



Harnessing the Capital of the Poor: Assessing the Acceptability of Community Based Health Insurance in Zimbabwe

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This Doctoral Thesis, *Harnessing the Capital of the Poor: Assessing the Acceptability of Community-Based Health Insurance in Zimbabwe*, presented by *Tatenda Rufaro Mujeni*, and Submitted to the Faculty of The Harvard T.H. Chan School of Public Health in Partial Fulfillment of the Requirements for the Degree of Doctor of *Public Health*, has been read and approved by:



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HARNESSING THE CAPITAL OF THE POOR: ASSESSING THE ACCEPTABILITY OF
COMMUNITY-BASED HEALTH INSURANCE IN ZIMBABWE

TATENDA RUFARO MUJENI

A Doctoral Thesis Submitted to the Faculty of
The Harvard T.H. Chan School of Public Health
in Partial Fulfillment of the Requirements
for the Degree of *Doctor of Public Health*

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Abstract

Thesis Advisor: Richard Bolton Siegrist

Tatenda Rufaro Mujeni

Harnessing the Capital of the Poor: Assessing the Acceptability of Community-Based Health Insurance in Zimbabwe

Most people in Zimbabwe face financial risk when seeking healthcare. Similar to other low- and middle-income countries, the population is largely informally employed or unemployed, with only 10% covered by private health insurance or limited government programs. Without health insurance or strong financial risk pooling mechanisms, both rural and urban populations must pay out-of-pocket, and the government collects insufficient tax revenue to fund equitable healthcare and achieve its goal of Universal Health Coverage (UHC).

Community-based health insurance (CBHI) has been proposed as a viable path toward providing high quality health services and financial protection for the population in low- and middle-income countries like Zimbabwe. CBHI involves forming local risk pools through community-managed insurance schemes that rely on voluntary contributions and social capital—trust and solidarity within communities. This social capital is essential for CBHI's success.

Faith-based organizations (FBOs), long trusted within communities, have been identified as well-positioned to help organize CBHI programs. This project aimed to assess the acceptability of FBO-led CBHI in predominantly rural communities near mission hospitals in Zimbabwe. The Old Mutare community, surrounding the United Methodist Church's Old Mutare Mission Hospital, was selected for the stud

Using a qualitative design, researchers conducted focus group discussions and key informant interviews. The Adapted Cooperative Healthcare framework was used to identify enablers and barriers to CBHI acceptance.

Findings suggest that CBHI is indeed acceptable to the Old Mutare community. FBOs can play a critical enabling role by offering financial and technical support. However, the study found that those interviewed felt the church should not lead the initiative outright. When CBHI is perceived solely as an FBO initiative, it may trigger mistrust in the community that could undermine success. Instead, strong community ownership and oversight will be essential.

Acceptability studies like this one are an important first step in CBHI development. Early community engagement and buy-in can build the foundation for long-term sustainability and contribute meaningfully to Zimbabwe's progress toward UHC.

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Introduction

Background

Zimbabwe has committed to achieving Universal Health Coverage (UHC) by 2030 like several other countries globally. Although the country has made efforts to address the healthcare access and quality goals of UHC, the equity component that addresses financial risk protection for most of the population is still lagging. With only 10% of the population covered by private health insurance schemes and limited exemptions for out-of-pocket (OOP) payments for special groups, 90% of the population, most of whom are informally employed or unemployed—remains uninsured. This group provides 39% of the total health financing through ineffective, single pool (OOP) payments.

This gap in health financing is problematic, first because it poses a significant obstacle to the country's progress toward achieving its goal of UHC. Second, the effects of financial risk have a ripple effect on the overall health outcomes of the population as high OOP costs deter people from accessing healthcare (Mhazo et al., 2023). This is especially alarming in a country undergoing epidemiological transition and dealing with a double burden of infectious and non-communicable diseases (NCDs).

The government has made several strides to increase the health financing fiscal space by allocating public tax revenue and earmarked taxes towards healthcare financing. However, these measures alone have not been sufficient to bridge the gap needed to protect the population from financial risk. Through their current National Health Strategy, the country has proposed the establishment of a national health insurance (NHI); however, since 90% of the population is

either informally employed or unemployed, it will be difficult to enforce the mandatory payroll prepayment or voluntary prepayment needed to support an insurance system of this nature.

Pooling of funds is a critical strategy for relieving individual financial risk of healthcare costs by distributing the risk across the population (WHO). The Zimbabwean government has attempted to pool the domestically generated resources. However, the funds are not pooled into a single fund but rather into multiple fragmented accounts, with most funds going towards salaries of civil servants working in the health sector, limiting the resources to invest in other areas in the health system.

The limited reach of pooled public resources has given rise to a private health insurance market in Zimbabwe. Private health insurance schemes are funded by contributions from the 10% of Zimbabweans who are formally employed. With 31 individual private insurance companies serving this minority of the population, very little has been done to relieve the financial risk to the larger uninsured population. External donor funds have also contributed to the health fiscal space in Zimbabwe. Although making up 19% of the total health revenue, external donor funds are not pooled into the government pool of funds. Rather, these funds are earmarked for medicines and other health commodities, often serving specialized groups of individuals such as people living with HIV, pregnant women, and children under five, who qualify for user fee exemptions, still leaving a large portion of the population uncovered.

Faith Based Organizations (FBO) have a long history of meeting the health needs of the most marginalized and often rural populations globally. Through their mission hospitals and clinics across Africa they have played a pivotal role in supporting national health systems by providing

access to primary healthcare to the often the hardest to reach population (Olivier et al., 2015). Along with delivery of healthcare, FBOs have helped to lessen financial risk by providing charity care as well as organizing community financing programs such as the ones organized by the Roman Catholic Church. With 62 mission hospitals, FBOs make up 45% of the secondary level facilities serving the rural populations in Zimbabwe (Zimbabwe National Health Strategy 2021-2025). This makes FBOs critical partners in the country's health equity aspirations. Figure 1 below shows the distribution of FBO facilities across Zimbabwe that could tentatively be leveraged for community financing initiatives.

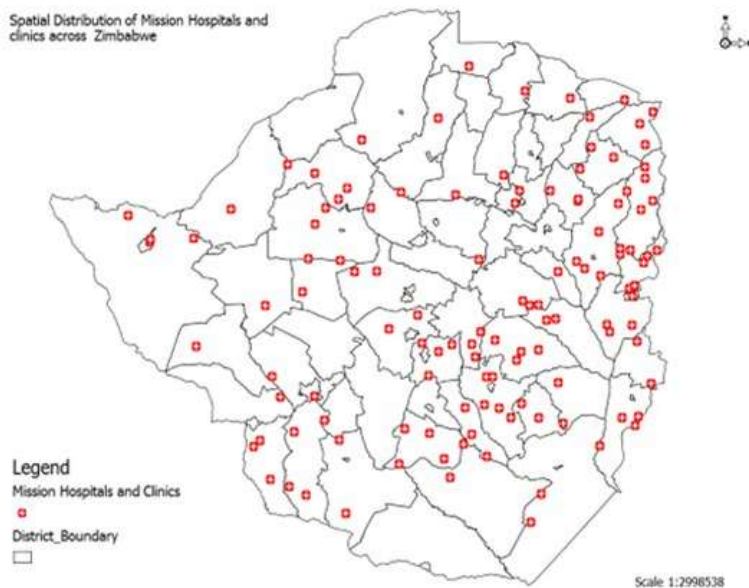


Figure 1: Distribution of Mission Hospitals and Clinics across Zimbabwe

Mission Hospitals & Clinics Overview (n.d.)

Proposed Intervention

The current health financing strategies have proven to be inadequate to support the needs within

the health delivery system, let alone relieve the financial burden of health-related costs on the majority of the Zimbabwean population. Although setting up a National Health Insurance scheme as proposed would be the ideal strategy to address issues of inequity created by exclusive private insurance schemes, a plan of that magnitude will not be feasible within the near future, given the current socioeconomic status of the country. With an estimated 90% of the adult population informally employed, the usual payroll deduction to collect funding is impossible. The government would therefore have to rely on the informally employed population to voluntarily contribute to a national insurance scheme as it would be difficult to mandate. Such a scheme could also face the challenge of adverse selection, with the population most at risk contributing to and benefiting from the scheme, therefore limiting the risk redistributive nature, resulting in an ineffective and chronically underfunded scheme. Setting up such a scheme would also require investment in the development of institutional systems that have been eroded over the years due to socio-political unrest.

In order to provide immediate relief from financial risk, smaller community-based risk pools for prepayment for healthcare, with affordable premiums that could effectively provide basic healthcare to the majority poor and informally employed population, have been proposed as a more feasible approach (Hsiao and Yipp, 2023). The proposed community-based health insurance (CBHI) scheme would be most effective in a largely informal and unemployed population such as exists in Zimbabwe, which still has a considerable leap towards the economic development required to increase employment levels and domestic funding to support a more extensive national health insurance scheme. (Hsiao and Yipp, 2023). A CBHI scheme would create localized risk pools that would leverage the social capital, the innate resources based on

solidarity, trust and altruism within the existing community structures. This social capital would encourage individuals to pay into the system voluntarily, thereby sharing the financial risk while guaranteeing basic quality health services (Hsiao and Yipp, 2023). Additionally, by using inexpensive and less complicated community accountability structures, such a system would require limited upfront institutional investment, allowing governments to allocate scarce resources to other crucial areas, such as improving service delivery and strengthening institutional systems.

Literature Review

A literature review was conducted to explore existing research regarding community-based health insurance (CBHI) in the broader health financing landscape, and the current gaps that exist. This literature review begins by outlining the relevance of healthcare financing as it relates to the sustainability development goal of universal health coverage and the urgency to address the current gaps in the pathway to UHC. Next, the review explores current challenges in healthcare financing that Sub-Saharan African nations face and the gaps that exist in their journey towards achieving the SDGs related to health financing and financial risk protection. This is followed by a description of the health financing functions and the pivotal role that resource mobilization plays in healthcare financing. An analysis is then conducted on the key resource mobilization strategies that countries can adapt to support their healthcare financing goals, including social health insurance, general tax revenue, private health insurance, and community-based health insurance. Through this analysis the literature review addresses how each mobilization strategy is suited for contextual characteristics of Sub-Saharan African health systems. The review then goes through a deep dive of CBHI as a viable strategy to accelerate Sub-Saharan nations like Zimbabwe towards UHC given their current socio-economic context. This analysis includes a history of community financing schemes and outcomes of small to largescale rollout of CBHI models across Africa. An assessment of both the challenges and successes of these schemes in addressing the UHC goals of access and financial risk protection are outlined to support the exploration of how such a scheme could be introduced in communities where it has previously not been adopted.

Health Financing as a Pathway to Universal Health Coverage

Universal Health Coverage is defined by the WHO as a system in which all people have access to quality health services, when and where they need them, without facing financial hardship when accessing this care (WHO). These goals of access, quality, and financial protection are inextricably linked and necessary in order to attain UHC (Kutzin 2013). Although countries in various capacities have been working towards UHC for decades, UHC was formally adopted as a global commitment by all nations as a target within the Sustainable Development Goals in 2015 (WHO Universal Health Coverage).

Two indicators have been adopted to measure the progress that countries are making towards UHC. First, indicator 3.8.1 tracks the service coverage goal of ensuring that all people have access to the health services they need, measured through an index calculated from an average of 16 essential services (“Tracking Universal Health Coverage 2023 Global Monitoring Report,” 2023). Second, indicator 3.8.2 tracks the exposure to financial hardship resulting from out-of-pocket payments associated with accessing care (“Tracking Universal Health Coverage 2023 Global Monitoring Report,” 2023). The recent UHC Global Monitoring Report has reported stagnation by most nations in service coverage and worsening of financial hardship associated with seeking care. Due to inequalities within countries, those from rural and lower income households are mostly affected with poor coverage and a growing financial burden for seeking care (“Tracking Universal Health Coverage 2023 Global Monitoring Report,” 2023).

For low-income countries where stagnation in progress toward UHC is more pronounced, the greatest hurdle is arguably the lack of resources required to realize this ambitious goal (Stenberg et al., 2017) (Sturmberg & Martin, 2021). Addressing how healthcare systems are financed is therefore critical in the pathways to UHC, where attainment of the goals relies on

innovative financing models that alleviate the burden of out-of-pocket costs (Karamagi et al., 2023).

The Challenge of Health Financing

The latest report of the global progress toward the UHC drew attention to the increasing obstacle that financial risk protection poses. The challenges are most amplified in the lower income countries with larger proportions of the population paying out-of-pocket for health services leading to an increase catastrophic health expenditure and impoverishing health expenditures (“Tracking Universal Health Coverage 2023 Global Monitoring Report,” 2023).

Catastrophic health expenditure (CHE) is defined as the percentage of the population with a household budget spent on health from out-of-pocket payments exceeding 10% of household consumption or 25% of the income. CHE has increased rather than lessened over the past 10 years, with an estimated 13.5% of the global population at risk of catastrophic health expenditure (“Tracking Universal Health Coverage 2023 Global Monitoring Report,” 2023). Similarly, the percentage of the population that has been impoverished or propelled further into poverty has significantly increased since 2015. This has led to 16.7% of the population becoming impoverished by seeking care. These numbers translate to up to 2 billion of the global population facing financial risk associated with seeking healthcare.

For the poor or near-poor population, OOP costs associated with an illness episode pose a double financial risk as these individuals face risks associated with paying for healthcare as well as the loss of income due to illness (Leive, 2008). As families deal with these unexpected shocks, they often must compromise their essential needs such as food and shelter, as funds are diverted from

these areas to cover health costs. In extreme cases families resort to selling assets and or taking on loans with collateral, often them to poverty (Leive, 2008).

The cost of seeking care often leaves many with no choice other than forgoing care altogether with an estimated 18.5% of the population forgoing care based on 2019 estimates (“Tracking Universal Health Coverage 2023 Global Monitoring Report,” 2023) Forgone care is defined as “when someone who realizes that she/he needs services, prior to establishing initial contact with services for a given condition or at any point along the patient pathway and continuum of care, is unable to access the services or required medicines and health products due to a range of barriers”(Koller, 2024).

As most of those who face financial hardship associated with seeking healthcare or forgo care altogether are the poor, addressing the OOP cost as a barrier to care becomes an issue of equity. Reaching the UHC financial risk goal would require a state where financial barriers are removed altogether or those who do pay OOP for healthcare services, do so without facing financial hardships (Fig 1). Addressing OOP as a function of national health financing is therefore critical in achieving UHC.

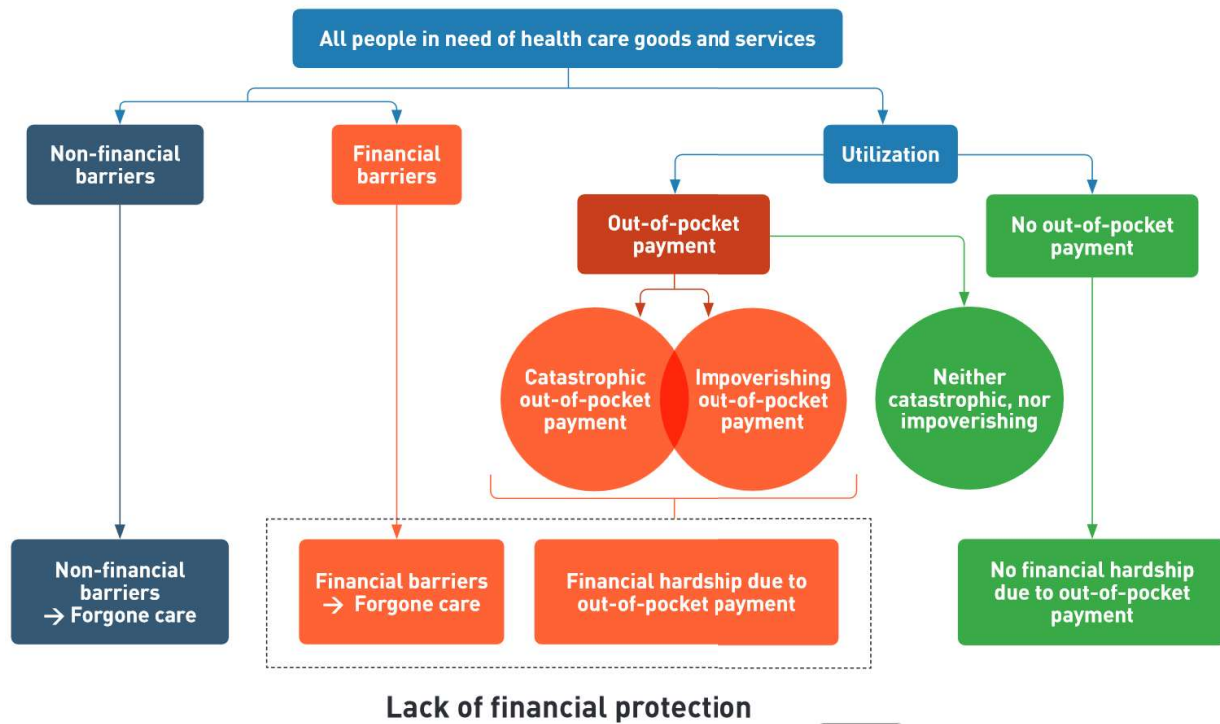


Figure 2: Effects of Out-of-Pocket on Financial Protection

“Tracking Universal Health Coverage 2023 Global Monitoring Report,” 2023

Health System Financing for UHC

Addressing the challenge of financial risk protection requires an understanding of how health systems are financed. Health care financing has been described as “the function of the health system concerned with mobilization, accumulation, and allocation of money at the individual and population level in health systems” (World Health Organization, 2010). There are four key functions that support the health system financing structure which can be summarized as: i) revenue collection; ii) pooling of funds; ii) purchasing of services on behalf of the population; and iv) benefit design and governance of the funds (Kutzin, 2013; Scheffler, 2016). These functions work in concert to ensure the achievement of health financing goals of access to a full range of quality health services while protecting the population from financial hardship.

While all the functions listed above are necessary in establishing national health financing strategies, mobilization of resources may be of the greatest importance when it comes to addressing financial risk protection. Other than countries that rely on significant contributions from donor funding, income generated for health care, regardless of financing mechanism, are largely raised from the country's citizens either directly or indirectly (Roberts et al., 2008; Scheffler, 2016). The goal for countries will then be to adapt the healthcare financing structures into a favorable mix of resource mobilization mechanisms that would be the least burdensome to their citizens, particularly the poorest people in the population. A single model or strategy towards health financing goals, therefore, does not exist (Scheffler, 2016). This is evidenced by the diverse funding structures that exist within many higher income countries that are further along the path towards universality in health care, illustrating that the nature of healthcare financing is both "dynamic and path dependent"(Scheffler, 2016).

There are five broad mechanisms for resource mobilization: general tax revenue; social insurance; direct out-of-pocket payments by patients; community financing; and external donor contributions (Roberts et al., 2008; World Health Organization, 2010). The mechanism that countries adapt for their resource mobilization strategy depends primarily on the country's fiscal capacity, i.e., its ability to generate funds (Scheffler, 2016). Other factors, including political will and administrative capacity to collect and pool these funds also play a large role in the resource mobilization strategy, but fiscal capacity is arguably the most critical. William Hsiao has proposed that the level of socioeconomic development of nations based on the GDP per capita is indicative of a country's fiscal capacity (Hsiao, 2001).As such, the GDP per capita has been utilized for categorization that predicts the breakdown and mix of resource mobilization

strategies that are most likely to be adopted by countries and their likelihood to achieve UHC (Roberts et al., 2008).

