. Ethiopia's CBHI program lacks grassroots initiation, in contrast to Thailand's policy, which was created with active community input. Research from several nations reveals difficulties with CBHI programs, including membership losses because of poor service, knowledge gaps, and cost concerns. Issues with sustainability and financial viability also impede CBHI programs in Ethiopia.

Low community involvement in policymaking in Ethiopia and other countries is reflected in the 65.1% of respondents who believed that community feedback was not considered during the formation of the CBHI plan. Research from several nations supports the belief held by 57.7% of respondents that low community feedback affects the finalization of CBHI policies because of power dynamics within the population. Successful CBHI programs necessitate significant community investments, unambiguous guidelines, continuous support, and community participation in decision-making processes to achieve widespread acceptance and efficient dissemination of policy needs.

Community engagement and participation and CBHI implementation have a positive and significant correlation, as seen by the 0.25 Pearson correlation coefficient. Higher rates of implementation are the result of greater community involvement and engagement in CBHI. The two-tailed sig. is significant even if it is less than 0.05. Participation and engagement in the community are significantly correlated with the implementation of CBHI.

Since community involvement in planning affects program performance, community engagement is essential to the long-term survival and success of CBHI in Oromia. In the context of CBHI, a "community" is a collection of people who live in the same geographic region or who have similar characteristics, interests, or social ties.

Continuous awareness and education enable CBHI members to participate in conversations concerning long-term objectives and tactics actively. Ethiopian community members actively discuss CBHI's long-term goals, which include lowering expenses, ensuring access to care, and raising funding. In Ethiopia, CBHI fosters a sense of pride and ownership among its members, which is advantageous for community health and sustainability. To achieve inclusion and efficacy, community perspectives, as well as professional ideas, must be considered while developing CBHI strategies. The CBHI approach reflects community ambitions for better healthcare and fulfils

requests for enhanced health services. Ethiopia's CBHI plan is in line with community aspirations for improved healthcare access and financial security, as well as eliminating disparities and improving healthcare utilization. Transparent communication is essential for community engagement within CBHI strategies, ensuring shared accountability and healthy dialogue. Strong partnerships between community organizations and local institutions, such as pharmacies and hospitals, support the long-term viability of CBHI initiatives in Ethiopia.

Incorporating traditional community support systems and local healthcare practices into the CBHI plan for the West Shewa zone increases program adoption and sustainability. The hypothesis investigates the favourable relationship between CBHI implementation and conventional community support systems (Traditional social networks, customs, and organizations that are in place within a community to support, help, and care for its individuals are referred to as conventional community support systems. These systems, which are often founded on historical conventions, cultural norms, and beliefs, are crucial for fostering social cohesion and resilience, indicating that their participation has a significant influence on CBHI sustainability. The deployment of CBHI and conventional community support networks in this study are positively and significantly correlated, according to the Pearson correlation coefficient of 0.26.

The initial study hypothesis in Ethiopia's CBHI programs includes outpatient/inpatient care, vital medications, maternity/child health services, and specialized testing but excludes costly procedures. A survey found that 96% of basic therapies were covered, but there was limited coverage for costlier specialist operations, prompting beneficiaries to seek additional funding. The correlation coefficient study demonstrated a favourable and statistically significant relationship between CBHI implementation and financial hardship protection. Enrolment in CBHI provides increased protection against catastrophic healthcare expenses, with a positive significant link identified between CBHI implementation and community health outcomes.

The covariance matrices of financial stress and community health outcomes are equal across the group, as shown by Box's test. The implementation of CBHI considerably shields the community from financial stress and improves health outcomes, as evidenced by Wilks Lambda test results. Levene's test reveals considerable disparities in error variances between financial stress and community health outcomes.

Between-subjects effects tests demonstrate that CBHI implementation provides considerable financial and health advantages to the community. The research hypothesis on the

benefits of CBHI in the West Shewa Zone is supported despite constraints such as insufficient financing and infrastructure. Implementing CBHI presents challenges such as uneven healthcare quality, complex claims reimbursement, and restricted healthcare provider networks. According to the results of the Wilks Lambda test, the null hypothesis should be rejected, and the hypothesis that CBHI enhances health and financial protection should be accepted.

The survey's sample group for the CBHI employees was well-educated, as evidenced by the fact that 60% of respondents had a master's degree, followed by those with a first degree (36%) and a PhD (4%). The involvement of various stakeholders from several CBHI departments, including team leaders, officers from health bureaus, and claim management officers, improved the study's feedback comprehensiveness and data quality. The study's dependability in evaluating the obstacles and implementation of CBHI in Ethiopia was bolstered by the respondents' substantial work experience, with 70% of them possessing over eight years of expertise.

Employees stated that the main issues facing the CBHI were the influence of political and bureaucratic processes, external factors such as unstable economies, bureaucratic obstacles, low awareness, limited funding, and problems with ICT infrastructure. Significant reductions in government funding to CBHI's general and target subsidies have been brought about by the decline in foreign aid from outside partners. Furthermore, Ethiopia's outstanding foreign debt has grown and is influencing how much money is allocated to various areas of the economy, including the health sector. Now, Ethiopia pays more toward its foreign debt each year than it does on health spending. The IMF estimates that 25% of the nation's overall budget, or $286.61 billion, is used to pay down its foreign debt. This suggests that the government may cut back on or stop funding the CBHI, which would influence the program's ability to remain financially viable.

