BETWEEN POLICY AND REALITY: A STUDY OF A COMMUNITY-BASED HEALTH INSURANCE PROGRAMME IN KWARA STATE NIGERIA

by

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submitted in accordance with the requirements for

the degree of

DOCTOR OF PHILOSOPHY

in the subject

SOCIOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROFESSOR JIMI ADÉSÍNÀ

OCTOBER 2020

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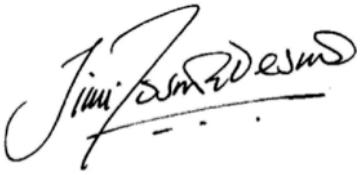

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DEDICATION

This thesis is dedicated to my deceased Dad and Sister, late Alhaji Shaykh AbdulRahman Kamiludeen Owolabi Lawal and late Azeezat Bukola Lawal. May the Almighty Allah forgive and grant them Aljannah Firdaus (Aameen).

ACKNOWLEDGMENTS

I give honour and praise to Almighty Allah for his unceasing blessings on me.

I wish to express my deepest gratitude to my Supervisor and Chairholder, South African Research Chair in Social Policy, Professor Jimi Adésínà, for his insightful comments and intellectual guidance. I appreciate his confidence in my abilities and unwavering supports towards the completion of this work. Without his persistent help, the project would not have reached its goal.

I wish to thank the University of South Africa (UNISA) and the National Research Fund (NRF) for the financial support for this project. I am also grateful to Al-Hikmah University Ilorin, Nigeria, for keeping me on the payroll while on the programme.

More than anyone else, I am highly indebted to my lovely wife, Rasheedat Dayo Lawal. I especially appreciate your sacrifice, patience, encouragement and prayers throughout the programme. You are indeed a blessing to me. To my kids; AbdulRahman and Radhiyah, I truly appreciate your endurance while I was away for the study.

I would like to pay my special regards to my mum, Hajia Mulikat Ronke Lawal for her love, care and prayers. I will continue to appreciate you, mum. My appreciation also goes to our mum, Haija Nurat Lawal. I am grateful to my brothers and sisters; Alhaji AbdulRasheed, Barrister AbdulHakeem, Shakirah, Lateefah, Saheed, Rofeeah, Haneefah, Sherif, Lawal, Khaleel, Maryam, Fatimah and Baghlaf. To my in-laws; Alhaji and Alhaja Hassan, I sincerely appreciate your show of love and prayers. I also thank Mr Bashir Lawal and Hajia Rafat Abass for their support.

I sincerely acknowledge the immense contributions and assistance of a dear friend, Dr Olalekan Oladipo David. I cannot appreciate you enough, brother.

I am indebted to my colleagues at the SARChI Chair. They include Newman Tekwa, Kafui Tsekpo, Madalitso Phiri, Kim Usher, Sivuyisiwe Wonci, Dr Kehinde Omotoso, Dr Marion Ouma, Dr Ashley Sarimana-Adesina and Ipeleng Chauke. I appreciate the invaluable assistance that you all provided during my study.

I humbly thank the founder of Al-Hikmah University, Alhaji Chief (Dr) AbdulRaheem Oladimeji, OFR, for his financial and moral support. I thank the current and the immediate past vice-chancellors of the University, Professor Noah Yusuf and Professor Taofeek Ibrahim for their encouragement. I also appreciate the Registrar, Dr Rasheedat M. Oladimeji and the

University Bursar, Alhaji M.A. Oladejo, for their moral supports. I would like to thank my colleagues at the University for their prayers and support, particularly Mr T.O. Aleshinloye, Mr Y.A. Brimmo-Ibrahim, Mr J.J. Salaudeen, Mr A.A. Adisa, Mr M.B. Taiwo, Mrs T.K. Araba, Mrs M. Bayero-Jimoh, Mrs T.R. Yusuf, Mrs R. AbdusSalam, among others.

I wish to acknowledge the support of Dr S.E. Opowoye, particularly during my fieldwork. I also appreciate the research assistants for their help during data collection.

Finally, I express my profound gratitude to everyone who has contributed directly or indirectly to the successful completion of this project. I thank you all.