Using the socioeconomic development categorization, lower income countries have a larger percentage of their health expenditures financed through direct out-of-pocket payments from the population, with estimates as high as 50% of the total (Roberts et al., 2008) . This puts populations in these countries at higher risk of impoverishment or catastrophic spending. On the contrary, populations in higher income countries are exposed to less financial risk as the healthcare expenditures rely less on the out-of-pocket payments from the population and more on financially protective, general tax revenue and social health insurance financing mechanisms along with private health insurance. All of these rely on a form of prepayment, whether voluntary or involuntary, among a large pool of the population. Regardless of the mobilization strategy, the source of the income remains the same – the citizens.

The ability to collect and pool funds through prepayment mechanisms is then one of the factors that differentiates the higher and lower financial risk mechanisms and a country's progress on their pursuit of UHC. As countries consider the best mix of resource mobilization strategies to employ, the understanding of these resource mobilization strategies and the associated fiscal impact on the individuals is therefore critical. Additionally, the feasibility of adopting these strategies based on local context should also be considered. As noted above, a one-size-fits-all strategy does not exist as there is no single best path for financial reforms towards UHC even among those countries which have made significant progress towards UHC (Kutzin, 2012).

Resource Mobilization Strategies and Financial Risk Protection

Social Health Insurance (SHI)

Social health insurance is a form of resource mobilization that collects and pools funds from the population in order to support the financial needs of the poor population (Hsiao et al., 2007). To prevent adverse selection caused by the propensity for younger and healthier populations from opting out of the larger diverse risk pool, social health insurance relies on compulsory contributions (Roberts et al., 2008). Social health insurance is redistributive in nature, where it pools both high- and low-risk, rich and poor individuals into one pool that mandates contribution by ability to pay. This also provides a safety net for the poor and those unable to contribute, to be covered by the pooled resources from the larger population (Hsiao et al., 2007). It is no surprise, therefore, that due to the equitable makeup of this strategy, it is promoted as a top resource mobilization mechanism in the pursuit of the UHC goals, particularly the financial risk protection goal (Kutzin, 2012; Scheffler, 2016).

The promotion of SHI for resource mobilization is a result of the success of this mechanism in high income countries such as Germany in achieving universal health coverage (Fenny et al., 2018). This level of universality, however, has not been achieved in LMICs implementing SHI. While the national health insurance in Ghana, for example, was associated with an increase in healthcare utilization by 26%, almost 50% of the population were not enrolled in the health insurance over 10 years after adoption of this strategy (Sarkodie, 2021). The success of the German SHI system demonstrates the path-dependent nature of this mechanism as it was a result of over 100 years of health financing strategy (Hsiao et al., 2007). This path-dependent trajectory depends on the economy of the country and is characteristic of high-income countries. The high

per capita income and large formally employed sectors have been shown to significantly contribute to the success of SHI.

Unfortunately, this is not the reality for many LMICs. While some social health insurance schemes do exist, they do not cover everyone, as many LMICs have multiple schemes that only cover the formally employed population (Fenny et al., 2018). First, the high proportion of informally employed individuals, with estimated ranges between 7% and 84% of the population, leaves the burden of contribution and maintaining the fiscal capacity of the health insurance on the minority of formally employed individuals (Lagamarisano et al., 2012). This leads to chronically underfunded schemes. Second, the irregularity of income and inability to determine income levels prevent effective determination of contribution scales, making it difficult to have an equitable sliding scale, where poorer individuals are not burdened with inhibiting contributions. Third, the large unemployed population poses an administrative burden on governments which have limited capacity to collect voluntary contributions from this segment (Hsiao et al., 2007; Lagamarisano et al., 2012).

While the national health insurance schemes in countries like Ghana and Kenya are based on this social health insurance mechanism, “many have questioned whether African countries have been too eager to adopt Western Style policies that are not necessarily appropriate to their fiscal context” (Fenny et al., 2018).

General Tax Revenue

General revenue refers to the funds that the government can mobilize from the economic activities within the country. The volume of the income generated from general revenue depends on the size of the tax base and the availability and accessibility of the taxable resources (Roberts et al., 2008). Availability of easily taxable resources such as oil increases the revenue pool for the

gouvernement. Conversely, limited resources and a small taxable formal sector reduce the tax base and limit the resources that the government can tap into to generate funds to finance development activities (Evans & Etienne, 2010)"

While general tax revenue may be an equitable financing mechanism, this is not always feasible in many LMICs due to limited tax revenue collection (Hsiao & Yip, 2024). Because of the limited size of the formally employed population, low-income governments have resorted to earmarked taxes, typically in the form of consumption taxes on staple foods or sin taxes on harmful goods such as alcohol and tobacco. While these earmarked taxes may have the capacity to generate revenue, these funds are not sufficient to fill the large health financing gap.

Additionally, earmarked taxes on consumption goods have been criticized for their regressive nature, as the goods and services taxed are those consumed by poor populations and indirectly compound the financing burden on these populations (Reeves et al., 2015).

Higher income countries that have effectively leveraged general revenue to finance public services have done so through taxes on profits and capital gains along with vast income taxes.

With the fear of deterring foreign or private investment, LMICs may be disincentivized from this type of taxation. Additionally, the higher proportion of informally employed populations compared to the formally employed population would make efforts to rely on income taxes futile as countries do not have systems in place to collect these taxes (Hsiao and Yipp, 2023).

In 2001, upon recognition of the considerable gaps in healthcare goals within their nations, member states of the African Union committed to a 15% contribution from annual total budgets. This ambitious, yet achievable, goal would accelerate progress towards UHC for countries that had been struggling to control the financial burden of healthcare for their majority poor population. At the 10-year mark after the commitment, only two of 29 countries had achieved the

15% health expenditure goal. Over 20 years since the declaration, the situation has only become worse, with expenditures falling to levels below precommitment years, indicating significant underfunding for healthcare (WHO The Abuja Declaration: Ten Years On, n.d.) (Biegon, n.d.).

Given the limited capacity of the country to collect compulsory contributions for healthcare, the lion's share of the funds would be expected to be from the general government coffers. This, however, has not been the case as many countries simply do not have the capacity due to poor economic performance. The World Bank has noted that most past increases in public financing for health have been driven by economic growth. The economic growth required to drive the required level of public financing may not be possible in LMIC countries (Hsiao & Yip, 2024). There is also immense competition with other competing social development priorities such as education and infrastructural development, requiring the government to make difficult tradeoffs (Scheffler, 2016).

Funding projections have indicated that an increase in general government revenue contributions to healthcare expenditure has the potential to significantly reduce the gap in the population exposed to health-related financial risk (Verguet et al., 2021). General tax revenue may indeed support the move towards UHC for middle income and higher income countries with a larger tax base or existence of natural resources such as oil; however, this financing model is not feasible for many of the LMICs. General government revenue and innovative resource mobilization strategies will be necessary but will not be sufficient to meet the needs of the poor. Other resource mobilization strategies should be considered.

Often included in the general revenue has been development assistance for health (DAH). Reported increases in government spending for many low-income countries can be attributed to these external sources. In 2018, the global DAH was estimated at a staggering \$38.9 billion

dollars (Chang et al., 2019). While these funds can make a considerable contribution to a government's health revenue, they often come with strings attached; they may be allocated to restricted siloed programming such as for malaria or TB, with little impact on general healthcare expenditure outside of these areas. Bias in allocation of donor financing has also been reported on specific functions of the health system like service delivery and human resources for health, with large multilateral donors like The Global Fund channeling an approximate 82% of their funds to these areas, at the expense of other critical functions such as financing and governance (Karamagi et al., 2023). Some countries such as Rwanda have been successful in defining how these funds are used, with allocation to

Out-of-Pocket Payments

Out-of-pocket payments refer to the direct payments made by individuals at the point of service when receiving care. In LMICs across Africa, OOP payments make up a significant portion of the healthcare financing with estimates as high as 37% of healthcare financing contributions coming from OOP contributions (Karamagi et al., 2023).

Out-of-pocket costs are the major culprit in the financial risk associated with seeking care in LMICs as these “costs force people to choose between health expenses and other necessities” (McIntyre et al., 2018; Sirag & Mohamed Nor, 2021). Given the limited contributions from general revenue and social health insurance mechanisms, several LMICs still rely on OOP payments as a significant contribution to the healthcare financing structure. Such payments are associated with reduced demand for care and can lead to catastrophic health expenditures, the two key challenges that the health finance protection goal UHC aims to address (Lagamarisano et al., 2012).

A legacy of post-colonial structural financing strategies, OOP payments were a result of global financing policies that shifted the burden of health financing from government sources to point of care user fees (McIntyre et al., 2018). The burden of these prohibitive costs have disproportionately been shifted to the poor population in an inequitable health financing structure that has led the poor, who cannot afford the restrictive costs of private insurance, paying more for health than those with more resources (McIntyre et al., 2018). Despite their regressive nature, OOP payments still account for approximately 35% of health care funding structure in Sub-Saharan Africa with ranges between 2% to 75% across the countries (McIntyre et al., 2018).

Aside from the regressive nature of OOP payments that place the most vulnerable populations at a higher financial risk, this financing mechanism also has limited utility in revenue generation. This a result of inefficiency in revenue collection and administration costs, leading to very few funds remaining to be reinvested into the healthcare system (McIntyre et al., 2018). Despite the evidence that the adverse effects of OOP payments outweigh any intended objectives of revenue generation, this is still one of the leading financing mechanisms in many countries in Sub-Saharan Africa (McIntyre et al., 2018).

In a multi-country analysis of 59 countries, Xu et al. demonstrated that people can be protected from financial risk, particularly catastrophic healthcare expenditures, by reducing the OOP contributions in financing of the health system (Xu et al., 2003). Given the evidence that has indicated some willingness to spend and ability to spend, on outpatient care, even among the poor, opportunities do exist to use this direct payment potential to augment national health financing strategy (Roberts et al., 2008). This is in line with the understanding that the population is the primary contributor to financing the health system (Kutzin, 2012b).

This mechanism, however, should be structured in a manner that transfers this payment into the health system, while protecting the most vulnerable from financial risk associated with seeking care. The Brookings Institute proposes that LMICs could leverage the over 31% portion of healthcare financing contributions from OOP payments by pooling these funds for strategic purchasing (Osondu, Ogbuoji et al., 2019). This would be in the form of a health insurance scheme that prevents the risk of direct payments at the point of care. Compulsory prepayment has been proposed as a necessary prerequisite for such a system to work to allow for a large enough risk pool that includes both the riskier sicker individuals and the less risky healthier population (Scheffler, 2016).

Without such a system, this large vulnerable segment of the population could be paying directly out of pocket for pricier private providers in non-protective single risk pools. Hsiao proposes that if households are willing to pay these funds out of pocket into an organized insurance scheme, this could result in collective gains and reduce the financial risk posed by OOP payment as well as contribute to improving the quality of services provided (Hsiao, 2001).

Community Based Health Insurance

Community-based health insurance (CBHI) is a mechanism where “communities operate and control the provision of their own primary care and secondary services through locally based prepayment schemes.” (Roberts et al., 2008). CBHI is a response to gaps in access to quality health services for the poor and often rural and informally employed populations. These underserved populations, who are most affected by health system failures in poorly run and under-resourced government funded health systems, respond through local funding and delivery alternatives. In addition to financing and delivering healthcare, these systems also address the ubiquitous challenges of inadequate health workforce, shortages in medicines and supplies,

corruption and inefficient service delivery through the imbedded local accountability structures (Musango et al., 2012; Roberts et al., 2008).

History of Community Based Financing for Health in Africa

CBHI is not a new phenomenon, but one that has existed in several rural and low resource communities for centuries. The first were supported by religious organizations and institutions such as churches, synagogues and mosques (Hsiao, 2001) . Later, community financing was adopted by many sovereign nations as they sought to provide healthcare for their populations. The poor had long been underserved by colonial health systems that had neglected primary healthcare, particularly in rural locations, despite this being where most of the population resided (Hsiao and Yipp, 2023). When governments with strained tax revenue resources had to make tradeoffs for healthcare financing, it was the publicly-funded secondary and tertiary facilities, often located in cities, that were prioritized at the expense of lower level primary care facilities located in remote and rural locations (Hsiao, 2001). In cases where resources were channeled to the primary healthcare networks serving a vast majority of the population, inefficient use of resources and mismanagement due to inadequate public administrative structures contributed to shortages of medical supplies and human resources leading to poor quality service delivery (Hsiao 2021). Communities therefore took the management and delivery of healthcare into their own hands.

Before UHC, the promotion of community participation in health was introduced through the Alma Ata Declaration and Bamako Initiative (Boidin, 2021). The primary healthcare-focused Alma Ata Declaration led to the proliferation of community healthcare insurance systems or mutual health organizations. Although going by various names, they shared the same characteristics of voluntarism and solidarity of community funded and managed schemes. The

introduction of structural adjustment policies, however, quickly compromised the integrity of these systems as a stronger emphasis was placed on privatization and user fees, placing individuals at financial risk. Although the Bamako Initiative called for increased community participation in health structures, this participation was ultimately skewed towards non-pooled community financial contribution in health structures, again placing the poorest and underserved at higher financial risk when seeking care. (Boidin, 2021; “THE BAMAKO INITIATIVE,” 1988).

CBHI as a Path to UHC

Given the goal of UHC, a community financing structure would have to meet the goals of providing: i) access to services and ensure these services are of superior quality and meet the needs and expectations of the communities served; and ii) equity, by ensuring that individuals do not face financial risk while accessing these services.

Despite the documented challenges of the earlier iterations of community-based financing mechanisms such as those arising from the Bamako initiative, the schemes were successful in mobilizing communities in a shared goal of access to essential care and medications (“THE BAMAKO INITIATIVE,” 1988).

While equity may not have been a driving factor in the establishment of the earlier community financing mechanism, it could be seen as a covert motive for community financing. First, CBHI was built on the inherent social connections and solidarity that existed in communities which could be taken as evidence of an underlying equity motive. Second, when community members contributed to a pool of funds to support the provision of care, they were creating a risk pool that reduced the risk of an individual facing catastrophic out-of-pocket costs. With drug revolving funds, for example, and access to care being brought closer to the community through these local

mechanisms, communities did not have to travel as far to receive basic healthcare, expanding this protection by reducing transport costs (Boidin, 2021). The more recent CBHI programs have a clearer equity motive, with the imbedded structures that attempt to protect the most vulnerable members of the community from the financial burden of paying for health care (Criel & Waelkens, 2003; Mladovsky, 2014)

One may argue that this ability of communities to organize and support these earlier initiatives, albeit with some challenges, provides an opportunity to build on and develop a superiorly structured, improved, equity-focused financing system. Adaptation of such a structure, however, would require an understanding first of the political economic characteristics of LMICs that make CBHI a viable option in their journey towards universality in health. Second, the mechanisms in which the system would address the goals of access, quality, and financial risk protection would be necessary. At that point, clearly defined considerations could be made on how to adapt and optimize CBHI contextually.

Characteristics of Healthcare Financing That Support Viability of CBHI in LMICs

The commitment and efforts made by LMICs in their progress towards the UHC financing goals are commendable. Despite these efforts through financing reforms, however, most LMICs are not on track to reaching the 2030 SDG goals. In Africa, where the majority of countries are ranked within the LMIC category, the average total health expenditures as part of GDP is 10%, significantly lower than the 15% espoused goal of the Abuja declaration (*World Health Organization Global Health Expenditure Database*, n.d.). Out-of-pocket expenditure accounts for an average of 40% of health expenditure in over half of the LMICs in Africa (State of Health Financing in the African Region, 2013). For countries such as Liberia and Sierra Leone where government expenditures for healthcare are higher, the OOP expenditures as a percentage of the

total health expenditure is alarming, as high as 24.68% in Liberia and 51.41% in Sierra Leone according to World Bank global health expenditure estimates (World Health Organization Global Health Expenditure Database, n.d.). These expenditures are as high as 74.68% in Nigeria, placing a large percentage of the population at financial risk when seeking care.

These glaring challenges are occurring despite the adoption of health financing mechanisms that encourage healthcare resource mobilization and redistribution through an increase in government tax revenue, social health insurance, and private health insurance. The drawbacks in health financing goals in LMICs can be attributed to the socio-, political, and economic characteristics that make these strategies unfavorable and limit their success. This, therefore, necessitates strategies for optimization for these contexts of which CBHI may be a viable alternative strategy.

Community based health financing could address some of the challenges posed by domestic resource mobilization through the ability of this mechanism to identify and tap into the largely unemployed population for collection and pooling of funds. The imbedded solidarity and community ownership of this system could potentially address the concern with the challenge of voluntary enrollment into the scheme, which is almost impossible for any alternative government-leading social health insurance scheme. According to a study, only one of the nine established universal health insurance programs with compulsory contributions in Africa actually effectively enforced the compulsory stipulation (Ly et al., 2022). Given the limited success of compulsory prepayment collection, voluntary health insurance with some pooling of funds has been proposed as preferable for financial risk protection over the current state, with higher OOP individual risk pools (Pettigrew & Mathauer, 2016).

Other characteristics of LMICs that make CBHI a more suitable resource mobilization strategy include the lack of administrative capacity and inefficiencies to redistribute and manage

resources serving the majority unemployed and informally employed populations (Hsiao, 2001). The resultant gap in quality public services leads the poor to seek care from private providers with riskier and higher out-of-pocket costs.

Analysis of CBHI in Practice

Determining the success of CBHI as a viable mechanism towards the equitable healthcare aspirations of UHC requires assessing the examples of implementation of CBHI and understanding attributes that have contributed to the success and failure of CBHI in various contexts.

Inequitable access across populations and difficulty in retaining members which would in turn affect the long-term sustainability of the program have been highlighted as some key challenges in the CBHI models (Ifeagwu et al., 2021). An assessment of the CBHI program in Nouna health district in Burkina Faso measured the viability of CBHI through the equity measures of enrollment and utilization of healthcare. The results indicated that poor individuals were less likely to be enrolled in CBHI than rich and adults. Individuals with a higher education were also more likely to be enrolled than those with lower education (Parmar et al., 2014). While there was a slight increase in the equity measure with subsidies for poor in later years of the CBHI implementation, the overall low enrollment rates are telling of the equity gaps that need to be addressed to make CBHI a viable option (Parmar et al., 2014). These inequitable outcomes have also been reported in evaluations of CBHI models in other African countries including Ethiopia which has one of the most extensive institutionalized CBHI models (Begna et al., 2024).

