Towards Realizing the Right to Health for Women Through Community-Based Health Insurance Schemes in the Case of Ethiopia

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Abstract

This thesis aims to analyze the role of Ethiopia's community-based health insurance (CBHI) program in realizing women's right to health. The study explores the flaws of the current healthcare system and the advancements made in enhancing access to healthcare. It also examines the budget allocation from local resources and the nation's dependence on foreign assistance for funding healthcare. The study uses a mixed-methods approach to investigate the current state of Ethiopia's healthcare system and gauge how well it serves all of its residents' healthcare requirements. It identifies the problems and shortfalls in the infrastructure, the accessibility of necessities, and the provision of healthcare services. The results show that although Ethiopia's healthcare system has made steps, The budgetary allocation from domestic sources is meager, placing significant reliance on foreign aid financing healthcare. This dependency could jeopardize the long-term viability and growth of the healthcare system. In addition, despite progress in advancing women's right to health, there are not enough women covered by the CBHI program.

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List of Abbreviations

AAAAQ	Availability, Accessibility, Acceptability, Adaptability, and Quality
ANC	Antenatal Care
CBHI	Community-Based Health Insurance
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHF	Community Health Fund
EHIA	Ethiopian Health Insurance Agency
EPHI	Ethiopian Public Health Institute
ESCR	Economic, Social, and Cultural Rights
ETB	Ethiopia Birr
FDRE	Federal democratic republic of Ethiopia's
FGM	Female Genital Mutilation
FMoH	Federal Ministry of Health
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GEWE	Gender Equality and Women's Empowerment
GTP	Growth and Transformation Plan
HDA	Health Development Army
HIA	Health Insurance Agency
ICESCR	International Covenant on Economic, Social, and Cultural Rights
LMIC	Low- and Middle-Income Countries
MDG	Millennium Development Goals
MoH	Ministry of Health

NGO	Non-Governmental Organization
NHI	National Health Insurance
OHCHR	Office of the United Nations High Commissioner for Human Rights
OOP	Out-Of-Pocket
OPERA	Outcome, Policy Effort, Resource, and Assessment
PC	Population Coverage
PFSA	Pharmaceutical Fund and Supply Agency
PHC	Primary Health Care
PHI	Private Health Insurance
PNC	Postnatal Care
PPIUCD	Postpartum Intrauterine Contraceptive Device
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
SNNP	Southern Nations, Nationalities, and People's
SSA	Sub-Saharan Africa
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
US	United States
WHO	World Health Organization

Introduction

People all around the world suffer and die as a result of a lack of access to essential medical care. Every year, 150 million people in low- and middle-income countries experience a financial catastrophe due to their health, and 100 million (the equivalent of three people every second) are forced into poverty due to out-of-pocket (OOP) medical expenses.[1] Compared to developed nations, low-income and developing economy countries' OOP health expenditures make up most of their healthcare finance. As a result, individuals are forced to pay a large percentage of their medical costs out of pocket, with little assistance from government-funded programs.[2]

Additionally, these nations' insufficient finance limits the availability of health treatments; one of the leading causes of the health funding shortage in LMIC countries is the excessive reliance on OOP payments and development aid money.[3] This suggests that health service prices are a significant barrier to access to and use of healthcare and that the only way for governments to achieve Universal Health Coverage (UHC) and lessen their reliance on direct OOP payments is to promote risk-pooling prepayment arrangements. The World Health Organization (WHO) urged member states to "ensure that health-financing systems provide or develop prepayment of financial contributions for the health sector, to share risk

[1] Participants at the Bellagio Workshop on Implementing Pro-Poor Universal Health Coverage et al., "Implementing Pro-Poor Universal Health Coverage," *The Lancet. Global Health* 4, no. 1 (January 2016): e14-16, https://doi.org/10.1016/S2214-109X(15)00274-0.

[2] Nemanja Rancic and Mihajlo (Michael) Jakovljevic, "Long Term Health Spending Alongside Population Aging in N-11 Emerging Nations," *Eastern European Business and Economics Journal* 2, no. 1 (2016): 2–26, https://ideas.repec.org//a/eeb/articl/v2y2016n1p2-26.html.

[3] Global Burden of Disease Health Financing Collaborator Network, "Evolution and Patterns of Global Health Financing 1995-2014: Development Assistance for Health, and Government, Prepaid Private, and out-of-Pocket Health Spending in 184 Countries," *Lancet (London, England)* 389, no. 10083 (May 20, 2017): 1981–2004, https://doi.org/10.1016/S0140-6736(17)30874-7.

among the population and avoid catastrophic healthcare expenditure and destitution of individuals as a result of seeking care" in a 2005 statement.[4]

Ethiopia is a country with a population of more than 100 million people, and it has one of the world's poorest healthcare systems. Severe problems, including corruption and a lack of access to care, plague the healthcare system in Ethiopia. The country has switched from a socialist to a free market economy since the early 1980s. The healthcare system significantly improved due to this shift, considerably enhancing access to medical treatments and services. However, there are still numerous issues with Ethiopia's healthcare system.

One of the most critical inputs to the health system is financing, which helps to raise enough money to protect individuals from financial risk, allocate resources, and make purchases that will increase quality, equity, and efficiency. The Ethiopian healthcare system has put much work into reforming the health system to mobilize sufficient resources and encourage effective utilization to ensure that all segments of society can get health care without facing financial hardship. However, poor healthcare finance in Ethiopia continues to be a severe problem for the health system, leaving families at risk of going bankrupt from unaffordable medical expenses and restricting access to crucial healthcare for the underprivileged.

In Ethiopia, healthcare is not free; thus, everyone needs to have resources and a consistent source of income to access health services and receive medical attention. In addition, there is significant variation in the quality of healthcare services in different parts of the country due to limited funds and other resources. In fact, most Ethiopians cannot afford to pay for

[4] "Healthcare Must Be Affordable and Accessible, but Also High Quality – ACCESS," accessed June 9, 2023, https://accessh.org/healthcare-must-be-affordable-and-accessible-but-also-high-quality/.

medical care, and limited access to medicine and different health services results in tens of thousands of deaths each year from preventable diseases. Due to an inadequate healthcare system, patients must pay for services when they receive them or have their medical costs paid for when they visit a clinic. The conventional healthcare system in Ethiopia is similar to that in the rest of Africa; most medical expenses are paid OOP, which may be very expensive for people with low incomes. As a result, the Community-Based Health Insurance (CBHI) initiative has been underway since 2011 with support from the Ethiopian Health Insurance Agency (EHIA). Its goal is to increase healthcare service utilization by easing financial constraints and eliminating the inefficient OOP healthcare expenditure system.

It is widely known in Ethiopia that psychological stress brought on by out-of-pocket medical expenses affects patients and their families. It also negatively affects health since patients may decide not to receive necessary care due to cost, worsening poverty in a home that is already struggling.[5]

The primary goal of the present thesis is to evaluate Ethiopia's healthcare system and the CBHI program. The thesis focuses specifically on examining the healthcare system, state obligation, Analyzing the effectiveness of CBHI with a focus on how it enables women to realize their right to health by discussing factors such as access to quality healthcare, affordability, coverage, equity, and the involvement of women in healthcare decision-making. This study aims to contribute to this area of research by exploring Community

[5] Margaret Whitehead, Göran Dahlgren, and Timothy Evans, "Equity and Health Sector Reforms: Can Low-Income Countries Escape the Medical Poverty Trap?," *The Lancet* 358, no. 9284 (September 2001): 833–36, https://doi.org/10.1016/S0140-6736(01)05975-X.

Based Health Insurance Schemes in achieving the fulfillment of the right to health for women in Ethiopia.

The healthcare system and CBHI are closely related because they depend on one another for efficient healthcare delivery. The existence of insurance becomes worthless in the absence of an accessible healthcare system. Similarly, absent insurance, even if healthcare services are easily accessible, people would encounter financial obstacles that would make it difficult to use the care they require. As a result, there is a symbiotic link between the healthcare system and CBHI, with both components being necessary to guarantee that everyone has access to healthcare and financial security.

Based on examining other countries' experiences (the advancements as well as the shortcomings) in implementing the CBHI program, such as Rwanda and Tanzania, after carefully considering various variables such as economic context and population needs, I hypothesize that the CBHI program in Ethiopia has significant potential for success in its objectives. However, based on my study, I argue that, firstly, the state lacks commitment to resource allocation and political commitment to realizing the right to health. Due to this shortcoming, the countries lag in achieving Universal Health Coverage. Secondly, the CBHI program was launched to assist non-informal sectors; however, the initiative has not accomplished its objective due to low enrollment rates. For individuals who can use the insurance, it is crucial to recognize that the CBHI has made progress toward realizing the right to health. Finally, many women remain vulnerable due to low enrollment and other societal factors, given that they lack access to healthcare.

Content of the Thesis

Chapter one thoroughly overviews national, international, and regional human rights law, focusing on women's health rights. It examines the legal frameworks and tools, such as international agreements and declarations, that recognize and defend human rights. The chapter further emphasizes how important it is for nations to uphold women's rights to health and their dedication to realizing the right to health. It looks at the state's obligations under the law to guarantee equal access to healthcare, end discrimination, and advance the health and well-being of women.

The second chapter of the thesis explores several facets of healthcare spending, concentrating on out-of-pocket costs. It starts by giving a thorough overview of personal healthcare spending and its effects. The chapter also looks at how community-based health insurance (CBHI) programs, universal health coverage (UHC), and sustainable development goals are related. Detail presentations of the development of CBHI in Ethiopia, along with its policy framework and execution, help to illuminate the nation's unique setting. The chapter also investigates the experiences of Sub-Saharan countries implementing the CBHI system, providing insightful information about its usefulness in various contexts.

The third chapter analyzes State Commitments to providing healthcare services for its people; evaluates the CBHI Program in achieving women's right to health by lessening financial burden. This chapter introduces the Opera framework as a tool for evaluating state commitments to the right to health and the efficacy of the CBHI program. The Opera framework, which includes standards for availability, accessibility, acceptability, and quality (AAAAQ), is described in detail in this chapter, along with how it can be used to assess

Ethiopia's healthcare system. In terms of the state's commitment to enforcing the right to health, it considers how closely that commitment aligns with international law. The chapter also evaluates how CBHI affects women's use of healthcare and their right to health, examining whether the program makes it easier for women to receive healthcare. It also discusses women's challenges in participating in the CBHI program.

Finally, the thesis concludes with a complete review of all the arguments and findings offered throughout the chapters; It brings the main ideas, critical considerations, and insights that are examined in each chapter and provides recommendations based on the gap pointed out during the analysis.

Chapter One: The Right to Health Legal Framework

Chapter introduction

To set the background for the evaluation of the Ethiopian health care system that I will focus on in the third chapter, this chapter provides a literature review overview of the right to health under domestic, regional, and international provisions and a description of state obligations regarding women's right to health. This chapter also aims to demonstrate Ethiopia's responsibility to achieve the right to health under international and national provisions recognized by Ethiopia. Therefore, I argue that based on these provisions, Ethiopia must fulfill everyone’s rights under its jurisdiction.

Background

Before 1946, health was not considered a right, and many nations still do not recognize it as a binding legal right; the right to health has become a legal matter due to several provisions. Thus, it is crucial to comprehend the significance of recognizing health as a right. As such, numerous international conventions, regional human rights instruments, and domestic constitutional and legal laws uphold the right to health. Each human rights treaty that outlines the essential elements of the right to health requires state parties to guarantee access to healthcare while promoting and protecting the well-being of their citizens.

Before examining the current healthcare condition of Ethiopia, it is necessary first to analyze the history of healthcare systems. Ethiopia introduced modern medicine in the 16th century, and every ruler embraced medicine and health after that. Sweden’s medical team introduced

Western medicine in 1886, and additional Western nations began devoting time and money to developing countries, namely Ethiopia.[6] According to Torrey, the Russian Red Cross constructed the country's first hospital in Addis Ababa in 1909. Ethiopia had eleven hospitals by 1936, two leprosaria, and a serological for vaccine manufacturing.[7] As Torrey continues, opening the Public Health Laboratory and Research Institute in 1946 was followed by the Public Health Proclamation, which established the legislative framework for health initiatives. Subsequently, the Ministry of Public Health found, in 1948.[8]

One could argue that the Ethiopian government is, in principle, trying to improve the health sector. A health policy and related strategic plans are released and implemented every five years, providing direction for the nation's health sector.[9] When looking at the delivery of health services in Ethiopia, it is divided into three tiers. The primary healthcare units, which comprise the first layer of the healthcare system, include primary hospitals, health centers, and health posts.[10] Primary hospitals offer inpatient and ambulatory services to over 100,000 people, and one health center is connected to five satellite health posts and serves about 25,000 people.[11]

To evaluate the state's commitment to achieving the right to health, this thesis looks at the obligations imposed by the international, domestic, and regional provisions.

[6] The International Trade Administration, U.S. Department of Commerce, "Ethiopia - Country Commercial Guide," 2022, https://www.trade.gov/country-commercial-guides/ethiopia-healthcare.
[7] E. Fuller Torrey, "Health Services in Ethiopia," *The Milbank Memorial Fund Quarterly* 45, no. 3 (July 1967): 275, https://doi.org/10.2307/3349007.
[8] Torrey.
[9] Addis Kassahun Mulat et al., "Scaling up Community-Based Health Insurance in Ethiopia: A Qualitative Study of the Benefits and Challenges," *BMC Health Services Research* 22, no. 1 (December 2022): 473, https://doi.org/10.1186/s12913-022-07889-4.
[10] Ibid
[11] Ibid

International Provisions

Several international conventions and declarations use the language of rights to refer to health-related issues. These conventions obligate states to take the necessary steps to ensure that all individuals have access to the right to health and that it is respected and protected.

Since the Universal Declaration of Human Rights (UDHR) is not a treaty, it does not give states legal duties. However, UDHR was passed in 1948 as the first human rights document and recognized a person's right to health and healthcare as a fundamental human right. UDHR is not initially enforceable under international law. However, the UDHR has grown in moral, political, and, at least informally, legal significance.[12] It comprises fundamental legal concepts and human rights standards recognized by customary international law; therefore, it has legal force. In addition, Article 25 of the declaration stated, "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in the circumstances beyond his control."[13] Subsequently, the United Nations passed several conventions to implement the UDHR.

The 1946 World Health Organization (WHO) Constitution has influenced many treaties' provisions; according to the preamble, "The enjoyment of the highest attainable standard of

[12] Krennerich Michael et al., "The Human Right to Health.," 2022.
[13] "Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc A/810 at 71 (1948).," accessed January 16, 2023, http://hrlibrary.umn.edu/instree/b1udhr.htm.

health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[14] In addition, the Constitution, which affirms health as a fundamental human right and pledges to provide everyone with the best possible level of health, serves as the foundation for Universal Health Coverage (UHC).[15] Moreover, the right to health is manifested by UHC, which also acts as an essential instrument for bringing about the right's eventual realization and dealing with UHC entails addressing laws, policies, and practices that reveal governments' willingness and ability to fulfill their pledges and uphold human rights obligations.[16] Moreover, UHC has been discussed extensively in General Assembly and World Health Assembly resolutions. Its formulation resulted in Sustainable Development Goals (SDG) target 3.8, which outlines member states of the United Nations' commitment to "achieve universal health coverage, including financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all."[17] UHC is crucial for achieving the right to health because it ensures everyone has access to and can afford health care. The right to health can only be guaranteed when UHC is attained and people and communities have unrestricted access to the medical care they require. In other words, UHC ensures that no one is denied access to medical care as stated in the General Assembly resolution, "No one must be left behind."[18]

[14] "Constitution of the World Health Organization," accessed April 11, 2023, https://www.who.int/about/governance/constitution.
[15] "Universal Health Coverage (UHC)," accessed April 8, 2023, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).
[16] Nygren-krug helena, "The Right(s) Road to Universal Health Coverage," h. Nygren-krug / human rights for Health across the United Nations, December 2019, 215–28.
[17] "A/RES/70/1 Transforming Our World: The 2030 Agenda for Sustainable Development," 2030.
[18] Ibid

The International Covenant on Economic, Social, and Cultural Rights ICESCR is the core of the UN Human Rights Treaty on the right to health; according to Article 12(1) and (2) of ICESCR, the Right to Health stated below;[19]

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

The Right to Health for women relies on other rights being protected without prejudice. Therefore, to avoid discrimination against women in the healthcare field, the Convention on the Elimination of all Forms of Discrimination Against Women CEDAW brings certain content to the right to health in Article 12 by guaranteeing equal access to healthcare services, explicitly mentioning that family planning healthcare services are part of the term healthcare system.[20]

Regional Provisions

African Commission on Human and People's Rights (Banjul Charter);[21] in Article 16, the Banjul Charter stipulates that "every individual shall have the right to enjoy the best attainable state of physical and mental health"[22] It also imposes the responsibility to state members "to take the necessary measures to protect the health of their people and to ensure

[19] "International Covenant on Economic, Social and Cultural Rights," OHCHR, accessed January 16, 2023, https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights.