Regarding stakeholder influence, CBHI staff members reported that they worked closely with governmental and non-governmental organizations such as Abt Global to develop and expand CBHI. The involvement of multiple stakeholders in the West Shewa Zone improves the implementation of the CBHI plan in a holistic manner, which has a substantial impact on enrolment rates and satisfaction levels. Stakeholder engagement influences program implementation and sustainability. This encompasses both formal sector personnel and families. Thus, involving a diverse range of stakeholders is crucial for the effectiveness of CBHI activities in Ethiopia.

Collaboration among stakeholders improves the CBHI strategy's flexibility to adjust to Ethiopia's unique demands. Team-based reflection, internal leaders, and external change agents

are all necessary for effective data-driven decision-making in the healthcare industry. Pilot projects, community organizing, and government assistance all contribute to CBHI's effective growth in Ethiopia. Working together with stakeholders guarantees that CBHI programs enhance transparency and adapt to changing healthcare requirements. Involving religious organizations and community leaders increases CBHI awareness and resource mobilization. Collaboration between NGOs and the government raises CBHI membership retention and enrolment rates in Ethiopia. Enrolment in the CBHI lowers medical expenses, promotes universal health coverage, and strengthens financial security. The CBHI program's capacity building and knowledge exchange are improved through cooperative efforts with NGOs. Partnerships in CBHI programs enhance community involvement, empower women, and provide access to healthcare. Coordination amongst stakeholders helps CBHI projects fit in with Ethiopia's larger health objectives and policies. In CBHI programs, stakeholder participation enhances awareness, enrolment, sustainability, and health outcomes. Practical stakeholder cooperation is essential for achieving Ethiopia's health policy objectives, maximizing resource efficiency, and successfully implementing CBHI. In CBHI efforts, stakeholder collaboration results in more community involvement and engagement, better healthcare quality, and comprehensive execution.

CBHI implementation is hampered by a lack of administrative competence due to inadequate training and development initiatives. Problems with staffing levels, finances, and poor management have an impact on the quality and enrolment of CBHI. Differences in administrative capabilities impact district-level enrolment efficiency and the success of CBHI implementation. Having strong administrative capabilities is essential for tailoring CBHI programs to Ethiopian communities' specific requirements. The availability of skilled personnel highly impacts the quality of CBHI services and user satisfaction. The success of community knowledge and CBHI awareness programs is influenced by administrative competence. Customizing awareness efforts and working with local leaders are essential for the effective acceptance and sustainability of CBHI. Capabilities for district-level administration are essential to enhancing outreach and program execution for the CBHI in Ethiopia. District decentralization, which increases the responsiveness and transparency of local administration, impacts the success of CBHI awareness efforts. District-level mentoring and teaching initiatives can boost community

involvement and awareness campaigns in healthcare initiatives like CBHI, hastening favourable outcomes.

Employee perceptions regarding the influence of resources on the CBHI implementation reveal disparities in resource allocation among districts, impacting membership enrolment, services, and resource mobilization. Several factors, including knowledge, financial status, and treatment, influence enrolment in CBHI. This highlights the need for resources like technology and stakeholder involvement for sustainability and trust. Enough money has a favourable impact on CBHI enrolment and service quality, but in some districts, resource limitations hampered outreach and education programs. The effectiveness of CBHI in Ethiopia depends on financial resources to enhance household well-being, financial security, and health service utilization.

7.2. The New Scientific Results

1. Community-based health insurance enhances healthcare access for women and other marginalized groups in the community. By enhancing their general health and well-being, marginalized groups can become more empowered and able to engage more fully in society, thanks to access to healthcare.
2. A community leader's endorsement boosts trust in community-based health insurance programs. Within the Oromoo nation, Abba Gadaa and Hadhaa Siqee are frequently regarded as reliable individuals. The involvement of these local leaders is creating positive incentives for people to participate in CBHI. Their support gives CBHI programs legitimacy and increases the likelihood that people will see them as dependable and advantageous. These leaders have been working with the local CBHI offices to shape the attitudes and actions of the community by promoting the CBHI, and their endorsement has changed the target communities' opinions and boosted enrolment. Leaders are encouraging community members to take part in CBHI activities by planning gatherings that highlight the significance and advantages of these initiatives, such as seminars and meetings. To make CBHI programs more palatable and valuable in the community, leaders assist in customizing them to fit with regional cultural norms and values.
3. Community-based health insurance implementation significantly protects the community from financial hardship and empowers social cohesion by encouraging mutual support and solidarity.

In general, by lowering the cost of paying out of pocket, improving healthcare cost predictability and management, and encouraging better health outcomes through timely treatment and preventative care, CBHI strengthens communities' financial resilience against health-related spending. It can protect individual families while bolstering the community's general social and economic fabric.

4. Community-based health insurance implementation improves community health outcomes significantly, as households are investing in education, nutrition, and housing, leading to better socio-economic development. CBHI is raising the community's standard of living by enhancing healthcare access, reducing OOP (out-of-pocket spending), and increasing healthcare-seeking behaviour. Psychologically, they are not concerned about the expense of healthcare and are instead allocating their budget to other investments.
5. According to the results, CBHI staff members recognized several significant obstacles influencing the program's execution. These difficulties include poor stakeholder coordination, the negative consequences of political and bureaucratic procedures, and outside variables, including unstable economies, red tape, low community awareness, a lack of money, and shortcomings in ICT infrastructure. Implementation gaps are caused by a lack of coordination amongst different groups, including local administrations, healthcare providers, and government agencies. This problem frequently leads to ineffective resource use, delays in decision-making, and inefficiencies in service delivery. The program's efficiency and adaptability may be impacted by slowed processes caused by political dynamics and bureaucratic red tape. For example, too complicated administrative processes could prevent timely approvals or cause needless delays in the distribution of funds.