Of the countries in Sub-Saharan Africa that have adapted CBHI, Rwanda is the only one with wide coverage of the poor. Fenny et al. note that Rwanda's Ubuhde program has adapted an effective stratification program rooted in culture where assistance is provided to community

members in need (Fenny et al., 2018). “For women of reproductive age, Rwanda’s poor groups have almost the same level of access to a doctor or midwife as richer groups, whereas in Ghana less than 50% of women in the poorest quintile deliver with assistance of a skilled professional, compared to 97% in the richest quintile (Fenny et al., 2018). The Rwandan CBHI model may have benefited from the prevailing cultural environment and context, but the ability to understand and adapt the structure of the CBHI model also played a role in the mode’s success.

On one hand the inequitable enrollment in CBHI by the poorest quintiles in the communities where the program has been implemented may be indicative of larger socio-economic inequalities impacting the potential success of such a program. On the other hand, low enrollment has been linked with limitations related to inadequate demand creation before roll-out and expansion of the program. Lack of knowledge of the national health insurance in Kenya for example was the most critical barrier to enrollment in the program (Mathauer et al., 2008).

Retention has been another hurdle that many CBHI models have had to navigate in implementation. In Guinea-Conakry, a comprehensive Malindo Mutual Organization (MHO) provided its members with access to first line health services, emergency surgical and obstetric services and supplement for transportation costs to the health facility (Criel & Waelkens, 2003). This scheme was far from achieving the goal of universality as it was only able to reach 8% of the targeted population. Enrollment declined by a quarter after two years, with dropout rates as high as 72% in a Senegal program, with perception of poor quality of health services a leading determinant of dropout (Mladovsky, 2014). Perceived trustworthiness of the program associated with effective management and accountability of the program also determined retention in the program. While the members ability to pay for the CBHI models affected retention of poorer members and associated lower enrollment rates in Burundi and Ethiopia, perceived quality and

trust were demonstrated to be more important in Kenya (Mladovsky, 2014; Parmar et al., 2014; Umeh & Feeley, 2017).

Community-based health insurance schemes rely on voluntary contributions. As such the challenges of voluntary contribution also affect the success of this mechanism. Low uptake, for example, could lead to a small risk pool, with the potential of exhausting funds after a few high capital intense episodes within the group. Poor retention due to perceived utility for those relatively healthy who may not use the services regularly therefore do not use the services regularly. As a large enough risk pool and the ability to generate enough money for cross-subsidization between sick and poor populations is necessary for the sustainability of prepayment models, assessing for and addressing these drawbacks in CBHI will be necessary as countries consider adoption of a CBHI prepayment mechanisms.

Given the low enrolment and retention rates, Hsiao rightfully asserts that community-based health systems do not have the capacity to increase the total amount of funds to finance universal equitable healthcare access, as the systems consist of largely poor populations who do not have the means to support their comprehensive health needs (Hsiao, 2001). Community-based initiatives therefore needs to be supplemented by other government financing mechanisms. In this mutually beneficial effort, CBHI's would aid the government in covering the most challenging population to reach, while the government works on addressing the larger systemic and institutional factors while awaiting the slow progress of economic growth. CBHI could therefore be a mechanism towards low-income countries attaining the next milestone in the journey towards UHC.

When they work effectively, CBHI models provide the protective effect and access to health services for people who have previously not received these services. In addition to addressing the

compounding problem of financial risk protection, CBHI's can contribute to the larger population level health outcomes through increased uptake of preventative measures. A study of the effects of CBHI enrollment in rural Uganda, indicated an increase of uptake of long-lasting insecticide treated nets (LLINs) utilization by 26% and deworming 18% (Nshakira-Rukundo 2019)

CBHI in the Zimbabwean Context

An analysis of the inequality in health insurance coverage across 36 African countries, including Zimbabwe, showed that coverage through prepaid insurance is below the 20% mark of the countries studied (Barasa et al. 2020). The Zimbabwean health financing case supports this finding with private insurance coverage rates reported at 10% and out-of-pocket payments by the poorer uninsured population as high as 39% (NHS 2016-2020). Such levels of OOP expenditure are alarming as the population that pays out-of-pocket for healthcare are typically poor and are often placed at risk of catastrophic and impoverishing health expenditure. Evidence from a study by Zeng et al. indicated that levels of catastrophic health expenditure in Zimbabwe were as high as 13.4% among the lowest wealth quintile, with concerns that these figures do not provide a full account of the magnitude of the problem as many people are expected to forgo healthcare altogether due to the high cost of care (Zeng et al. 2018). These challenges paint a picture that although Zimbabwe has made some progress towards their UHC goals, the issue of inequality in healthcare, mainly through financial risk protection, is still a serious threat and will be a significant deterrent from meeting the 2030 goals of UHC for all if no immediate actions are taken (World Bank 2023).

Community-Based Health Insurance models (CBHI) have been proposed as alternative financing models for low to middle-income countries that still face challenges of a high unemployment rate

as well as poor systems to collect and redistribute tax income at the level required for universal health coverage (Hisao and Yipp 2023). A study from Rwanda indicated that the CBHI model reduced individual per-capita expenditure by 83% compared to expenditure before the implementation of the study (Woldemichael et al. 2019). Similar evidence has been demonstrated in CBHI models in Ethiopia and Ghana, despite some operational and income disparities that need further investigation.

The feasibility of CBHI has been studied in a rural population in the Musana district in Zimbabwe, where a 3-year study indicated positive results on the populations' willingness to pay into the CBHI model as well as the long-term sustainability in the low-income, rural population (Muchabaiwa et al. 2017). Recommendations for adopting community-based health financing models as the most appropriate and feasible intervention given the socioeconomic context in Zimbabwe were further supported by evidence through a social policy study by Goodman Nhapi (Nhapi 2019). Additionally, a survey among informally employed urban industrial workers in Harare indicated a general desirability of national health insurance or a prepayment structure (Chipunza and Nhamo 2023). As outlined above, there are several considerations to be made to ensure the success of a CBHI scheme. Along with a clear implementation strategy to address the shortcomings of widespread enrolment and retention, the contextual characteristics that would favor a CBHI scheme should also be explored, to understand the acceptability which in the long run informs the feasibility of CBHI. To do this an analysis of the Zimbabwean context using the Hsiao and Yip's cooperative financing model is proposed.

Study Goal and Aims

The goal of this study was to assess the acceptability of a FBO-led community-based health insurance (CBHI) in Zimbabwe, using the case study of Old Mutare Mission Hospital¹ and the surrounding communities.

This research aimed to contribute to growing evidence of the acceptability and feasibility of community-based health insurance (CBHI) models as an alternative health financing model in Zimbabwe to address the need for financial risk protection for the majority of the population and contribute to the country's efforts towards universal health coverage.

Other studies have been conducted on the feasibility of CBHIs, including one by Muchabaiwa et al. This study explore the feasibility and the acceptability of a CBHI in a rural population of Musana, Zimbabwe, with results indicating that the model was feasible in this rural community (Muchabaiwa et al., 2017). Chipunza and Nhamo also recently published results of the demand of health insurance in urban informal sectors in Harare, Zimbabwe(Chipunza & Nhamo, 2023).

- i. This study aimed to contribute to this knowledge by exploring the acceptability/demand of community-based health insurance by mostly informally employed and unemployed peri-urban and rural populations in Zimbabwe., using the Old Mutare Mission Hospital and its surrounding community as a case study.
- ii. Additionally, this study also aimed to contribute to the research through the exploration of faith-based organizations, in general, as trusted and feasible engines to establish CBHI models in Zimbabwe. Although there has been evidence from other countries including Burundi and Rwanda where FBOs have contributed to the establishment of CBHIs. there

¹ Old Mutare Mission Hospital is a 70-bed hospital located in Mutare on the eastern border of Zimbabwe, serving approximately 15,000 people in a largely rural area of the country.

has been limited evidence of the possible role of FBOs in establishing CBHIs in Zimbabwe.

- iii. While the study would be focused on the community surrounding one secondary level mission hospital, this study would also contribute to the generalizability of its findings to other missionary health facilities and faith communities in the country and provide recommendations on how the model can be adapted to other facilities in the United Methodist Church network.

The specific study questions were:

1. What are some contextual considerations (enablers and barriers) to the establishment of community-based health insurance in the community served by Old Mutare Mission Hospital?
2. What are the community perceptions of health insurance, and the possibility of a faith-based organization facilitating a community-based health insurance programs in surrounding existing faith-based health facilities?
3. What factors would influence the establishment and implementation of successful community-based health insurance in the communities surrounding Old Mutare Mission Hospital?

Frameworks

Cooperative Healthcare

Community-based health insurance, a form of community financing, is defined as “any scheme that has three features: i) community control; ii) voluntary membership, and, iii) prepayment for healthcare by the community members (Hsiao, 2001). Given the broad definition, there are several community financing schemes that exist, and the characteristics are too broad to assess the capacity of specific schemes as an effective health financing mechanism. Hsiao, therefore, recommends assessing the capability of a community -based health insurance scheme through a framework that is based on two criteria which are: i) their potential to mobilize fiscal resources and attract a large percentage of the target population to enroll; and ii) by the final outcomes they produce (Hsiao & Yip, 2023).

Through their Cooperative Healthcare model, Hsiao and Yip outline core concepts of community financing based on the assessment of elements that have been demonstrated to contribute to the success of CBHI models in LMICs. (Hsiao & Yip, 2023).

The three criteria outlined in the Cooperative Healthcare model are:

1. A scheme operated in a community with residents who have some means to prepay
2. The existence of a stock of social capital in the community
3. A scheme that is valued and trusted by the residents linked to the
 - a. Existence of basic services of reasonable quality, including primary healthcare and drugs;
and
 - b. Community management and control of the funds

Utility in assessing acceptability of CBHI:

The Cooperative Healthcare framework encompasses all the elements of community-based health insurance and community financing, outlining the concept in three clear criteria which are helpful for framework analysis. Therefore, this framework was used to guide development of the questionnaires and tools used for the study, and the analysis of the data. While all three criteria from Cooperative Healthcare were adapted for study design and analysis, one criterion stood out as most important and was also referred to in other models and studies. That is the existence of a robust stock of social capital as a determining factor of the feasibility and sustainability of a CBHI model (Fenenga et al., 2018). The role of social capital and existence of a stock of social capital was therefore further analyzed as a key determining factor in the acceptability of a community-based health insurance model. Both the Cooperative Healthcare and adapted social capital framework were used throughout the study.

Social Capital

While CBHI is a form of health insurance, unlike traditional health insurance models, the success of this model relies on the existence of solidarity and mutual aid within a community (Bennett, 2004). The social capital framework aims to assess the influence of this unique concept of solidarity on the acceptability and the success of community-based health financing models.

Among the several definitions of social capital the most prominent may be one by Woolcock et al. who define social capital simply as “the norms and networks that enable people to act collectively” (Woolcock, 1998). Nahapiet and Ghoshal define social capital as “the sum of the actual and potential resources embedded within, available through, and derived from the network of relationships possessed by an individual or social unit. Social capital thus comprises both the network and the assets that may be mobilized through that network” (Nahapiet & Ghoshal, 1998). Put simply, social capital can be described as the close network around an individual

comprised of family, neighbors, friends and associates who act as an invaluable asset that the individual can tap into in times of crisis, and a form of a social safety net that individuals can rely on when they fall on hard times (Woolcock & Narayan, 2000). This also extends to communities as they have linkages to other community networks and civil associations that make them stronger and more able to withstand crises (Woolcock & Narayan, 2000).

Social capital has been referred to as the “capital of the poor” (Woolcock & Narayan, 2000). Studies have indicated an association between high levels of social capital and the improved development outcomes in areas such as agriculture, water and sanitation and most recently, associations have been made between increased social capital and success of CBHI (Mladovsky, 2014).

The social capital framework that has been adapted for this study is the Community Social Capital Model from the University of Minnesota Extension (“Community Social Capital Model,” n.d.). The model consists of seven components of social capital presented in a circle, divided into three rings. When they work together, these components determine the strength of social capital in a community (“Community Social Capital Model,” n.d.). The community’s social capital is described as being built on three different types of social networks or ties, similar to the ones presented by Woolcock et al. These are:

- i) Bonding ties within communities, consisting of close family, friends and neighbors where “residents have close connections and a sense of belonging that helps them get by” (“Community Social Capital Model,” n.d.);
- ii) Bridging ties between communities, where “residents with different social background engage with each other and allowing them to expand opportunities,” and get ahead (Woolcock & Narayan, 2000) (“Community Social Capital Model,” n.d.);

- iii) Linking ties in which “residents have connections to organizations and systems that help them gain resources and bring about change” (“Community Social Capital Model,” n.d.).

At the core, or inner circle of the social capital framework is efficacy, “which is the belief that one can make a difference in a variety of social contexts,” a foundation that is necessary for social capital to exist (“Community Social Capital Model,” n.d.). The middle ring focuses on trust across the three networks –bonding, bridging and linking described above. The third outer ring focuses on engagement across the networks. Together these seven aspects describe and determine the strength of social capital within a community. If strong, social capital can be harnessed to solve challenges affecting the community (“Community Social Capital Model,” n.d.).

This simplified model was adapted to assess the strength of social capital in the community surrounding Old Mutare Mission Hospital. The goal of this study was to determine the ability of the community to harness the social capital that exists to solve the challenge of gaps in financial risk protection in this community.

The Community Social Capital Model

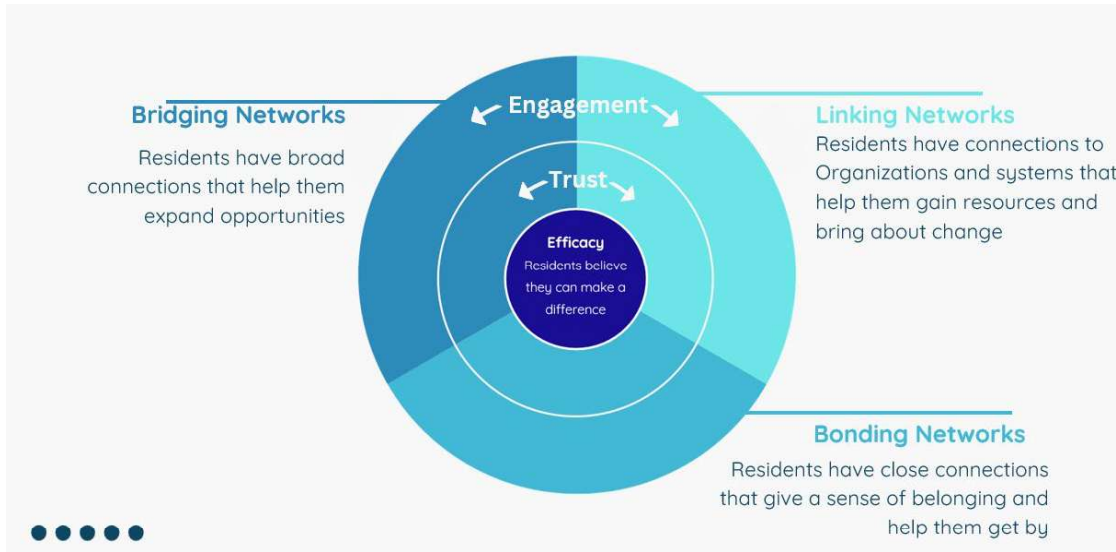


Figure 3: Community Social Capital Model

Adapted Cooperative Healthcare Model



Figure 4: Adapted Cooperative Healthcare Model.

This framework that will be applied in the data analysis is an adaptation of the cooperative healthcare model by Hsiao and Yipp including the community social capital aspects from the University of Minnesota Extension. (“Community Social Capital Model,” n.d.; Hsiao & Yip, 2024)

Methods

Study Design

The study primarily employed a qualitative study design as the research questions were aimed at exploring the experience or understanding of a specific phenomenon, the acceptability of CBHI, within the Old Mutare community. For example, one of the study questions asked, “*What are some contextual considerations (enablers and barriers) to the establishment of community-based health insurance in the community served by Old Mutare Mission Hospital?*” The aim of the question to the community was to provide a description of current practices and learn from that context rather than prove or disprove a specific hypothesis (Murphy & Dingwall, 2017) (Carter & Little, 2007)

Given that the study sought contextual understanding of a phenomenon or theory, this study took on a contextualism epistemology approach. As described by Braun and Clarke, “contextualism epistemology does not assume that a single reality exists, rather knowledge emerges from the context” (Braun & Clarke, 2013). Specifically, through the exploration of social capital in the community, the study sought to understand unique characteristics that would describe how social capital was influenced and could be harnessed for social action in the Old Mutare community.

Study Tools

The study employed two study tools to obtain qualitative data, which were focus group discussions and in-depth key informant interviews, detailed below.

Focus Group Discussions Focus

Focus group discussions (FGDs) were the primary data collection tool. FGDs, rather than individual semi-structured interviews, were more appropriate for this study as the research

questions sought to understand the information from a community perspective. This was important as encouraging social interactions among group members has been identified as a key strength of focus group methodology (Braun & Clarke, 2021). The responses and comments among the participants guided the understanding of some of the shared attitudes towards the concept of health insurance and social capital and how they were formed within the social context of the Old Mutare community (Morgan, 1997).

Given the number of focus groups and the diverse representation in the groups, this method allowed for a wide range of views on the study topics allowing for opportunities for often marginalized or less engaged groups to provide their perspectives (Braun & Clarke, 2021). Additionally, as the topic required a social interaction component, the interactions in the focus group discussions provided insights into some of the social interactions that contribute to a stock of social capital (Morgan, 1997). While the focus group discussion questions were based on existing cooperative healthcare and social capital frameworks, the nature of focus group allowed additional issues or themes to emerge, contributing to richer findings.

In-depth Key Informant Interviews

Focus groups were supplemented by in-depth interviews with key informants to gain a greater understanding of the experiences and opinions of specific individuals within the community. Along with social components that influence the concept of social capital, individual's actions and buy-in are critical components to building the stock of social capital. Therefore, understanding individual perceptions, motivations and experiences through interviews was necessary. The interviews also provided an opportunity for the key informants to share sensitive information about feelings of solidarity and trust of other group members that may not have been

comfortable to share in a group setting. The key informant interviews contributed to the development of a stakeholder analysis from the diverse perspectives in the community.

All study tools used for focus group and in-depth interviews were developed based on the adapted framework from the social capital and cooperative healthcare frameworks, which was also used for analysis. Questions within the guides were aligned to key themes in the cooperative healthcare and social capital frameworks. An example of question and their alignment is provided in Appendix 3.

Procedure

Participants and Sampling Method

A purposive sampling method was used as the study called for exploring the experience of and understanding of health insurance along with the concepts of social capital from diverse perspectives. This included purposively selected homogenous groups, such as the school administrator group. The diverse perspectives from the community at large were also important. This called for heterogenous focus groups to include richer vs poorer; sicker vs healthier; younger vs older participants among other comparisons.

To aid this purposive sampling, we solicited the support of the local gatekeepers who identified and engaged the groups. These gatekeepers included local religious leaders who were able to identify congregants from women's, men's and young people's groups to organize the local church focus groups. The matron at the health facility was able to identify a diverse group of community members to include in the community focus group, and the hospital administrator contacted the local hospital community board that naturally consisted of a diverse group of community members including village and health facility leaders.

Purposive sampling was also utilized to select individuals for key informant interviews to supplement the insights gathered from the focus groups. These mostly consisted of hospital administrators and church leaders who shared their insights on the acceptability of a CBHI program from their perspective and experience based on their knowledge of the community.