[20] "Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979," OHCHR, accessed January 18, 2023, https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women.

[21] "African Commission on Human and Peoples' Rights Legal instruments," accessed January 18, 2023, https://www.achpr.org/legalinstruments/detail?id=49.

[22] Ibid

that they receive medical attention when they are sick."[23] Moreover, the right to health has also been passed under Women's Protocol.[24] Although the African Charter and its drafting have been commendable, enforcing the established norms has been challenging. Integrating the provisions into domestic issues and their practical application has proven to be the greatest obstacle to accomplishing the objectives. And yet, through constitutional provisions, a few African nations have gone further in recognizing and incorporating the right to health into their domestic policy.[25]

Domestic Provisions

Human rights must be protected internationally; however, national protection ensures their viability and effectiveness on a local level. For rights to be called for and given in the daily lives of individuals and communities, national legislation, regulations, and enforcement systems are essential. Federal entities are frequently competent to hear complaints of violations and enforce the human rights principles inherent in international and regional human rights law, in addition to the fact that national laws provide varying degrees of protection against human rights violations.[26]

Several laws, regulations, and codes of conduct have been established in Ethiopia; beginning with Article 13 and continuing through Article 44, the Federal democratic republic of

[23] "African Commission on Human and Peoples' Rights Legalinstruments."
[24] AFRICAN UNION, "PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND PEOPLE'S RIGHTS ON THE RIGHTS OF WOMEN IN AFRICA," 2003, https://au.int/sites/default/files/treaties/37077-treaty-charter_on_rights_of_women_in_africa.pdf.
[25] Moses Mulumba, David Kabanda, and Viola Nassuna, "Constitutional Provisions for the Right to Health in East and Southern Africa," n.d.
[26] Asher Judith, "The Right to Health: A Resource Manual for NGOs," 2004.

Ethiopia's (FDRE) Constitution devotes one-third of its overall provisions to a topic addressing "Fundamental Rights and Freedoms." This Constitutional Bill of Rights provides the fundamental legal framework for protecting human rights in Ethiopia.[27] Constitution's Bill of Rights includes provisions on civil, political, and other rights in addition to socioeconomic ones; this demonstrates that the FDRE Constitution's strategy for addressing human rights is comprehensive, which is a holistic approach.

Most significantly, the majority of international human rights treaties that recognize the right to health have been ratified by Ethiopia, according to the FDRE Constitution Article 9(4). and these conventions are stated to be a part of the country's law. Therefore, Not only is everyone in Ethiopia subject to the protections outlined in the Constitution, but also in those international human rights treaties that have been ratified.

In addition to the government enacted, public health Proclamation No.200/2000 clauses deal with the right to health. This indicates how the FDRE has prioritized protecting, respecting, promoting, and fulfilling the human right to health. According to the public health proclamation, "health is not only the absence of disease but also the complete physical, mental and social well-being of an individual."[28]

[27] "Ethiopia's Constitution," 1994, https://www.constituteproject.org/constitution/Ethiopia_1994.pdf.
[28] "Ethiopia Public Health Proclamation No 200/2000, Federal Negarit Gazeta," accessed January 26, 2023, https://chilot.me/wp-content/uploads/2011/08/proc-no-200-2000-public-health.pdf.

Obligations of the State Toward Women's Right to Health

Numerous health threats that women face are not faced by men, such as female genital mutilation, domestic abuse, the neglect of women's health in medical research, issues with reproductive health, a lack of family planning information, and unique health risks women face at work.[29] In addition, many of the same health issues that afflict men also affect women; because of their genetic makeup and the socially constructed notion of gender, women react to these issues differently.[30] Several societal realities negatively impact women's health, such as poverty and economic dependency, gender-based violence and discrimination, and a lack of personal autonomy, particularly regarding sexual and reproductive choices. [31] A productive and entire life requires good health, and all women's freedom and emancipation depend on their ability to manage every element of their health, including their fertility.[32] One of the most direct and effective methods to lessen health inequities and ensure the efficient use of health resources is to take action to increase gender equity in health and to address women's rights to health. A potent tool to inspire and energize governments, people, and especially women is strengthening and consistently applying human rights instruments.[33]

Therefore, under international and domestic provisions, the Ethiopian government must respect its responsibility to guarantee and protect women's health rights. Given the

[29] J. Cook Rebecca, "Human Right in Relation to Women's Rights" (WHO/DGH/93.1, 1993).
[30] Anne F. Bayefsky, "Office of the United Nations High Commissioner for Human Rights," in *The UN Human Rights Treaty System in the 21 Century*, ed. Anne Bayefsky (Brill | Nijhoff, 2000), 451–58, https://doi.org/10.1163/9789004502758_044.
[31] Bayefsky.
[32] "WMA - The World Medical Association-Women and Health," accessed May 6, 2023, https://www.wma.net/what-we-do/human-rights/women-and-health/.
[33] Martha Canning Chair Target Health Education, "Women's Right To Health," June 13, 2019, https://www.fawco.org/global-issues/target-program/health/blog-health-matters/4107-xxxxlearningw.

fundamental significance of this right, the government must move promptly to address women's particular health requirements. For instance, CEDAW places responsibility on the state to take all necessary steps to eradicate discrimination in the healthcare sector to guarantee gender equality, access to healthcare services, and family planning. In addition, Article 14 of CEDAW emphasizes the issues that rural women face and reaffirms that women have the right to "Access to adequate health care facilities, including information, counseling, and services in family planning." [34] Furthermore, it is also essential to comprehend that Article 5[35] of CEDAW advocates for the abolition of "prejudices and customs" since it is widely known that gender norms and traditional beliefs and practices significantly negatively impact women's health. For instance, Female Genital Mutilation. (FGM)

Moreover, the ICESCR also has obligation clauses; however, the treaty also acknowledges that the enjoyment of these rights may also be subject to "progressive realization," indicating that the state may not fully realize these rights yet must use the full extent of its resources. Interpretations of ESCRs have persisted in demonstrating that the "progressive realization" paradigm, which grants states an unbounded margin of appreciation, is being constrained. According to the Vienna Convention on the Law of Treaties, which Ethiopia ratified, conditions are required to fulfill their obligations under treaties in good faith[36], and cannot use the progressive standards as an excuse for failing to do so, nor can they use them to limit or deviate from ESCRs justifiably. Not all parts of the rights may be instantly realized;

[34] "Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979."
[35] Ibid
[36] "Vienna Convention on the Law of Treaties (1969)," n.d.

however, States must at least demonstrate that they are making all efforts possible within the limits of their resources. [37]

Regarding the FDRE constitution, Article 41(4) of the Constitution is also concerned about the right to health issues, stipulating, "The state must allocate every increasing resource to provide to the public health, education, and other social services." Using broad and open-ended provisions may aid in including unlisted rights established in conventions Ethiopia has ratified, which is the ICESCR.

Conclusions

Ethiopia's ratification of several international treaties, which consists of clauses concerning the right to health, demonstrates its devotion to human rights; the country has taken on the obligation of protecting the right to health for women by signing on to these covenants. This reflects the significance of promoting and protecting women's well-being in the nation and understanding the worldwide responsibilities that come with such commitments. However, as I will demonstrate in the final chapter, there are still significant gaps that need to be addressed, and there needs to be a political commitment to fulfill the citizens' right to health in general and women's right to health in particular.

[37] Bayefsky, "Office of the United Nations High Commissioner for Human Rights," 2000.

Chapter Two: Community-Based Health Insurance

Chapter introduction

This chapter discusses the relationship between Universal Health Coverage and the right to health, with a particular emphasis on the development of CBHI as a strategy to support the poor's access to healthcare. It covers CBHI policy and implementation in Ethiopia, offering insights into the nation's initiatives to increase health insurance coverage through CBHI programs.

In addition, this chapter aims to examine Ethiopia's CBHI program and how it relates to the international human rights law that Ethiopia has ratified and explore the scheme's efficacy in easing the burden placed on vulnerable groups, exploring it from the perspective of state obligation as a policy initiative. Additionally, this chapter will look into the effectiveness of such processes in other nations to conclude the scheme. After careful examination, I argue that implementing the scheme correctly can potentially lessen the financial burden on everyone, especially women, and foster health-seeking behavior.

Background

Despite numerous international promises to enhance health care for the least fortunate, millions of individuals, mainly from developing countries, continue to suffer and struggle to get primary health care. Due to the continuing and pervasive poverty, they are more vulnerable to several diseases and health problems, including HIV/AIDS, pneumonia, TB,

malaria, diarrhea, and epidemic diseases.[38] Notwithstanding everyone agreeing that everyone has the right to receive essential healthcare services. Accordingly, Governments must provide sufficient social and health schemes to meet their obligation to protect the health of their citizens.[39]

However, most of the population has been forced into poverty to pay for healthcare, and numerous developing-nation states have failed to recognize the need for healthcare among their poor citizens. In fact, since the late 1970s, the actual public sector per capita spending in the health sector has been declining across Africa.[40]

Concerning, a prior study has revealed differences in how women can obtain health insurance; it is also different in the factors influencing this access; age, education, economic situation, work position, marital status, ethnicity, number of children, and chronic sickness affect whether women in many nations have access to health insurance.[41] In contrast to men, women frequently have less access to health services, including health insurance.[42] Due to socioeconomic and cultural factors, men have better access to facilities than women, perpetuating gender bias in health care. More specifically, impoverished women are more susceptible to diseases and ill health because they live in unclean

[38]Dean T. Jamison, Joel G. Breman, and Anthony R. Measham, "Disease Control Priorities in Developing Countries" (A copublication of Oxford University Press and The World Bank, n.d.).

[39] "Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978," *Development* 47, no. 2 (June 2004): 159–61, https://doi.org/10.1057/palgrave.development.1100047.

[40] Johannes P. Jütting, "Do Community-Based Health Insurance Schemes Improve Poor People's Access to Health Care? Evidence From Rural Senegal," *World Development* 32, no. 2 (February 2004): 273–88, https://doi.org/10.1016/j.worlddev.2003.10.001.

[41] James K Kimani et al., "Determinants of Health Insurance Ownership among Women in Kenya: Evidence from the 2008–09 Kenya Demographic and Health Survey," *International Journal for Equity in Health* 13, no. 1 (2014): 27, https://doi.org/10.1186/1475-9276-13-27.

[42] GUMBER ANIL, "HEALTH INSURANCE FOR THE INFORMAL SECTOR: PROBLEMS AND PROSPECTS," 2002.

conditions, the significant burden of childbearing, the lack of emphasis placed on their personal healthcare needs, and the considerable obstacles they face in accessing healthcare.[43]

However, most low- and middle-income nations have been dealing with healthcare system sustainability problems over the past few decades.[44] 8.2% of African people, or 97 million, experience "catastrophic healthcare costs" annually.[45] Several states in developing nations have fallen short of recognizing the need for health treatment for their underprivileged citizens. Therefore, 15 million individuals will be impoverished yearly due to out-of-pocket expenses. [46] Thus, Jütting argues that the CBHI programs arose due to a healthcare crisis in many developing-country regions.[47] CBHI initiatives were developed as an emerging alternative to increase healthcare under the Sustainable Development Goals (SDGs) of the United Nations to achieve UHC.

Universal Health Coverage: Making Healthcare a Human Right

Since it was made a Sustainable Development Goal (SDG) aim, universal health coverage (UHC) has gained prominence on the global health agenda and is now a key component of institutional advocacy for global health.[48] Although UHC has been in place for a while, the UN Sustainable Development Goals for 2015 have given it new weight on the global health

[43] GUMBER ANIL, "HEALTH INSURANCE FOR THE INFORMAL SECTOR: PROBLEMS AND PROSPECTS," 2002.
[44] Joseph L Dieleman et al., "National Spending on Health by Source for 184 Countries between 2013 and 2040," *The Lancet* 387, no. 10037 (June 2016): 2521–35, https://doi.org/10.1016/S0140-6736(16)30167-2.
[45] "Universal Health Coverage: Only Half Of Africans Have Access To Health Care - Health Policy Watch," March 8, 2021, https://healthpolicy-watch.news/only-half-of-africans-have-access-to-health-care/.
[46] Ibid
[47] Jütting, "Do Community-Based Health Insurance Schemes Improve Poor People's Access to Health Care?"
[48]Nygren-krug Helena, "The Right(s) Road to Universal Health Coverage," h. nygren-krug / human rights for health across the United Nations, December 2019, 215–28.

agenda by adopting a new resolution.[49] Moreover, SDG target 3.8 underlines the UN member states' dedication to achieving UHC, including financial risk mitigation and accessible, necessary medications.[50]

One way to describe the 2030 Agenda for Sustainable Development, which builds upon and broadens the Millennium Development Goals (MDG) scope, is as a non-binding consensus UN policy document that should be construed under the conventions and principles of international law.[51] Specifically, the 2030 Agenda states that the 17 SDGs and 169 focus on "seeking to realize the human rights of all," that it is "grounded in the Universal Declaration of Human Rights and international human rights treaties," and that it must be "implemented in a manner that is consistent with the rights and obligations of States under international law."[52]

Resolutions on UHC passed by the General Assembly and World Health Assembly throughout the years have repeatedly emphasized how the fundamental framework for UHC is provided by human rights, particularly the right to health.[53] Similarly to this, it has been stressed by the UN Special Rapporteur Dainius Puras on the right to health that UHC must be viewed as being consistent with the right to health.[54] Even though some elements of targets 3.7 and 3.8, such as universal coverage, financial risk protection, access to quality essential healthcare services, access to safe, adequate, quality, and affordable essential medicines and vaccines, and universal access to sexual and reproductive healthcare services,

[49] "A/RES/70/1 Transforming Our World: The 2030 Agenda for Sustainable Development," 2030.
[50] Ibid
[51] helena, "The Right(s) Road to Universal Health Coverage."
[52] "A/RES/70/1 Transforming Our World: The 2030 Agenda for Sustainable Development," 2030.
[53] United Nations, *UNCITRAL Expedited Arbitration Rules 2021: UNCITRAL Rules on Transparency in Treaty-Based Investor-State Arbitration.* (United Nations, 2022), https://doi.org/10.18356/9789210021753.
[54] "UNGA, A/71/304," 2016.

can be interpreted as being consistent with the right to health, they obfuscate necessary right-to-health standards.[55]

According to the special Rapture, under the right to health, progress towards achieving UHC must be tracked to determine who is protected, what services are covered, and the degree of financial protection, with data being broken down to analyze progress across various sectors and populations.[56] In addition, the cornerstone of UHC is access to high-quality, affordable primary healthcare.[57] Therefore, the UHC is defined in a way that guarantees everyone has access to high-quality healthcare without putting them in financial hardship. It also encompasses three essential components: Population coverage (PC), the provision of healthcare services, and out-of-pocket (OOP) costs.[58]

The ICESCR Article 2 (1) must be considered alongside the right to health, which affirms "take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, to achieve progressively the full realization of the rights recognized in the present covenants by all appropriate means…."[59] Hence, the right to health doesn't mean automatically providing access to the highest quality healthcare. This Article emphasizes the need for nations to actively pursue the rights recognized by the ICESCR, both individually and through international support and cooperation. To make such development, states must put forth a consistent effort, be

[55] "UNGA, A/71/304."
[56] Ibid
[57] "Universal Health Coverage," Text/HTML, World Bank, accessed May 3, 2023, https://www.worldbank.org/en/topic/universalhealthcoverage.
[58] M.R. Mathur et al., "Universal Health Coverage: A Unique Policy Opportunity for Oral Health," *Journal of Dental Research* 94, no. 3_suppl (March 2015): 3S-5S, https://doi.org/10.1177/0022034514565648.
[59] "International Covenant on Economic, Social and Cultural Rights."

dedicated to continuous improvement, and recognize that achieving human rights is a shared duty that calls for national and international action.

The state must "take steps toward"[60] providing the best possible healthcare options. And UHC is "a practical expression of the concern for health equity and the right to health," according to the WHO.[61] This manifests that UHC and the right to health are inextricably linked and complemented. The realization of one goal aids in accomplishing the other; therefore, UHC and the right to health go hand in hand. UHC programs can support equal healthcare resources and service distribution, which is crucial for attaining the right to health because it guarantees everyone can access healthcare services regardless of their social or economic position.