LIST OF ABBREVIATIONS AND ACRONYMS

ACCA	Association of Chartered Certified Accountants
AIGHD	Amsterdam Institute for Global Health and Development
AIID	Amsterdam Institute of International Development
ANPP	All Nigeria Peoples Party
APC	All Progressive Congress
BHCPF	Basic Health Care Provision Fund
BHSS	Basic Health Services Scheme
BMPHS	Basic Minimum Package of Health Services
CAPDAN	Computer and Allied Products Dealers Association of Nigeria
CAQDAS	Computer-Aided Qualitative Data Analysis Software
CBHIS	Community-Based Health Insurance Scheme CBHIS
CHIS	Community Health Insurance Scheme
COHSASA	Council for Health Service Accreditation of Southern Africa
COVID	Coronavirus
CS	Caesarean Section
CSOs	Civil Society Organisations
DANIDA	Danish International Development Agency
DFID	Department for International Development
DMOs	District Mutual Health Organisations
ERGP	Economic Recovery and Growth Plan
FCT	Federal Capital Territory
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
FT/IFC	Financial Times/International Finance Corporation

GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
GHC	Ghanaian Cedi
HCHC	Hygeia Community Health Care
HCPs	Health Care Providers
HFG	Health Financing and Governance Project
HIF	Health Insurance Fund
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMOs	Health Maintenance Organisations
HRH	National Human Resources for Health
HSDF	Health Strategy and Delivery Foundation
HSS+	Health Systems Strengthening Plus
HTR	Hard-To-Reach
ICT	Information Communication Technology
IDI	In-Depth Interview
IFIs	International Financial Institutions
ILO	International Labour Organisation
IMF	International Monetary Fund
JCI	Joint Commission International
KII	Key Informant Interview
KWSG	Kwara State Government
LGAs	Local Government Areas
LMIC	Low-and-Middle-Income Countries
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals

MHOs	Mutual Health Organisations
MMI	Military Medical Insurance
MMR	Maternal Mortality Ratio
MMR	Mixed-methods Research
NCH	National Council on Health
NDHS	National Demographic and Health Survey
NEEDS	National Economic Empowerment and Development Strategy
NEPAD	New Partnership for Africa's Development
NGOs	Non-Governmental Organisations
NHA	National Health Act
NHI	National Health Insurance
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NHS	National Health System
NISUCO	Nigeria Sugar Company
NPC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
NPP	New Patriotic Party
NSHDP	National Strategic Health Development Plan
PDR	People's Democratic Republic
TB	Tuberculosis
OECD-DAC	Organisation for Economic Co-operation and Development-Development Assistance Committee
OOP	Out-Of-Pocket

PAF	PharmAccess Foundation
PATHS	Partnership for Transforming Health Systems
PCHIS	Private Commercial Health Insurance Scheme
PDP	People's Democratic Party
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PHI	Private Health Insurance
PMHIS	Private Mutual Health Insurance Scheme
PRRINN-MNCH	Programme for Reviving Routine Immunisation in Northern Nigeria Maternal, Newborn and Child Health
QIP	Quality Improvement Plan
RAMA	Rwandaise d'Assurance Maladie
RPF	Rwandan Patriotic Front
RwF	Rwandan Franc
SAPs	Structural Adjustment Programmes
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
SLAB	Saving Lives At Birth
SPSS	Statistical Package for Social Sciences
SSA	Sub-Saharan African
SSNIT	Social Security and National Insurance Trust
SWAPs	Sector-Wide Approaches
TWG	Technical Working Group
UITH	University of Ilorin Teaching Hospital
UN	United Nations
UNFPA	United Nations Population Fund

UNHCR	United Nations Higher Commissioner for Refugees
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
USD	United States Dollars
VAT	Value Added Tax
WEF	World Economic Forum
WHO	World Health Organization
WTP	Willingness To Pay

ABSTRACT

Between policy and reality: A Study of a Community-Based Health Insurance Programme in Kwara State Nigeria