Reflexivity and Adjustments to Study Participants

Upon reflection on the groups that were sampled and references from the focus group discussions of important groups to include, we recognized that the initial data that were collected did not reflect the diverse views in the community. The preliminary focus group and key informant interview selection reflected the bias that I as a researcher had as an outsider. My understanding of the relevant participants to include in the study through the purposive sampling approach was therefore flawed by this bias.

To address this bias and potential gap in data, the local health facility leadership as well as the focus group moderator were consulted on selection of additional groups to include in the study. This was done to provide diverse perspectives and understanding of the topic. This enhanced the insights gathered from the initial focus groups. The additional participants were groups or individuals identified as ones whose perspective would be beneficial in generating knowledge and understanding of the social context.

Missing from the initial group, for example, was a group of women, particularly pregnant women, who deliver at the facility. These women had previously not been considered for inclusion as pregnant women are typically exempt from user fees. However, upon further investigation, it was discovered that pregnant women were only exempt from relatively cheaper antenatal services, while they still had to pay for costs associated with delivery at the facility.

This included the high cost cesarian sections that most were paying for out-of-pocket. Table 2 and 3 below show the initial focus groups included and additional groups included after consultation with local contacts.

Table 1: Initial Focus Group Selection

Focus Group #	Focus Group Description	Number of Focus Groups	Number of Participants	Relevance to Study
1	Hospital Committee/Board	2	20	Diverse groups. consists of community members, village head, VHWs, Administrator, Hospital staff
2	Faith Based Community Groups (urban and rural)	3	24	2 representatives each from clergy, men's group, women's group, and youth group
3	Hospital Patrons/Community	1	8	Diverse group of patrons of the Old Mutare Hospital

Table 2: Additional Focus Group Selection

Additional List and Composition of Focus Group Participants				
Focus Group #	Focus Group Description	Number of Focus Groups	Number of Participants	Relevance to Study
4	Waiting mothers' shelter – pregnant women	1	8	Group of women who are exempt from antenatal care services but pay for delivery
5	Teachers and Parents at local mission school	1	8	Teachers, access to health insurance as civil servants and can share perspective of formally employed
6	Farm workers group	1	5	Formally employed, been enrolled in private health insurance in existing payment arrangement with the hospital
7	Village Health Workers	1	5	Direct contact with community, through community provision of care
	Total	10	78	

Data Collection

An experienced focus group moderator with knowledge of the language and community was selected to conduct the focus group discussions.

Once identified, moderator training was conducted where the study background, interviewing techniques, as well as review of the research standards and confidentiality for the study were shared. During the training period the study tools were reviewed with the moderator before the tools were translated to the local language, Shona. The accuracy of the translated questions was verified both by the researcher and the moderator before the study was conducted. Participants were identified and invited to participate through the purposive sampling strategy described above.

Data Analysis

Framework Analysis as described by Goldsmith, a more structured version of the Theoretical Thematic Analysis as presented by Braun and Clarke, was selected for the analysis of the data. This specific approach was selected due to its alignment with applied policy research (Goldsmith, 2021) (Braun & Clarke, 2013). Contributions from this specific study would add to the knowledge base of CBHI and provide evidence for this scheme with potentially important policy implications in the Zimbabwean healthcare financing landscape. A framework analysis was considered to be the most suitable approach as the study focused on both understanding and providing a descriptive account of the phenomenon of social capital and associated themes, as well as developing a contextualized analysis of the findings (Goldsmith, 2021) (Braun & Clarke, 2013).

This approach also allowed for both inductive and deductive thematic analysis (Goldsmith, 2021). On the practical side, framework analysis was adapted for its accessibility and understandability by a diverse population. The output of this project is one that needs to be understood by a diverse audience, including the local community, to encourage and facilitate social action towards community financing. This method is arguably one that is most accessible by a diverse group, including those with limited experience in qualitative research (Braun & Clarke, 2013).

Data Familiarization

Data was transcribed in Shona and translated to English soon after each focus group and interview. The initial step of the analysis was familiarization with the data. This included listening to all original recordings, while reviewing both the Shona and translated English

transcripts for accuracy. This process allowed for familiarization with the data and initial notes were taken regarding some of the early themes that emerged during this familiarization process, (Goldsmith, 2021). New themes that did not fit into existing framework themes were highlighted. The familiarization step was completed once we a reasonable understanding of the data including variation among various participant stakeholder groups (Goldsmith, 2021).

Framework Identification

Next the analysis focused on framework identification. Considering the study started with an existing adapted cooperative healthcare model, the framework identification step focused on optimizing this framework. This involved reviewing the broad data and notes from the familiarization step to assess their alignment with the proposed framework. In addition, outlining any broader themes or components that emerged that did not fit into the initial framework.

Coding and Analysis

This next step focused on coding which was approached from both a deductive and inductive approach.

Deductive: Considering this study primarily used the adapted cooperative framework, coding related to this framework initially followed a deductive approach. The broader concepts that were already defined in the social capital section of the framework, particularly trust, engagement and efficacy were used as broad theoretical concepts.

Complete coding of all the transcripts was conducted where any quotes of interest from the data in reference to these broad concepts were derived and placed in buckets of the

sub-concepts; for example, all data quotes related to trust as a broad concept and specifically Bonding, Bridging or Linking networks within this broad concept were collated. This step ensured that all quotes and information of interest within the transcripts were identified and assigned to the relevant codes (Braun & Clarke, 2013).

Inductive: While a deductive approach was used primarily in data analysis, an inductive approach was adapted to identify any emergent themes that would inform additional insights to the theoretical framework. Additionally, the broader concepts in sections 1 and 3 of the frameworks did not have explicit or salient preexisting codes like social capital section, therefore in this section codes were developed from the data and grouped to identify themes that emerged.

Ethical Approvals

Ethical approval for this study was obtained from the Harvard Institutional Review Board (IRB). Additionally, local ethical approval was secured through the Old Mutare Mission Hospital approval process.

Results

Before answering the study's, specific research questions and applying the selected framework to assess the community's readiness to accept a community-based health insurance scheme, it was worthwhile understanding the context where the framework would be applied. This was done by reviewing the status of the Old Mutare Mission Hospital health system, specifically as it pertains to healthcare financing and associated health service delivery. In addition to the health facility status, it was also important to

understand the current experience of the community that is served by Old Mutare in paying for healthcare, including the means of payment.

Healthcare Financing at Old Mutare Mission Hospital

Old Mutare Mission Hospital (OMMH), a United Methodist Church (UMC) affiliated mission hospital, is a secondary level health center in the Zimbabwean health system. While affiliated with the UMC, the facility does not receive any financial support for hospital operations from the faith-based organization. Rather, the UMC supports the facility through capital improvements and purchase of equipment and supplies. The hospital's financing structure is governed within the Government of Zimbabwe's (GOZ) Health Financing Policy, as follows:

Revenue raising: Old Mutare benefits from the revenue raised from the mixture of domestic resource mobilization, including funds raised from the national government budget allocation, non-profit organizations and philanthropies as well as external donor funding.

Pooling: The hospital also benefits from the pooled resources from GOZ's Consolidated Revenue Fund (CRF), which subsidizes funds in health facilities. While these funds cover the full operational costs in government facilities, it only covers salaries in mission hospitals such as Old Mutare. That leaves a significant portion of the operational costs to be covered through revenue generated at the health facility. This is accomplished by facility-level pooling of funds through the Health Services Fund (HSF). The HSF is an account that allows the health facility to pool revenue generated from user fees, grants, and donations to support hospital operations (Zimbabwe National Health Financing

Policy “Resourcing Pathway to Universal Health Coverage” 2016, 2016). For government facilities, this fund subsidizes the operational funds allocated through a global budget. For Old Mutare and other mission hospitals that do not receive government subsidies, however, the funds generated from the HSF make up a significant portion of the hospital’s operational revenue. This means most of the financing for Old Mutare comes from funds generated from out-of-pocket fees for consultations and sales from medications and supplies. The population served by the hospital primarily funds the operations of the facility through out-of-pocket payments.

Purchasing: The Government of Zimbabwe (GOZ) is the largest purchaser of health services, purchasing most inputs, paying the health workforce through the wage bill, and purchasing essential commodities through the National Pharmaceutical Company (NATPHARM). Old Mutare specifically benefits from the pooled purchasing, and from the government paid salaries. Other than two missionary staff, a medical doctor and a nurse, all salaries are covered by the GOZ. The hospital also benefits from essential commodities from the National Pharmaceutical Company (NATPHARM). NATPHARM provides all medications free of charge for government-designated exempt groups, which include pregnant women, children under 5, people living with HIV and TB and citizens over the age of 65. Old Mutare is, however, permitted to sell some of the other subsidized commodities provided at a nominal price as part of their health services fund for the non-exempt groups.

Population Experiences in Paying for Healthcare

In addition to understanding how the healthcare system was financed, it was important to understand the current experiences of paying for healthcare from the population’s

perspective. To gain this contextual knowledge, study participants were asked about their personal experiences or that of their immediate family accessing and paying for healthcare. Through this question, we aimed to evaluate the experience of out-of-pocket versus other protective measures such as those provided to the population that is stipulated by government exemptions or those with private insurance.

The hospital runs on a fee-for-service basis with a consultation fee of \$10 USD paid by all patients upon arrival at the facility. This consultation fee does not cover the cost of medications and any additional diagnostics or procedures. Patients are therefore expected to pay additional funds to cover these costs. Populations with an exempt status from the government are expected to receive services for free, including the required medication. This, however, is not always the case as the stockouts of essential medications results in the hospital having to prescribe these medications for patients to purchase elsewhere, often at external pharmacies that require additional transportation costs.

When asked how patients pay for these services, the Medical Superintendent expressed that most patients do not have medical aid (health insurance) because they are coming from “farming communities or gold panners” (artisanal miner communities). As a result, these costs are passed on to the patient directly where they are expected to pay out-of-pocket.

An experience that highlighted the experiences of many residents regarding paying for health care was described by a farm worker who had recently delivered a baby at OMMH. The farm worker, like most of the participants, indicated that they were paying out-of-pocket for themselves or their family members to receive care at the hospital. The cost was almost always over the \$10 consultation fee mark, as they had to pay for

medications and additional services. Expenses were predominantly expected to be the responsibility of the patient. There were several payment mechanisms that were described by the participants, which through analysis were all encompassed within the out-of-pocket payment bucket. These were considered out-of-pocket payments as these were funds coming directly from the patient or their immediate family, without any prepayment mechanism to reduce the financial risk. Table 2 outlines examples of these out-of-pocket categories from data and below is a quote from the farm worker.

In 2023, when I was expecting to deliver a baby, the hospital required \$172 for the medical expenses: \$100 for the c-section and \$72 for the medication. I had \$60 that I was keeping from my day labor jobs of farming for other families (maricho) to cover the costs of my delivery. At the time I was leaving for the hospital, I borrowed \$50 from a friend and the rest I went to the farm where I was given a sick note. This is where the farm pays the money to Old Mutare Hospital, it only works at Old Mutare and then they will be taking some money from you monthly. This is not free because they will be holding money from your salary until all the funds are paid back. Fortunately, our farm manager was kind enough to provide me with a sick note. I was able to use the sick note to cover the remaining \$50 of the hospital expenses for the delivery of my baby.

Table 3: Summary of Patient Experiences

Current Patient Experiences	Code	Specific Payment Mechanism
I always keep money aside for medical expenses, but that responsibility is mainly done by us as mothers, because fathers don't care about saving money for health	Out-of-pocket	Personal savings
My family and I decided to come together and contribute financially. We all understood the importance of ensuring that we received the necessary medical care, and so we pooled our resources to cover the costs	Out-of-pocket	Contributions from family
When someone has an issue, they can go to microinsurance programs that exist and borrow from these schemes and then pay back at an interest	Out-of-pocket	Loans from family or microinsurance
We can send the bill to the farmer and some of the commercial farmers pay some funds to the hospital, which helps with the healthcare costs of those employed at farms.	Out-of-pocket	Loans from employer
A pregnant neighbor and they come without money and needed a c-section for \$150 and the husband did not have money and they had to bring corn to the health facility to pay for the services.	Out-of-pocket	In-kind payment
Patients who are unable to pay their bills in cash have the option to work at the hospital, performing tasks such as cleaning, gardening, or assisting nurses, in exchange for reducing their medical expenses	Out-of-pocket	Labor

The farmer, like many patrons at the Old Mutare, faced the financial risk of paying out-of-pocket directly when she received care. Others often deal with the long-term burden from repayment of loans from employers, friends and neighborhood microloan groups. Those burdened by these expenses include those in exempt groups like pregnant women and seniors above 65, who still have to find funds to pay for unavailable or uncovered medications and services.

Several of the accounts from the study participants noted the responsibility of families to contribute to paying healthcare costs in the case of a health emergency. As expressed in the following quote, these costs are also prohibitive to the family, which may not be in a

financial position to support these out-of-pocket expenses. Several resort to selling livestock or farm produce to cover these costs, affecting their livelihoods. For the very poor, who may not have access to grain or livestock to pay for their medical costs, payment in the form of labor at the hospital is expected, affecting their ability to work elsewhere, again affecting their livelihoods and placing them at increased financial risk. The following account describes these challenges that many patrons are facing.

We did not have money as a family. So we had to sell a cow that was left by the family when they died, but there kept on being several expenses, the person who had sold the cow did not pay us all the money upfront so we paid for what we had, but there were several tests,the hospital process took long and the person died without the help needed given and we were disappointed that we had sold the cow. The challenging process is that at the hospital they will tell you what is needed and although you have the cow, you must wait to get someone to purchase the cow, so you pay for medication. It was painful, that the person has died, the cow died also.

Other payment mechanisms that were shared were charity payments either from organizations, including FBO's or from personal notes from the chief or village head, who identify the indigent poor unable to contribute in any of the out-of-payment methods listed above. The most concerning of all the accounts were those who had to forgo care altogether due to lack of funds or social connections. The expression from the Medical Superintendent below describes how dire this situation is:

Some opt not to receive care altogether; we have a big burden of cervical cancer in Zimbabwe. So sometimes you may find a patient when we are doing cervical screening. They have identified lesions, which are small, and they haven't progressed to cancer yet, and if treated early, we can prevent progression of cancer. But maybe because of funding gaps someone does not have money to go, for further investigations or treatment and sometimes they may just stay at home with them because they don't have money. Then they come bac, after 2 years, and they have advanced cancer. So, if you have community health insurance sometimes you can do small things early, so that we avoid maybe a more serious illness, which will be difficult to treat maybe later.

Both the hospital financing structure and accounts from the study participants demonstrate the gap in healthcare financing in the Old Mutare community that place patients at increased financial risk when receiving care at the hospital. These necessitate strategies to protect the population from this risk. CBHI is a proposed strategy to address these gaps through protective risk pooling measures for the community.

To do this, however, the financing mechanism has to be accepted by the population. The following section shares the results of the application of the Adapted Cooperative Healthcare Framework, which aimed at measuring the readiness and acceptability of the Old Mutare community for a CBHI.

Analysis - Cooperative Healthcare Framework

I. Ability to Prepay for Insurance

The first condition for CBHI success, as assessed through the model, is the ability to prepay for healthcare. This is described by Hsiao and Yipp as people having the means to prepay for healthcare determined by the amount of funds that the population contributes towards healthcare each year. While specific data on how much each family was paying towards healthcare was not determined through empirical data as this was beyond the scope of this project, some inferences were made from the qualitative data about the ability to pay.



Figure 5: Residents' Ability to Prepay for Insurance

The population served by OMMH consisted of two groups: those who were formally employed, and the majority who were informally employed or unemployed[?]. The formally employed population included the teaching and hospital staff at the mission, and farm workers from the surrounding farms. The income of the civil servants and the farm workers was determined to be approximately \$300 and \$180 a month respectively. This indicated these groups had some means to contribute a nominal fee towards health insurance and most had done so in the past.

The informally employed groups primarily consisted of subsistence farmers and most recently a proliferation of artisanal miners in mines surrounding the mission. While the income of the subsistence farmers and artisanal miners could not be verified, an estimate of day wages was determined to be approximately \$5 a day. Although minimal, the population was earning some income that could be contributed towards pre-paying for CBHI. This information was supported by evidence where several participants reported

contributing to burial societies or other community financing schemes monthly. The comment below is a response from a community member who was informally employed, but was able to make several community financing payments, to a total of \$60 a month. Indicating that although a majority of the population was informally employed, they did have some means to contribute to financing schemes they deemed important.

At the burial society you pay \$5 to start and pay an additional dollar for every additional family member so I pay \$10. For the rukando² (microfinancing scheme) we pay \$20 each month and I pay I pay \$20 for the grocery group. Each month I pay as much as \$60 for various schemes.

Key Finding:

Most residents, regardless of employment type, demonstrated the ability to prepay for healthcare, contributing up to \$60 monthly to community schemes. Existing structures like village heads and in-kind payment systems offer pathways to design an equitable, inclusive CBHI with sliding scales and exemptions.

² Rukando is a form of microinsurance where individuals contribute to a pool of funds that the group lends to other community members at an interest. At the end of the year, profits from the microinsurance are shared among the members.

II. Determining the Stock of Social Capital

The Cooperative Healthcare Model stipulates that a stock of social capital that would enable communities to support each other is required for CBHI to be successful. For communities to harness the full stock of social capital required for effective community action such as CBHI, each of the seven aspects within the **Efficacy, Engagement, and Trust** categories should be strong. This next section of results addresses the research question: *What are some contextual considerations (enablers and barriers) to the establishment of community-based health insurance in the community served by Old Mutare Mission Hospital?* These considerations will be analyzed through the social capital lens, as outlined in the study framework presented in Figure 6.



Figure 6: Stock of Social Capital

Findings from study participants will be organized according to the three social capital categories: **Efficacy, Engagement, and Trust**. Within each category, the results will be further disaggregated by the **Barriers and Enablers** into the three types of social ties:

Bonding, Bridging, and Linking. Participant quotes will be used to illustrate each theme and provide concrete examples. In addition to identifying what could enable or hinder the establishment of CBHI, this section will offer recommendations on how the findings can be leveraged to guide community efforts. These insights aim to inform practical strategies for addressing identified gaps and supporting the successful implementation of CBHI. Accordingly, this section also responds to the second research question: What factors would influence the establishment and implementation of successful community-based health insurance in the communities surrounding Old Mutare Mission Hospital?

Below are brief definitions for each of the terms that will be presented in this section.

- i. **Enablers** describe the existing resources and activities the community is currently tapping into to increase the engagement that contributes to the stock of social capital.
- ii. **Barriers** highlight the challenges and limitations that hinder the community's ability to increase or tap into social capital.
 - a) Bonding ties – internally, between family, friends and close neighbors
 - b) Bridging ties – intercommunity, between other communities and,
 - c) Linking ties-externally with organizations and other entities connected to communities

A full analysis of the Enablers and Barriers to social capital, broken down by each of the three categories, efficacy, engagement and trust are provided in Appendix 5.