UHC, which has its roots in the right to health, is largely regarded as one of the front-runners to represent the health element.[62] It aims to make sure that everyone may get necessary medical care without suffering financial hardship.[63] It is typically accomplished by combining several strategies, including boosting public healthcare financing, expanding coverage under social health insurance, and enhancing the effectiveness and caliber of healthcare delivery systems. Contrarily, a community-based health insurance program is dedicated to offering insurance to low-income households and has its roots in the community. There are four primary types of health insurance systems: National Health

[60] "International Covenant on Economic, Social and Cultural Rights."
[61] Gorik Ooms et al., "Is Universal Health Coverage the Practical Expression of the Right to Health Care?" *BMC International Health and Human Rights* 14, no. 1 (December 2014): 3, https://doi.org/10.1186/1472-698X-14-3.
[62] Devi Sridhar et al., "Universal Health Coverage and the Right to Health: From Legal Principle to Post-2015 Indicators," *International Journal of Health Services* 45, no. 3 (July 2015): 495–506, https://doi.org/10.1177/0020731415584554.
[63] "Universal Health Coverage," Text/HTML, World Bank, accessed April 11, 2023, https://www.worldbank.org/en/topic/universalhealthcoverage.

Insurance (NHI), Social Health Insurance (SHI), Private Health Insurance (PHI), and Community-Based Health Insurance (CBHI).[64] CBHI is non-profit private health insurance founded on a mutual aid ethic among people in the informal sector and rural areas. Evidence suggests that CBHI programs can effectively reach disadvantaged groups and expand access to healthcare for low-wage rural and informal sectors. [65] Therefore, UHC policies may benefit significantly from CBHI programs, especially in low-income nations where conventional health insurance systems may not be viable or affordable.

In addition, UHC has long been a source of concern worldwide. The WHO and other international organizations have suggested achieving UHC primarily through health insurance.[66] However, most healthcare expenses in developing nations were paid for out-of-pocket at the time and location of service. [67] Most developing nations' governments have been unable to meet the poor population's healthcare requirements.[68] In particular, according to the world bank report 1993, the state's failure to meet the healthcare requirements of people with low incomes is demonstrated by declining budgetary allocations to healthcare services, ineffective public health service delivery, unacceptable low quality of public health services, and the subsequent imposition of user fees.[69] In various parts of developing nations, especially in sub-Saharan Africa, the "health care crisis" caused the emergence of various community-based health insurance schemes.[70]

[64]Wang H, Zurita B, and Switlick K, Ortiz C, "Health-Insurance-Handbook-How-to-Make-It-Work." (This publication was produced for review by the United States Agency for International Development, Health Systems 20/20 Project., 2010).
[65] Ibid
[66] Yikeber Abebaw Moyehodie, Solomon Sisay Mulugeta, and Seyifemickael Amare Yilema, "The Effects of Individual and Community-Level Factors on Community-Based Health Insurance Enrollment of Households in Ethiopia," *PLoS ONE* 17, no. 10 (October 10, 2022): 1–14, https://doi.org/10.1371/journal.pone.0275896.
[67] Ibid
[68] Jütting, "Do Community-Based Health Insurance Schemes Improve Poor People's Access to Health Care?"
[69] Ibid
[70] Ibid

Community-Based Health Insurance Scheme

Access to affordable and high-quality healthcare is not a luxury but a fundamental human right to which every individual should be entitled, and it is the state's responsibility to ensure its availability. CBHI program deployment is a potential strategy for addressing the problem of accessible healthcare.[71] CBHI program is also called micro health insurance or insurance for the uninsured; the program is a "voluntary insurance scheme organized at the community level."[72] It is a form of non-profit health insurance that impoverished people have used to protect themselves from the high costs of obtaining treatment and medical services for sickness.[73] Members of CBHI programs routinely pay small premiums into a joint fund, which is subsequently utilized to pay for the necessary medical care.[74] The program is intended for individuals who live in rural areas or work in the informal economy and cannot obtain sufficient health insurance through the public, private, or employer sectors. [75]

CBHI has the potential to improve access to healthcare by providing financial security for underserved populations, reducing equity gaps and lowering out-of-pocket expenses, increasing the self-confidence of those who participated through community control techniques, and raising awareness of the value of insurance.[76]

[71] K. S. Mohindra, Slim Haddad, and Delampady Narayana, "Can Microcredit Help Improve the Health of Poor Women? Some Findings from a Cross-Sectional Study in Kerala, India," *International Journal for Equity in Health* 7, no. 1 (2008), https://doi.org/10.1186/1475-9276-7-2.
[72] Guy Carrin, Maria-Pia Waelkens, and Bart Criel, "Community-Based Health Insurance in Developing Countries: A Study of Its Contribution to the Performance of Health Financing Systems," *Tropical Medicine & International Health* 10, no. 8 (2005): 799–811, https://doi.org/10.1111/j.1365-3156.2005.01455.x.
[73] OE Onwujekwe and N Ezuma S Eze, "CBHI_brief.Pdf" (University of Nigeria, February 2010).
[74] Ibid
[75] Ibid
[76] Abebe Shimeles, "Community Based Health Insurance Schemes in Africa: The Case of Rwanda," n.d.

Jütting argues that neither the state nor the market can effectively provide health insurance for low-income individuals in rural and informal sectors.[77] Because Rural areas face substantial barriers to providing adequate coverage due to distance from cities and transportation issues, a lack of a reliable transportation infrastructure makes it difficult for locals to obtain essential health insurance.[78] Likewise, formal providers frequently have a deficit regarding information and have expensive transactions.[79] For instance, the lack of financial incentives may cause private healthcare providers to be reluctant to invest in certain regions. Additionally, in some circumstances, the market might be unable to offer services tailored to the particular requirements of low-income people, like affordably priced medicine.

CBHI schemes differ significantly regarding demographic coverage, services provided, regulation, administration, and goals. While some NGOs that run CBHI schemes serve as both an insurer and a provider, others only serve as an insurer or serve neither a provider nor an insurer within the CBHI framework. In one Bolivian program, participants trade agricultural labor and seed potatoes for unlimited use of healthcare services.[80] This indicates, based on the requirements and goals of the community they serve, these programs are created and put into action. As a result, the way they are set up, what they offer, and how they function can all differ depending on aspects such as the region's degree of development,

[77] Jütting, "Do Community-Based Health Insurance Schemes Improve Poor People's Access to Health Care?"
[78] Gashaw T. Abate et al., "Geography of Public Service Delivery in Rural Ethiopia," *World Development* 136 (December 2020): 105133, https://doi.org/10.1016/j.worlddev.2020.105133.
[79] Jütting, "Do Community-Based Health Insurance Schemes Improve Poor People's Access to Health Care?"
[80] Ozawa Sachiko, "TRUST MATTERS: VILLAGERS' TRUST IN PROVIDERS AND INSURERS IN THE CONTEXT OF A COMMUNITY-BASED HEALTH INSURANCE SCHEME IN CAMBODIA" (2010).

the demands of the local population in terms of health, the accessibility of infrastructure and services for healthcare, and the members' financial standing.

One of the significant advantages of the CBHI scheme is its ability to provide a certain level of financial security while also improving access to healthcare for low-income people. Considerable evidence supports the idea that CBHI offers a certain level of financial stability by lowering out-of-pocket expenses and preventing individuals from falling into poverty due to catastrophic health costs.[81]

In many underdeveloped nations, the need for affordable and accessible health insurance is becoming more and more critical as healthcare expenses rise. The CBHI program is one remedy that has grown in favor recently. The program was created to give low-income individuals and families access to healthcare who would not otherwise be able to afford conventional health insurance policies. It is managed by the communities they serve at the local, grassroots level. In most cases, community members combine their funds and contribute to a shared fund to pay for medical costs.[82] In exchange for their contribution, members of a CBHI scheme have access to various healthcare services, including hospitalization, outpatient care, and prescription medication, at considerably lower costs than they would have to pay with no insurance.[83]

[81] B. Ekman, "Community-Based Health Insurance in Low-Income Countries: A Systematic Review of the Evidence," *Health Policy and Planning* 19, no. 5 (September 1, 2004): 249–70, https://doi.org/10.1093/heapol/czh031.

[82] "Community-Based Health Insurance in Ethiopia – Participedia," January 2, 2011, https://participedia.net/case/4958.

[83] Chaw-Yin Myint, Milena Pavlova, and Wim Groot, "Health Insurance in Myanmar: Knowledge, Perceptions, and Preferences of Social Security Scheme Members and General Adult Population," *The International Journal of Health Planning and Management* 34, no. 1 (2019): 346–69, https://doi.org/10.1002/hpm.2643.

CBHI in Sub-Saharan Countries

Sub-Saharan African nations accounted for over 90% of financial problems in the healthcare sector; SSA has a generally low level of health insurance coverage.[84] The formal sectors comprised 10% of the population and were primarily the only ones with access to health insurance. Poor Africans who work in the informal sector and live in rural areas as self-employed workers have never had access to social security through health insurance programs.[85] Therefore, most people get health care through out-of-pocket expenses, frequently resulting in less than the ideal use of health care services. As a result, a significant disparity in the amount spent on health-related needs across income levels in various nations could exist.[86]

In SSA, states have failed to recognize the need for health care for their poorest citizens in many developing countries. For instance, the health systems have been characterized in recent decades by declines in financing for healthcare services, inefficiencies, and poor public health services. The "healthcare crisis" revealed the failure of states to address the healthcare demands of vulnerable people adequately. CBHI programs have become more popular as a result in several areas.[87]

The Bamako Initiatives 1987, which WHO and UNICEF sponsored, seeks to guarantee that all people have access to high-quality and reasonably priced primary healthcare.[88]

[84] Desta Debalkie Atnafu, Hiwot Tilahun, and Yihun Mulugeta Alemu, "Community-Based Health Insurance and Healthcare Service Utilisation, North-West, Ethiopia: A Comparative, Cross-Sectional Study," *BMJ Open* 8, no. 8 (August 2018): e019613, https://doi.org/10.1136/bmjopen-2017-019613.
[85] Atnafu, Tilahun, and Alemu.
[86] Shimeles, "Community Based Health Insurance Schemes in Africa: The Case of Rwanda," n.d.
[87] Jütting, "Do Community-Based Health Insurance Schemes Improve Poor People's Access to Health Care?"
[88] Asila Pangu Kasa, "The Bamako Initiative," 1997.

Subsequently, many Sub-Saharan countries adopted the initiative to promote healthcare strategies and strengthen equity in healthcare access through local decentralization. The initiative supported the Rwandan vision for healthcare before the 1994 genocide that destroyed health infrastructure and disrupted other healthcare initiatives.[89] Despite the tragedy, Rwanda is one of the best at using CBHI programs as a significant component of its national healthcare finance system. The *Mutuelle de santé* program, first introduced in 1999 as a pilot in three regions, was permanently implemented nationally in 2004. Coverage increased from 36% of the population in 2006 to more than 86% in recent years when the nationwide deployment began.[90]

Evidence demonstrates that Rwanda's CBHI program has mainly been successful in raising healthcare utilization rates, lower out-of-pocket medical expenses, and lowering the risk of financial disaster.[91] Additionally, other evidence supports that the CBHI program in Rwanda not only boosts the use of current healthcare services but also acts as a crucial instrument for lowering severe financial risks and eradicating poverty.[92] [93] Therefore, in the history of CBHISs, there has never been such quick expansion and coverage as in Rwanda.[94]

This achievement is attributed to Rwandan policymakers for giving CBHISs a crucial role, making them essential components of the nation's health program with solid administrative and political support for their growth and operation. Due to the successful outcome, the

[89] HABIYONIZEYE Yvonne, "Implementing Community-Based Health Insurance Schemes Lessons from the Case of Rwanda," 2013.
[90] Woldemichael Andinet, "The Impacts of Community-Based Health Insurance on Poverty Reduction" (African Development Bank Group, May 2020).
[91] Shimeles, "Community Based Health Insurance Schemes in Africa: The Case of Rwanda," n.d.
[92] Chunling Lu et al., "Towards Universal Health Coverage: An Evaluation of Rwanda Mutuelles in Its First Eight Years," *PLOS ONE* 7, no. 6 (June 18, 2012): e39282, https://doi.org/10.1371/journal.pone.0039282.
[93] Shimeles, "Community Based Health Insurance Schemes in Africa: The Case of Rwanda," n.d.
[94] Ibid

experiment has generated so much attention that other countries are investigating the Rwandan model as a substitute for financing the health sector and providing essential healthcare services.[95]

In response to growing support for the CBHI program, Tanzania formally formed the Community Health Fund (CHF) in 1996 for rural areas.[96] However, enrolment rates have remained low despite the potential advantages of CHF. Tanzania's national CHF enrolment rate for 2015 was approximately 4.5%, which is much less than the year's target of 30%.[97] This failure to reach the goal raises the possibility that efforts to boost CHF enrolment may not have been successful. There are various possible reasons why CHF enrollment rates in Tanzania have remained low. Several studies have looked into the causes of low enrollment. A few of them illustrated that it was due to the lack of faith in the plan or the healthcare provider, the high premium rates, the restricted benefit packages, and the inability to understand the purpose of insurance.[98] [99] In addition, according to a recent Tanzanian study, exemption restrictions and healthcare-seeking behavior severely impacted the highest possible enrollment rate for the CHF program. Additionally, the study demonstrated how

[95] Shimeles, "Community Based Health Insurance Schemes in Africa: The Case of Rwanda," n.d.
[96] Ramadhani Kigume and Stephen Maluka, "The Failure of Community-Based Health Insurance Schemes in Tanzania: Opening the Black Box of the Implementation Process," *BMC HEALTH SERVICES RESEARCH* 21, no. 1 (July 3, 2021): 646, https://doi.org/10.1186/s12913-021-06643-6.
[97] Sabine Renggli et al., "Looking at the Bigger Picture: How the Wider Health Financing Context Affects the Implementation of the Tanzanian Community Health Funds," *Health Policy and Planning* 34, no. 1 (February 1, 2019): 12–23, https://doi.org/10.1093/heapol/czy091.
[98] Ntuli A. Kapologwe et al., "Barriers and Facilitators to Enrollment and Re-Enrollment into the Community Health Funds/Tiba Kwa Kadi (CHF/TIKA) in Tanzania: A Cross-Sectional Inquiry on the Effects of Socio-Demographic Factors and Social Marketing Strategies," *BMC Health Services Research* 17, no. 1 (April 27, 2017): 308, https://doi.org/10.1186/s12913-017-2250-z.
[99] Albino Kalolo et al., "Factors Affecting Adoption, Implementation Fidelity, and Sustainability of the Redesigned Community Health Fund in Tanzania: A Mixed Methods Protocol for Process Evaluation in the Dodoma Region," *Global Health Action* 8 (December 15, 2015): 10.3402/gha.v8.29648, https://doi.org/10.3402/gha.v8.29648.

healthcare employees prioritized user fees above CHF revenues due to increased user fee revenues, user fee policies, and money pooling mechanisms.[100]

As such, the CBHI schemes suffer from a chronically low membership rate, which may be related to poorer socioeconomic position, inadequate medical care, a lack of benefits, a lack of confidence in the program's administration, and disappointment with the program's services.[101] Furthermore, other studies also reported poor council commitment from management, expensive administration costs, insufficient supportive oversight, an ineffective medical supply chain, needing more service purchase procedures, claim to process, and risk equalization or cross-subsidization.[102] This resulted in inadequate enrolments and made it difficult for some people to get the required healthcare. Therefore, the schemes failed in Tanzania to provide poor communities access to vital healthcare services.

The lessons learned from these two countries provide an important point of comparison for evaluating CBHI in Ethiopia. As the case of Rwanda indicates, the government of Rwanda is fully committed to implementing the scheme for everyone by prioritizing CBHI as a mechanism for the eradication of poverty and increasing access to healthcare. At the same time, as the case of Tanzania highlighted, poor commitment, lack of support, etc.

[100] Renggli et al., "Looking at the Bigger Picture."
[101] Kigume and Maluka, "The Failure of Community-Based Health Insurance Schemes in Tanzania."
[102] Stephen O. Maluka, "Why Are Pro-Poor Exemption Policies in Tanzania Better Implemented in Some Districts than in Others?" *International Journal for Equity in Health* 12, no. 1 (September 26, 2013): 80, https://doi.org/10.1186/1475-9276-12-80.