The challenge of accessing affordable healthcare services in the developing countries prompted the promotion of community-based health insurance (CBHI) as an effective alternative. CBHI has been implemented in many countries of the South over the last three decades for the purpose of improving access and attaining universal health coverage. However, the sudden stoppage of a CBHI programme in rural Nigeria raised a lot of concerns about the suitability of the health financing scheme. Thus, this thesis examines the stoppage of the CBHI programme in rural Kwara, Nigeria. Premised on the health policy triangle as a conceptual framework, mixed-methods approach was adopted for data collection. This involved 12 focus group discussions, 22 in-depth interviews, 32 key informant interviews and 1,583 questionaires. The study participants were community members, community leaders, healthcare providers, policymakers, international partner, health maintenance organisation officials and a researcher. Findings revealed that transnational actors relied on various resources (e.g. fund and 'expertise') and formed alliances with local actors to drive the introduction of the programme. As such, the design and implementation of the policy were dominated by international actors. Despite the sustainability challenges faced by the programme, the study found that it benefitted some of the enrolled community members. Though, even at the subsidised amount, enrolment premium was still a challenge for many. The main reasons for the stoppage of the programme are a paucity of fund and poor management. The stoppage of the programme, however, signified a point of reversal in the relative achievements recorded by the CBHI scheme because community members have deserted the healthcare facilities due to high costs of care. In view of these, the thesis notes that short-term policies often lead to temporary outcomes and suggests the need to repurpose the role of the state by introducing a long-term comprehensive healthcare policy – based on the reality of the nation – to provide equitable healthcare services for the citizenry irrespective of their capacity to pay.

Keywords: Healthcare reform; Healthcare financing; Community-based health insurance; Universal health coverage; Social policy; Enrolment; Health benefits; Policy transfer; Stoppage; Kwara; Nigeria.

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

The healthcare system is a critical institution in society ideally designed to ensure the health and well-being of every member of society. This is because the development of any nation relies heavily on the health and well-being of its human population (Wiesmann & Jutting, 2000:1). Many countries consider health policy reform for improving access to good healthcare services. The 1960s and 1970s saw a raft of countries winning their independence from former colonial powers (John & Taylor, 2003). The leaders of these newly independent countries faced the challenge of providing quality healthcare services to their people and more importantly, reducing mortality and the spread of diseases.

Between 1973 and 1978, the World Health Organization (WHO) was persuaded by China, the Soviet Union and certain African countries, on the importance of revisiting healthcare delivery "that stressed primary health care (PHC) and the social roots of illness" (Lee, 1997). The leadership of the WHO was "impressed by developments in China, India, Africa and Latin America that provided healthcare via local community-controlled services" (Gunn *et al.,* 2008:110). Indeed, comprehensive healthcare programmes which covered the poor were successfully implemented in countries such as Venezuela, Tanzania, Sudan and China (Bennett, 1979).

Consequently, in 1978, the WHO and the UNICEF organised at Alma Ata (now Kazakhstan) an international joint Conference where all WHO member countries unanimously resolved that "health is a fundamental human right". All relevant sectors must pursue the provision of comprehensive and quality healthcare for all through comprehensive primary healthcare (Alma Ata, 1978:16). The Declaration was viewed across the world as a success, bringing about the establishment of a global template for promoting and delivering quality healthcare services. Alma Ata "outlined a strategy that would respond more equitably, appropriately and effectively to basic health needs and also address the underlying social, economic and political causes of poor health" (Sanders, 2003:2). It further provided the opportunity for WHO member states to exchange ideas and knowledge as well as collaborate towards realising the target objective of "Health for All by the Year 2000".

However, it appears that the time coincided with the period of attempts to fix the economic crises in Europe and the US. This gave way to the emergence of neoliberal ideas and the aggressive neoliberalism in the Western nations. Consequently, it became how foreign economic policy was shaped and driven. Neoliberalism became entrenched around the world, with an adverse effect on Nigeria specifically, and many countries in the global South. The effect imposed so much burden on these developing countries and the 'palliative programmes' put in place by the international financial institutions led to significant alterations in the healthcare system of most of the nations.

The position of the World Bank became evident in the wake of the neoliberal ascendancy in the 1980s and 1990s, and it involved massive personnel and ideational changes at the Bank. More broadly, a combination of the adverse impact of the monetary policy in the US to rein in inflation – which led to a spike in the interest rate on contracted debt and balance of payment crisis – triggered the balance of payment crisis that forced countries to seek the IMF balance of payment support. The "World Bank and the IMF initiated the Structural Adjustment Programmes (SAPs) as a condition for the balance of payment support and debt relief" (Baum, 2007:38). The conditionalities required a 'stabilisation' of public finance involving deep cut in public spending, especially social spending, and long-term liberalisation of the economy (privatisation, withdrawal of the state from economic activities and social provisioning – to be replaced by the private sector).