Category 1: Efficacy

Unlike the Engagement and Trust categories of the social capital framework, Efficacy is not divided into Bridging and Bonding and Linking aspects. In contrast, Efficacy is an all-encompassing altruistic belief held by residents within a community that they can make a difference. Results of the enablers and barriers of efficacy in the community are shown below.

Table 4: Efficacy -Enablers and Barriers

Social Capital	Efficacy	<p><i>Enablers</i></p> <p><i>Community Adaptation to past challenges shapes people's belief in their ability to make a difference</i></p> <p><i>Past examples of community response shape belief in collective efficacy</i></p> <p><i>Belief in a community's collective strength enhances its sense of efficacy</i></p> <p><i>Viewing the community as family reinforces the responsibility to support one another</i></p> <p><i>Recognition that community responsibility extends to supporting one another in health, sickness, and tragedy</i></p> <p><i>Recognizing that community resources extend beyond cash, including livestock, fosters mutual support</i></p> <p><i>Influence from other communities on social media inspires similar actions</i></p>
	Residents believe they can make a difference	<p><i>Barriers</i></p> <p><i>Belief that reliance on external support weakens community efficacy</i></p>

Enablers

When responding to questions about their belief that individuals and the community could make a difference to address financial risk, the response was a resounding yes among most of the participants. This belief stemmed from experiences where the community came together in response to a shared challenge that they were able to overcome together. The example of COVID-19 was still fresh on many participants' minds. The COVID-19 example also demonstrated a theme of efficacy as an adaptation

to past challenges. “We have been helping each other since COVID-19”, one participant noted, recognizing the ongoing community actions to make a difference in other areas.

Such examples could be leveraged in mobilization strategies for CBHI.

Efficacy was also linked to the belief in the community’s collective strength, where there was recognition that there was strength in numbers. A key enabler for CBHI as the success of the program would depend on community wide enrolment to allow cross subsidization among rich and poor, sick and healthy to ensure effectiveness and sustainability. Such beliefs, when used as examples would also address early concerns of adverse selection in a CBHI program.

The recognition of the diversity of resources within the community was also identified.

While cash payments may be the primary source of payment, recognition of the value of other resources which include agricultural supplies and livestock, contributed to the individual’s belief that they could make a difference. A quote from one of the participants demonstrates this efficacy

People pay to support this program; if they don’t have money, they will sell their livestock they have to pay. People can sell a chicken or a goat to pay the fees, people will find the small fee like \$2.

Barriers

Despite the several enablers identified, a barrier hindering individual and community agency was reliance on external support. This was based on evidence from the farm workers group who only connected their efficacy in a health initiative to the involvement of the farm owner. In response to their ability of a community to come together in a community financing program, one of the participants commented, “I think what would

be best is to speak to the farm owner to look for another health insurance as he had done at Eland”. Although this identified the farm owner as a key stakeholder to engage for buy-in from this specific group, it also highlighted potential challenges in efficacy within this group, if the farm manager was not involved. Efficacy requires a group to believe they can make a difference within themselves.

Efficacy - Key findings: Residents demonstrated a strong sense of collective efficacy to support a CBHI scheme with perceived ability to contribute, whether financially or in-kind. Some, like farm workers, remain dependent on external actors for health initiatives, which could be a hinderance as efficacy requires a group to believe they can make a difference within themselves.

Category 2: Engagement

The **Engagement** category will now be examined through the three dimensions of social capital: **Bonding**, **Bridging**, and **Linking** ties. This breakdown will help determine how each layer of social interaction may either support or hinder community organizing efforts around community-based health insurance (CBHI). A summary of the identified enablers and barriers related to engagement is presented below, followed by a detailed analysis of each dimension.

Table 5: Engagement: Enablers and Barriers

Social Capital	Engagement	Bonding	<p>Enablers</p> <p><i>Engagement based on previous experiences of communities organizing for shared benefit</i></p> <p><i>There is a responsibility to family and engagement is based on identification as family (brothers and sisters)</i></p> <p><i>There is a strong responsibility to supporting neighbors in times of trouble, particularly those that people have close interactions with</i></p>
			<p>Barriers</p> <p><i>Engagement as reaction to tragic events; sickness is not recognized as important to activate this social capital aspect</i></p>
		Bridging	<p>Enablers</p> <p><i>Ongoing interaction fosters trust and lasting community bonds beyond any single program</i></p> <p><i>Communities support each other with the understanding that circumstances can change, and those who give today may find themselves in need tomorrow</i></p> <p><i>Tragic events can unite communities, sparking engagement and driving development initiatives</i></p>
			<p>Barriers</p> <p><i>Limiting responsibility to tragic events can hinder ongoing community engagement</i></p> <p><i>Individualism exists that can hinder community support</i></p>
		Linking	<p>Enablers</p> <p><i>People engage more in health initiatives when connected to organizations</i></p>
			<p>Barriers</p> <p><i>Organizations may be perceived as the sole avenue for engagement by some (those already associated with formal organizations – farmers, teachers) hindering community led initiatives</i></p>

Bonding: Residents with a common social background engage with each other

Enablers

First, we assessed enablers associated with the individuals closest to the participants. The strong sense of responsibility for family and kin folk, especially in times of need, was associated with increased engagement. When describing their engagement as a responsibility to their immediate family one participant noted. *“For my family I will pay freely, if have family that is my responsibility and if I have the money I will pay.”* This

bonding network extended to close neighbors and close friends. As described in the following comment, the association of neighbors and communities to the family structure, contributed to unlocking the agency to engage.

If there is a spirit that people will say, my community is also my family, that will push people to sacrifice and contribute to others, because we will want to support each other. When you get into trouble yourself you will need your next-door neighbor, so it is support each other.

Positioning the community and members with a CBHI as part of larger family network, could support in further unlocking this beneficial bonding social capital during member mobilization.

Barriers

This sense of responsibility beyond the family unit, appeared to be strengthened during emergencies or tragic events. While this ability to engage with family and neighbors was identified as an overall enabler of the stock of social capital in the community, reaction as a response to crisis is a barrier to the proactive engagement needed to fully harness social capital. For CBHI to work individuals should be willing to engage and support one another without activation from a tragic event or crisis. Prepayment for health would require all to contribute even when themselves or neighbors are not in a medical emergency. Expanding the sense of responsibility to neighbors and community beyond tragedy to maintaining health will therefore be important to increase this bonding social capital. A participant recommended: “People are doing it, but people are just not educated about health. What people know about are funerals, but we should say we can help each other before people die.” Education of the population on how insurance functions and

connecting prepayment for healthcare to this sense of responsibility to support one another will be important during early stages of community engagement.

Bridging: Residents with different social backgrounds engage with each other

Enablers:

The importance of social interactions was highlighted as instrumental to engagement among groups from different social backgrounds. Ongoing interactions were highlighted with engagement that would lead to social action. A participant shared an example of a community group connected on the WhatsApp social media platform. The group maintains communication throughout the year and often serves as a platform for trade among the members. This network has also been used for community contributions to support members in times of need. The existent WhatsApp groups already organized around other social initiatives may be relevant in the early stages of mobilization of a CBHI.

Barriers

Individualism was identified as a barrier, particularly among the younger focus group participants. Some expressed that they do not feel a sense of responsibility toward the larger community and would prefer to use their meagre resources on themselves. This is important as the participation of young people in a risk pool would be necessary for cross-subsidization. Youths are often healthier and higher income earners among community groups. Specific strategies targeted towards motivating the younger population to be engaged will be critical. This could be connected to creating opportunities for ongoing interaction as cited in the comment below.

I think for this to work, I think people need to get to know each other. I think people could gather maybe once a year so they can get to know each other, maybe at a festival. That way if they know each other, they are more willing to support each other. For example, the events when the elderly have parties where they get food hampers. So, if we have these festivals, we get to know each other and would be more trusting to appoint a person as a treasurer.

Linking Residents engage with organizations and systems

Enablers

People were more inclined to engage with initiatives that were associated with trusted organizations that had structures in place to oversee the management of the initiatives. Some organizations that were identified in this specific context included local religious organizations, like the UMC and, specifically, the women's groups in these organizations, like the RRW in the UMC. Identifying and engaging trusted organizations in the early stages of CBHI design will be critical in harnessing linking social capital for CBHI.

Barriers

Overreliance on organizations could hinder the advancement of community-led activities like CBHI. For example, the farmers' focus group participants unanimously agreed that they do not trust anyone in their community to lead the program and would only engage in health financing initiatives if their farm owner was involved and would select health insurance for them. One participant noted, *"I would trust people to contribute if money is being withheld at work but for people coming to give money directly, I do not think it will work."*

Considering that community control and management of funds has been identified as being essential to the success of community financing schemes like CBHI, it will be important to balance meaningful engagement with organizations, while ensuring that the

communities maintain their leadership and oversight of the CBHI programs. This was expressed in the recommendation provided by one of the participants.

Engagement - Key Findings:

- **While strong bonding ties reflect a community willing to engage around shared needs, engagement often hinges on crises. Expanding the sense of responsibility to community beyond tragedy to maintaining health will therefore be important for prepayment to be successful.**
- **Ongoing social interactions foster engagement; this could also form a sense of belonging and counter the individualism identified as a barrier among youths.**
- **WhatsApp platform was identified as encouraging engagement in addition to physical interactions.**
- **Trusted Organizations, such as women's groups with transparent accountability structures could foster engagement and encourage mobilization.**
- **Overreliance on organizations may undermine community-led ownership; organizations can be involved, but communities should maintain their leadership and oversight of the CBHI programs**

Category 3: Trust

The **Trust** category will now be examined through the three dimensions of social capital: **Bonding**, **Bridging**, and **Linking** ties. This breakdown will explore how different forms of trust—within groups, between groups, and with institutions—may influence community willingness to participate in and support community-based health insurance

(CBHI). A summary of the key enablers and barriers related to trust is presented below, followed by a detailed analysis of each dimension.

Table 6: Trust - Enablers and Barrier

Social Capital	Trust	Bonding	<i>Enablers</i> <i>Established, trusted relationships are crucial in shaping program leadership</i>
		Residents with a common social background trust each other	<i>Barriers</i> <i>Trust lies with known community members, not outsiders and perception of some being outsiders may inhibit trust in group</i>
		Bridging	<i>Enablers</i> <i>Experience with past community programs and established accountability structures</i> <i>longstanding relationships and position in community</i> <i>Trust in community oversight</i> <i>Belief in the majority to act rightly</i>
		Residents with different social backgrounds trust each other	<i>Barriers</i> <i>Past negative experiences with community initiatives erode trust</i> <i>People hesitate to trust leaders who take on multiple roles</i> <i>Fear of misuse and moral hazard threatens trust in pooled-risk programs and should be addressed</i>
		Linking	<i>Enablers</i> <i>The church is valued for its resources, financial support for the poor, administrative capacity, and ability to mobilize communities</i>
		Residents trust organizations and systems include UMC	<i>Barriers</i> <i>Fear of bureaucracy, inexperience, and the UMC Church's capacity to manage the program</i> <i>Mistrust in leadership capacity due to past experiences and known corruption within the church</i> <i>Unclear role distinction between the church and the CBHI program with stronger leadership from the community</i> <i>Past negative experiences with medical aid societies, leaving individuals with costly shortfalls</i> <i>Fear of transparency issues and favoritism</i> <i>Trust lies in organizations with established financial management systems</i>

Bonding: Residents with a common social background trust each other

Enablers

There was a tendency of individuals from common backgrounds to trust each other based on longstanding established relationships. This was not surprising as trust is often built on relationships. This was important when managing funds in community initiatives. When commenting on their level of trust of other individuals from similar social backgrounds a respondent shared: *“When it comes to who holds the money in our neighborhood account, we do not approach it from doubt..... I have never been afraid to share the money with the treasurer.”* Leveraging this stock of social trust based on longstanding relationships will be important as considerations are made on how CBHI funds are managed.

Barriers

Unsurprisingly, identification of individuals as outsiders was a barrier that hindered trust as it pertained specifically to leadership of the program. Efforts should be made to ensure that the individuals placed in leadership roles of the CBHI are ones that the community identifies as trusted individuals. External support, from the UMC for example, should be there in a supportive role of trusted community members and not leaders.

Bridging: Residents with different social backgrounds trust each other

Enablers

Bridging trust among people from different backgrounds was strengthened through the experience participating in past community organizations, particularly those that had

clear accountability structures in place. The accountability that existed through having defined leadership roles such as a board treasurer and secretary, for example, contributed to the participants' confidence and trust in other individuals, leading them to follow group guidelines required for the success of community initiatives. A participant commented, *"All that is needed is for the program to be organized and people will pay their monthly subscriptions,"* This indicates that the CBHI program should prioritize clear accountability structures in program design. This will strengthen trust needed at the mobilization stage. CBHI could also benefit from making reference to examples of these positive experiences while garnering community support.

The study participants expressed how having an individual of good character would increase their confidence in enrolling and paying their contributions. Village headmen and village health workers (VHWs) were identified by all groups as trusted individuals to be involved in the leadership or in an advisory role of the program. Individuals who work across different social communities, including village heads and village health workers, should be considered for early leadership roles as they will support in unlocking bridging trust social needed for effective member mobilization for the CBHI.

Barriers

The largest barrier was the participants' previous negative experience with community initiatives that required monetary contributions. Previous experiences with community fundraising initiatives such as burial societies and microfinancing programs contributed to the stock of bridging social capital in the community. Such experiences could pose a serious threat during mobilization due to eroded trust. One participant shared,

We tried it with a burial society, but it did not work in the larger community, those who understood came together and supported each other but mistrust in the larger community prevented it from taking off at a larger scale.

CBHI organizers should consider the possible negative effects of past community financing initiatives on trust and ensure these barriers are addressed to increase the trust social capital needed for effective enrollment.

The dangers of moral hazard were also identified as a barrier, where some individuals would take advantage of the CBHI program through overconsumption by unnecessarily seeking healthcare. Some community members were concerned that funds would not be available when they needed them, deterring them from enrolling in the CBHI. Clear guidelines to prevent overuse should be in place, to strengthen the bridging trust aspect.

Linking: Residents trust organizations and systems

Enablers

When it comes to the community's trust in the United Methodist Church, the organization's values and strong commitment to helping others in need were highlighted as contributing factors. The resources that the church could contribute to a CBHI initiative was another enabler of trust. These resources were in the form of finances to support implementation or provide subsidies for the poor. The church was identified as being able to provide resources in the form of training and capacity building for administration of the program. The role of the church in building trust through its ability to mobilize people for the CBHI initiative given the large UMC membership in the community was also highlighted.

The resources that the UMC or other organizations can contribute to the CBHI should be highlighted and leveraged to foster the trust needed for the larger community to engage in the program.

Barriers

Concerns were raised regarding the lack of capacity of the UMC to run a health insurance program. A participant shared “Let it [the CBHI program] be run separately and professionally,” alluding to the lack of relevant capacity of the church to run the program. Concerns regarding bureaucracies and competing priorities were also raised as potential barriers to trust in the program, particularly under UMC leadership. These were also associated with having unqualified individuals running the program, with the possibility of having clergy in key leadership roles as a key concern prohibiting trust in the community. The comment below demonstrates how the lack of trust in the leadership of clergy from the UMC could deter community trust in the initiative.

“In the UMC we do not have accountability, because we have put clergy in leadership and people do not want to be accountable to the clergy..... Many church initiatives have failed by putting clergy in charge.”

Clear differentiation of roles between church and CBHI activities will be required to strengthen the trust of the community’s trust of the UMC as an organization. This includes assuring community members that qualified representatives of the UMC would lead the initiative, separate from the church leadership structures.

Other than the UMC, the negative experiences that participants had with private health insurance contributed to the general level of mistrust in organizations. Several participants had previous experience with insurance plans not reimbursing for services.

Additionally, the concern of high cost sharing due to shortfalls that many experienced was another deterrence. Participants who had also experienced rejection of their policies at the point of care by several healthcare providers, including Old Mutare Mission Hospital due to low reimbursement from insurance companies, were also mistrustful of insurance programs. These experiences with mistrust in private health insurance posed a significant threat to the establishment of CBHI.

Educating the community on how the non-profit community managed CBHI, would differ from profit-focused private health insurance would be critical to address this barrier and increase trust in the early stages of CBHI membership mobilization.

Trust - Key Findings

- **Communities will be more trusting of individuals with longstanding relationships and are more likely to place them in leadership roles; however, the involvement of outsiders in key positions can undermine that trust and hinder progress.**
- **Trust is built through positive experiences in community-led initiatives with clear organizational structures, while negative experiences could severely hinder success. CBHI programs should reference successful initiatives; while addressing concerns of the negative experiences and how clear organization and accountability will be prioritized to ensure success.**
- **Engaging trusted individuals of integrity, such as VHWs and VHs, early can build community confidence and trust in the initiative.**

- **Organizations like the UMC were trusted for their values and commitment to supporting those in need, as well as for tangible resources that could be leveraged for CBHI such as training, broad membership, and financial support.**
- **Concerns were raised about religious organizations with limited capacity taking over financing schemes, as well as organizations appointing unqualified individuals to leadership roles; differentiation of roles will be critical.**

III. A Scheme That is Valued and Trusted by Residents

The final application of the Adapted Cooperative Healthcare framework is to determine that the community would value and trust the services provided through the proposed CBHI model. Given that this model would primarily be associated with the Old Mutare Mission Hospital, the framework was applied to assess the community’s perceptions of the current services provided at the Old Mutare Mission Hospital. This included the availability of quality services such as primary healthcare and medical supplies.



Figure 7:Scheme that is Valued and Trusted by Residents

Enablers to community value and trust in Old Mutare Mission Hospital

The perception regarding the quality of services at Old Mutare as it related specifically to the physical infrastructure was positive. The UMC has made significant investment in infrastructural revitalization as well as the purchase of medical equipment and supplies to improve the service delivery at the health facility. One such improvement in the past 10 years has been the construction of a waiting mothers’ shelter, where expectant women,

particularly those with high-risk pregnancies are accommodated at the facility until they deliver their babies. The focus group from the mothers' shelter collectively agreed that they were pleased with the services provided at Old Mutare. This included the accommodation as well as the treatment they received from the staff during their perinatal period. The value that these services bring was demonstrated through the women choosing to deliver at Old Mutare where they would pay up to \$172 dollars for a c-section over a government facility, where they could receive these services for free. The UMC should continue investing in ensuring the availability of updated infrastructure and equipment as this will increase the value of the community in the quality of care at the health facility.

Barriers to community value and trust in Old Mutare Mission Hospital

The updated infrastructure was not sufficient for the community to express their full confidence and trust in the services and quality of care provided at Old Mutare Hospital. One of the most significant gaps identified at the facility was irregular supply of medications and supplies at the facility. Participants also expressed concern about the absence of other essential diagnostic capacity such as an ultrasound at the facility. Many patients were concerned about consulting external providers to conduct diagnostic tests that were not offered at Old Mutare, adding additional transportation costs along with high costs for these services. They found hospital consultation costs unjustified without comprehensive or one-stop essential services. The \$10 USD consultation fee that OMMH charges was also reported as prohibitive by most participants. some participants noted was out of the reach of many residents.

Mistrust in the transparency in pricing of services at the hospital was also a concern, particularly among the hospital committee. This group that is tasked in community oversight of the facility, noted that they were not involved in the decision to increase the previous consultation fees from \$5 to \$10.