    Meanwhile, the primary outside variables, such as the program's financial viability, may be jeopardized by an unstable economy since members may find it difficult to pay premiums during recessions. Program engagement and enrollment rates are negatively impacted when the target group is unaware of the advantages of CBHI. The operational efficiency of the program is jeopardized by inadequate or antiquated ICT systems that make it difficult to handle data, track enrollment, and process claims. Insufficient funding limits the program's capacity to expand operations, provide comprehensive services, or make investments in necessary infrastructure and technologies. The study indicates that the difficulties are being gradually resolved as the CBHI system exhibits the ability to learn and grow. The program is gradually

improving its coordination mechanisms, resolving bureaucratic inefficiencies, fortifying its infrastructure, and engaging the community by recognizing its flaws. By taking care of these problems, CBHI programs may be better implemented, provide better services, and accomplish their goals of making healthcare more accessible and protecting the target population financially.

6. The decline in foreign aid from international partners has led to substantial reductions in government funding for both general and targeted subsidies of the CBHI program. Additionally, the distribution of resources among Ethiopia's economic sectors, especially the health sector, is greatly impacted by the country's mounting foreign debt load. Currently, Ethiopia's annual foreign debt repayments exceed its healthcare expenditures. According to International Monetary Fund (IMF) estimates, the country allocates $286.61 billion, equivalent to 25% of its total budget, toward servicing its foreign debt. This financial strain raises concerns that the government may reduce or even discontinue its funding for CBHI, thereby undermining the sustainability of the program. Given that CBHI operates on a non-profit model, its continued functionality relies heavily on external financial support from the government or international partners. Without such resources, the program faces significant challenges in maintaining its operations and achieving its intended goals. The reduction in external aid diminishes the fiscal space available for government programs, particularly those like CBHI, which depends on subsidies to provide affordable healthcare to vulnerable populations. The high proportion of the national budget allocated to foreign debt repayment reduces the funding available for critical sectors, including health. This fiscal constraint creates a ripple effect, limiting government support for social programs. CBHI is a solidarity-based health financing model designed to provide equitable access to healthcare. Unlike for-profit models, it lacks mechanisms to generate revenue independently. As such, it is heavily reliant on subsidies and external funding to remain viable. Without these resources, the program risks collapse, potentially leaving beneficiaries without access to affordable healthcare services.

Addressing these financial challenges requires exploring alternative funding mechanisms, such as diversifying revenue sources, improving efficiency, or advocating for renewed support from international partners.

7.3. Recommendations

To minimize the inequities in coverage and contribution rates, new procedures should be designed by organizing the CBHI scheme at the regional level (cross-subsidization) rather than the district level, that is, from the district level CBHI to the regional level scheme to create a larger risk pool.

Two important policy windows, international initiatives toward universal health coverage and domestic resource mobilization, were utilized in the implementation of the CBHI. To do this, CBHI authorities should focus on boosting risk pooling to improve financial sustainability. Prioritizing the quality of medical care and medication availability is crucial, as it involves a variety of stakeholders, providing operational staff with training and keeping a robust health information system.

To raise the calibre of the health service provided to the insured, the SHIS must establish a monitoring and evaluation method and identify the best method of maximizing health system performance based on the ensured service provided under CBHI, contractual deals with the hospitals that provide these services, and methods of payment for these hospitals.

To improve the lack of administrative competence, SHIS should work on training and development for its employees through Comprehensive Training Programs (CTP) and create and carry out recurring training courses for CBHI administrators on important subjects such as customer service, data analysis, financial management, and health insurance management. Courses for certification assist educational establishments in providing health insurance administration certification programs.

In order to improve delays in reimbursement, SHIS should work on enhancing administrative efficiency by establishing standard procedures, training administrative staff, introducing automated systems, designing robust information systems by establishing integrated health information systems (IHIS) among providers, insurers, and members, strengthening financial management (efficient fund allocation, regular audits, and prompt payments to providers), and simplifying the claim submission process and procedures.

Encouraging equitable health outcomes for all CBHI members requires addressing disparities in healthcare access between paying and non-paying members. The following policy can improve the disparities in medical services among indigent and paying members of the CBHI: Subsides and financial support through state subsidies and cross-subsidization (introduce cross-

subsidization into the CBHI program so that the premiums of wealthier members help to pay for the coverage of less fortunate members partially), ensure equitable resource allocation through inclusive benefit packages and targeted funding, Developing and implementing assertive outreach and enrolment programs can be done through active enrolment drives and community engagement to promote CBHI participation among indigent populations and address any barriers to accessing health services. Develop quality assurance monitoring through uniform quality standards and regular monitoring; integrate health care services via a holistic care approach that integrates CBHI with other social services programs, tackling not only medical treatment but also related social elements of health; and, in partnership with NGOs and policy, create regulations that uphold the rights of impoverished individuals to fair access to healthcare and require their inclusion in CBHI programs; and introduce legislation mandating that healthcare providers treat all CBHI members equally, irrespective of their ability to pay.