The cut in social spending and retrenchment of public social provisioning triggered mass entitlement failure (including declining public healthcare services). The initial effort at introducing co-payment for healthcare services did nothing to compensate for the cut in public spending. It hit most citizens hard on the back of the general decline in income and rising poverty. The response was not to restore public expenditure and investment in healthcare but to press for a stratified, segmented, and segregated social policy architecture for health (see Fischer, 2018). Countries were encouraged/forced to introduce social (health) insurance, and a variety of pre-payment systems outside the top-tier (and middle-tier) social insurance scheme. An example of such low-tier (pre-paid) health insurance systems is the Community-Based Health Insurance Scheme.

However, to rationalise the 'imposition' of the adjustment programme, the World Bank argued that such adjustment was "clearly needed for long-run health gains" (World Bank, 1993:8). The report also argues that as the government could not provide healthcare service for the

entire people, the sector should be opened up to market forces whereby individuals who could afford to pay could get value for their money. To further entrench the neoliberal objectives, the concept of 'consumer' was used in reference to the citizen in the discussion of healthcare delivery (see World Bank, 1993:70; Alubo, 1985:331; McGregor, 2001). This is a very sharp contrast from the principles envisaged in the Alma Ata Declaration, which declared healthcare as a fundamental human right. Though, it is argued that the Declaration was not visionary enough to address environmental issues and issues of sustainability (Baum, 2007:36), the problems would have been easily accommodated if the Declaration was effectively put to work. However, it was crippled by the neoliberal forces.

The SAPs imperilled the operations of the healthcare sector with the imposition of fiscal austerity, reduction in the size of the budget, significant reallocation of intra-sectoral scarce resources, and a significant shift in health policy (Sahn & Bernier, 1995; McGregor, 2001:2) due to large debt repayment. There were cases where development aids meant for health in the developing countries were diverted to repay national debts (Stuckler & Basu, 2009, cited in Ruckert *et al.,* 2015:41). The IMF and World Bank did little to clarify the likely impact of the programmes (Simms *et al.,* 2001).

Nevertheless, we can observe significant differences among countries in terms of the acceptance of the imposition of neoliberalism (Tinel, 2011:119). For instance, the leadership and academic circles in Latin America took note of the prevailing ideas and initiated policies that suit their contexts based on their local realities. More so, "unlike Chile, where the military government introduced neoliberal market reforms, Mexico and Costa-Rica policy innovations in health were home-grown, affecting countries in the region and international agencies" (Atun *et al.,* 2015:233). That was easier because the "multipolar global order provided policy space for local policymakers to manoeuvre between various policy advice, but this changed radically after the 1980s when the policy space shrunk remarkably, and the impulse of policy advice became one-dimensional and neoliberal" (Adésínà, 2009:39). Governments were reluctant to commercialise healthcare despite their numerous financial problems (Van der Geest, 1992:667). Unfortunately, most of these nations could not do much to resist the pressure because of the impending 'economic doom'.

There was a strong synergy between the WHO and IMF in entrenching the global health crisis. In 2000, the WHO set up the Commission on Macroeconomics and Health to examine the position of Health in economic development across the world. The report, submitted in 2001

recommended donor-financing of 'intervention programs' by high-income countries in the developing countries (WHO Commission on Macroeconomics and Health Report, 2001). According to Waitzkin (2003:1), the report shifts "emphasis from the social determinants of disease, such as class hierarchies, inequalities of income, ethnic origin and racism". Meanwhile, it "is clear that social and economic development is entwined and the level of health affects both" (Baum, 2007:35). The report also focuses "on economic productivity and diminishes the importance of health as a fundamental human right" (Waitzkin, 2003:1). Also, the report seemingly reiterates the argument of Walsh and Warren (1979) that only intervention programmes should be donor-funded rather than comprehensive programmes that could solve the problems of healthcare delivery around the world. By implication, the donors are likely to have the most influence when designing and implementing health policies and programmes.