CBHI in Ethiopia

Contextual Background

Ethiopia has made enormous advancements in health, education, and food security in the last ten years; however, it continues to rank among the ten lowest nations in the world.[103] Despite these efforts, Ethiopia continues to face significant challenges in its healthcare system. The country has one of the lowest doctor-to-patient ratios in the world, with just one doctor per 33,000 people, and many doctors operate in big cities.[104] Furthermore, the lack of funding, poor facilities, and a scarcity of healthcare professionals pose severe problems for Ethiopia's healthcare system.[105]

Ethiopia has experienced recent economic growth at a rapid pace, but it is still a developing nation with a significant disease load. The health system faces funding issues and depends on foreign assistance; [106] Healthcare services are not being used to their full potential due to lack of funding; the government spends a small amount on health compared to other low-income African states.[107] Therefore, to address the poor rate of healthcare service utilization and increase access to high-quality healthcare reasonably, effectively, and long-lastingly, the government introduced CBHI programs in 2011.[108] The schemes have been implemented as

[103] ETHIOPIA USAID, "COUNTRY PROFILE," n.d.

[104] "Physicians (per 1,000 People) - Ethiopia | Data," accessed April 3, 2023, https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=ET.

[105] Sehrish Bari et al., "Surgical Data Strengthening in Ethiopia: Results of a Kirkpatrick Framework Evaluation of a Data Quality Intervention," *Global Health Action* 14, no. 1 (January 1, 2021): 1855808, https://doi.org/10.1080/16549716.2020.1855808.

[106] Asmamaw Atnafu and Amare Tariku, "Perceived Quality of Healthcare and Availability of Supplies Determine Household-Level Willingness to Join a Community-Based Health Insurance Scheme in Amhara Region, Ethiopia," *ClinicoEconomics and Outcomes Research* Volume 12 (November 2020): 683–91, https://doi.org/10.2147/CEOR.S279529.

[107] Ibid

[108] Moyehodie, Mulugeta, and Amare Yilema, "The Effects of Individual and Community-Level Factors on Community-Based Health Insurance Enrollment of Households in Ethiopia."

the first step toward obtaining national health insurance coverage in developed and African countries. It has become one of the most significant risk-mitigation initiatives.

The Emergence of CBHI in Ethiopia

The Federal Democratic Republic of Ethiopia's 1995-adopted Constitution governs the Executive, Legislative, and Judicial parts of the country's government. The Constitution created a federation of nine National Regional States, two incorporated cities, and other nationalities and major ethnolinguistic nations in Ethiopia.[109] The regions have downward governmental decentralization power through Zonal and Woreda administrative divisions. The lower administrative level, or woreda (district), is where fundamental public functions are offered. As a result, the organizational management of health services is set up in a similar administrative framework.[110]

In 1998, the Federal Ministry of Health (FMoH) suggested a health financing plan to improve and diversify resource mobilization for health, guarantee equitable allocation and efficient use of resources, and financial protection for its citizens. [111] Since then, the nation has advanced by adopting wise strategies to keep success in domestic resource mobilization and leverage health financing for its primary healthcare services.[112]

[109] "Ethiopia Political Map and Regions | Mappr," January 14, 2019, https://www.mappr.co/political-maps/ethiopia/.
[110] Yonas Getaye Tefera and Asnakew Achaw Ayele, "Community-Based Health Insurance Scheme Implementation in Ethiopia: A Mini-Review on the Experience and Its Implementation Process," *World Medical & Health Policy* n/a, no. n/a, accessed November 23, 2022, https://doi.org/10.1002/wmh3.539.
[111] Tefera and Ayele.
[112] Tefera and Ayele.

The "Social Health Insurance Proclamation no. 690/2010" bill was enacted in Ethiopia on August 19, 2010.[113] The Council of Ministers established the Ethiopian Health Insurance Agency with Proclamation no. 691/2010 as an autonomous agency to implement the healthcare system, following "Council of Ministers regulation no. 191/2010."[114] Subsequently, the government introduced a CBHI Scheme in 2011 to improve access to medical care and lessen family vulnerability to out-of-pocket medical expenses with a goal of having 80% of its population and 80% of its districts reached by 2020.[115]

In the beginning, 13 rural woredas (districts) in the Amhara, Oromia, Southern Nations, Nationalities and People's (SNNP), and Tigray regions implemented the program as an experiment to learn from them before expanding them nationwide.[116] Simultaneously, the government trained various stakeholders to introduce CBHI design ideas and strengthen implementation and monitoring competence. The CBHI National Coordination Unit prepared specialized materials on monitoring and evaluation, financial and administrative administration, and a communications plan. In addition, task forces at the federal, regional, woreda, and kebele levels were set up to ease policy development, implementation, monitoring, and assessment of the schemes.[117] The pilot's performance aimed to collect data on how CBHI schemes affected members' financial risks, quality of treatment, access to and utilization of health services, and mobilization of resources for the health sector. The trial

[113] USAID, "EVALUATION Ethiopia Health Sector Financing Reform Midterm Project Evaluation," December 2011.
[114] Ibid
[115] USAID, "Ethiopia's Community-Based Health Insurance: A Step on the Road to Universal Health Coverage," accessed November 23, 2022, https://pdf.usaid.gov/pdf_docs/PA00KDXT.pdf.
[116] "Linking Poverty-Targeted Social Protection and Community Based Health Insurance in Ethiopia: Enrolment, Linkages, and Gaps | Elsevier Enhanced Reader," accessed April 4, 2023, https://doi.org/10.1016/j.socscimed.2021.114312.
[117] USAID, "Ethiopia's Community-Based Health Insurance: A Step on the Road to Universal Health Coverage."

results suggested expanding CBHI in Ethiopia and putting it into practice.[118] Subsequently, the Ethiopian government implemented the CBHI scheme in 161 other woredas in 2013 for 125,142 people following a successful three-year pilot program;[119] as of 2019/2020, the CBHI includes nearly 7 million households (or roughly 32 million people).[120]

One crucial aspect of the right to health is ensuring financial access to medical treatment. This implies that fundamental human freedom cannot be upheld without a reliable financial security mechanism against medical expenses[121] Because the lack of such mechanisms has significant economic, psychosocial, and medical repercussions. For instance, it is well known that patients and their families experience psychological duress due to out-of-pocket medical expenses.[122] Additionally, it exacerbates poverty in a home that is already struggling and has detrimental effects on health because patients may choose not to receive necessary care due to cost. Out-of-pocket medication spending will have the most significant impact because it accounts for the largest share of a household's health-related expenses, particularly for low-income families.[123]

Studies have shown that having health insurance encourages the use of the medical system.[124] Therefore, the goals of the CBHI in Ethiopia are to: "improve financial access to health care services, improve quality of health care services, increase resource mobilization

[118] Tefera and Ayele, "Community-Based Health Insurance Scheme Implementation in Ethiopia."
[119] USAID, "Ethiopia's Community-Based Health Insurance: A Step on the Road to Universal Health Coverage."
[120] "Linking Poverty-Targeted Social Protection and Community Based Health Insurance in Ethiopia."
[121] "Access to Care and Medicines, Burden of Health Care Expenditures, and Risk Protection: Results from the World Health Survey | Elsevier Enhanced Reader," accessed April 4, 2023, https://doi.org/10.1016/j.healthpol.2010.08.004.
[122] "Access to Care and Medicines, Burden of Health Care Expenditures, and Risk Protection."
[123] "Access to Care and Medicines, Burden of Health Care Expenditures, and Risk Protection."
[124] Atnafu, Tilahun, and Alemu, "Community-Based Health Insurance and Healthcare Service Utilisation, North-West, Ethiopia," August 2018.

in the health sector, strengthen community participation in the management of health services and strengthen national capacity for policy development and scale-up of health insurance coverage in the rural and urban informal sectors."[125] Moreover, the primary goal of the CBHI program is to end Ethiopians' crippling and possibly disastrous out-of-pocket medical expenses, which affect 85% of the country's population.[126]

CBHI Policy Description and Implementation in Ethiopia

The Ethiopian parliament approved Social Health Insurance Proclamation 690/2010, which established the program, and the Council of Ministers' approval of Regulation 191/2010, which formed the Health Insurance Agency (HIA), were significant federal accomplishments. The prototype was created and disseminated at the national level.[127]
The Ministry of Health (MoH) mainly directs CBHI implementation, with technical support from several development agencies. The HIA Strategy was developed through several technical and policy consultation and dialogue procedures. A technical committee's suggestions supported implementing two distinct health insurance programs to help the transition to UHC.[128]

Under the direction of the FMOH/Ethiopian Health Insurance Agency (EHIA), a CBHI National Coordination body was established to act as the executive body. Regional CBHI implementation units were formed to serve as executive secretariats for Regional Advisory

[125] USAID, "Ethiopia's Community-Based Health Insurance: A Step on the Road to Universal Health Coverage."
[126] Atnafu, Tilahun, and Alemu, "Community-Based Health Insurance and Healthcare Service Utilisation, North-West, Ethiopia," August 2018.
[127] USAID, "EVALUATION Ethiopia Health Sector Financing Reform Midterm Project Evaluation."
[128] USAID, "Ethiopia's Community-Based Health Insurance: A Step on the Road to Universal Health Coverage."

Committees headed by Regional Health Bureaus. The committees offer technical and administrative assistance for the planning and execution of CBHI in each area. The planning and implementation of CBHI at the community level are facilitated by Kebele (grassroots) Health Insurance Initiative Committees. Each woreda has a single health insurance pool, and kebele sections form the network of local schemes. [129]

The household head, eligible dependents, and members will pay the yearly membership price to the plan. The families will be given a membership card (with family information) to access essential medical services from the neighborhood public hospitals. Membership must be renewed yearly, and any new child or family member will incur a higher subscription charge.[130] It is an annual contract created based on the members' yearly advance contributions to insurance coverage. All regions have guidelines governing the implementation process, including the specified registration period (a maximum of three months). Therefore, before their contracts expire (or the specified registration period ends), regular CBHI members are expected to renew, and new members must also register during this time.[131]

In principle, 50 percent of the people or more of a woreda (district) must approve for CBHI to start operating. The greatest challenge, however, is persuading the community to join and alleviating the administrative load, which calls for political commitment and cooperation

[129] USAID.
[130] "Federal Democratic Republic of Ethiopia Ethiopian Health Insurance Agency: EVALUATION OF COMMUNITY-BASED HEALTH INSURANCE PILOT SCHEMES IN ETHIOPIA: FINAL REPORT," May 2015.
[131] "Ethiopia Health Insurance Agency: CBHI Members' Registration and Contribution 2011 2020 GC," September 2020.

from all parties involved. As a result, implementation in less developed regions stayed difficult.[132]

Although Ethiopia's progress in implementing health insurance is regarded as successful, during the implementation period, until 2020, the national insurance membership enrollment rate was at most 50% of eligible households, despite significant coverage differences between regions.[133] There are differences in premium rates between areas when it comes to premiums. In 2013, Oromia had the highest premiums per individual. In SNNP, the average yearly household premium is Birr 126 (US$ 6.98), while in Oromia, it is Birr 180 (US$ 9.97).[134] In 2020, the annual premium per family was raised to ETB 350 (US $10) in Addis Ababa and 240 ETB (US $6.85) in the rest of the country. [135]

Conclusion

CBHI demonstrates that it is a viable strategy for achieving UHC by Lessening the financial burden of healthcare costs and promoting the more effective use of healthcare services. Nonetheless, despite increased CBHI participants in Ethiopia, the low enrolment rate remains a concern. To ensure CBHI's long-term success in offering its population equitable and inexpensive healthcare, Ethiopia must solve its problems and shortfalls.

[132] "Ethiopia Health Insurance Agency: CBHI Members' Registration and Contribution 2011 2020 GC."
[133] Ibid
[134] USAID, "Ethiopia's Community-Based Health Insurance: A Step on the Road to Universal Health Coverage."
[135] "Ethiopia Health Insurance Agency: CBHI Members' Registration and Contribution 2011 2020 GC."

Chapter Three: Assessment of Ethiopia's Efforts Towards Realizing the Right to Health

Chapter introduction

The previous chapters examined the international human rights law, the convention that Ethiopia ratified, and the obligations that go along with it. It also discussed the Community-Based Health Insurance program as a crucial aspect of Ethiopia's healthcare system. The emphasis of this chapter now switches to evaluating the results of the healthcare system and the Ethiopian government's accompanying duties.

Using the OPERA framework, this chapter examines whether the Ethiopian government fulfills its responsibilities and obligations under international human rights law, particularly in relation to the right to health. Based on a thorough examination, the Ethiopian government was found to have failed to adequately satisfy its citizens' fundamental right to health and healthcare. This conclusion is supported by clear evidence pointing to the state's lack of commitment to allocating adequate financial resources to the healthcare sector, resulting in an inability to effectively utilize the available resources to meet its people's healthcare needs.

Moreover, after conducting an analysis that includes an examination of the policy framework, the implementation strategies used for the CBHI program, and a complete review of other relevant evidence, I argue that, despite its commendable contribution to helping insurance beneficiaries get toward realizing their right to adequate healthcare, the CBHI program has significant flaws which include low enrolment rate, as well as shortcomings regarding women's access to health care, which I will elaborate upon below.

Background

The Office of the United Nations High Commissioner for Human Rights (OHCHR) developed the OPERA framework to evaluate the progressive realization of economic, social, and cultural rights (ESCR). Analysis and evaluation of state compliance with ESCR responsibilities are done using the OPERA framework. [136]

The OPERA framework effectively assesses the state's obligation to uphold the right to health. It underlines the requirement that states offer a basic standard of treatment and services to protect, promote, advance, realize, and guarantee the enjoyment of the right to health.[137] To progressively realize economic, social, and cultural rights, the framework also emphasizes nations' need to allocate enough resources and make healthcare investments. The framework also calls for accountability mechanisms to ensure that civil society holds governments responsible for upholding citizens' rights to health. The OPERA framework offers a thorough and transparent method for assessing the state's responsibility to enforce the right to health.

The OPERA framework is significant because it offers a thorough and organized method for evaluating economic, social, and cultural rights fulfillment. [138] It aids in systematically and regularly assessing and monitoring ESCR implementation by governments, human rights

[136] "The OPERA Framework Assessing Compliance with the Obligation to Fulfill Economic, Social and Cultural Rights," 2015.
[137] Ibid
[138] Ibid

groups, and civil society organizations. Using this framework; stakeholders can pinpoint gaps, difficulties, and opportunities for improvement in the ESCR's fulfillment.

By examining Availability, Accessibility, Acceptability, Adaptability, and Quality (AAAAQ), the OPERA framework identifies gaps and flaws in applying the right to health. [139] It offers a comprehensive framework for assessing how well states uphold their duties. Governments, civil society organizations, and other stakeholders can evaluate the condition of the right to health using this approach and create focused actions to solve shortcomings. Therefore, this chapter examines the healthcare system through the lens of the OPERA framework by looking at the pattern of state commitment over different years to all vulnerable people without discrimination.

Measuring Health Care: A Framework for Assessing the Right to Health

To evaluate a nation's compliance with the obligation to "take steps" that are "deliberate, concrete, and targeted" by looking at its commitments to international human rights and the laws and policies that make those commitments a reality. The AAAAQ of pertinent initiatives that put economic and social rights into practice shows how these legal and political commitments have been implemented.[140] Numerous projects have attempted to offer a quantitative indicator connecting resources and ESCR realization. However, the OPERA analytical framework is a four-step framework that blends quantitative and

[139] "The OPERA Framework Assessing Compliance with the Obligation to Fulfill Economic, Social and Cultural Rights."
[140] Ibid

qualitative research methods. The OPERA framework stands out because it directly connects the human rights norms and values that support the need to uphold ESCR.[141]

Under the OPERA framework assessment, the UN Office of the High Commissioner for Human Rights (OHCHR) suggested Three categories of indicators—structural, process, and outcome- at the conceptual framework's center.[142] The structural indicator refers to the existence of fundamental institutional procedures to promote the implementation of the right in question and the ratification of treaties.[143] As discussed in the first chapter, Ethiopia has ratified almost all of the international human rights treaties, demonstrating its dedication to upholding social justice and safeguarding the fundamental rights of its citizens. As a result of Ethiopia's adherence to international human rights law, which has significant ramifications for its people, the government must make sure that all of its rules and regulations align with these standards. Furthermore, now that Ethiopia has ratified these agreements, its people can use them to hold the government responsible for human rights breaches.

Concerning institutions from the structural indicator procedure mentioned above, Ethiopia has developed essential institutions mandated to promote, implement, and enforce these rights throughout the nation in compliance with domestic and international laws and regulations that uphold and protect people's rights. For instance, the Federal Ministry of Health (FMOH) is the principal administrative body responsible for creating and implementing national health policies and plans.[144] Ethiopia has nine regional states, two

[141] "The OPERA Framework Assessing Compliance with the Obligation to Fulfill Economic, Social and Cultural Rights."
[142] Ibid
[143] Ibid
[144] "MOH | MINISTRY OF HEALTH - Ethiopia," accessed May 22, 2023, https://www.moh.gov.et/site/node/35.

city administrators, and regional health bureaus.[145] The planning, coordinating, and execution of the healthcare system within each region is the responsibility of the regional health bureau. Ethiopian Public Health Institute (EPHI) is a research and public health organization tasked with performing academic research, keeping track of illness outbreaks, and offering technical assistance to the healthcare industry. Attempting to prevent, control, and respond to decease is essential.[146] The Pharmaceutical Fund and Supply Agency (PFSA) is responsible for purchasing, storing, and dispersing pharmaceuticals and medical supplies.[147] Health Development Army (HDA) is a community-based initiative that mobilizes and involves residents in activities that promote health, prevent disease, and provide local healthcare.