Generally, governments and CBHI programs can endeavour to lessen healthcare access inequities by putting these policy ideas into practice, guaranteeing that both paying and impoverished members receive fair and excellent healthcare services.

7.4. The Practical Applicability of the Research Results

The findings of the study's investigation on Community-Based Health Insurance (CBHI) have several practical applications that can significantly impact local healthcare systems and community engagement. Here are some key points regarding their applicability:

Community Engagement: The research focused on the importance of community input in shaping the key elements of CBHI. This suggests that incorporating communities in the planning and execution of health insurance programs can lead to better outcomes and increased acceptance of these initiatives.

Impact on Healthcare Practices: The research highlights how local healthcare practices and conventional methods influence the effectiveness of CBHI. Policymakers can improve overall health outcomes by better tailoring health insurance policies to the requirements of the community by having a better understanding of these dynamics.

Methodological Insights: The comprehensive overview of the research methodology employed in the study provides valuable insights into how data collection and analysis can be

structured. This can work as a roadmap for further research in related fields, guaranteeing that investigations are solid and produce valid findings.

Resource Allocation: The findings regarding the impact of resource allocation on CBHI implementation indicate that effective management of resources is crucial for accommodating diverse healthcare needs. This insight can help organizations and governments optimize their resource distribution to enhance the efficacy of health insurance programs.

Challenges and Solutions: The research identifies various challenges faced during the implementation of CBHI, such as administrative issues and community participation willingness. Addressing these challenges through targeted strategies can improve the success rate of CBHI programs in Ethiopia and similar regions.

Policy Recommendations: The study's conclusions can inform policymakers about the necessary adjustments needed in the CBHI framework to ensure it aligns with the healthcare needs of local communities. This can lead to more effective health policies that promote better health outcomes.

In summary, the practical applicability of the research results lies in their potential to enhance community engagement, optimize resource allocation, and inform policy decisions, ultimately leading to improved health outcomes in the regions where CBHI is implemented.

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Appendix

Appendix A: Survey Questioner for CBHI beneficiaries

National University of Public Service

Doctoral School of Public Administration Sciences

Questions for the Beneficiaries of CBHI

The title of the Dissertation is Community-Based Health Insurance Implementation and Challenges in Ethiopia: Case of West Shewa Zone Oromiya National Regional State.

You are asked to take part in a study on the involvement of Community-Based Health Insurance Implementation and Challenges in Ethiopia. This questionnaire is part of a PhD research study at Hungary's National University of Public Service's Doctoral School of Public Administration Science. The goal of this in-depth study is to determine the extent to which the CBHI strategy is implemented in Oromia's national and regional state and what the challenges of CBHI implementation are. This Questioner has six parts and takes about 15 minutes to complete. Your correct answers will help the study's success. You may rest assured that your information will be kept private and only utilized for the research topic. I confirm that respondent anonymity is completely guaranteed and that your participation in the study is entirely voluntary.

Thank you Very Much in advance

Questioner

I. Background of the respondents

1. Gender

A. Male B. Female

2. Age

A. 18-30 Year
B. 31-40 Year
C. 41-50 Year
D. 51-60 Year
E. >=61 Year

3. Level of education

A. Basic Education C. High school
B. Grade 1-8 D. Diploma E. Degree F. Do not write and read

4. Marital Status

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

5. Family size

A. 1-3 children's C. 8-11 Children's
B. 4-7 children's D. >=12 children's

6. Income level per year

A. 1000-3000birr C. 6100-9000 birr

B. 3100-6000birr D. 9100-12,100 E. >12,100 birr
7. What is your village/District?
A. Ambo C. Chaliya
B. Bako Tibe
8. What is your type of membership
A. Premium paying
B. Non-paying member (Indigent-member)
9. When you become a member of this insurance
A. Since 2018 G.c C. Since 2020 G.c
B. Since 2019 G.c D. Since 2021 G.c E. Other_____

1. Questions related to CBHI Implementation

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where one indicates "Strongly Disagree," two indicates " Disagree", three indicates "Neutral", four indicates " Agree", and five indicates "Strongly Agree."

Items	**5**	**4**	**3**	**2**	**1**
The policies governing CBHI in the West Shewa Zone are clear and well-defined.					
The process of enrolling members into CBHI is efficient and accessible to all residents.					
The benefit packages offered by CBHI are comprehensive and meet the healthcare needs of residents.					
The payment mechanisms for CBHI are convenient and easy to understand					
There is enough awareness and education about CBHI among residents in the West Shewa Zone.					
I am satisfied with the communication channels used to inform residents about CBHI.					
Are the benefits offered by CBHI enough to meet the healthcare needs of residents?					
I am satisfied with the accessibility of information about CBHI enrollment and benefits.					
Do you think the enrollment process for CBHI is inclusive and accessible to vulnerable populations (e.g., low-income families and elderly individuals)?					
I am satisfied with the level of trust and transparency in managing community-based health insurance funds.					
The community awareness campaigns about CBHI are effective.					
Does CBHI have the potential to be sustainable in the long term in the West Shewa Zone?					

1. The overall progress of CBHI implementation is good in the West Shewa Zone?					

II. Challenges facing CBHI implementation

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where one indicates "Strongly Disagree," two indicates " Disagree", three indicates "Neutral", four indicates " Agree", and five indicates "Strongly Agree."