1.1.1 Healthcare Reforms in Africa since 1980

Like in other continents around the world, health sector reforms in Africa is characterised by extensive macroeconomic policies and the implementation of SAPs that required "control of public expenditure and changes in public and private sector institutional structures" (Sahn & Bernier, 1995:195). "The implementation of the structural adjustment programmes negatively impacted the health systems in Africa" (Adésínà, 2007:18). Long-standing policies favouring comprehensive primary healthcare and de-emphasising user fees were criticised and jettisoned (Gilson & Mills, 1995:216).

According to Lambo and Sambo (2003:3):

> The adoption of the Three-Phase African Health Development Scenario in 1985 (to revive healthcare systems in Africa), the Harare Declaration in August 1987 (to strengthen the district health systems based on primary healthcare), and the Bamako Initiative in September 1987 (to revive primary healthcare and promote community participation) were the earliest attempts made to revive the health systems in Africa.

The Bamako Initiative, promoted by the WHO and UNICEF (Barry *et al.,* 2009:28), "served as a platform for the introduction of user fees and private health provision" (Asakitikpi, 2015:193). Kainji (1989) cited in McPake *et al.* (1993:1385) cautioned that the introduction of user fees might negatively impact the entire household budget. However, Litvack and Bodart (1993:380) ignored the fact that the Initiative could limit access (especially for the poorest) and argued that the policy was essential to improve quality of care.

The World Bank rationalised the policy that there were indications that people will be able to pay based on the prevailing spending at that time (see Akin *et al.,* 1987:31). Regarding the poor, the Bank suggested that charges for care should be based on the user's place of residence or that voucher should be issued to the poor based on certification of poor households by local community leaders (Akin *et al.,* 1987:31). A decade after the introduction, Dercon and Ruttens (1998:16) opined that "it would be advisable to stay away from the general introduction of higher charges for primary healthcare, in order not to jeopardise the future health of a large part of the population" who cannot pay for care. This is because of the observable adverse effects of the reform. Therefore, in the early 1990s, "some countries resorted to the establishment of Mutual Health Organisations (community-based health insurance schemes) with claims of the increasing availability of resources to enhance access to healthcare services" (Willis & Khan, 2009:1001).

In the mid-1990s, with the coordination of WHO, the Health Sector-Wide Approaches (SWAPs) was adopted by many countries for effective coordination and use of various financial resources from donors (Walford, 2007:6). Another claim made for the Approach was to ensure that donors did not determine or influence the nature of health reforms. However, most of the health reform programmes on the continent are under the 'coordination' of WHO and some other multilateral agencies, perhaps to ensure that the implementation is within their desired framework. Further, in 2000, "Health Policy for All for the 21st Century in the African region was formulated and adopted by WHO member states in Africa" (WHO Regional Office for Africa, 2000:1). The policy was based on the framework and design of the Global Health for All launched by the WHO in 1998 to renew commitments to the principles of the Alma Ata Declaration (Ajayi, 2009:18).

Other major attempts to reform health in Africa include:

1. The Abuja Declaration by African Union member states in 2001 "to allocate at least 15% of national budgets to health by 2015" (WHO, 2011:1);
2. The Addis Ababa Declaration in 2006, to strengthen the interaction between health services and the communities being served;
3. The Africa Health Strategy 2007-2015, to achieve socio-economic development through the provision of improved health services;
4. The Ouagadougou Declaration in 2008, to reinforce the healthcare system through effective governance, human resources, delivery of healthcare service, financing,

information systems and technologies, community ownership, partnership and research, and

5. The Performance-Based Financing framework introduced in the 2000s, to improve health outcomes and reduce health spending and to catalyse comprehensive health reform (WHO Regional Office for Africa, 2006, 2018:ix; New Partnership for the Development of Africa, n.d.; Ridde *et al.,* 2018).

Unfortunately, all the reforms have not been able to resolve the healthcare challenges in Africa. I will take up a more in-depth discussion of health reform later in the next chapter (Literature Review).