Along with gaps in operations and management of the facility affecting the availability of medications and provision of basic package of care. The participants also expressed concerns about the quality of services provided at the hospital. One prominent concern was with the responsiveness of the staff to patients, demonstrated through long waiting times. The comments from the participants below indicate how responsiveness of care is affecting the community's value and trust of health facility. One participant noted,

The issue at Old Mutare is the delay in being attended to as a patient. You can spend a long time waiting to be attended and if you come during lunch or are there is the queue, you will have to wait until they finish having lunch.

Old Mutare has low services and is not quick to provide assistance to people as compared to other hospitals.

All the challenges listed above indicate gaps in operations and service delivery at Old Mutare Mission Hospital, indicating that in its current state the community does not fully value and trust the Old Mutare Mission hospital. If not addressed, rapidly the barriers listed above could significantly hinder the establishment and success of the CBHI.

These concerns, however, provide some directions on how the operations and service deliver at OMMH can be strengthened to increase the confidence of the population in the services provided. Ultimately, increasing acceptability of a tentative CBHI tied to this

facility. Some recommendations on how to address the concerns regarding OMMH are provided in the discussion section.

Key Findings:

- **The community members value the improved infrastructure and maternal services at Old Mutare Mission Hospital**
- **However, significant gaps through irregular supply off medications, insufficient diagnostic capacity, service responsiveness, and transparent pricing undermine full trust—posing a risk to CBHI acceptability unless addressed through operational and service delivery improvements**

Discussion

Significance of Study

The experiences paying for healthcare paint a grim picture of the gap in protective health financing structures in the community surrounding Old Mutare Mission Hospital, a reality affecting many across Zimbabwe. The reliance on close family, friends, and neighbors to lend support during a crisis or the accrual of individual debt are not sustainable measures.

Unfortunately, this reality has led many to forgo care altogether, necessitating alternative protective measures. Through its risk pooling mechanism, CBHI provides an immediate reprieve to individuals and communities, who are otherwise at risk of the impoverishing and catastrophic effects of health expenditures.

The primary purpose of this study was to assess the acceptability of a CBHI in the Old Mutare community to ensure this early buy-in for the proposed programs viability. Evidence gathered suggests that CBHI would indeed be acceptable in the community surrounding Old Mutare Mission Hospital. So much so, that a community group met to establish a CBHI after learning about this community approach through the focus group discussions.

Along with the overall acceptability of the initiative, this study aimed to assess how initial demand would be sustained and whether an FBO could lead the process of establishing a CBHI in the community. The UMC, through its affiliation with Old Mutare Mission Hospital, was positioned for this community organizing role. Unexpectedly, the results from this study indicated resistance to the UMC taking on the leadership in the proposed CBHI initiative. The study therefore highlights barriers to success that UMC and other FBOs would need address to successfully support CBHI implementation.

The key learnings from the study share insights into factors that would enable wider acceptability and establishment of a CBHI in the Old Mutare Community. This includes recommendations on how the community could best harness the social capital that exists, by either leveraging the strengths identified through the enablers or addressing the challenges highlighted through the barriers.

Key Learnings

1. Community out-of-pocket payments present an opportunity to pool funds into protective risk-sharing mechanisms.

Evidence from the study indicated that most people pay out-of-pocket for healthcare, despite their employment status, showing there is some ability to pre-pay, an important requirement for a successful CBHI scheme. The community also had systems in place through the village head to ensure the very poor receive free care at the hospital. This was encouraging, as these structures could be leveraged to identify those most at need within the community for exemptions and inform the development of a sliding scale within a CBHI program. While the population pays for healthcare, the costs—ranging from \$30 to \$50 per visit due to medication and examinations—are prohibitive, with some resorting to payment through livestock or grain.

Some considerations to make while designing the CBHI risk pools could include creating risk pools that will be attractive to both formally and informally employed residents. For example, for the formally employed, a guarantee that the CBHI would prevent the shortfalls they previously experienced through private health insurance. There should be systems in place to accommodate in-kind payments in the CBHI, as this payment modality has been accepted at OMMH.

The mechanisms could include utilization of existing systems, including the village head, to identify those in extreme poverty for premium exemptions and support in establishing an equitable sliding scale that organizations such as the UMC could support with funds.

2. Trust could be the greatest hurdle towards harnessing the social capital in the community and initiatives to strengthen trust across communities should be prioritized.

The category with the most barriers outweighing the enablers was trust. For the financial risk associated with seeking care to be effectively shared, community members must trust that others will participate by contributing their share.

Priority should be given to rebuilding trust in the community that has been undermined by earlier failed social initiatives. Community organizers must not overlook these initiatives. However, it will be important to identify some of these barriers to trust through early community conversations such as this study. Then include deliberate control measures within the design to address some of the challenges that led to the failure of these social initiatives. This would reassure the community that the CBHI would not be run in a similar manner, and this would be communicated during early engagement.

Transparent oversight and leadership mechanisms should be in place to assure the public of the initiative's integrity. Given the emphasis on the importance of an individual's character in building trust throughout the study, identification of the trusted individuals within all communities will be required. These individuals can be engaged early to facilitate other education and mobilization strategies, including reassuring the community on the integrity of the program. Two individuals that were repeatedly identified during the discussions were the village head and village health worker.

Individuals with multiple competing responsibilities should not be assigned demanding roles within the CBHI leadership structure. Leadership appointments should be based on technical and adaptive skills, with clear role differentiation to ensure public confidence.

3. FBOs like the UMC can strengthen community confidence in CBHI initiatives by building trust through clarity of roles and contribution.

The most salient barriers to trust identified were linking barriers and how mistrust associated with organizations and systems could hamper the establishment and success of CBHIs. One such organization was the UMC which was proposed as the organizer of the CBHI program.

Resistance towards the UMC was based on its role as a religious organization which many felt made it inappropriate for taking on the ultimate leadership role in a community initiative.

Despite this resistance, the resources and strengths that the UMC and other organizations could contribute to a CBHI initiative were also identified as enablers. The considerations in strengthening the trust in the UMC are therefore based on leveraging the organization's strengths. This includes clear articulation of the role that the UMC would take in the initiative — one of facilitator and co-creator within a shared leadership structure alongside the community.

The UMC would therefore not be the ultimate provider and outright leader of the CBHI.

Ensuring clear differentiation of religious activities from community organizing activities will be necessary during early engagement stages in the CBHI. The UMC, like several FBOs, has a separate development branch that runs their health programs, with a designated office that functions like a non-profit rather than a religious entity. These non-profit arms of religious organizations which often have clear financial management structures and technical capacity in health systems are best positioned to support the community in their CBHI process.

Leveraging resources the FBO offers can contribute to building trust and garner support for the CBHI. For the UMC these can be the technical capacity to facilitate the early organization and mobilization of stakeholders. FBOs can also provide human resources to support with early administrative tasks of the CBHI in a supportive role as the program is being established. FBO's

also have connections to financial resources, through grant funds that could offset early expenses, or subsidization in the program implementation.

4. Investment in strengthening the bridging ties between individuals from different community groups is crucial

The strong bonding ties between close family and friends' units will not be sufficient to unlock the social capital that is necessary for social action through the proposed CBHI. While these bonding ties have allowed people to *get by*, they do not allow for the larger risk pools that would protect the family units from health-related financial costs, especially in unexpected medical crises – *getting ahead*.

What the communities need is to couple the strength of these bonding ties with investment in strengthening the bridging ties, between communities where residents of different social backgrounds come together for social action.

This could be done through creating opportunities for interaction and relationship building within the community for people from diverse backgrounds. The health committee at Old Mutare Mission is an example of a diverse group coming together to provide community governance and accountability structures for the facility. Each representative could support by creating opportunities for wider community interaction. Town halls or community festivals, proposed as a recommendation by one of the younger participants, could foster this interaction.

5. The CBHI should be positioned as valuable for all

Old Mutare is made up of diverse community groups whose perceptions of the utility of a CBHI program vary. Some who previously had private health insurance like the farm workers may prefer such an arrangement. While some individuals immediately recognize the value of a

CBHI, the program faces the risk of adverse selection—where primarily older and sicker individuals enroll. This can threaten the sustainability of the scheme. To ensure long-term viability, it is critical to promote wider enrollment by ensuring that diverse community groups see clear value in participating. The following strategies can help strengthen value creation and encourage broad-based participation:

The CBHI design should reflect the diversity of the community served by Old Mutare Mission Hospital. Younger and healthier individuals may not perceive immediate value in the program, which could negatively impact its sustainability. To engage this group, the scheme should incorporate health promotion and preventive care services, which offer tangible benefits and encourage long-term participation.

Village Health Workers (VHWs) emerged as highly trusted individuals across all focus groups and interviews, highlighting their vital role in the community. Their significance is further underscored by cases where local farms have employed VHWs as regular staff to provide basic primary healthcare services. Embedding a VHW or Primary Health Care nurse within communities as part of the CBHI program could offer dual benefits: enhancing program appeal and encouraging broader enrollment by providing regular preventive wellness checks and participation in health promotion activities. Over time, it could also generate cost savings by preventing diseases or enabling early detection, thereby reducing the burden and expenses associated with advanced illnesses on healthcare facilities

6. Leveraging partnerships strategically and early will support acceptability of CBHI

Evidence shows that due to low enrolment and retention rates, community-based health systems do not have the capacity to increase the total amount of funds to finance universal equitable

healthcare access as the systems consist of largely poor populations who do not have the means to support their comprehensive health needs (Hsiao, 2001). Support through subsidies from the government and other donors would be necessary to ensure inclusion of the poorest households who may not be able to pay even a minimal prepayment premium (Hsiao and Yipp, 2023).

Additionally external partnerships could support the CBHI with building capacity of the community members in effective management and accounting of the program. Skillsets that other CBHI programs have relied on the government to provide. While in their infancy, proposed CBHI programs may not have the full support of the government and will need to tap into the support of other partners. Their effectiveness in leveraging these partnerships to establish a well-functioning CBHI could provide growing evidence to convince the government to invest in such programs.

It will therefore be important to identify some of the key partnerships from this early engagement with the Old Mutare community and clarify each partner's role, how they could best be leveraged for the success of CBHI. The partnership analysis matrix presented in Table 7 analyzes the role of three key partners. While this list is not exhaustive, it represents some of the influential groups that could support the program's successful establishment.

These motives and values could be used in early engagement with the partners to encourage their buy-in. Their early participation in and commitment to the CBHI program would support the demand-creation and acceptability of the program from the larger population.

This strategic engagement may involve other key stakeholders who may not be associated with an organization. The local Member of Parliament (MP) was identified as one such stakeholder. In a political community, the association of a program with the opposition party could discourage

some people from participating. Having the MP from the ruling party endorse the program as one that is neutral and beneficial for all would be helpful.

7. Ensuring that services provided at Old Mutare Mission Hospital are valued by the community is a critical step toward securing community buy-in

One of the key partners in the partnership matrix is the Old Mutare Mission Hospital (OMMH). The program will not be valuable if it is not connected to an efficient delivery system that provides quality services (Hsiao and Yipp, 2023). The general perception of the quality of services at Old Mutare Mission Hospital was sub-optimum, indicating that the community does not value and trust the services at Old Mutare Hospital in their current state. The irregular supply of medications that has led several patients to incur additional costs as they travel to get these basic essential medications, has left many dissatisfied with the health facility. This was exacerbated by a high consultation fee of \$10 USD. The chronic unavailability of essential medications and supplies also led the population to question the management of the health facility, with suspected corruption and mismanagement of funds.

Along with these gaps in operations, the population was dissatisfied with the responsiveness of the care. Many reported long wait times at the health facility, a significant concern for informal workers, due to the opportunity cost of seeking care, leading to potential lost revenue.

Improving the efficiency and quality of services at Old Mutare will improve the confidence of the community in the health facility, which is imperative to ensure the acceptability and success of a CBHI. A list of recommendations of some actions that Old Mutare Hospital can take to improve how the community values and trust in the health facility as their primary healthcare provider for a CBHI program is provided in Appendix 7. These steps, which include conducting

a hospital capacity assessment and working on a transparent improvement plan that involves the hospital community board will be critical. This along with immediate measures to address shortages in medication supplies and a clear business plan on how the CBHI funds will be managed while ensuring operational efficiency will need to be reported back to the community with regular updates.

Table 7: Partnership Analysis Matrix

	UMC	Old Mutare Mission Hospital	Neighboring Farms
Motive	<ul style="list-style-type: none"> -Aligns with UHC goal of church - Increases access to quality health services to population -Addresses sustainability challenge at mission hospitals - Opportunity for enrolment of wider church membership in the greater Mutare area 	<ul style="list-style-type: none"> - Improving health outcomes through increased access to care -Sustainability - Addresses challenges in equitable care -Expanding services to larger population -Guaranteed cashflow 	<ul style="list-style-type: none"> - Healthier workers -Workforce motivation -Cost savings from preventative care
Resources	<ul style="list-style-type: none"> - Large membership - Human resources -Financial resources through membership and global philanthropy -Capacity in financial management - Capacity in Health Systems Strengthening to improve the health facility 	<ul style="list-style-type: none"> -Healthcare facility -Connection to other FBO networks, UMC network to access capital improvements -Access to government health workforce, could request for more if needed 	<ul style="list-style-type: none"> -Financial resources - Organized workforce for voluntary deductions from salary -Experience with insurance schemes to support with demand creation
Roles	<ul style="list-style-type: none"> -Facilitation of early acceptability discussions - Operational support computer and accounting training -training and support for community interventions VHW (bike etc) - Financing - subsidizing CBHI program with annual grant -Documentation for training and replication in other communities -Support in improving service delivery at hospital (capital improvements, equipment etc.) -Investing in revolving drug funds 	<ul style="list-style-type: none"> -Shared development of equitable price scale - Ongoing quality improvement strategies to ensure responsive care -Hosting community gatherings and meetings -Support in supply chain management to ensure ongoing supply of medications and supplies 	<ul style="list-style-type: none"> -Subsidizing CBHI program with annual contribution - Representatio n in CBHI leadership

Next Steps

The acceptability study, which was the first of its kind within this community and possibly across the nation, underscored the demand for CBHI and the role that FBOs can take to make this a reality. By involving the community in preliminary conversations, we were able to gain valuable insights to inform the success of such a CBHI. This includes the role the UMC should take as a facilitator and not leader of this initiative.

The Cooperative Healthcare Model emphasizes the importance of experimentation (Hsiao and Yipp, 2023). This acceptability study is therefore a catalyst in this experimental process. To maintain the momentum from this study, demonstrated by the community initiative beginning the establishment of a CBHI, we propose the following next steps including the responsible people/ organizations to facilitate each step.

Table 8: CBHI Community Engagement & Reporting

Task	Description	Responsible Person/Group
Community Report Back	Share findings from the CBHI acceptability study, including identified enablers, barriers, and recommendations. These will inform leadership selection, CBHI design, and accountability structures.	Research Team & UMC
Further Community Engagement	Conduct focus group discussions with additional key groups such as artisanal miners, parents of mission school students, and African University students. Their feedback will inform the final community report.	Research Team & UMC
Key Stakeholder Engagement	Engagement with potential partners such as commercial farmers, miners, and Old Mutare Hospital Administration to reflect on their potential roles in the CBHI before larger community-wide discussions.	Research Team
Detailed UMC Report	Submit a detailed report to the United Methodist Church with recommendations on their facilitative role in the program, including participation in group and stakeholder engagements. And their role with supporting quality of care improvement at Old Mutare Mission Hospital	Research Team

Conclusion

CBHI is not just an option, it is a critical need in Zimbabwe's pathway to UHC

This research comes at a time when Zimbabwe, like many countries around the world, is facing the financial crisis of reduced external donor funding due to the US government aid freeze.

Donor funds contribute up to 19% of the healthcare financing. If reduced, these funds are at risk of being transferred to the already burdened individual out-of-pocket payments that the majority of the population has been paying. Evidence from the study indicated that even special groups with government provisions exempting them from paying for health services such as the elderly, were paying out-of-pocket for healthcare due to shortages of essential medications for chronic diseases and lack of access to diagnostic services. A situation that only stands to be exacerbated in the current climate.

While the government has put measures in place towards increasing domestic resource mobilization to lessen the financial burden on the wider population, these measures are far from adequate. As it is, there is no clear feasible pathway towards achieving universal health coverage in the country. With the current plans, there will be no reprieve for the majority informally and unemployed population. An alternative financing measure is therefore a necessity. Given the large informally employed population that is already paying out of pocket for healthcare, CBHI will be the most feasible pathway to UHC for the country. With its ability to access and raise funds through voluntary pre-payment and pooling through organized community groups that could govern how these funds are efficiently used for maximum benefit, CBHI is the most viable option in Zimbabwe.

CBHI also provides additional benefits as it creates systems that the government can later integrate or leverage for voluntary prepayment for national scale-up efforts. CBHI also presents an opportunity to improve service delivery and health outcomes, particularly through strengthened preventive and promotional health activities. These foundational systems not only support financial protection but also lay the groundwork for a more resilient and inclusive health system.

Acceptability studies can position emerging CBHI programs for success

Ensuring that the capital of the poor, the under tapped social capital is effectively leveraged for CBHI has been the goal of many studies. This study provides additional insights on how this resource can best be harnessed, by centering the communities themselves at the early stages of CBHI establishment. Through rolling out an acceptability study such as the one conducted in Old Mutare, CBHI facilitators can garner context specific insights, learning from both the enablers and potential barriers of CBHI early in the process. The acceptability study builds on Hisao and Yipp's encouragement for communities to experiment with CBHI to support its long-term success. The studies could play a critical role in introducing the concept of CBHI to the community while garnering essential information required for the early set up. This was demonstrated through the community's initiative to gather and begin initial planning for a CBHI after the focus group discussions. Acceptability studies could also direct the community in the identification of trusted leadership and technical team from within their own community to drive the process. By providing the communities with a context specific blueprint for CBHI design that would best position it for success in their context, acceptability studies should be considered as an initial step in future CBHI establishment efforts.

FBOs can be effective drivers and advocates for CBHI in its infancy

The evidence from this study indicated that various community groups within the Old Mutare community are ready for and would accept the establishment of a community-based health insurance (CBHI) program. This study not only brought these groups together but also acted as a catalyst for their organization—an important gap that we believe faith-based organizations (FBOs), like the United Methodist Church (UMC), are uniquely positioned to fill.

Although there was initial resistance to the idea of the UMC leading the CBHI program, further conversations and analysis revealed that the community's hesitation stemmed from concerns about a UMC-administered program specifically, not from a rejection of the CBHI concept itself. This insight was enlightening, especially since we initially expected the research to point to the UMC as the natural leader of the initiative.

Despite these concerns, the UMC was recognized for its wealth of resources, including its potential to act as a catalyst in organizing communities for CBHI, particularly by facilitating acceptability studies such as this one. We propose that FBOs take on this critical role of facilitator. Doing so would not detract from their mission to advance health equity; instead, it would center community voices, ensuring that community members maintain leadership and oversight of the CBHI program as a truly community-owned initiative.