Items	**5**	**4**	**3**	**2**	**1**
The quality of healthcare services under CBHI coverage can be inconsistent and lead to member dissatisfaction.					
Inadequate infrastructure and healthcare facilities in certain regions impact the effectiveness of CBHI.					
The process of claims reimbursement within CBHI systems can be complex and time-consuming.					
Lack of awareness about CBHI options hinders enrollment among community members.					
A limited healthcare provider network is hindering access to quality services under CBHI.					
CBHI programs struggle to accommodate the diverse healthcare needs of the community.					
A limited understanding of insurance concepts and procedures has made it difficult for the community to engage with CBHI.					

III. Questions Related to the level of community engagement and participation in the formulation of the CBHI Strategy

1. To what extent do you believe that community members were involved in the formulation of the CBHI strategy?

A. Very Low C. Medium

B. Low D. High E. Very high

2. How informed do you feel about the decisions made during the formulation of the CBHI strategy?

A. Very Informed C. Somewhat Informed

B. Moderately Informed D. Slightly Informed E. Not Informed at All

3. In your opinion, are community perspectives adequately considered in the CBHI strategy formulation?

A. Not at All C. Somewhat

B. Slightly D. Moderately E. Completely

4. To what extent do you think community feedback was considered when finalizing the CBHI strategy?

A. None C. Some

B. A little D. Quite a bit E. A lot

5. How much influence do you believe community members had on shaping the key components of the CBHI strategy?

A. No Influence C. Some Influence

B. Minimal Influence D. Significant Influence E. Very Significant Influence

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where one indicates "Strongly Disagree," two indicates " Disagree", three indicates "Neutral", four indicates " Agree", and five indicates "Strongly Agree."

Items	5	4	3	2	1
The CBHI strategy development process effectively engaged community members.					
Community participation and ownership are adequately ensured in CBHI schemes.					
Community members were given meaningful opportunities to contribute to the CBHI strategy.					
Enough efforts were made to raise awareness and educate community members about CBHI.					
Community input played a crucial role in shaping the key elements of the CBHI strategy.					
Community leaders actively participated in the CBHI strategy formulation process.					
Community engagement significantly contributes to the success of the CBHI programs.					
The CBHI strategy genuinely represents the needs and preferences of our community in accessing health services.					
Community members were well-informed about the progress and decisions related to the CBHI strategy.					
The CBHI strategy demonstrates a collaborative effort between community representatives and policymakers.					
The CBHI strategy will contribute positively to our community's health and well-being.					
The CBHI strategy was developed in a way that encourages ongoing community involvement.					
The CBHI strategy demonstrates a commitment to addressing the unique challenges of our community.					
Community members were actively engaged in discussions about the long-term goals of the CBHI strategy.					
The CBHI strategy development process fostered a sense of ownership and pride among community members.					
Community perspectives were given equal importance to expert opinions in the CBHI strategy formulation.					
The CBHI strategy reflects the collective aspirations of our community for better healthcare.					
Community engagement in the CBHI strategy was characterized by transparent communication.					
The CBHI strategy showcases a strong partnership between local institutions and the community.					

IV. Questions related to how traditional community support systems and local healthcare practices influencing the program acceptance by the community in the study area.

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where one indicates "Strongly Disagree," two indicates " Disagree", three indicates "Neutral", four indicates " Agree", and five indicates "Strongly Agree."

Items	5	4	3	2	1
The involvement of respected community elders in endorsing healthcare programs positively impacts community members' willingness to participate.					
The accessibility of healthcare programs within the community positively influences community member's acceptance of such programs.					
The level of integration of local healthcare practices in modern healthcare programs impacts the community's perception of the program's relevance.					
The current healthcare programs are gaining acceptance among community members because they prioritize community input and feedback.					
The presence of effective communication channels between healthcare providers and community members facilitates program acceptance.					
Traditional rituals and ceremonies that incorporate healthcare messages contribute to the community's openness to healthcare programs in my area.					
Traditional community leaders' endorsement of healthcare programs fosters a sense of trust and credibility among community members.					
The availability of healthcare information in local languages increases the likelihood of program acceptance by the community.					
The involvement of women and mothers in healthcare decisions positively influences the community's acceptance of healthcare initiatives.					
The presence of community-based healthcare workers enhances the community's understanding and acceptance of healthcare programs.					

V. Contents of CBHI

1. CBHI programs in Ethiopia cover outpatient and inpatient care, critical drugs, and maternity. However, specialized and high-cost medical procedures have limited coverage, requiring beneficiaries to seek additional financial assistance.

A. Strongly Disagree C. Neutral

B. Disagree D. Agree E. Strongly Agree

VI. Impact of CBHI on the Protection of members from financial hardship

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where one indicates "Strongly Disagree," two indicates " Disagree", three indicates "Neutral", four indicates " Agree", and five indicates "Strongly Agree."

Items	5	4	3	2	1
As a member of CBHI, I can afford healthcare services without experiencing financial hardship.					
I am satisfied with the level of financial risk pooling in the healthcare system.					
As a CBHI member, I feel financially secure in case of a major illness or medical emergency.					
My current health insurance provides adequate coverage for my healthcare needs.					
After being enrolled in CBHI, I am not concerned about the financial impact of healthcare expenses on my household budget.					
Improvements in financial protection would encourage more people to seek healthcare services in the West Shewa Zone.					