Most importantly, Ethiopia has come a long way toward universal health coverage. Many Ethiopians now have better access to healthcare services due to the government implementing several health finance initiatives, such as the CBHI program.[148] Collectively, these organizations build a health system, increase access to healthcare and protect and promote the human right to health.

Looking at the second indicator, namely process indicators, such as measuring goods and services against the AAAAQ criteria, link public programs and particular initiatives to milestones more directly tied to fulfilling human rights.[149] The implementation of human

[145]"Regional Health Bureaus | MINISTRY OF HEALTH - Ethiopia," accessed May 22, 2023, https://www.moh.gov.et/site/rhb.
[146] "Ethiopian Public Health Institute – To Be Center of Excellence in Public Health in Africa," accessed May 22, 2023, https://ephi.gov.et/.
[147] "Home," Ethiopian Pharmaceuticals Supply Service - EPSS, accessed May 22, 2023, https://epss.gov.et/.
[148] Tefera and Ayele, "Community-Based Health Insurance Scheme Implementation in Ethiopia."
[149] "The OPERA Framework Assessing Compliance with the Obligation to Fulfill Economic, Social and Cultural Rights."

rights in one specific setting, individually and collectively, is captured by outcome indicators.[150] General Comment 14 states that the right to health should always be understood as the availability and use of a wide range of commodities, services, and facilities necessary to achieve the highest possible level of health.[151] Therefore, a state must have enough functioning public health and healthcare facilities and related products and services. In addition, realizing other elements of the right to health, such as accessibility and quality, depends on it. It is one of the fundamental elements of the right to health. The ability of people to obtain and receive the healthcare they require to sustain their health and well-being depends in large part on the availability of healthcare.[152] However, the specific characteristics of the facilities, products, and services will differ depending on many variables, including the degree of development of all nations, the particular set of health challenges it faces, the financing options available, and the distribution of public and private service providers.

The three stages of the health service mentioned earlier, primary hospitals, health clinics, and health posts, are all considered to be at the primary level of treatment. General hospitals comprise the second level of care—the specialized hospitals at the tertiary level of healthcare.[153] In general, Ethiopia has the following medical facilities available: There are 17,699 health posts, 3,777 health centers, and 367 hospitals available. There are 43 private hospitals and 3,867 private clinics, serving almost 120 million people together.[154] While

[150] Ibid
[151] "General Comment No. 14: The Right to the Highest Attainable," n.d.
[152] Ibid
[153] Kesetebirhan Admasu, Taye Balcha, and Tedros Adhanom Ghebreyesus, "Pro–Poor Pathway towards Universal Health Coverage: Lessons from Ethiopia," *Journal of Global Health* 6, no. 1: 010305, accessed May 15, 2023, https://doi.org/10.7189/jogh.06.010305.
[154] The International Trade Administration, U.S. Department of Commerce, "Ethiopia - Country Commercial Guide."

there are many healthcare facilities in Ethiopia, they are distributed in different ways. Rural inhabitants only have a few access points to healthcare because most healthcare institutions are in urban areas. The achievement of fair access to healthcare services in the nation is substantially hindered by this distributional disparity, which also contributes to significant differences in the delivery of health services.

Moreover, the difficulty with these facilities is the lack of healthcare workers.[155] The WHO advises 2.3 healthcare professionals (doctors, nurses, and midwives) per 1,000 inhabitants to attain minimal health coverage.[156] However, Ethiopia has a substantially lower personnel density in the healthcare sector, only 0.7 healthcare professionals per 1,000 people,[157] much below the minimum number advised by the World Health Organization in the ratio of healthcare workers to the population. Delivery of high-quality healthcare services is significantly hampered by this workforce deficit, especially in rural areas where it is more severe.

Regarding women, only 29.8% have access to healthcare, which highlights a considerable discrepancy in the accessibility of healthcare. The study identifies several obstacles hindering women from getting the necessary health care. 42% of women were concerned about going alone, showing a need for help, or lacking trust in using the healthcare system

[155] Abraham Haileamlak, "How Can Ethiopia Mitigate the Health Workforce Gap to Meet Universal Health Coverage?" *Ethiopian Journal of Health Sciences* 28, no. 3 (May 2018): 249–50, https://doi.org/10.4314/ejhs.v28i3.1.

[156] World Health Organization, *Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals. (Human Resources for Health Observer, 17)* (Geneva: World Health Organization, 2016), https://apps.who.int/iris/handle/10665/250330.

[157] Yohannes Hailemichael et al., "Health Workforce Deployment, Attrition and Density in East Wollega Zone, Western Ethiopia," *Ethiopian Journal of Health Sciences* 20, no. 1 (March 2010): 15–23, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3275894/.

independently.[158] This suggests societal or cultural factors may impact women's healthcare decision-making. Another significant impediment affecting 51% of women was the distance to medical facilities. It was found that the geographic distribution of access to health services was clustered, indicating that some regions of the nation had better access than others.[159] It suggests that geographic location significantly affects whether healthcare services are accessible and available. It also indicates that women living in isolated or rural areas will probably encounter more difficulties accessing healthcare. Financial difficulties were also a key factor, with 55% of the women expressing difficulty getting the money for therapy. This draws attention to the financial obstacles that restrict women from accessing healthcare.[160] Economic status is significant in determining access to health services in a nation with a wide range of socioeconomic levels. In higher socioeconomic classes, women are more likely to have the resources to pay for medical treatment. In addition, 32.3% of women had trouble getting authorization to get medical care.[161] This suggests that social or cultural constraints may limit women's autonomy in healthcare decisions. Women might occasionally need approval from their husbands or families to receive medical care.

According to the 2015 MDGs report, maternal and under-five child mortality has fallen 45 and 52%, respectively, from the baseline in 1990. For nations with low incomes, such as African countries, maternal health issues remain a significant concern and an unfulfilled MDG agenda item. [162] According to a national survey conducted in 2016 in Ethiopia, 22%

[158] Addisalem Workie Demsash and Agmasie Damtew Walle, "Women's Health Service Access and Associated Factors in Ethiopia: Application of Geographical Information System and Multilevel Analysis," *BMJ Health & Care Informatics* 30, no. 1 (April 28, 2023): e100720, https://doi.org/10.1136/bmjhci-2022-100720.
[159] Ibid
[160] Ibid
[161] Ibid
[162] Sanjiv Kumar, Neeta Kumar, and Saxena Vivekadhish, "Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs): Addressing Unfinished Agenda and Strengthening Sustainable Development and Partnership," *Indian Journal of Community Medicine : Official Publication of Indian*

of women reported unmet needs for family planning services, which were associated with several accessibility and use difficulties.[163]

Health disparities in rural communities are commonly acknowledged as mainly caused by inadequate healthcare services in rural areas. Due to this, it is more challenging to immunize kids fully, and pregnant women who live in these locations are more likely to get intestinal parasite infections and other diseases.[164] Pregnant women in rural areas have less access to healthcare services, which causes their weight to fluctuate above or below Institute of Medicine guidelines. This increases the chance of adverse pregnancy outcomes for the mother and the unborn child.[165]

Moving to the issue of accessibility, the provision of healthcare services must be accessible to all people, regardless of their financial situation, geography, or other circumstances. It is referred to as accessibility in the context of the right to health. This covers financial accessibilities, such as the availability of affordable healthcare options and insurance and physical accessibility to healthcare facilities and providers.[166]

Association of Preventive & Social Medicine 41, no. 1 (2016): 1–4, https://doi.org/10.4103/0970-0218.170955.

[163] Koku Sisay Tamirat, Zemenu Tadesse Tessema, and Fentahun Bikale Kebede, "Factors Associated with the Perceived Barriers of Health Care Access among Reproductive-Age Women in Ethiopia: A Secondary Data Analysis of 2016 Ethiopian Demographic and Health Survey," *BMC Health Services Research* 20, no. 1 (July 25, 2020): 691, https://doi.org/10.1186/s12913-020-05485-y.

[164] Sali Suleman Hassen and Mesfin Esayas Lelisho, "Determining Factors Associated with the Prevalence of Knowledge, Attitude, and Practice in Seeking Skilled Maternal Healthcare Services among Women in a Remote Area of Gesha District," *BMC Health Services Research* 22, no. 1 (November 4, 2022): 1318, https://doi.org/10.1186/s12913-022-08710-y.

[165] Akaninyene Otu et al., "Leveraging Mobile Health Applications to Improve Sexual and Reproductive Health Services in Nigeria: Implications for Practice and Policy," *Reproductive Health* 18, no. 1 (January 23, 2021): 21, https://doi.org/10.1186/s12978-021-01069-z.

[166] "General Comment No. 14: The Right to the Highest Attainable," n.d.

Despite the intricate procedures required, UHC is essential for ensuring everyone can access healthcare services. The UHC aim is not seen as an end in and of itself by the sustainable development goals; instead, UHC is a political decision to support nations' dynamic, complex systems in the direction of sustainable health progress.[167] Ethiopian Healthcare has been refocused on increasing its ability to respond to patient needs and expectations and attain Primary Health Care (PHC) universal access by 2017.[168] However, access to healthcare in Ethiopia is severely hampered by inadequate infrastructure. Most of the population lives in rural areas, lacking essential utilities such as clean water, power, and roads.[169] This prevents healthcare professionals from delivering high-quality care and makes it harder for those living in rural places to access healthcare services. The issue is further complicated because many healthcare facilities are understaffed, ill-equipped, and lack basic medical supplies and equipment.

Since hospitals are usually found in urban areas, those who live in rural areas, including women, cannot physically access them. For instance, General hospitals provide that care to one to five million patients; Specialized hospitals that provide care for 3.5 to 5.0 million people are located in Addis Ababa with full-time medical staff.[170] This implies that poor access to healthcare services may be caused by a lack of healthcare facilities and personnel, especially in rural and distant locations. Patients may receive inadequate or delayed care, harming their health and raising morbidity and mortality rates. Moreover, the health

[167] "Moving towards Universal Health Coverage: Lessons from 11 Country Studies - The Lancet," accessed May 7, 2023, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60002-2/fulltext.
[168] Abraha Woldemichael et al., "Availability and Inequality in Accessibility of Health Centre-Based Primary Healthcare in Ethiopia," ed. Srinivas Goli, *PLOS ONE* 14, no. 3 (March 29, 2019): e0213896, https://doi.org/10.1371/journal.pone.0213896.
[169] Chaya Nada, "Poor Access Tohealth Services: Ways Ethiopia Isovercoming It," 2007.
[170] "ETHIOPIA | Summary," Columbia University Mailman School of Public Health, August 25, 2020, https://www.publichealth.columbia.edu/research/others/comparative-health-policy-library/ethiopia-summary.

stations, staffed with two women each to care for their communities, are the lowest primary healthcare level. They have roughly more than 30,000 women trained to run their health posts.[171] A lack of healthcare workers may cause current employees to be overworked, resulting in burnout and reduced quality of healthcare services.

Thirdly, regarding the affordability issue, for many Ethiopians, especially those from lower socioeconomic origins, including women, the cost of healthcare services has been a significant barrier. Policy effort to address this issue, the government passed the "Social Health Insurance Proclamation No. 690/2010," a law on community health insurance, in August 2010. Therefore, Community-Based Health Insurance (CBHI) initiative was started in 2011 to put this law into effect. It was created to offer health insurance coverage for people who couldn't afford healthcare services out of pocket.[172] Many Ethiopians now have considerable access to healthcare services thanks to the CBHI program's implementation. Nevertheless, there are still issues that must be resolved, including making sure the program is long-term viable and that it covers a greater spectrum of medical services. However, the CBHI program represents a significant step toward ensuring access to inexpensive and reliable healthcare services.

Fourthly, moving on to the criteria of acceptability, General Comment 14 states that all health facilities, products, and services must be considerate of medical ethics and culturally appropriate, that is, considerate of the cultures of individuals, minorities, peoples, and communities; sensitive to gender and life-cycle requirements; and designed to protect

[171] Ibid
[172] Tefera and Ayele, "Community-Based Health Insurance Scheme Implementation in Ethiopia."

the confidentiality and enhance the health status of those who need it.[173] When assessing whether or not healthcare treatments are acceptable, cultural attitudes and traditions are important aspects to consider. With numerous ethnic groups and customs, Ethiopia offers a different cultural environment. There is plenty of research that demonstrates Ethiopia's issues with contraceptive acceptability. For instance, postpartum intrauterine contraceptive device (PPIUCD) acceptance usage is still low.[174] Low acceptance rates result from women and healthcare professionals and consumers' lack of knowledge about PPIUCDs. Lack of adequate counseling and information sharing on the advantages, safety, and efficacy of PPIUCDs may cause misunderstandings and discouragement of using this contraceptive technique. The acceptance of the healthcare system depends on fostering confidence and faith in it. Transparent communication, skilled medical staff, and a flexible healthcare system that attends to the wants and worries of the populace are all necessary for achieving this.

Finally, looking at the quality issue, healthcare refers to the extent to which healthcare services exceed patients' expectations and demands; It is delivered safely, efficiently, and effectively with quality, according to General Comment 14. Clinical results, patient satisfaction, safety, promptness, effectiveness, and equity are just a few of the many elements it covers. The best healthcare is of a high standard and available to all who require it.[175]

[173] "General Comment No. 14: The Right to the Highest Attainable," n.d.
[174] Alemayehu Gonie et al., "Acceptability and Factors Associated with Post-Partum IUCD Use among Women Who Gave Birth at Bale Zone Health Facilities, Southeast-Ethiopia," *Contraception and Reproductive Medicine* 3, no. 1 (November 6, 2018): 16, https://doi.org/10.1186/s40834-018-0071-z.
[175] "General Comment No. 14: The Right to the Highest Attainable," n.d.

There is an ongoing discussion concerning the variables, indications, and criteria that determine service-quality dimensions, which are contentious. Service quality is still an important question that has to be resolved. This creates difficulties in enhancing the standard of healthcare services, and Ethiopia is not an exception. Each country may have a different definition of quality with differing understandings of what it is. In healthcare, where patients frequently need more knowledge of the technical aspects of the services provided, service quality is crucial. Most studies on a model for evaluating the quality of medical services were conducted in the context of wealthy nations.[176] However, in developing countries, there are few of them. Researchers have noticed it and are attempting to determine whether it can be used in a real-world setting.[177]

Ethiopia has the most significant percentage of unfulfilled healthcare needs as a low-income nation with a population of over 100 million and a high fertility rate. However, notwithstanding substantial improvements in health outcomes over the previous ten years, Ethiopia's healthcare system still faces significant obstacles. Numerous healthcare services have been found to have considerable quality gaps, which indicate inadequate adherence to evidence-based standards of care.[178] For instance, 2014, a study comprised 424 facilities, including 270 health clinics, 45 primary hospitals, and 109 general hospitals in

[176] Dat van Duong et al., "Measuring Client-Perceived Quality of Maternity Services in Rural Vietnam," *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care* 16, no. 6 (December 2004): 447–52, https://doi.org/10.1093/intqhc/mzh073.

[177] Padma Panchapakesan, Chandrasekharan Rajendran, and Prakash Sai L, "A Conceptual Framework of Service Quality in Healthcare: Perspectives of Indian Patients and Their Attendants," *Benchmarking: An International Journal* 16 (April 10, 2009): 157–91, https://doi.org/10.1108/14635770910948213.

[178] Anna D. Gage et al., "The Know-Do Gap in Sick Child Care in Ethiopia," *PLOS ONE* 13, no. 12 (December 12, 2018): e0208898, https://doi.org/10.1371/journal.pone.0208898.

Ethiopia.[179] All facilities scored poorly on quality, ranging from 18 to 56%, with an average of 38%. The number of outpatients went from fewer than one every day to 581.[180] In addition, another study demonstrates that in 2018, On a scale of 0 to 1, Ethiopia's primary healthcare quality was rated at a low of 0.32.[181] This implies that Ethiopia's primary healthcare system only functions at about one-third of the level it should be, as indicated by the system's score of 0.32. It implies much space for development regarding the population's access to high-quality healthcare services.