1.1.2 Nigerian Healthcare System: a background

The Nigerian healthcare system has gone through a series of reform. Healthcare reform is an important component of nation-building and development. It is often necessitated by the need to solve a problem or strengthen the functioning of the health system. Berman (1995:15) defined it as "a sustained, purposeful, change to improve the efficiency, equity and effectiveness of the health sector". It "is motivated by the need to address fundamental deficiencies in health systems that affect all healthcare services" (Ijeoma, 2006:136). Also, reforming healthcare is an iterative process involving several issues that need attention (Mechanic & McAlpine, 2010:155).

However, there are different approaches to achieving health reform. According to Roberts *et al.* (2003:11):

> The broad forces driving health reform in countries around the world are rising costs in healthcare, rising expectations (from the government in general and from the healthcare system in particular), limits in governments' capacity to pay the costs of healthcare (mainly among developing countries) and growing scepticism about conventional approaches to the health sector (i.e. calls for new organisational forms, dismay at poor governance and ineffective bureaucratic performance, investigations into corruption and inefficiency, and the questioning of old dogmas).

For Cassels (1995:338), "the components of a health sector reform include decentralisation of power and resources; improving the performance of civil service; improving the function of national health ministries; broadening health financing options; introducing managed

competition; working with the private sector". All of these are to ensure adequate access to healthcare services.

Although, most of the problems addressed in healthcare reform are institutional, technical, and managerial; designing and implementing healthcare reform is, by and large, a political process (Lambo & Sambo, 2003:2; Sein, 2000:12). Also, Berman (1995:26) stressed that the "political dimensions of healthcare reform require attention that may be far more important than the specific technical issues". Thus, consensus building among all stakeholders is very crucial, because successful consensus building on every component of reform process facilitates implementation of reform agenda, even in situation of political change (Lambo & Sambo, 2003). In some countries, the reforms become more complex due to the presence of a wide range of international partners (Sein, 2000:2).

Saka *et al.* (2012:51) argued that "there is no consistently applied universal standard constituting health sector reform". Instead, the reform is usually based on the performance of existing structures. More so, in the discussion of health sector reform, Berman and Bossert (2000) noted that it could involve more strategic and fundamental programmes that touch on a significant part of the healthcare system – or even the society at large ("big R" or big Reform). It can also involve reforms that address only an issue with a more limited scope of change ("small R" or small Reform). In essence, "the Federal Government of Nigeria (FGN) and the Federal Ministry of Health (FMOH) undertake to carry out a comprehensive health sector reform in order to reposition the public health sector to be more responsive to the healthcare needs of the public" (Eneji *et al.,* 2013:263).

A clear understanding of the Nigerian healthcare system must be located within the context of colonial, post-colonial and neoliberal discourses. Following the colonisation of Nigeria, the orthodox (modern) healthcare system was introduced and co-existed with the traditional healthcare system. Relating to the conventional healthcare system, we can trace the healthcare reforms in Nigeria from the various colonial development plans and national development plans designed for the country (Alubo, 1985). Consequently, we can conclude that there have been some healthcare reforms in Nigeria with various magnitudes and degrees. The healthcare reforms are discussed as follows:

1.1.2.1 Colonial Reforms

During the pre-colonial era, in areas that constitute current Nigeria, the people relied totally "on indigenous herbal and spiritual knowledge to resolve various health conditions"

(Asakitikpi, 2019:2). This was usually part of the leadership structure of the societal system, and the healthcare practitioners constituted part of the revered and respected people in society. The advent of colonialism marked the introduction of orthodox or Western medicine to the country; and the neglect of the traditional medicine was due to its association with evil, witchcraft and satanism by the European missionaries (Asakitikpi, 2019:2).

Before independence, a ten-year (first) development plan (1946-1956) was introduced by the colonial authorities in Nigeria leading to the establishment of health schools and institutions to enhance healthcare delivery (Welcome, 2011:472). More precisely in the health sector, it focused on "training of medical personnel, extension of both curative and prevention facilities and greater cooperation with voluntary agencies" (Nkwam, 1988:218). As such, it included the provision of adequate and potable water supplies as well as other health facilities that could protect the people from infections as well as endemic and epidemic diseases (Dibua, 2013:57; Utietiang, 2015:10). It was also within this period that the University College, Ibadan (now University of Ibadan) was established and commenced with a Faculty of Medicine for personnel development in the healthcare sector. However, the plan was partly deficient because it was "based on the Western conception of health and illness in which the planning of health services was taken to be synonymous with the building of hospitals, dispensaries or medical schools" (Itavyar, 1987a:495). Though the plan was not designed optimally, it has its credits (Schram, 1971 cited in Beck, 1973:695).