The UMC can also serve as a model for other FBOs across Zimbabwe as they expand CBHI into communities surrounding their mission hospitals, all while continuing to provide quality care through these facilities. As trusted stakeholders in the national healthcare system, FBOs are also well-positioned to document this process and advocate for government buy-in to support further scale-up.

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Appendices

Appendix 1: Alignment of Questions to Framework

Questions	Social Capital Concept Addressed
<p>Question 1: Can you describe the last experience where you or someone in your immediate family was sick and required a doctor's visit or hospitalization?</p>	Ability to Pay
<p>a. How did you pay for the medical expenses for the treatment?</p>	
<p>Question 2: Are medical expenses something you believe you need to be prepared for? And if so, how can you and your family prepare for this?</p>	Efficacy
<p>Question 4: Do you think that as a community we could come together and put our money in a bucket in a similar manner (as private or government medical aid) to cover medical costs for each other? Why or why not?</p>	
<p>Question 7: The success of the Community Based Health Insurance model I have described requires everyone to pay ahead of time to ensure that funds are available when needed and when people do not pay it could affect the ability of the fund to pay for other individuals, do you believe that other people in your community can be trusted to do so? Why or why not?</p>	Trust
<p>Question 10: How about the United Methodist Church that is associated with Old Mutare Hospital, would you trust that the Church community run this insurance fund? Why would you trust them and if not, what would be your concerns?</p>	
<p>Question 12: Are there any other social groups that are present in your community that you would think are better positioned to manage such a scheme? Can you tell us about this group? What makes them the ideal group to manage such a scheme?</p>	
<p>Question 6: In our culture (hunhu wedu) are there any provisions for supporting each other in times of difficulty (sickness, death or tragedy like fire) can you tell us how this works?</p>	
<p>How would this affect your willingness to support such a program</p>	Engagement

<p>Question 14: We understand that there are some individuals in our community who seek care more often than others because of their health status, what are your thoughts on the healthier population who may be relatively younger individuals contributing to a communal fund that will benefit everyone.</p>	
<p>Question 15: How do you feel about the services provided at Old Mutare hospital this can include (care by physician or nurse, the waiting time to be seen and availability of medicines)</p>	<p>Quality Services Valued by the Community</p>
<p>a. How does it compare with services provided in other facilities that you may have visited or heard of?</p>	
<p>i. Probe for positive experiences and challenges faced at Old Mutare (what makes this experience better or worse than other facilities?)</p>	
<p>Question 17: With community- based health insurance, a community chooses the facility they would like to provide services and based on the amount of money contributed and the quantity of services provide. Given this, would you choose the Old Mutare Hospital as your choice facility to provide medical aid services for your family - What would you need in place for the UMC facility to be the choice facility your community to pay their collected health insurance funds towards?</p>	

Appendix 2: Thematic Analysis of Efficacy – Residents Believe They can make a difference

Quotes from Data	Enabler/Barrier	Code	Theme
We have been helping each other in our community since COVID-19. Now when it comes to the conviction to pay, as a person you reflect on the time when there was an issue in the community or in your family and the community came to support you	Enabler	Efficacy based on past tragic shared experiences	Past tragedies shape people’s belief in their ability to make a difference
We like this it is best to maintain life rather than wait to come together to get a shovel to dig a grave when someone dies. The death of people due to lack of money for treatment pushes people to like this program automatically	Enabler	Based on connections to the efficacy associated with support in tragic events and value of life	
How is this different from death, how many years have they been holding funds for my policy, but we do not know when it is going to happen as sickness	Enabler	Based on connections to the efficacy associated with support in tragic events and value of life	
Yes, it’s possible people will be receptive because we have already had other similar programs that are going well like burial societies.	Enabler	Based on previous experiences	Past community support efforts shape belief in collective efficacy
In my neighborhood, we have a rule that each family pays \$1 a month towards medical emergencies, then we have our treasurer who keeps those funds. We thought about this when we had a problem in our community, and we had nowhere to start.	Enabler	Based on previous experiences	
Gathering money ahead of illness like we do for funeral policies is very possible and the money will be available, especially if we come together as a group and come together	Enabler	Based on previous experiences	

<p>People will join because we have always done it indirectly when our relatives are sick at home; we contribute money to make sure that the person is treated at the hospital. There is not one person here who can say a family member has been sick and they have not helped. We just have not thought of it as a structured way of doing, but people will come in large numbers to participate in this program.</p>	<p>Enabler</p>	<p>Based on previous experiences</p>	
<p>Sickness is sickness, it is the same with funeral policy. We need to understand each other, if someone decides that they do not want to contribute because some others are more ill, they should leave the group and let us who believe in the group to work together</p>	<p>Enabler</p>	<p>Belief in the strength of community</p>	<p>Belief in a community's collective strength enhances its sense of efficacy</p>
<p>Looking at our communities, about 75% of people would likely contribute to the fund, with the remaining 25% choosing not to cooperate. It is important to remember that not everyone may have the means to contribute, and that must be taken into consideration when organizing such a program. However, by coming together as a community to support each other in times of need, we can help ensure that everyone has access to necessary medical care</p>	<p>Enabler</p>	<p>Belief in the strength of community</p>	
<p>We are sisters or brothers' keepers, Yes, it is our duty because usually a person in trouble may not see it but we who are outside can see it and help him in time.</p>	<p>Enabler</p>	<p>Identifying community as family and responsibility as family</p>	<p>Viewing the community as family reinforces the responsibility to support one another</p>
<p>If there is a spirit that people will say, my community is also my family, that will push people to sacrifice and contribute to others, because we will want to support each other. When you get into</p>	<p>Enabler</p>	<p>Identifying community as family and responsibility as family</p>	

trouble yourself you will need your next-door neighbor, so it is support each other. “Kugamana”			
For my family I am will pay freely, if have family that is my responsibility and if I have the money I will pay.	Enabler	Responsibility as family	
I do not think it is good when it is when a person is very ill and then we should help but when someone is not very ill. When the person is seriously ill it is when we should chip in. It is when you see also that individuals need help then we can begin helping from there	Enabler	Responsibility to support each other in all times even before severe illness or tragic events	Recognition of the diversity of resources within the community. These extend beyond cash, including livestock, foster mutual support
As a church, we do it when someone is sick, we make contributions as sections so that the person can be treated	Enabler	Based on organization affiliation including religious organizations	
Also, we are pushed because that when \$2 will not as difficult as paying for full services in the time a trouble	Enabler	Based on logic of risk protection and the strength in pooling resources	
People accept and like it because illness comes when you are not prepared.	Enabler	Recognition of a gap and a need	Recognition of the unpredictability of sickness, a gap that people can address
People they pay to support this program, if they don't have money they will sell their livestock's they have to pay. People can sell a chicken or a goat to pay the fees, people will find the small fee like \$2	Enabler	Belief use of available resources, looking beyond fiscal capacity	Recognizing that community resources extend beyond cash, including livestock, fosters mutual support
I don't have an example where a sick person was helped, but I have an example that I saw on the social media in a Kenyan community where women came together and started collecting	Enabler	Influence from social media and external experiences	Influence from other communities on social media

<p>0.16 per person to build flats, now they are given contracts for roads construction. – the power of coming together</p>			<p>inspires similar actions</p>
<p>Here at the Farm we are not united, especially when it comes to things to do with money. I think what would be best is to speak to the farm owner to look for another health insurance as he had done at Elan</p>	<p>Barrier</p>	<p>Reliance and responsibility given to organization</p>	<p>Belief that expectations of external support from community would deter efficacy</p>
<p>Yeah, it's not a priority, I think. Part of the issue is with, with the history of the healthcare system in Zimbabwe. Most of the times I must have liked previously before I don't know, since maybe since 1980, when the country got independence. Most of the times people were told that healthcare facility healthcare is subsidized by the government. It is free. So a lot of the times in the previous year's you'd come to the hospital and you'd get medications for free so people didn't have to budget for sickness</p>	<p>Barrier</p>	<p>Current situation would make it difficult</p>	

Appendix 3: Thematic Analysis of Engagement – Residents with a common background engage with each other

Bonding			
Residents with a common social background engage with each other			
Quotes from Data	Enabler/Barrier	Code	Emergent Sub-themes
In my neighborhood, we have a rule that each family pays \$1 a month towards medical emergencies, then we have our treasurer who keeps those funds. We thought about this when we had a problem in our community, and we had nowhere to start.	Enabler	Engagement based on previous experiences mostly tragic	Engagement based on previous experiences of communities organizing for shared benefit
If there is a spirit that people will say, my community is also my family, that will push people to sacrifice and contribute to others, because we will want to support each other. When you get into trouble yourself you will need your next-door neighbor, so it is support each other. “Kugamana”	Enabler	Engagement through association with family	There is a responsibility to family and engagement is based on identification as family (brothers and sisters)
We are sisters or brothers’ keepers, yes, it is our duty because usually a person in trouble may not see it but we who are outside can see it and help him in time	Enabler	Connection to family (brothers and sisters)	
My family and I decided to come together and contribute financially. We all understood the importance of ensuring that we received the necessary medical care, and so we pooled our resources to cover the costs	Enabler	Sense of responsibility for family	
Most people don't have enough, so they will just maybe be asking relatives to to help with contributions	Enabler	Sense of responsibility for family	

For my family I will pay freely, if have family that is my responsibility and if I have the money I will pay.	Enabler	Sense of responsibility for family	
It is our duty to look after our neighbors to see if things are going well.	Enabler	Sense of responsibility of neighbors	There is a strong responsibility to supporting neighbors in times of trouble, particularly those that people have close interactions with including illness
Yes, it is our duty to look after our neighbors because what affects my community also affects me as that is what our culture says	Enabler	Sense of responsibility of neighbors	
In the larger community we support when things have happened, and we go and support but for our line our immediate neighbors this is where we have a treasurer, and we support each other	Enabler	Sense of responsibility neighbors or closer community	
In my community we only do collections to help when there is a funeral in our neighborhood but for health insurance, or maybe the mother or father, there will be some plates of in-kind produce maybe some grain, we are not doing anything at the moment for the larger community	Barrier	Engagement in death, tragic situation or critical illness	
It is our duty to look after our neighbors so that we can see the problem of illness while it is still small and to support at an earlier stage.	Enabler	Sense of responsibility for neighbors	
People are more inclined to life insurance policies because death is inevitable, we are all going to die at some point, but when it comes to sickness we do not know if we are going to get sick	Barrier	Engagement in death, tragic situation or critical illness, illness not recognized as a serious concern	

	Bridging
Residents with different social backgrounds engage with each other	

Quotes from Data	Enabler/ Barrier	Code	Emergent Sub-themes
<p>It is true about getting to know each other, some people do not interact or know their neighbors, when there is an issue, these are the first people you should inform. Let's invite each other to events and include each other and support each other in general.</p>	Enabler	Continued engagement and interaction	Ongoing interaction fosters trust and lasting community bonds beyond any single program
<p>It is a group on WhatsApp of people buying and selling to each other, I have my vegetables I sell, and so if there are no issues about deaths we continue with our trade in the group. Even if I do not have enough money for school fees, I tell people in the group, come and support and buy from me and just like that people come and support</p>	Enabler	Continued engagement and interaction for other social development areas	
<p>I think for this to work, I think people need to get to know each other. I think if people could gather maybe once a year so they can know each other, maybe a festival. That way if they know each other, they are more willing to support each other. For example, the events when the elderly have parties where they get food hampers. So, if we have these festivals, we get to know each other and would be more trusting to appoint a person as a treasurer</p>	Enabler	Continued engagement and interaction for other social development areas	
<p>If the program covered the entire community registered in the program, regardless of whether my family got ill or not, I would be willing to contribute funds. This is because sickness can affect anyone at any time, and it is important to support others when they are in need. Knowing that my contribution could help provide financial assistance to those who are facing illness would influence my decision to contribute to the pool of money</p>	Enabler	Responsibility to the community in all circumstances	Communities support each other with the understanding that circumstances can change, and those who give today may find themselves in need tomorrow

<p>We have been helping each other in our community since COVID-19. Now when it comes to the conviction to pay, as a person you reflect to the time when there was an issue in the community or in your family and the community came to support you. This is why as a person you will not have trouble contributing to the community pocket of funds</p>	<p>Enabler</p>	<p>Connection to and taking advantage of tragic situations to activate social engagement</p>	<p>Tragic events can unite communities, sparking engagement and driving development initiatives.</p>
<p>We started with a gathering and people identifying people in the group and we looked at the personality of people to add in the group. Our group came from a tragic event within our neighborhood that hurt all of us. We recognized that we were not prepared so we said as a group we need to be prepared to support each other.</p>	<p>Enabler</p>	<p>Connection to and taking advantage of tragic situations to activate social engagement</p>	
<p>People are doing it but people are just not educated about health, what people know about is funerals, but we should say we can help each other before people die.</p>	<p>Enabler</p>	<p>Connection to and taking advantage of tragic situations to activate social engagement</p>	
<p>It is a group on WhatsApp of people buying and selling to each other, I have my vegetables I sell, and so if there are no issues about deaths we continue with our trade in the group. Even if I do not have enough money for school fees, I tell people in the group, come and support and buy from me and just like that people come and support</p>	<p>Enabler</p>	<p>Connection to and taking advantage of tragic situations to activate social engagement</p>	
<p>Sickness is sickness, it is the same with funeral policy. We need to understand each other, if someone decides that they do not want to contribute because some others are more ill they should leave the group and let us who believe in the group to work together</p>	<p>Enabler</p>	<p>Association of responsibility in illness to tragic situations including death and example of sense responsibility</p>	
<p>We have burial societies in our sections, what we do we pay \$10 per family when we have a funeral at our church, that money goes towards the</p>	<p>Barrier</p>	<p>Support in serious situations or emergencies, especially death</p>	<p>Limiting responsibility to tragic events can hinder ongoing</p>

buying of food and helping other things at the funeral			community engagement
As a community, we do not have examples of those who have benefited from the community for treatment, the examples that exist are when a person dies, we agreed that everyone brings a gallon of corns.	Barrier	Support in serious situations or emergencies, especially death	
When the person is seriously ill it is when we should chip in. It is when you see also that individuals need help that we can begin helping from there and not from the beginning.	Barrier	Only helping in serious situations or emergencies, especially death	
For the youth perspective, it becomes difficult for them to pay monthly. So, what are we doing, so when it happens. But for us we consider our own finances and budgets for health	Barrier	Responsibility to personal responsibilities first	Individualism can hinder community support
The other option is to borrow the money then return it after recovery, you will have to work after to pay that money, but the first option is to ask for family contributions.	Barrier	Personal responsibility even if it means taking a loan	

Linking			
Residents engage with organizations and systems			
Quotes from Data	Enabler/Barrier	Code	Emergent Sub-themes
As RRW we help pay hospital bills when one of us is hospitalized for more than three days, and we also check whether our patient in the hospital is getting a healthy diet, if not we help buy nutritious foods	Enabler	Organizations putting policies in place to support each other.	People engage more in health initiatives when connected to organizations
As a church, we do it when someone is sick, we make contributions as sections so that the person can be treated	Enabler	Organizations as an engine for people to support each other	

<p>Here at the Farm we are not united, especially when it comes to things to do with money. I think what would be best is to speak to the farm owner to look for another health insurance as he had done at Elan</p>	<p>Barrier</p>	<p>Organizations seen as the only engine to community development</p>	<p>Organizations may be perceived as the sole avenue for engagement</p>
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Appendix 4: Thematic Analysis of Trust – Residents trust organizations and systems including the United Methodist Church

Bonding			
Residents with a common social background trust each other			
Quotes from Data	Enabler/ Barrier	Code	Emergent Sub-themes
When it comes to who holds the money in our neighborhood account, we do not approach it from doubt, we identify someone as our leader, and we say to that person you are the one who is going to carry our money. I have never been afraid to share the money with the treasurer.	Enabler	Established relationships that determine trust and identify leaders	Importance of established relationships that would trusted determine leadership of the program
People look at leadership, so it is good for people to choose the people they are satisfied with.	Enabler	Trust in specific individuals to lead	
There should not be outsiders to lead, if we have a leader for someone from outside it won't work	Barrier	Trust in known individuals and community members	Trust lies with known community members, not outsiders

Bridging			
Residents with different social backgrounds trust each other			
Quotes from Data	Enabler/ Barrier	Code	Emergent Sub-themes
Also, since we already have groups, we can see through messages in the groups, that this person has already paid their money so there is a form of accountability from the group.	Enabler	Trust in accountability structures in established community groups	Trust is built through experience with past community programs and established accountability structures
There should be systems in place where people sign for the money they have contributed.	Enabler	Trust only established with accountability systems	
Yes, I trust them. All that is needed is the program to be organized people will pay their monthly subscriptions	Enabler	Trust only established with accountability systems and organization	

We need to make sure there is a board, a treasurer and secretary for accountability and there is accountability	Enabler	Trust only established with accountability systems	
I think if people are educated and told the advantages and benefits of the program they will pay on time and then use of influential people like chiefs to mobilize people and make sure everything is transparent to everyone it will go well. It needs to be described in the local language. Transparency is important, including what are the consequences of lapses in payment	Enabler	Trust after effective education and engagement of influential individuals	
And if we have household payments rather than individual would address this. (recommendation)	Enabler	Accountability at a household level	
Looking at the character of the people who will lead the program so that people feel comfortable entering the program without fearing that their money will be stolen	Enabler	Character determined through longstanding relationships and interactions	The character of individuals determined by longstanding relationships and position in community determine trust
People like David, that is the only one in the community I would trust to handle the funds	Enabler	Character determined through longstanding relationships and interactions	
We can find a chair, but the village health and the village health worker should be involved.	Enabler	Character of individuals in leadership	
It can be difficult for those who have just started doing this program since some of them do not understand it well, we do not really know each other that well. We do not know what one person does. So, it can make it difficult	Barrier	Trust based on longstanding relationships that determine character	Individuals whose characters have not been verified can undermine trust.
There should not be outsiders to lead, if we have a leader for someone from outside it won't work	Barrier	Character determined through longstanding relationships and interactions	
If it is in a community and the cash is contributed and kept in the community and we know it will be there then yes, it will be something good we can do	Enabler	Trust in local community ownership and oversight over organizations	Trust in community oversight and shared value in

I believe that most people in my community can be trusted to pay ahead of time because we all understand the importance of having access to healthcare when we need it. By contributing to the fund, we are helping each other and ensuring that no one is left without medical care due to financial constraint	Enabler	Shared value of health and wellbeing	health and wellbeing
It makes sense to have funds readily available when illness strikes, as unexpected medical expenses can be a heavy burden to bear. While some individuals may choose not to pay their contributions, I believe that the majority of people would be willing to participate in such a program	Enabler	Trust in the strength in integrity of the majority of population	Belief in the majority to act rightly
Looking at our communities, about 75% of people would likely contribute to the fund, with the remaining 25% choosing not to cooperate. It is important to remember that not everyone may have the means to contribute, and that must be taken into consideration when organizing such a program. However, by coming together as a community to support each other in times of need, we can help ensure that everyone has access to necessary medical care	Enabler	Trust in the strength of the majority of the population,	
It will do, because when we do it, we say it's a community thing, so people will be forced to follow the community rule. People must pay regardless of their age. And if we have household payments rather than individual would address this. recommendation	Enabler	Trust in community structures that already exist and a	
Personally, I have faced disappointment in a group where we contributed money monthly but did not receive any funds back. This has made me wary of joining the CBHI program at the community level, as I fear there may be fraudsters present	Barrier	Negative experience with past and existent community programs	Negative experiences with previous community initiatives could inhibit trust