Evaluating the State's Commitment to Achieve the Right to Health

The OPERA framework examines the government's budget from the standpoint of "maximum available resources." It evaluates expenditure to determine if resource allocations are fair and efficient and whether fiscal policy decisions provide enough resources.[182] In the following, this thesis evaluates the state commitment according to the opera framework.

Despite being a law requirement, several states are not upholding their obligations to provide necessary medical supplies and healthcare. This might devastate people and communities, especially those already marginalized and vulnerable. The right to health is a broad concept

[179] Catherine Arsenault et al., "Patient Volume and Quality of Primary Care in Ethiopia: Findings from the Routine Health Information System and the 2014 Service Provision Assessment Survey," *BMC Health Services Research* 21, no. 1 (December 2021): 485, https://doi.org/10.1186/s12913-021-06524-y.
[180] Arsenault et al.
[181] "Assessment of Quality of Primary Care with Facility Surveys: A Descriptive Analysis in Ten Low-Income and Middle-Income Countries | Elsevier Enhanced Reader," accessed May 12, 2023, https://doi.org/10.1016/S2214-109X(18)30440-6.
[182] "The OPERA Framework Assessing Compliance with the Obligation to Fulfill Economic, Social and Cultural Rights."

encompassing a wide range of different facets of health; it is comprehensive and covers "underlying determinants of health," such as access to clean, safe water and food and proper sanitation, nutrition, and shelter.[183]

International and regional human rights conventions require states to respect, protect, and fulfill the human rights of people within their jurisdiction. And also, the progressive realization of the right to health shouldn't be seen as freeing States parties from legal obligations.[184] Instead, it refers to the state parties' explicit and ongoing duty to advance the full implementation of Article 12 as quickly and effectively as possible.[185] Regardless of whether they are at the State, regional, or municipal level or are subordinate authorities, from the viewpoint of international law, all state powers, departments, and institutions are subject to human rights obligations.[186]

Obligations establish three different commitments; such as the obligation to respect, which refers to state parties are obligated to protect the right to health by keeping others from interfering with them; the duty to protect, which is the legal responsibility of the State to protect its citizens' right to health, which draws its basis from several international human rights laws and reflects this requirement and obligation to fulfill this includes promoting, and it demands the State to adopt constructive actions that help people and communities exercise their right to health.[187]

[183] Anne F. Bayefsky, "Office of the United Nations High Commissioner for Human Rights," in *The UN Human Rights Treaty System in the 21 Century*, ed. Anne Bayefsky (Brill | Nijhoff, 2000), 451–58, https://doi.org/10.1163/9789004502758_044.
[184] "General Comment No. 14: The Right to the Highest Attainable," n.d.
[185] Ibid
[186] Michael et al., "The Human Right to Health."
[187] "General Comment No. 14: The Right to the Highest Attainable," n.d.

The international community's description of the obligations relating to the right to health places a heavy emphasis on the responsibility of governments. Although states are ultimately responsible for upholding treaties' legal obligations, non-state actors play an essential role in advancing, defending, and maintaining the right to health. General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) states that the realization of the right to health is the responsibility of all members of society, including individuals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, and the private sector. States are the only parties to the Covenant and are ultimately responsible for its observance. Thus, state parties should create a setting that makes it easier to fulfill their obligations.[188] Concerning the core obligations, the Committee stressed in paragraph 45 that it is especially incumbent on States parties and other actors in a position to help to provide international assistance and cooperation, especially economic and technical, which enable developing countries to fulfill their core and other obligations.[189]

Chapter II of the African Charter on Human and Peoples Rights (African Charter) outlines individuals' roles in advancing human rights.[190] As a result, Articles 27, 28, and 29 urge people to have obligations to their families, societies, states, and communities. This obligation involves the need to uphold and build social and racial solidarity as well as to respect the rights of others.[191] Thus, individuals have the power to support others' rights to health through their coordinated efforts. Although firms and individuals may be obligated to uphold human rights, their obligations frequently differ from those of the government and

[188] Ibid
[189] Ibid
[190] United Nations High Commissioner for Refugees, "Refworld | African Charter on Human and Peoples' Rights ('Banjul Charter')," Refworld, accessed May 13, 2023, https://www.refworld.org/docid/3ae6b3630.html.
[191] Refugees.

other international organizations. As a result, the African Commission determined that The Gambia government failed to ensure the enjoyment of the right to health, which is essential to the realization of other fundamental freedoms and rights, under the provisions of Articles 16 and 18(4) of the African Charter in the case of Purohit and Another v. The Gambia.[192]

Most academics and court rulings concur that the State is responsible for ensuring the equitable provision of the facilities, services, and goods required to advance and protect the right to health through fundamental core commitments.[193] Despite being laid out in the Constitution, specific countries, particularly in sub-Saharan Africa, do not allow the State to be held accountable for the right to health violations. As a result, people might be unable to hold the government responsible for denying them access to quality treatment or violating their right to health. Numerous factors, including scarce resources, poor institutions, corruption, and political unrest, could be the reason. Because of this, many individuals in these nations cannot access essential healthcare services, which could negatively affect their health and quality of life. However, the general comment reaffirms that States must take measures to guarantee the availability and accessibility of high-quality public health and healthcare services, particularly for socially disadvantaged and excluded populations;[194] even while the right to health recognizes resource limitations and is subject to progressive realization, some obligations take place immediately away.[195]

[192] "Purohit and Anor v Gambia (Communication No. 241/2001) [2003] ACHPR 49; (29 May 2003) | African Legal Information Institute," accessed May 13, 2023, https://africanlii.org/afu/judgment/african-commission-human-and-peoples-rights/2003/49.
[193] Gorik Ooms et al., "A Global Social Contract to Reduce Maternal Mortality: The Human Rights Arguments and the Case of Uganda," *Reproductive Health Matters* 21, no. 42 (November 2013): 129–38, https://doi.org/10.1016/S0968-8080(13)42736-2.
[194] "General Comment No. 14: The Right to the Highest Attainable," n.d.
[195] "General Recommendations Made by the Committee on the Elimination of Discrimination against Women," accessed April 13, 2023, https://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm.

A universal framework is established by international human rights law, which includes numerous treaties and conventions, to direct and control how governments should protect and advance human rights. This framework sets a minimum standard that national laws and policies must adhere to guarantee that everyone, regardless of race, gender, nationality, or any other status, has access to the same fundamental rights and freedoms. However, one of the critical methods for ensuring successful implementation is incorporating the Bill of Rights into domestic legal systems and the justiciability of socioeconomic rights. The Ethiopian Constitution recognizes socioeconomic rights; It gives ratified international human rights treaties the authority to be used as guidelines for interpreting the Constitution's bill of rights, particularly those which treat socioeconomic rights as having a legal basis. Most importantly, international law becomes a part of domestic law after it is signed.

As part of evaluating policy commitments, the OPERA framework incorporates monitoring of legal and policy obligations, which Identifies the national laws and constitutional provisions that affect international agreements. It also verifies the presence of specific rights-related statutes and regulations and evaluates their requirements in light of global norms.[196] When analyzing Ethiopians' commitment through the OPERA framework, along with ratifying international treaties and incorporating them into national legislation, the Ethiopian government has demonstrated its commitment to the successful implementation of the 2030 Agenda for Sustainable Development by integrating the SDGs, Goal 5 on Gender Equality and Women's Empowerment (GEWE),[197] and other gender-sensitive indicators

[196] "The OPERA Framework Assessing Compliance with the Obligation to Fulfil Economic, Social and Cultural Rights," 2015.
[197] "In Focus: Sustainable Development Goal 5," UN Women – Headquarters, August 23, 2022, https://www.unwomen.org/en/news-stories/in-focus/2022/08/in-focus-sustainable-development-goal-5.

into its national development plans, particularly the Growth and Transformation Plan (GTP II).[198]

When measuring progress toward the right to health, the OPERA framework directs us to consider resource development, expenditure, and allocation to comprehend their impact on fair and non-discriminatory access to healthcare services.

To ensure that their citizens have access to high-quality health services, including preventative measures, treatment, and care, governments are required by the concept of the right to health to use the "maximum of its available resources"[199] [200] for domestic financing of healthcare services. This means that governments are required to use all resources at their disposal. This comprises not just financial resources but also people resources, technological resources, and physical infrastructure, all of which are essential for establishing and maintaining a strong and resilient healthcare system that can adequately address the requirements of its population. Because according to the general comment, "A State which is unwilling to use the maximum of its available resources for the realization of the right to health violates its obligations under Article 12. Suppose resource constraints render it impossible for a State to comply fully with its Covenant obligations. In that case, it has the burden of justifying that every effort has nevertheless been made to use all available resources to satisfy the above obligations as a matter of priority."[201]

[198] National Planning Commission, "FDRE The Second Growth and Transformation Plan (GTP II) Midterm Review Report," 2018.
[199] "International Covenant on Economic, Social and Cultural Rights."
[200] "General Comment No. 14: The Right to the Highest Attainable," n.d.
[201] "General Comment No. 14: The Right to the Highest Attainable."

Budget analysis is insufficient to draw any firm conclusions about whether a government has fulfilled its responsibilities. Especially when flaws persist, established human rights methodologies that quantify incremental steps of progressive realization remain essential. Ethiopia's healthcare system is financed by several sources, including out-of-pocket (OOP) payments (35.8%), other sources (0.9%), the Ethiopian government (16.5%), loans and offers from all over the world (46.8%)[202], Which makes approximately half of the finances come from donors, placing the nation highly dependent on donations. It also poses difficulties; it raises questions about the healthcare system's long-term viability to rely solely on donations. Because donors' priorities may change, and funding continuation is not assured.

A comparison of Ethiopia's healthcare budget with other sectors, such as education and road development, indicates a significant difference, suggesting the government's relative neglect of healthcare.[203] The healthcare system may be significantly impacted by this disparity in budget distribution, which could result in insufficient financing for facilities, medical equipment, and staff. It makes building and maintaining healthcare facilities more challenging and limits access to necessary medications and treatments. While not a complete indicator of the government's focus on healthcare, budget allocation does show how important it is to solve public health issues and guarantee the well-being of its population.

It is commonly agreed that paying out-of-pocket for healthcare puts an unfair financial burden on lower-income families or individuals. In Ethiopia, a sizable percentage of the

[202] "Ethiopia Health Accounts, 2013/14 | HFG," accessed May 14, 2023, https://www.hfgproject.org/ethiopia-health-accounts-201314/.
[203] UNICEF, Ethiopia, "Education Investments in Challenging Times," 2022.

populace has experienced financial disaster due to the high expense of medical care. A key determinant of a nation's capacity to finance and maintain its healthcare system over the long term is the percentage of health financing from domestic sources. It's encouraging that domestic health financing increased from 53% of US$ 1.3 billion in 2008 to 78% of US$ 2.7 billion in 2017, highlighting the significance of funding healthcare to advance human development and wellness.[204] The entire amount spent on health care in the nation increased as well, from ETB 1.45 billion (US$230 million) in 1995/96 to around Ethiopia Birr (ETB) 50 billion (over US$2.5 billion) in 2013/14. From a modest (US$4.5) in 1995/96, the per capita expenditure on healthcare increased to (US$28.65) in 2013/14.[205] However, it still pales compared to the WHO's recommended US$60 per capita expenditure by 2015 for critical health services.[206] Even though it is less than required, Ethiopia has made progress toward realizing the right to health. The government's commitment to funding healthcare is demonstrated by the rise in domestic health finance and the total increase in healthcare expenditures.

One of the nations in Africa with the lowest healthcare expenditures is Ethiopia. Before 1998, the government spent between $1.00 and $1.20 per person per year on health rates fluctuating from 1980 to the mid-1990s. The amounts were significantly less than sub-Saharan Africa's average per-capita health expenditure of US$6.70.[207] This demonstrated a lack of government emphasis on healthcare around that time, resulting in financial differences from regional norms and possibly affecting the population's access to and quality

[204] "Ethiopia Health Accounts, 2013/14 | HFG."
[205] "Ethiopia's Health Financing Outlook: What Six Rounds of Health Accounts Tell Us | HFG," accessed May 15, 2023, https://www.hfgproject.org/ethiopias-health-financing-outlook-what-six-rounds-of-health-accounts-tell-us/.
[206] Matthew Jowett et al., "Spending Targets for Health: No Magic Number," n.d.
[207] "How Ethiopia Is Empowering Women Through Community-Based Health Insurance | HFG," accessed May 18, 2023, https://www.hfgproject.org/ethiopia-empowering-women-community-based-health-insurance/.

of healthcare services. In 2016, Health spending as a percentage of GDP was only 1.4%;[208] Between 2017–18 and 202–21, Ethiopia's national health budget has been growing at an average rate of 19.5 percent. Compared to 2020/21, it rose by 14.6% in 2021/22.[209] After 2019/20, the government budget increased significantly, mostly to cover the COVID-19 reaction. However, between 2020/21 and 2021/22, the budget shrank by 14.5 percent. [210] The value of the government budget allocation is under much strain due to the high inflation rate, which is expected to be 34.5 percent in 2022. This is also affecting the amount of investment being made in the sector.[211]

The government's commitment to investing in the health sector to enhance population health outcomes is reflected in the rise in the national health budget, which is a positive trend. Concern about the budget's real-term fall due to excessive inflation should be expressed. The value of the government budget allocation is under intense pressure from the high inflation rate, which also threatens investment in the health sector. To prevent the budget's worth from being compromised, the government must act to control the excessive inflation rate. That includes "Appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health."[212] For instance, states must develop a national health strategy or plan for the public and private sectors. [213]

[208] UNICEF, Ethiopia, "Health Investments within a Constrained Economy," 2022 2021.
[209] Ibid
[210] Ibid
[211] Addis Kassahun Mulat et al., "Scaling up Community-Based Health Insurance in Ethiopia: A Qualitative Study of the Benefits and Challenges," *BMC Health Services Research* 22, no. 1 (December 2022): 473, https://doi.org/10.1186/s12913-022-07889-4.
[212] Bayefsky, "Office of the United Nations High Commissioner for Human Rights," 2000.
[213] Ibid

A more comprehensive, varied definition of UHC was provided by the UN General Assembly resolution in 2012, which demanded that. "All people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population." [214] In addition to reassuring everyone's right to health in clear and extensive terms, this resolution provided unambiguous UN member state political support for UHC by recognizing "the responsibility of Governments to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality healthcare services." A significant and unwavering commitment to upholding the fundamental principles of human rights that are founded on the idea of equality and justice for all, regardless of their socioeconomic status, can be seen in the statement mentioned above regarding the emphasis on non-discriminatory access to basic health services and essential medicines, which is specifically intended to support people who belong to the poor, vulnerable, and marginalized communities. The idea that certain services, ranging from those deemed as key to those considered fundamental and essential, are crucial to the overall well-being and development of individuals and communities is a widely accepted idea that has gained significant traction in the discourse on sustainable development. This specific idea has been explicitly stated in SDG 3.8, which unambiguously commits states to "achieve universal health coverage, including financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all."[215]

[214] "Global Health and Foreign Policy Resolution 2012_67th GA," 2012.
[215] "A/RES/70/1 Transforming Our World: The 2030 Agenda for Sustainable Development," 2030.

A significant issue with these problems is that women have insufficient access to family planning, prenatal and postnatal care, and other vital reproductive healthcare services. Moreover, persistently harmful cultural practices threatening women's health and rights, such as child marriage[216] and female genital mutilation, are a severe danger. These behaviors frequently cause bodily and mental harm, feeding the cycle of female inequity and powerlessness. Furthermore, gender-based violence is still a significant problem, with high rates of domestic abuse, sexual assault, and exploitation that affect victims immediately and have long-term effects on women's physical and mental health.[217] These issues, taken as a whole, indicate how urgently Ethiopia needs comprehensive interventions and policies that tackle gender equality, women's health inequities, and empowering women to live healthy lives.

However, there is still a noticeable imbalance in the lack of a state commitment, including a dedicated budget for women's healthcare. This leads to a lack of focused efforts to promote and meet their unique health needs. In addition to widening health inequities, this financial neglect prevents access to necessary services, including reproductive healthcare, maternity care, and gender-specific treatments. As a result, Ethiopian women lack the complete care and assistance required to address their particular health concerns, which feeds a cycle of unfavorable health outcomes and limits their capacity to develop and thrive.

[216] Rabindra Nath Pati and Selemawit Tekie, "Biocultural Dynamics of Teenage Pregnancies in Ethiopia: Medico Anthropological Appraisal," *International Journal of Social Sciences and Management* 3, no. 1 (January 21, 2016): 68–77, https://doi.org/10.3126/ijssm.v3i1.14368.

[217] "GBV AOR Ethiopia: Situation of GBV in Ethiopia (September 2022) - Ethiopia | ReliefWeb," October 6, 2022, https://reliefweb.int/report/ethiopia/gbv-aor-ethiopia-situation-gbv-ethiopia-september-2022.