VII. The impact of CBHI on community's health outcome

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where one indicates "Strongly Disagree," two indicates " Disagree", three indicates "Neutral", four indicates " Agree", and five indicates "Strongly Agree."

Items	5	4	3	2	1
CBHI has increased access to preventive healthcare services (e.g., vaccinations and screenings) for residents.					
CBHI has reduced the financial burden of healthcare expenses on residents, leading to better health-seeking behaviour.					
Residents covered by CBHI are more likely to seek early treatment for health issues, leading to improved health outcomes.					
CBHI has contributed to a decrease in the prevalence of communicable diseases (e.g., malaria, tuberculosis) through improved access to treatment.					
The availability of health insurance has improved the overall health status of residents in the community.					
CBHI has led to a decrease in the number of residents experiencing catastrophic health expenditures.					
There has been better availability of healthcare services (e.g., clinics and hospitals) in our community since the introduction of CBHI.					
CBHI has helped to improve the overall health awareness and health literacy of residents.					

I am satisfied with the quality of healthcare services available to you through CBHI.					
I Have noticed positive changes in the utilization of healthcare services (e.g., frequency of doctor visits and hospital admissions) among CBHI members.					
CBHI has an impact on reducing the burden of non-communicable diseases (e.g., diabetes, hypertension) in your community.					
CBHI has contributed to decreasing the prevalence of preventable diseases (e.g., vaccine-preventable diseases) in your community.					
CBHI is effective in promoting a healthy lifestyle and preventive care among residents.					

Appendix B: Survey Questioner for CBHI employees

The title of the Dissertation is Community-Based Health Insurance Implementation and Challenges in Ethiopia: Case of West Shewa Zone Oromiya National Regional State.

You are asked to take part in a study on the involvement of Community-Based Health Insurance Implementation and Challenges in Ethiopia. This questionnaire is part of a PhD research study at Hungary's National University of Public Service's Doctoral School of Public Administration Science. The goal of this in-depth study is to determine the extent to which the CBHI strategy is implemented in Oromia's national and regional state and what the challenges are facing CBHI implementation. This questionnaire has four parts and takes about 15 minutes to complete. Your correct answers will help the study's success. You may rest assured that your information will be kept private and only utilized for the research topic. I confirm that respondent anonymity is completely guaranteed and that your participation in the study is entirely voluntary.

Thank you Very Much in advance

Questioner

I.Background of the respondents

1. Gender

A) Male B) Female

1. Age

A) 18-30 Year B. 31-40 Year C. 41-50 Year D.51-60 years E. >=61 years

2. Level of education

A) Diploma C) Master's Degree

B) First Degree D) PhD E) other_____

3. Designation

A. Monitoring and evaluation officer (Federal office EHIS)

B. Claim Management officer (Federal office EHIS)

C. Zonal CBHI Expert
D. Zonal Coordinator
E. Oromia Health Bureau CBHI expert
F. Provider affairs and quality assurance senior officer (Federal Office EHIA)
G. Members Senior Officer (EHIS)
H. Higher officials at EHIS
I. Team Leader at EHIS

4. Work Experience

A. 1-3 Years B. 4-7 Years C. 8-11 Years D. >=12 Years

I. Challenges of CBHI Implementation

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where one indicates "Strongly Disagree," two indicates " Disagree", three indicates "Neutral", four indicates " Agree", and five indicates "Strongly Agree."

Items	5	4	3	2	1
Limited financial resources are a significant challenge in the implementation of the CBHI strategy.					
Inadequate healthcare infrastructure poses a significant challenge to CBHI Implementation.					
A lack of awareness about the benefits of health insurance hinders CBHI enrollment.					
Socioeconomic disparities affect the enrollment rates of CBHI programs in different communities.					
Inconsistent administrative capacity across districts affects the implementation of the CBHI strategy.					
The CBHI strategy faces difficulties in recruiting and training local healthcare workers.					
The CBHI strategy encounters challenges in reaching remote and underserved areas.					
The CBHI strategy faces challenges in building trust and credibility within communities.					
The CBHI strategy faces difficulties in negotiating agreements with healthcare providers.					
Challenges related to political and bureaucratic processes affect CBHI implementation.					
External factors, such as economic instability, can affect the sustainability of CBHI programs.					
Financial sustainability is a significant challenge faced by some CBHI programs in Ethiopia.					
The complex claims reimbursement process is a common challenge with CBHI systems.					

II. Questions related to Influence of stakeholders on the success of CBHI strategy implementation in the study area

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where one indicates "Strongly Disagree," two indicates " Disagree", three indicates "Neutral", four indicates " Agree", and five indicates "Strongly Agree."