Currently here in the Mission, there is a burial society program running but among the members, there is tension	Barrier	Negative experience with past and existent community programs	
At first it goes well, then there may be a problem, let's say after 6 months some will stop paying.	Barrier	Waning trust over time	
Here it is an issue of lack of knowledge, so many people may not be educated on how this would work. We tried it with a burial society, but it did not work in the larger community, those who understood came together and supported each other but mistrust in the larger community prevented it from taking off at a larger scale	Barrier	Lack of education in financial matters	
Here at the Farm, we are not united, especially when it comes to things to do with money. I think what would be best is to speak to the farm owner to look for another health insurance as he had done at Elan	Barrier	Trust in formal networks over community networks	Formal employment networks foster higher trust among the formally employed.
I would trust people to contribute if money is being withheld at work but for people coming to give money directly, I do not think it will work	Barrier	Trust in formal networks over community networks	
Absolutely no to the village head, they have so many responsibilities – consensus from the group.	Barrier	People with multiple responsibility and lack of capacity leading	People hesitate to trust leaders who take on multiple roles
We would be happy to contribute some funds as a community, but we would need some support. We would need proof that someone has been ill a note from the doctor then yes we would be happy to take money from this pocket of funds to pay for healthcare. Based on the health condition	Barrier	Fear of moral hazard, people taking advantage of community programs	Fear of individuals misusing the program and taking advantage of the pooled risk through moral hazard

<p>There were quite few benefits from the Elland, the services were very good and you would see that those who went would continue returning, This means when we have a medical aid we need to have some rule to deter from overuse from a small group of people. Maybe once of six months someone will go for a checkup. People were going there for the cup of tea they received.</p>	<p>Barrier</p>	<p>Fear of moral hazard, people taking advantage of community programs</p>	
<p>We will also need to discuss who is going to be covered in this health insurance, for example, I will bring my father, would my father be included in this program for example. We need to announce that it is the immediate family and not including extended family. Because if we include the extended family, it will be complicated. We should also consider if we say we are contributing \$2 is it just for the father who is working in the farm or should there be a contribution for each member of the family, for 5 people it should \$10. Consider if there is an infectious disease let's say flu it will affect everyone and if they all go to the hospital, they are all utilizing the program.</p>	<p>Barrier</p>	<p>Fear of people taking advantage of the program</p>	

<p>Linking</p>			
<p>Residents trust organizations and systems including UMC</p>			
<p>Quotes from Data</p>	<p>Enabler /Barrier</p>	<p>Code</p>	<p>Emergent Sub-themes</p>
<p>When we hear about people going to church there is a level of trust considering their social standing.</p>	<p>Enabler</p>	<p>Trust in the character of individuals of people in church organizations</p>	<p>Respect for individuals is tied to their character</p>

<p>The idea of the United Methodist Church being involved in running an insurance fund for Old Mutare Hospital is both exciting and concerning. On the one hand, the church community is known for its strong values and commitment to helping others in need.</p>	<p>Enabler</p>	<p>Respect and influence of the church</p>	<p>and UMC affiliation</p>
<p>From another point of view, it can go well because the majority trusts that the people in the church fear God in terms of finances, so there will be no problem.</p>	<p>Enabler</p>	<p>Trust of character of people in churches</p>	
<p>The church could just be coordinating, maybe collecting the funds from the different communities surrounding the Old Mutare Mission. Each community can manage and oversee their own programs, but the church would just be there for administration of funds since they are connected to Old Mutare Mission.</p>	<p>Enabler</p>	<p>Trust in the church in the role of coordinator or administrator and not leader</p>	<p>The church is valued for its resources, financial support for the poor, administrative capacity, and ability to mobilize communities</p>
<p>The presence of wealthy and influential businesspeople within the church could potentially bring financial stability and success to the insurance fund.</p>	<p>Enabler</p>	<p>The church can provide resources to support program</p>	
<p>Some community members may not be able to afford the premium. By working with the church, the program can be more organized and have greater community support, ultimately leading to its successful implementation</p>	<p>Enabler</p>	<p>Church key role through financial support especially for the subsidy for the indigent poor</p>	
<p>I think the church should be involved but it should not lead. We will lead ourselves to the church should be involved in the board. It is important to include the church because funds will be coming from the church</p>	<p>Enabler</p>	<p>Lack of trust of church leading the program. Clear differentiation between church and community projects leadership, but recognized for the resources they provide</p>	

If the church takes the lead, it can work because the majority of people in our surrounding communities are UMCs	Enabler	Church has the ability to mobilize a large group of individuals	
There needs to be a church-related scheme but not run directly by the church, there need to be clear roles, let be operated separately and professionally.	Barrier	Fear of unprofessionalism of church	Fear of bureaucracy, inexperience, and the UMC Church's capacity to manage the program
It can work, the church is ok but we need some outsiders who would see what is going on, because the church has other programs and money. The church may take the funds from health insurance for other programs. So if there is an outsider there would be an accountability that the church is running the program well.	Barrier	Church as an organization with known bureaucracies and multiple priorities that could affect CBHI	
In our burial societies, they worked well without the church, if we formalize it and make it church, next the church will be asking for approvals. The UMC members can join but they cannot lead. We can advertise to the church, and they can get involved.	Barrier	Church identified as an organization with bureaucracies that could affect CBHI	
We don't want the church	Barrier	Negativity regarding the church	Mistrust in leadership capacity due to past experiences and known corruption within the church
We don't trust them, if church members want to join the program, they should not be more involved.	Barrier	Lack of trust of church leading the program. Clear differentiation between church and community projects leadership	

<p>The moment we give a church leader, in the UMC we do not have accountability, because we have put clergy in leadership and people do not want to be accountable to the clergy. We need to find people who are accountable so that we can be held responsible. I think 50/50 will work. We have people who can run this. We have some corruption of placing people in these places. In order for this work, we may consider missionaries who can manage this for now. Personnel need to be rewarded adequately. Many church initiatives have failed by putting clergy in charge</p>	<p>Barrier</p>	<p>Incapacity of the clergy and the church to lead</p>	
<p>No, people from the church should not oversee the program because they are very corrupt, the program should be led by other people from the community.</p>	<p>Barrier</p>	<p>Negativity towards the church's capacity to lead due to corruption</p>	
<p>When I went to the hospital with my father, I saw that corruption is rampant in the hospitals. I was asked by the nurses to give them \$10 USD for them to treat my father and I paid it on top of the hospital fee I had already paid</p>	<p>Barrier</p>	<p>Concerns of corruption at the Old Mutare Hospital</p>	
<p>No, how does the leadership of the church fit into a community project. This should be separated from the church.</p>	<p>Barrier</p>	<p>Clear differentiation between church and community projects leadership</p>	<p>There needs to be clear differentiation of roles between church and the CBHI program with more effective leadership from community or other formal organizations</p>
<p>We can never be under the church. The moment the illness leaves Old Mutare, then it has nothing to do with the church any longer</p>	<p>Barrier</p>	<p>Importance of differentiation or roles because the health system goes beyond Old Mutare Mission</p>	

<p>I paid for the monthly subscriptions for one or two years and not go to hospital but when I finally get ill and go to the hospital and you are told to pay a shortfall, but when you look at it the money you have paid before is much more than what is needed for your services</p>	<p>Barrier</p>	<p>Previous bad experiences with organizations including health insurance company</p>	<p>Past negative experiences with medical aid societies, leaving individuals with costly shortfalls, have led to mistrust in pooled funding schemes</p>
<p>I have challenges that I have had medical aid but when I have paid, I was asked to top up. It could not cover everything that I needed.</p>	<p>Barrier</p>	<p>Previous experience with health insurance not meeting expectations</p>	
<p>I went with medical aid, but it was said that it does not cover everything, including medicines, so I bought the medicines at the pharmacy.</p>	<p>Barrier</p>	<p>Previous experience with health insurance not meeting expectations</p>	
<p>I ended up not having confidence in the medical aid societies (private health insurance in Zimbabwe). We were paying for insurance, but medical aid society was not paying out as expected. The idea of health insurance is that we pool funds both healthy and ill with the expectation that a healthy population is greater than the sick so there should be money for services, so I am confused on why the medical aid society does not have enough money to pay for services. The money is being stolen.</p>	<p>Barrier</p>	<p>Previous experience with health insurance not meeting expectations</p>	
<p>Sometimes you'll be contributing premiums for health insurance to maybe even most of the major health care insurances people contribute but because of inflation maybe the contributions may not be enough to sustain a viable service after maybe a few months, or after a few years. So, you find that maybe after paying health insurance for 5 years, we can't support claims to to healthcare service providers after</p>	<p>Barrier</p>	<p>Inflation and the economic environment affecting the program</p>	

So I think it is the greatest challenge now. if the distrust or the lack of confidence in the in the system	Barrier	Broad lack of trust in the system	
It may not work out as we hoped because some people are not Christians. (working with UMC)	Barrier	Barrier for community level bridging network and would rather trust in systems	Fear of transparency issues and favoritism toward church members in CBHI benefits
However, there is also the risk of potential bias or favoritism towards members of the church when it comes to accessing the insurance benefits. To ensure transparency and fairness, it would be necessary to include non-UMC members in the committee overseeing the fund's operations	Barrier	Fear of corruption of favoritism in the church	
I would trust people to contribute if money is being withheld at work but for people coming to give money directly, I do not think it will work	Enabler	Trust in systems supporting or running over individuals	Trust in organizations with established systems manage finances
Church should not be there, if the church is going to be there it should only be there secondary to our farm owner	Barrier	Trust in formal organization over church, fear of unprofessionalism of church	

Appendix 5: Summary of Enablers and Barriers to Social Capital in the Old Mutare Community

Social Capital	Engagement	Bonding Residents with a common social background Engage with each other	Enablers <i>Engagement based on previous experiences of communities organizing for shared benefit</i> <i>There is a responsibility to family and engagement is based on identification as family (brothers and sisters)</i> <i>There is a strong responsibility to supporting neighbors in times of trouble, particularly those that people have close interactions with</i>
			Barriers <i>Engagement associated with tragic events; sickness is not recognized as important to activate this social capital aspect</i>
		Bridging Residents with different social backgrounds Engage with each other	Enablers <i>Ongoing interaction fosters trust and lasting community bonds beyond any single program</i> <i>Communities support each other with the understanding that circumstances can change, and those who give today may find themselves in need tomorrow</i> <i>Tragic events can unite communities, sparking engagement and driving development initiatives</i>
		Barriers <i>Limiting responsibility to tragic events can hinder ongoing community engagement</i> <i>Individualism exists that can hinder community support</i>	
	Linking Residents engage with organizations and systems	Enablers <i>People engage more in health initiatives when connected to organizations</i>	
		Barriers <i>Organizations may be perceived as the sole avenue for engagement by some (those already associated with formal organizations – farmers, teachers) hindering community led initiatives</i>	
Trust	Bonding Residents with a common social background trust each other	Enablers <i>Established, trusted relationships are crucial in shaping program leadership</i>	
		Barriers <i>Trust lies with known community members, not outsiders and perception of some being outsiders may inhibit trust in group</i>	
	Bridging Residents with different social	Enablers <i>Trust is built through experience with past community programs and established accountability structures</i> <i>The character of individuals determined by longstanding relationships and position in community determines trust</i>	

	<p>backgrounds trust each other</p>	<p><i>Trust in community oversight and shared value in health and wellbeing</i> <i>Belief in the majority to act rightly</i></p> <p>Barriers <i>Past negative experiences with community initiatives can erode trust</i> <i>Formal employment networks foster higher trust among the formally employed</i> <i>People hesitate to trust leaders who take on multiple roles</i> <i>Fear of misuse and moral hazard threatens trust in pooled-risk programs and should be addressed</i></p>
	<p>Linking Residents trust organizations and systems include UMC</p>	<p>Enablers <i>Respect for individuals is tied to their character and UMC affiliation</i> <i>The church is valued for its resources, financial support for the poor, administrative capacity, and ability to mobilize communities</i></p> <p>Barriers <i>Fear of bureaucracy, inexperience, and the UMC Church's capacity to manage the program</i> <i>Mistrust in leadership capacity due to past experiences and known corruption within the church</i> <i>Clear role distinction between the church and the CBHI program is needed, with stronger leadership from the community or formal organizations</i> <i>Past negative experiences with medical aid societies, leaving individuals with costly shortfalls, have led to mistrust in pooled funding schemes</i> <i>Fear of transparency issues and favoritism toward church members in CBHI benefits</i> <i>Trust lies in organizations with established financial management systems</i></p>
	<p>Efficacy Residents believe they can make a difference</p>	<p>Enablers <i>Adaptation as a response to past tragedies shape people's belief in their ability to make a difference</i> <i>Past community support efforts shape belief in collective efficacy</i> <i>Belief in a community's collective strength enhances its sense of efficacy</i> <i>Viewing the community as family reinforces the responsibility to support one another</i> <i>Recognition that community responsibility extends to supporting one another in health, sickness, and tragedy</i> <i>Recognizing the lack of health support as a gap, given sickness's unpredictability, highlights a need for community action</i> <i>Recognizing that community resources extend beyond cash, including livestock, fosters mutual support</i></p>

	<i>Influence from other communities on social media inspires similar actions</i>
	Barriers <i>Belief that reliance on external support weakens community efficacy</i>

Appendix 6: Analysis of the Perception of Quality of Services Offered at Old Mutare

Positive Perceptions of Services

Confidence in Current Services Provide	Code	Key Insights	Recommendation
The services are good. Sometimes the medications are not available here, you will have to go out and look for medications	Generally good perceptions of the facility	There is general confidence in the physical facilities at Old Mutare	The UMC should continue investing in ensuring the availability of updated and quality infrastructure and equipment at the facility to maintain the confidence of population
I have heard from others in the community that this is a good hospital you should go there.			
The accommodation is great, having a waiting mother's shelter this is great. We are so grateful for this. This is something new, we like this.	Pleased with the facilities, specifically the waiting mothers' shelter		

Negative Perceptions of Services

Gaps in Services	Code	Insights	Recommendations
I think the challenge is the gap in diagnostics. You may be seen by a doctor and then you are told that there is no scan and if there is an emergency as a pregnant woman for example, then I have to consider getting money to pay for transportation fees to go into town and pay extra money for a scan	Limited range of essential services such as diagnostics	The population highly values the availability of medications and supplies. Gaps in medications and supplies at Old Mutare Mission Hospital will be a significant	Old Mutare Mission to prioritize a strategy to address the gaps in medications and supplies. This could be through a drug revolving fund that is linked to the CBHI.
The major challenges I am hearing from other people are the lack of medications, when we go to the facility, we want to get treatment and if treatment is not available, what is the use of going there. This is why people go to pharmacy directly rather than go to the facility	Unavailability of essential medications	hindrance to the acceptability of the CBHI connected to the hospital	
And Saturday, you go and get consulted and you are told medication is not available, the facility will be open on Monday	Non-comprehensive services, including availability of	Patients value a one-stop-shop of basic services including	Old Mutare and UMC to consider investing in basic diagnostics and

	services during weekends	medications and diagnostic services	services at Old Mutare Mission to ensure comprehensiveness of care as much as feasible
The set up is well placed, it is very good, the problem is it is not set up to support the low-income people it serves. As soon as you come in you have to pay \$10 in consultation fees and as soon as you are seen you are told there are no medications, and you are told to get medications at Felix pharmacy. I don't know if the health facility has a connection to this facility because any medication you cannot find at the pharmacy are available at Felix. What we would need is when you go to the health facility you are treated at the health facility, and it all ends there. I have seen people now going to the pharmacy and getting the medication directly is cheaper, because all necessary medication is out of stock. Medication is a big problem. We need to figure out who owns Felix	Non-comprehensive services		
Old Mutare has low services and is not quick to provide assistance to people as compared to other hospitals.	Poor responsiveness	Poor responsiveness of care demonstrated by long wait times may affect the populations trust in the quality of services at Old Mutare	Old Mutare Team to work on improvement plans to address improving wait times and general responsiveness of care to meet the needs and expectations of the population
The issue at Old Mutare is the delay in being attended to as a patient. You can spend a long time to be attended and if you come during lunch or are there in the queue, you will have to wait until they finish having lunch	Poor responsiveness		
The healthcare system at Old Mutare Mission Hospital is characterized by a high consultation fee of \$10. To accommodate those who may not be able to afford the full cost of treatment upfront, the hospital offers payment plans to patients.	Inhibitive high cost of services \$10	Lack of transparency in pricing and suspected inequitable pricing for those receiving sick notes from employer	Old Mutare Mission Hospital to consider a transparent process in determining the cost of services, including a fair cost of

<p>Or you may go to the chemist, and you get there and there is no medication, but they have already paid the \$10 consultation fee</p>	<p>Inhibitive high cost of services at \$10 that does not cover medications</p>		<p>comprehensive services to be covered through the CBHI. This should consider the hospital committee and selected CBHI community leadership for transparency. Transparency also includes financial reporting to the community, so they understand how their funds are being used.</p>
<p>Also, what I want to know is that Old Mutare is collecting funds, do they know that this is money is coming from a worker, or they think it is the farm owner is paying. When you look at the charges for the cash and charges for the sick note you will see the cash is cheaper and the sick note charges are more expensive. The sick note is so hard on us, we would prefer to go and get a loan and pay overtime than to get a sick note that the farm owner is taking off our pay every month</p>	<p>Inhibitive high cost, for those receiving payment from employer</p>		
<p>I think Old Mutare is better than the general hospital. But things like the c-section, old Mutare is charging while the general hospital has it for free</p>	<p>Inhibitive high cost of services</p>		

Appendix 7: Recommendations to Improve Quality at Old Mutare Hospital

Recommendation Area	Action Steps
Hospital Capacity Assessment and Operational Improvement	<ul style="list-style-type: none"> • Conduct a capacity assessment with inclusion of the hospital committee for transparency. • Identify key operational challenges and develop improvement plans with staff. • Report progress to the hospital committee and broader community.
Financial & Performance Reporting	<ul style="list-style-type: none"> • Share quarterly financial and performance reports with the hospital committee. • Use reporting to boost engagement and support demand creation.
CBHI Business Plan	<ul style="list-style-type: none"> • Develop a business plan for managing CBHI income and integrating it into operations. • Include mechanisms for community accountability.
Revolving Drug Fund	<ul style="list-style-type: none"> • Incorporate a revolving drug fund into the CBHI business plan. • Ensure continuous medication supply through this mechanism.
Government Engagement	<ul style="list-style-type: none"> • Facilitate discussions with the government for ongoing support with subsidized medications. • Explore potential for expanding health workforce (e.g., nurses, village health workers).
CBHI Program Design Support	<ul style="list-style-type: none"> • Support community leaders during initial CBHI design stages. • Provide data on priority health issues (e.g., cervical cancer, chronic diseases) to inform benefit packages.