Assessment of the CBHI Scheme

The OPERA framework recognizes policy effort as a crucial component that assesses the commitment of governments to implement necessary measures.[218] By making the CBHI scheme an official policy in Ethiopia, the government has shown its commitment to increasing healthcare accessibility and affordability. This strategic choice tries to solve the problem of high out-of-pocket healthcare costs. The Ethiopian government is making significant progress toward lowering financial barriers to healthcare and improving the nation's overall health system by adopting the CBHI scheme. This policy commitment reflects the government's recognition of ensuring equitable access to healthcare services for all its citizens.

Women's Enrolment in the CBHI Scheme

Before 1998, a large majority of Ethiopians were uninsured, making them susceptible to the costs connected with medical care. Furthermore, the government's per capita health spending was worrisomely low, showing a lack of investment and attention to the healthcare industry.[219] Most of the population needed more access to high-quality healthcare due to insufficient government investment, resulting in scarce resources dedicated to providing vital medical services. Ethiopians faced additional healthcare issues due to a lack of coverage and low government spending, especially those who could not afford private insurance or out-of-pocket medical bills.

[218] "The OPERA Framework Assessing Compliance with the Obligation to Fulfill Economic, Social and Cultural Rights."
[219] "How Ethiopia Is Empowering Women Through Community-Based Health Insurance | HFG."

The main goal of SDG 3.1, a vital element of the global agenda for sustainable development set forth by the United Nations, is to comprehensively address the urgent problem of maternal mortality, with the ambitious goal of reducing the number of maternal deaths to a rate that is noticeably less than 70 deaths per 100,000 live births by the year 2030.[220] Having said that, a lack of resources is the main barrier to accessing quality treatment for families without health insurance. Especially women choose to forego or postpone receiving treatment in healthcare systems where prompt payment is necessary because they concern about the high and financially extreme costs. Due to their lack of financial independence, they frequently encounter additional barriers when seeking healthcare independently.[221] However, a shift in Ethiopia's healthcare system will benefit women and their families and revolutionize how healthcare is delivered to its citizens; through the government's help, Ethiopia has made significant progress in giving its residents access to healthcare and financial security since 2011.[222] Because Protecting women's health is crucial because it profoundly impacts everyone's health, including individuals, families, communities, and even the broader spheres of national and global health; despite its importance, women frequently have more difficulty than males in obtaining essential healthcare services, including the availability of health insurance.[223]

A 2013 pilot project review revealed that households signed up for CBHI used more health services. Additionally, households headed by women were more likely to join than those led

[220] "A/RES/70/1 Transforming Our World: The 2030 Agenda for Sustainable Development," 2030.
[221] "How Ethiopia Is Empowering Women Through Community-Based Health Insurance | HFG."
[222] Ibid
[223] Anil Gumber, "Extending Health Insurance to the Poor: Some Experiences from SEWA Scheme," *Health and Population: Perspectives and Issues* 24 (January 1, 2001).

by men.[224] Somehow, the scheme appears to be one of the social protection strategies that improve underprivileged community members' access to healthcare. Similarly, according to the 2015 evaluation of the pilot CBHI Female-headed households were more likely to utilize the CBHI than male-headed households; therefore, CBHI could offer a starting point and a road for women's economic empowerment by removing the financial obstacles to accessing healthcare.[225]

For many households in Ethiopia, the cost of healthcare can be a substantial financial hardship, even though the government launched the Community-Based Health Insurance program to give its inhabitants access to inexpensive healthcare. Despite this program's advantages, there is an issue with women enrolling in it. It was shown that the household head's gender significantly influenced patterns of health insurance enrolment. Notably, compared to households headed by men, households by women were more likely to get health insurance.[226] This could be because single-parenting women usually shoulder various domestic duties; financial hardships and poor socioeconomic status are frequent when there is no one else to support the family, making it more probable that people may consider joining a backup strategy or plan.[227] In addition, it could result from homes with female heads having dependents. Women frequently take on most caregiving duties for young children or elderly family members. The necessity for health insurance coverage to protect their dependents' health and well-being may become more vital with this increased

[224] "How Ethiopia Is Empowering Women Through Community-Based Health Insurance | HFG."
[225] Sophie Romana, Claudia Canepa, and Celeste Molina, "Women's Economic Empowerment and Community-Based Health Insurance: Lessons from Ethiopia," n.d.
[226] Getiye Dejenu Kibret et al., "Willingness to Join Community Based Health Insurance and Its Determinants in East Gojjam Zone, Northwest Ethiopia," *BMC Research Notes* 12, no. 1 (January 17, 2019): 31, https://doi.org/10.1186/s13104-019-4060-3.
[227] Joseph Kawuki, Ghislaine Gatasi, and Quraish Sserwanja, "Women Empowerment and Health Insurance Utilisation in Rwanda: A Nationwide Cross-Sectional Survey," *BMC Women's Health* 22, no. 1 (September 16, 2022): 378, https://doi.org/10.1186/s12905-022-01976-8.

duty, which may further encourage female household heads to prioritize signing up for health insurance.

For instance, looking at the reproductive age of women, in the 2016 survey mere 5% participated in the CBHI program.[228] This study implies that women in this cohort have a substantial healthcare coverage gap. The low enrollment rate suggests that the vast majority of women in Ethiopia's reproductive age group do not have access to the advantages and assistance offered by CBHI, which may result in fewer family planning resources, fewer antenatal services, and a more significant financial burden on households when seeking reproductive health care. This inequality must be addressed to guarantee complete healthcare coverage and better reproductive health outcomes for Ethiopian women.

Moreover, in 2019, approximately four out of ten (43.2%) Ethiopian women of reproductive age participated in CBHI.[229] Even if the uptake within this particular group is less than 50%, it illustrates a significant level, indicating that many women in their reproductive years have access to financial protection for healthcare services. On the contrary, this implies that more than 50% of women's health expenditure comes from household out-of-pocket, which also means the risk of financial catastrophe remained a significant obstacle. This could be regarded as a substantial achievement in the rise in CBHI program enrollment among Ethiopian women of

[228] Hubert Amu et al., "Mixed Effects Analysis of Factors Associated with Health Insurance Coverage among Women in Sub-Saharan Africa," ed. Calistus Wilunda, *PLOS ONE* 16, no. 3 (March 19, 2021): e0248411, https://doi.org/10.1371/journal.pone.0248411.

[229] Simegnew Handebo et al., "Enrollment of Reproductive Age Women in Community-Based Health Insurance: An Evidence from 2019 Mini Ethiopian Demographic and Health Survey," *Frontiers in Public Health* 11 (March 30, 2023): 1067773, https://doi.org/10.3389/fpubh.2023.1067773.

reproductive age, from 5% in 2016[230] to 43.2% in 2019. [231] This shows progress in enhancing women's access to healthcare and financial security in Ethiopia. However, it's crucial to consider the causes of this increase carefully. While the increase in participation is positive, it is also essential to understand why 56.8% of women are still not participating in the program. Despite an increasing number of women enrolling in healthcare programs, overall enrolment is still lower than that of non-enrolled individuals. This disparity suggests that substantial fractions of women cannot utilize the advantages and services offered by healthcare initiatives. As a result, these women continue to encounter obstacles and constraints while attempting to access crucial healthcare treatments, which may negatively impact their general well-being and quality of life.

Factors Affecting Women's Enrolment in CBHI

The OPERA framework affirms that, Initially, assessing policy efforts incorporating international health duties inside the national framework appeared promising. The practical application of these policies, however, reveals a clear contrast. It became clear that the national framework fell short when measured against the AAAAQ standards for several reasons. In the case of Ethiopia, sociocultural attitudes and behaviors substantially impede women's right to health.[232] Women are frequently placed in inferior situations due to power dynamics and gender norms, which restrict their ability to make essential decisions

[230] Amu et al., "Mixed Effects Analysis of Factors Associated with Health Insurance Coverage among Women in Sub-Saharan Africa," March 19, 2021.
[231] Handebo et al., "Enrollment of Reproductive Age Women in Community-Based Health Insurance," March 30, 2023.
[232] "Gender Roles In Ethiopia," *Ethiopiaforum* (blog), November 21, 2013, https://ethiopiaforum.wordpress.com/2013/11/21/gender-roles-in-ethiopia/.

and exert control over their health.[233] Social discrimination and shame further entrench inequalities, making it challenging for women to access healthcare services without judgment or prejudice.[234] Moreover, cultural norms and societal expectations also influence gender discrepancies in healthcare. For instance, women frequently have less control over their health decisions and face discrimination in the healthcare system.[235]

Expanding healthcare access is one of CBHI's most important contributions to women's rights to health. CBHI programs frequently focus on disregarded rural areas where women struggle to access healthcare facilities. It aims to eliminate geographic barriers to access to high-quality treatment for women by broadening the geographic reach of healthcare services. With fewer financial obstacles, women are more likely to get preventive treatments, prenatal care, skilled birth attendance, and postpartum care, which lowers the incidence of mother and infant mortality. To guarantee the accessibility of critical services and meet the healthcare requirements of women in their local communities, additionally, it promotes primary healthcare facilities.

Studies demonstrate that compared to women living in urban areas, the enrollment rate for women living in rural regions was lower. Urban residents have better access to knowledge and economic benefits that make it possible for them to participate in CBHI, which can be the cause of this gap.[236] As Woldesenbet puts it, people in rural areas have less access to information and media exposure, which has led to a decline in their involvement in health

[233] "Gender Roles In Ethiopia."
[234] Ibid
[235] Demsash and Walle, "Women's Health Service Access and Associated Factors in Ethiopia."
[236] Hubert Amu et al., "Mixed-Effects Analysis of Factors Associated with Health Insurance Coverage among Women in Sub-Saharan Africa," *PLOS ONE* 16, no. 3 (March 19, 2021): e0248411, https://doi.org/10.1371/journal.pone.0248411.

insurance programs.[237] As discussed in the previous chapter, most healthcare services are focused in the urban area; thus, access to healthcare is frequently a problem for women of reproductive age, especially during pregnancy and childbirth. According to a study, women's enrolment in CBHI and educational attainment are positively correlated. It was discovered that women with greater levels of education were more likely to enroll in CBHI than women without formal education.[238] This study implies that education has a substantial role in facilitating access to health insurance. Similarly, studies carried out in different areas, including Ethiopia[239] and Nigeria[240] particularly, and countries in east and sub-Saharan Africa produced comparable results and revealed similar conclusions.[241]

One potential factor is that educated women enrolling in CBHI at higher may be partly due to their increased awareness of health insurance benefits, enabling them to make wise decisions about their health.[242] Education gives people a more vital awareness of financial security, preventive care, and the significance of having access to healthcare services. Women who have had more education are probably better familiar with the ideas behind health insurance, the many types of coverage available, and the possible advantages it may provide in terms of lowering financial risks and assuring prompt access to treatment.

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[237] Adisu Birhanu Weldesenbet et al., "<p>Health Insurance Coverage and Its Associated Factors Among Reproductive-Age Women in East Africa: A Multilevel Mixed-Effects Generalized Linear Model</P>," *ClinicoEconomics and Outcomes Research* 13 (July 28, 2021): 693–701, https://doi.org/10.2147/CEOR.S322087.

[238] Simegnew Handebo et al., "Enrollment of Reproductive Age Women in Community-Based Health Insurance: An Evidence from 2019 Mini Ethiopian Demographic and Health Survey," *Frontiers in Public Health* 11 (March 30, 2023): 1067773, https://doi.org/10.3389/fpubh.2023.1067773.

[239] Weldesenbet et al., "<p>Health Insurance Coverage and Its Associated Factors Among Reproductive-Age Women in East Africa."

[240] Bolaji Samson Aregbeshola and Samina Mohsin Khan, "Predictors of Enrolment in the National Health Insurance Scheme Among Women of Reproductive Age in Nigeria," *International Journal of Health Policy and Management* 7, no. 11 (November 1, 2018): 1015–23, https://doi.org/10.15171/ijhpm.2018.68.

[241] Amu et al., "Mixed-Effects Analysis of Factors Associated with Health Insurance Coverage among Women in Sub-Saharan Africa."

[242] Handebo et al., "Enrollment of Reproductive Age Women in Community-Based Health Insurance," March 30, 2023.

Education is directly related to having access to information and having a more significant income, which are elements that lead to CBHI membership.[243] Because they are more exposed to health-related information through formal education and community networks, educated people are more equipped to grasp and value the benefits of CBHI. They are more likely to know the advantages of CBHI's financial safety net and healthcare accessibility. On the other hand, because they have less access to health-related information, illiterate women might not be aware of the benefits of CBHI. This information gap can make them less motivated to join CBHI initiatives.

Considering another aspect, women were less likely to sign up for CBHI if they had many children. In contrast, research showed that those with large families were more inclined to contribute to the CBHI program than people with small families.[244] One possible factor might be that women with more children already experience financial hardship due to the higher costs of supporting a larger household. Thus, they might have a more challenging time finding additional resources for health insurance, which would result in a decline in enrolment. On the other hand, for people with large families, having a more prominent family may also make people feel like they need more health insurance because there is a higher chance that someone may get sick while they are together. However, the idea that the size of the family affects insurance enrollment substantially is refuted by a Nigerian study.[245] This study's results show no significant relationship between CBHI

[243] Handebo et al.

[244] Amare Minyihun, Measho Gebreslassie Gebregziabher, and Yalemzewd Assefa Gelaw, "Willingness to Pay for Community-Based Health Insurance and Associated Factors among Rural Households of Bugna District, Northeast Ethiopia," *BMC Research Notes* 12, no. 1 (January 24, 2019): 55, https://doi.org/10.1186/s13104-019-4091-9.

[245] Bolaji Samson Aregbeshola and Samina Mohsin Khan, "Predictors of Enrolment in the National Health Insurance Scheme Among Women of Reproductive Age in Nigeria," *International Journal of Health Policy and Management* 7, no. 11 (November 1, 2018): 1015–23, https://doi.org/10.15171/ijhpm.2018.68.

enrollment rates and the number of family members. This contradicts the findings that those with larger families were more inclined to pay for CBHI, which were previously reported observations. As noted by researchers in prior studies, there are differences between countries in the factors affecting women's access to insurance, which has led to the identification of disparities in women's capacity to receive health insurance. Age, education, economic situation, work position, marital status, ethnicity, number of children, and chronic sickness influence whether women in many nations have access to health insurance.[246] [247]

Like other traditional societies, men are typically the head of household in many Ethiopian communities, the primary decision- and income-makers.[248] Men frequently handle all household financial decisions, particularly those involving healthcare spending. [249] Having said that, one of the other reasons for low enrolment for women is the requirement that the husband join the insurance. This marital reliance clause limits women's capacity to seek health services, which is a substantial barrier independently.[250] When spousal enrollment is required, women's ability to choose their healthcare depends on their husbands' participation, which may result in unequal enrollment rates. This requirement supports a system in which women's healthcare demands are subordinate to those of their husbands, which not only fosters gender inequality. To address this problem, policy interventions that acknowledge and value women's agency and autonomy are required. These initiatives must enable women to independently and fairly access health insurance programs based on their

[246] Francis Mhere, "Health Insurance Determinants in Zimbabwe: Case of Gweru Urban," n.d.
[247] Cristian Pardo and Whitney Schott, "Health Insurance Selection in Chile: A Cross-Sectional and Panel Analysis," *Health Policy and Planning* 29, no. 3 (May 1, 2014): 302–12, https://doi.org/10.1093/heapol/czt017.
[248] USAID, "HOW ETHIOPIA IS EMPOWERING WOMEN THROUGH COMMUNITY-BASED HEALTH INSURANCE," 2016.
[249] Ibid
[250] Romana, Canepa, and Molina, "Women's Economic Empowerment and Community-Based Health Insurance: Lessons from Ethiopia."

unique needs and circumstances. In addition, the government must take prompt, decisive action to address and confront the ongoing problem of women's active participation in entering and using the CBHI program and accessing and utilizing the existing, comprehensive healthcare system.