Items	5	4	3	2	1
We have strong collaboration between government agencies and non-governmental organizations.					
The involvement of multiple stakeholders fosters a more comprehensive and holistic approach to CBHI strategy implementation within the West Shewa Zone.					
The collaboration among different stakeholders positively influences the coverage and reach of the CBHI program within communities in the West Shewa Zone.					
The active engagement and communication between government agencies, non-governmental organizations, and community leaders significantly contribute to the success of the CBHI strategy implementation in West Shewa Zone.					
Collaborative efforts create a sense of shared responsibility for achieving the goals of the CBHI program in the West Shewa Zone.					
Stakeholder coordination facilitates the identification and mitigation of challenges faced during the implementation of the CBHI strategy in the West Shewa Zone.					
Collaboration between government and non-government entities ensures a more equitable distribution of resources to support CBHI implementation in the West Shewa Zone.					
The diverse expertise brought by different stakeholders enhances the overall quality of healthcare services provided through the CBHI program in the West Shewa Zone.					
Effective stakeholder coordination leads to improved community engagement and participation in the CBHI program in your area.					
Collaborative decision-making processes between stakeholders contribute to the adaptability of the CBHI strategy to local contexts in your area.					
Stakeholder collaboration ensures that the CBHI program is responsive to the evolving healthcare needs of the population in your area.					
A well-coordinated approach among stakeholders enhances the accountability and transparency of the CBHI program in your area.					
Collaboration facilitates the identification and utilization of local resources to support the sustainability of the CBHI program in your area.					
Stakeholder involvement enhances the understanding and awareness of the CBHI program and the local population in your area.					
Effective collaboration between government and non-government entities positively affects the enrolment rates and membership retention of the CBHI program in your area.					

Collaborative efforts create opportunities for capacity-building and knowledge-sharing among different stakeholders involved in the CBHI program in your area.					
Coordination between stakeholders ensures that the CBHI program is aligned with the broader health policies and goals in your area.					

III. **Questions related to the effect of Administrative capacity/ Manpower and resources on CBHI implementation in the West how zone.**

Instructions: Please indicate your level of agreement with the following statements by selecting the appropriate response on a scale of 1 to 5, where one indicates "Strongly Disagree," two indicates " Disagree", three indicates "Neutral", four indicates " Agree", and five indicates "Strongly Agree."

Items (Administrative capacity and manpower)	**5**	**4**	**3**	**2**	**1**
There is a lack of administrative capacity among Woreda CBHI employees.					
There is a lack of enough workforce to carry out membership renewal, cash reimbursement and other activities of CBHI.					
The differences in administrative capacity among districts within the west shewa zone significantly impact the success of CBHI implementation.					
The level of administrative expertise in each district affects the efficiency of CBHI enrollment processes.					
Variations in the number of trained personnel in different districts contribute to differences in CBHI service quality.					
Districts with more substantial administrative capacity are better equipped to adapt CBHI programs to local community needs.					
The effectiveness of CBHI awareness campaigns varies based on the administrative capacity of each district.					
Items (Resource Allocation)	**5**	**4**	**3**	**2**	**1**
Differences in resource allocation among districts in the west shewa zone contribute to varying challenges during CBHI implementation.					
The availability of adequate funding influences the success of CBHI enrollment and service delivery efforts.					
Resource constraints in certain districts hinder the implementation of CBHI outreach and education initiatives.					
Equitable allocation of resources among districts is essential for consistent CBHI implementation outcomes.					
Resource availability aligned with population needs is crucial for the success of CBHI service delivery.					

Appendix C: Interviews: Interview questions for CBHI officials

The title of the Dissertation is Community-Based Health Insurance Implementation and Challenges in Ethiopia: Case of West Shewa Zone Oromiya National Regional State.

You are asked to take part in a study on the involvement of Community-Based Health Insurance Implementation and Challenges in Ethiopia. This questionnaire is part of a PhD research study at Hungary's National University of Public Service's Doctoral School of Public Administration Science. The goal of this in-depth study is to determine the extent to which the CBHI strategy was implemented in Oromia's national and regional state and what the challenges of implementation are. This Interview has six questions and takes about 10 minutes to complete. Your correct answers will help the study's success. You may rest assured that your information will be kept private and only utilized for the research topic. I confirm that respondent anonymity is completely guaranteed and that your participation in the study is entirely voluntary.

- How is the CBHI strategy formulated and implemented in Oromia's national regional state, and what are the challenges of implementation?
- What is the status of community-based health insurance (CBHI) implementation in different parts of West Shewa Zone Oromiya National Regional State?
- What are the significant challenges faced by CBHI programs in Ethiopia, including issues related to governance, financing, administration, and accountability?
- How does the regulatory and policy framework in Ethiopia facilitate or hinder the growth and functioning of CBHI schemes?
- What are the key factors influencing the adoption and enrollment rates of CBHI schemes among various socioeconomic groups in West Shewa Zone?
- What is the effect of CBHI on healthcare access, utilization, and financial protection for vulnerable populations in the West Shewa zone?

Appendix D. Consent Letter

YUUNIVARSITII AMBOO

Ambo University

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College of Business and Economics

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Department of Public Administration and Development Management

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Ref. No: AU/PADM/0010/2016

Date: 12/04/2016

To: West Shawa Zone Health Bureau

Subject: <u>Requesting Cooperation</u>

Mr. Gutema Nemomsa Dereje is an academic staff of Ambo University, department of Public Administration and Development Management and currently Pursuing his PhD degree in Hungary, Budapest at National University of Public Service. As part of the program he is going to gather data for his PhD dissertation with a title, Implementation and Challenges of CBHI in Ethiopia, the Case of West Shawa Zone. The study is already underway and it is believed to benefit the country in general and your zonal office in particular. In this view, the department kindly requests you to cooperate with the candidate so that he will get access to relevant data in your office.

With Best Regards

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Head, Department of Public Administration & Development Management

Department of PADM

16/04/2016

P.O.Box 19 AMBO ETHIOPIA E-mail: padm.department@ambou.ed.edu.et Telephone: 251118766169

Appendix E. List of Publications by the researcher
Articles

1. Namomsa, G. (2019). Assessing the practice and challenges of Community Based Health Insurance in Ethiopia: Case of Oromia National Regional State District of Gimbichu. Journal Homepage: -www. journalijar. com.

2. Daraje, G. N. (2022). The Enrollment of Households in Community-Based Health Insurance (CBHI) in Ethiopia: The Case of the Aletu District. *Hungarian J. Afr. Stud.*, *16*, 47.

3. Daraje, G. N. (2021). Challenges and Achievement of Public Sector Reform Using the Kaizen Philosophy: The Case of Ambo University= Wyzwania i Osiągnięcia Reformy Sektora Publicznego z Wykorzystaniem Filozofii Kaizen: Przypadek Uniwersytetu w Ambo. *INTERCATHEDRA: SCIENTIFIC QUARTERLY-FACULTY OF ECONOMICS AND SOCIAL SCIENCES POZNAŃ UNIVERSITY OF LIFE SCIENCES*, *48*(3), 123-131.

4. Daraje, G. N. (2023). Evaluation of Achievement and Challenges of health care reform using Community-based health insurance in Ethiopia. Verejná Správa a Spoločnosť, 24(2). https://doi.org/10.33542/VSS2023-2-1.

5. Vértesy, L., & Namomsa, G. (2023). The Role of Community-Based Health Insurance in Empowerment of Women‟s Health and Economic Rights in Ethiopia. *Jogelméleti Szemle*, (3), 33-48.

6. Namomsa Daraje, G. (2023). Disability and response to COVID-19. On social protection in Sub-Saharan African countries–The case of Ethiopia.

7. Daraje Gutama Namomsa (2023). Evaluation of Achievement and Challenges of health care reform using Community-based health insurance in Ethiopia VEREJNA SPRAVA A SPOLOCNOST 24: 2 pp. 25-36., 12 p. (2023)

8. Namomsa Daraje, G. (2023). DIGITALIZING COMMUNITY-BASED HEALTH INSURANCE IN ETHIOPIA.

9. Chali, B. D., Lakatos, V., & Daraje, G. N. (2024). Enhancing Well-Being Through Cooperative: Strengthening Social Capital for Public Welfare in Ethiopia. Acta Academiae Beregsasiensis. Economics, (6), 207-222. https://doi.org/10.58423/2786-6742/2024-6-207-222

10. Daraje, G. N., & Phyu0000, A. K. GADAA SYSTEM: INDIGENOUS POLITICAL AND ADMINISTRATION SYSTEM OF OROMO PEOPLE IN ETHIOPIA. https://doi.org/10.47833/2025.1.ART.005

Appendix F. List of Scientific lectures by the researcher

1. **Assessing the Current type of University-Industry Linkage in the Higher Education Institution of Ethiopia: Case of Ambo University**. *ICABEP2021 International Conference on Accounting, Business, Economics and Politics* 3rd joint conference organized by the collaboration of the Faculty of Administrative Sciences and Economics, Tishk International University, College of Administration and Economics, Salahaddin University-Erbil, and University of Szczecin, Poland.
2. **"Children's rights vs. Parental Responsibility"** International Doctoral Conference. 11 October 2021, Budapest/Miskolc.
3. **The Impact of Community Based Health Insurance (CBHI) on health status and the Financial Risk Protection (FRP) case of Ethiopian rural areas**. In the Service of the Nation Conference 2021, A Haza Szolgálatában 2021 Konferencia ‖ Budapest ‖ 9, November 2021 ‖ 2021 November 19.
4. **The Role of EU on Supporting Health Projects in Ethiopia. In:** Kiss, R. (2022). European Union Policies International Thematic Conference-October 21, 2022. Budapest, Hungary-Book of Abstracts. European Union Policies International Thematic Conference Doctorates' Council of Ludovika – University of Public Service ‖ October 21, 2022
5. **Challenges and Achievements of health care reform using Community-Based Health Insurance in Ethiopia** in: Kiss, R. (2022). Critical Rethinking of Public Administration: April 08, 2022. Budapest, Hungary: Book of Abstracts.
6. **Indigenous Political and Administration system of Oromo people in Ethiopia: Conference lecture** (2023) XVIII. Debrecen PhD Conference, 9.6.2023, Debrecen, Hungary, Country: Hungary.
7. **Role of Community-based Health Insurance on Health and Economic Empowerment of Women's rural parts of Ethiopia: Conference lecture** (2023) XVIII. Debrecen PhD Conference, 9.6.2023, Debrecen, Magyarország, Country: Hungary.
8. **Investigating Language Barriers in Public Healthcare Services: A Case Study of International Students in Budapest, Hungary in**: Hristina, Rucheva Tasev (eds.) International Virtual Academic Conference - Book of Abstracts: Education and Social Sciences; Business and Economics Thessaloniki, Greece: International Academic Institute (2023) 8 p. pp. 6-6., 1 p.
9. **The significance of CBHI on health and economic empowerment of women in Ethiopia. In:** Kiss, R. (2023). Critical Rethinking of Public Administration: April 21, 2023, Budapest, Hungary–Book of Abstracts.
10. **The state and issues of Urban Governance in Ethiopia in**: Bátori, Annamária; Mezei, József (eds.) In the Service of the Nation Conference - 2024 - Book of Abstracts Bp, Hungary: Doktoranduszok Országos Szövetsége (DOSZ) (2024) 77 p. pp. 68-68., 1 p.