The Outcome of the CBHI Program in Advancing Women's Health

Regarding their biology, the tasks and obligations society assigns them, and their standing in the family and community, men and women are distinct. The effectiveness of policies and programs for promoting health is greatly influenced by these elements, as are the causes, effects, and management of illnesses and diseases. Women spend more out-of-pocket on healthcare than men do, partly because of the unique health requirements associated with pregnancy, delivery, contraception, and abortion, among other things.[251] Moreover, health systems are rarely gender-neutral, instead reinforcing restrictive social norms that harm women compared to men.[252]

It has been shown repeatedly in numerous studies done in the past that CBHI enrollment is associated with a variety of favorable outcomes, highlighting its potential to significantly improve healthcare utilization, cost-effectiveness, personal health outcomes, and overall

[251] Piroska Ostlin et al., "Gender and Health Promotion: A Multisectoral Policy Approach," *Health Promotion International* 21 Suppl 1 (December 2006): 25–35, https://doi.org/10.1093/heapro/dal048.
[252] Katherine Hay et al., "Disrupting Gender Norms in Health Systems: Making the Case for Change," *The Lancet* 393, no. 10190 (June 22, 2019): 2535–49, https://doi.org/10.1016/S0140-6736(19)30648-8.

service quality.[253] [254] In particular, Demissie's statement emphasizes the context of southern Ethiopia, where CBHI membership is associated with a three-fold increase in outpatient healthcare services.[255] Another study, carried out by experts in the field, has further supported the conclusions by providing empirical evidence that demonstrates how households who took part in and were enrolled in CBHI programs illustrated a significantly greater tendency, when compared to their non-enrolled counterparts, to utilize a comprehensive range of essential healthcare services.[256] This experience is linked to CBHI members having a substantially lower financial barrier to accessing healthcare services. Easing the financial burden encourages people to seek medical attention earlier and more frequently, leading to earlier diagnoses, better disease management, and improved overall health outcomes.

Moreover, the number of outpatient visits per person increased from 0.3 in 2013/14 to 0.9 in 2019, although the rate still falls well short of the WHO-recommended standard of 2.5 per person per year.[257] Despite this development, it's critical to remember that the current outpatient visit rate has drastically lowered than recommended; this disparity shows that there is still a substantial gap between actual healthcare consumption and intended levels of involvement with outpatient services. In addition, this suggests that there is still a sizable

[253] Desta Debalkie Atnafu, Hiwot Tilahun, and Yihun Mulugeta Alemu, "Community-Based Health Insurance and Healthcare Service Utilisation, North-West, Ethiopia: A Comparative, Cross-Sectional Study," *BMJ Open* 8, no. 8 (August 8, 2018): e019613, https://doi.org/10.1136/bmjopen-2017-019613.
[254] Bekele Demissie and Keneni Gutema Negeri, "Effect of Community-Based Health Insurance on Utilization of Outpatient Health Care Services in Southern Ethiopia: A Comparative Cross-Sectional Study," *Risk Management and Healthcare Policy* 13 (2020): 141–53, https://doi.org/10.2147/RMHP.S215836.
[255] Demissie and Gutema Negeri.
[256] Hiwot Tilahun et al., "Factors for Healthcare Utilization and Effect of Mutual Health Insurance on Healthcare Utilization in Rural Communities of South Achefer Woreda, North West, Ethiopia," *Health Economics Review* 8, no. 1 (August 22, 2018): 15, https://doi.org/10.1186/s13561-018-0200-z.
[257] "Essential Health Services Package of Ethiopia 2019 | HumanitarianResponse," accessed May 29, 2023, https://www.humanitarianresponse.info/en/operations/ethiopia/document/essential-health-services-package-ethiopia-2019.

gap between the degree of utilization and the demand for healthcare services. It emphasizes improving outpatient services' accessibility, availability, and affordability to appropriately address the population's healthcare demands. Although most of the participants in this extensive dataset are from the general population of the CBHI, women are also included. Although most of the participants in this comprehensive dataset are from the general population of the CBHI, women are also included.

A significant portion of the studies that have been conducted so far in Ethiopia have primarily focused on the general population, failing to adequately account for the crucial factor of households' active participation or non-participation in CBHI programs; it becomes increasingly clear when analyzing the current landscape of research carried out within the Ethiopian context. It is also important to note that, while aiming to illuminate the larger healthcare landscape, the studies as mentioned earlier, unfortunately, failed to focus their analytical lens on the critically important aspect of women's enrollment in CBHI schemes and, consequently, the subsequent impact and outcomes on the overall sphere of women's health, creating a significant knowledge gap that requires immediate attention and further in-depth investigation.

Based on the opera framework, contextual elements can be identified. For instance, socioeconomic norms might disempower women and limit their freedom to decide their reproductive health,[258] as discussed above. However, it ensures that women receive adequate and efficient care that meets their unique health requirements by raising the quality of services. This covers all aspects of family planning, prenatal and postnatal care, and the

[258] "The OPERA Framework Assessing Compliance with the Obligation to Fulfill Economic, Social and Cultural Rights."

management of prevalent illnesses affecting women. By ensuring that women get respect, dignity, and gender-sensitive treatment, CBHI's focus on quality care helps realize women's right to health. [259]

It was discovered after examination of gender-related data that the scheme's adoption in Ethiopia not only significantly increased access to healthcare but also served as a light for women's economic emancipation.[260] The CBHI program lessened the financial burden of medical bills on women by offering affordable and comprehensive healthcare coverage, freeing up resources that could be applied to other worthwhile undertakings.[261] By allowing them to independently attend health centers for themselves and their children without depending on financial support from their spouses, it became clear that CBHI contributed a critical role in improving their agency and autonomy. Women could proactively care for their healthcare needs and protect their families' well-being because of their increased financial independence.[262] The CBHI promoted a sense of self-reliance among women, putting them to take control of their health and claim their rights to necessary healthcare services. This ultimately led to the traditional barrier of asking male family members for permission or assistance.

Now, through the scheme, women are economically empowered when they control their time, health, and ability to handle risks. They are also empowered when they have the freedom and confidence to that change their lives. This involves enjoying equal rights to males and having the agency and authority to organize and influence decision-making on

[259] Romana, Canepa, and Molina, "Women's Economic Empowerment and Community-Based Health Insurance: Lessons from Ethiopia."
[260] Ibid
[261] Ibid
[262] Ibid

their and their children's health.[263] The CBHI scheme's dedication to equal access, financial security, and social inclusion considerably affects women's empowerment, especially in the economy, by ensuring that women may obtain healthcare services and lowering financial barriers. The CBHI program greatly impacts healthcare utilization and cost-effectiveness, as shown by the convincing results of the PILOT Analysis. According to the study, the CBHI system is associated with a significant 30–41% increase in the use of outpatient treatment at public facilities, indicating that more people are getting access to essential medical services.[264]

Furthermore, there has been a significant 45–64% rise in outpatient visits to public facilities, indicating that the program encourages timely and regular healthcare-seeking behavior. The data also reveals a stunning 56-87% drop in the price of an outpatient visit to a public facility, demonstrating the program's capability to control healthcare costs efficiently. These findings highlight the CBHI scheme's benefits and contribution to improving healthcare accessibility, utilization, and cost-effectiveness.[265]

Under the CEDAW, having access to health care, particularly reproductive health care, is a fundamental right.[266] Looking at the frequency of deliveries made at facilities has significantly increased recently. From 26% in 2016 to 48% in 2019, the percentage of

[263] Romana, Canepa, and Molina.
[264] Anagaw D. Mebratie et al., "The Impact of Ethiopia's Pilot Community Based Health Insurance Scheme on Healthcare Utilization and Cost of Care," *Social Science & Medicine* 220 (January 1, 2019): 112–19, https://doi.org/10.1016/j.socscimed.2018.11.003.
[265] Mebratie et al.
[266] "General Recommendations Made by the Committee on the Elimination of Discrimination against Women."

deliveries in a medical facility has grown substantially.[267] This increased trend shows improvement in encouraging and enabling expectant mothers' access to healthcare services, guaranteeing safer and more closely supervised laboring situations. These figures show positive maternal and neonatal care developments, even though more must be done to boost facility-based births.

Regarding women over time, it has been clear from the evidence that empowering women economically involves more than merely "putting money in women's hands." The CBHI scheme offered resources that expanded women's access to and use of health services and their security by granting them freedom from financial anxiety. This was done by removing financial restrictions. According to research, both single and married women claimed that CBHI enhanced their capacity to visit health facilities independently or with their children without needing financial assistance from a male head of household, putting them in a better position to meet their and their family's healthcare demands.[268] Government authorities acknowledged that joining the CBHI gave women and other family members more flexibility and control over their health decisions.[269] However, the utilization of essential prenatal and postpartum care services among women still has significant discrepancies. Alarmingly, just 43% of women had their previous pregnancy required a minimum of four antenatal care appointments, indicating a lack of access to or knowledge of the value of routine prenatal checkups.[270] Furthermore, only 34% of women received postnatal care (PNC) in the crucial two days following birth, which is essential for keeping

[267] Essa Chanie Mussa et al., "Impact of Community-Based Health Insurance on Health Services Utilisation among Vulnerable Households in Amhara Region, Ethiopia," *BMC Health Services Research* 23, no. 1 (January 19, 2023): 55, https://doi.org/10.1186/s12913-023-09024-3.
[268] Romana, Canepa, and Molina, "Women's Economic Empowerment and Community-Based Health Insurance: Lessons from Ethiopia."
[269] Ibid
[270] Ministry of Health, "Mini Demographic and Health Survey," 2021.

track of the health of both the mother and the baby. These figures demonstrate the need for focused initiatives to increase the accessibility and caliber of ANC and PNC services, ensuring that pregnant women have access to all-encompassing care during pregnancy and the crucial postpartum period. [271]

Conclusion

This chapter evaluated Ethiopia's right to health using the OPERA framework, highlighting the improvements and shortcomings. Although the nation has worked to create institutions for the promotion and execution of the right to health, there are still not enough healthcare facilities, especially in rural areas. Furthermore, a sizable proportion of women encounter obstacles when seeking healthcare due to various issues. According to the AAAAQ evaluation, Ethiopia remains far from fulfilling the requirements for the right to health. The government's budget allocation for healthcare is noticeably low and mainly dependent on foreign help, exacerbating the problem. Given Ethiopia's ratification of respecting human rights law, it is clear that the right to health is neither properly promoted nor respected.

Moreover, efforts to expand the enrollment of women in the CBHI scheme have not been successful, and there is a severe shortage of insurance use among women. Women continue to be neglected by the program, as seen by the scant data available on their insurance journey. This gap results from several reasons, such as sociocultural standards, gender roles, a lack of autonomy, and structural constraints. A complete strategy is required to solve this problem, including gender-responsive policies, empowerment programs, targeted awareness

[271] Ministry of Health, "Mini Demographic and Health Survey," 2021.

efforts, and enhanced accessibility. Policymakers can promote a more equitable and inclusive healthcare system that ensures everyone can access high-quality care and financial protection by prioritizing women's needs and experiences.

Conclusion and Recommendations

Conclusion

This study assessed the right to health and healthcare the contribution of the CBHI scheme in realizing the human right to health care, particularly for women. To achieve the study's objective, the human rights law that Ethiopia ratified and incorporated into domestic law was adopted. The main research questions concerning realizing women's right to health and healthcare through CBHI insurance were discussed.

Ethiopia has a clear duty to prioritize and advance healthcare services. The state must provide the right to health for its residents under international human rights documents, including Article 12 of the ICESR and the African Charter. Unfortunately, Ethiopia has historically spent the least on healthcare in Africa, and the healthcare sector receives insufficient funds and resources. Despite these advancements, significant problems remain, especially with women's health. The state's commitment to meeting women's healthcare needs is noticeably unbalanced, as seen by women's lack of access to and use of healthcare, notably in areas like family planning, prenatal and postnatal care, and the prevalence of hazardous behaviors.

Moreover, using the OPERA framework, I examined Ethiopia's healthcare system and the accompanying state duty to realize the right to health. As such, I argued that despite progress in healthcare access in Ethiopia, it is far from achieving the right to health for its citizens.

Researchers have examined the effects of the CBHI program in Ethiopia, and their findings consistently point to success. These studies have shown that the program has increased

Ethiopians' access to affordable healthcare, including for women. Many people, especially those from low-income households, could not purchase critical healthcare before the advent of the CBHI. The program has allowed individuals to obtain necessary medical care without bearing heavy financial obligations. However, despite the CBHI's efforts to make the healthcare system more affordable, a significant percentage of people without insurance have not been able to take advantage of its benefits.

I discovered that households with insurance coverage through the CBHI program used health services more frequently. Therefore, several factors should be prioritized to increase community health insurance enrolment and attain universal health coverage. These factors include the level of education, family size, occupation, marital status, distance to the nearest medical facility, perception of the standard of care, first choice of location for treatment during illness, and anticipated healthcare costs of a recent procedure. By putting more of an emphasis on these elements, it is possible to boost community health insurance enrollment, which will improve everyone's access to healthcare services and result in the establishment of universal health coverage.

Through the existing qualitative data analysis, I confirmed that the Ethiopian government's efforts to maintain the recent advancements in healthcare accessibility would be seriously hampered by the lack of health insurance for low-income people. Therefore, it is clear that the CBHI policy is essential for increasing access to healthcare and enhancing overall healthcare outcomes in Ethiopia. However, to ensure the program's sustained effectiveness, steps must be taken to solve the issues with enrollment.

The analysis of this study provides insight into the numerous elements that affect women's participation in the CBHI program. The prevalent socioeconomic conventions, which frequently require the head of the household, which is typically male, to be engaged in the program, play a crucial role. Education also has a significant impact since women with more education are more likely to participate in CBHI. Women's enrollment is also hampered by a lack of knowledge about the program and its advantages, demonstrating the need for better awareness initiatives. Geographical variables can also impact women's participation rates, such as the inaccessibility of CBHI facilities or services in some regions. Designing interventions that encourage equal access and the inclusion of women in CBHI programs requires an understanding of these complex dynamics.

Finally, I would like to reveal an extensive research gap, which also produced some unexpected results. It was discovered that neither the government nor any other interested parties had conducted thorough research on women in the context of CBHI. This lack of focus is alarming because it shows a lack of thorough knowledge of women's specific difficulties, requirements, and experiences inside the healthcare system. Developing focused treatments and policies that advance gender equality in healthcare requires researching women's engagement, impediments, and outcomes in CBHI initiatives. To provide an inclusive and equitable healthcare environment that adequately meets the healthcare needs of women, it is imperative to close this research gap.

Recommendations

Regarding the CBHI, the result of this study demonstrates that different factors hamper women's access to healthcare through insurance. The right to health and UHC cannot be accomplished without focusing on equity. However, socioeconomic position is frequently used as a proxy for equity, with other social stratifies receiving less attention. Research has shown that efforts to achieve UHC may not increase equity or worsen existing gender imbalances unless policymakers pay particular attention to gender.[272]

Therefore, I recommend that the government create policies that expressly handle the special requirements and difficulties women encounter. This may involve taking steps to advance gender equality, widen access to education, protect women's freedom to choose, and deal with problems such as domestic violence and discrimination.

Moreover, a policy strategy focusing on gender-specific insurance challenges, for instance, a spouse's enrollment, is frequently required for women to be eligible for insurance policies. This could provide obstacles for women who do not have a spouse or in circumstances where their spouse is unable or unwilling to enlist. The government may empower women to take charge of their healthcare needs and guarantee access to necessary services by allowing them to enroll in insurance plans independently of their spouses.

As stated in other documents as well, to address gender-specific issues, in general, the government must adopt and put into practice intersectional strategies that take gender,

[272] Sophie Witter et al., "Minding the Gaps: Health Financing, Universal Health Coverage and Gender," *Health Policy and Planning* 32, no. suppl_5 (October 1, 2017): v4–12, https://doi.org/10.1093/heapol/czx063.

vulnerability, and marginalization into account when creating and implementing health system finance mechanisms. Make sure that such strategies address gender and other factors that contribute to inadequate resources in homes and across various family types. To ensure full access to a complete sexual and reproductive health package, secure sustained local and international financing.[273]

Given the CBHI's success in Rwanda, I recommend using that country's general implementation method, which also benefited women. a thorough understanding of poverty, health needs, and issues with access to care; influence and backing of civil society, with important contributions from religious authorities; The leadership of the federal, state, and municipal governments, which developed, issued, and oversaw the process as well as policies and legislation; The important role of the Ministry of Health (MOH) in formulating and promoting policy, which frequently took part in official scheme launches and emphasized the significance of CBHI in the battle against poverty;[274]

Finally, conducting a quantitative analysis of women's healthcare enrollment and access rates is crucial. For the government to better understand women's insurance program participation rates and determine how insurance might enhance women's access to healthcare, quantitative research must be conducted more effectively. This study can shed light on women's obstacles while accessing healthcare services and signing up for insurance. Policymakers can establish targeted initiatives to address these issues by identifying and filling gaps in the data, which will ultimately improve the health outcomes for women.

[273] Gita Sen, Veloshnee Govender, and Salma El-Gamal, "UNIVERSAL HEALTH COVERAGE, GENDER EQUALITY AND SOCIAL PROTECTION A HEALTH SYSTEMS APPROACH," n.d.
[274] "The Development of Community-Based Health Insurance in Rwanda: Experiences and Lessons," March 2016.

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