Also, the plan was hampered by limited financial resources, weak public policymaking and exclusion of beneficiaries (i.e. Nigerians) in the planning process (Ibietan & Ekhosuehi, 2013:299) with negative implications for the health system. Moreover, the social services provided at that time were not for the benefit of the common people. This is because, "with the high incidence of disease and death, it became non-profitable for the colonial capitalists to ignore the need for a healthy skilled workforce. Thus, most of the healthcare services were consumed by both foreigners and indigenes in the service of colonial capitalism" (Itavyar, 1987a:494).

However, the plan was abruptly ended in 1951 due to the constitutional introduction of federalism in the territory (Ibietan & Ekhosuehi, 2013:299) and the regional governments launched their different health plans to cover their respective areas of jurisdiction (Anaemene, 2016:53; Okoli, 2004 cited in Godbless *et al.*, 2019:4). For instance, "five separate development plans emerged in 1955—the three Regional Development Plans, the Plan for the

Federal Government, and one for the Southern Cameroons which was then part of the Federation of Nigeria" (Ekundare, 1971:148).

The second colonial development plan (1955-1962) laid great emphasis on training at all level, from specialists to laboratory assistants (Anaemene, 2016:53). A significant part of the administration of healthcare services was under the regional governments (Suleiman *et al.*, 2017:7), with most funding by the federal government. The colonial development plans "became necessary only when the heat of nationalism and the possibility of independence for the country become evident" (Ikeanyibe, 2009:200). More so, the plan did not make significant achievement. For Iheanacho (2014:51), it could not be regarded as a real plan "because it contained mainly a list of uncoordinated projects sited in various regions".

1.1.2.2 Post-Colonial Reforms

As experienced during the colonial era, after independence, there was also no clear-cut healthcare plan or reform in Nigeria. However, some short-term healthcare reforms can be traced to the National Development Plans [1962-1968, 1970-1974, 1975-1980 and 1981-1985] (Nigeria Federal Ministry of Health, 2009:19; Scott-Emuakpor, 2010:55; Anaemene, 2016:54). The first "national development plan (1962-1968) contained the groundwork for the promotion of industrial development, building of hospitals in major cities, dispensaries and maternity homes in rural towns and villages" (Federal Government of Nigeria, 1970 cited in Anaemene, 2016:54). During this period, major projects were executed across many sectors (Iheanacho, 2014:52) including clinics, health centres and hospitals (see Okpala, 1980:161). The plan was, however, truncated by civil war (1967-1970).

The second national development plan (1970-1974) improved on the first plan. According to Anaemene (2016:54), "the second national development plan focused in part at correcting some of the deficiencies of the health delivery services carried over from the first plan". This period featured a rapid expansion in the modern health facilities with an increased level of utilisation among the people (Orubuloye & Oni, 1996:302), though, there were still areas requiring improvement (Lambo, 1982:119; Scott-Emuakpor, 2010:60).

The Basic Health Services Scheme (BHSS) was introduced through the third national development plan (1975-1980). "The plan was developed based on the insights drawn from the performance assessments of the first and second national development plans" (Adésínà, 2012:294). Its goals included the construction of new hospitals, and expansion of existing ones, training of more health personnel and establishment of pharmaceutical and drug manufacturing

laboratories (Lambo, 1982:120). According to Omuta *et al.* (2014:23), some of the goals of the programme also "included increasing the proportion of the citizenry receiving healthcare from 25 per cent to 60 per cent, initiating the provision of adequate and effective health facilities for all Nigerians and correcting the imbalance in the distribution and location of health facilities". Asakitipi (2016:32) argued that the "first two decades after independence witnessed the relative functioning of public health centres in terms of the provision of essential drugs and access to qualified medical officers". For instance, during this period in public hospitals, there were free medical services for all and hospitalised patients were provided with meals (Alubo, 2001:314; Asakitikpi, 2019:7). Also, "between 1960 and 1980, hospital beds per 1,000 persons increased from 0.42 to 6.4; and there was a gradual drop in the incidents of infant and under-five mortality" (Adésínà, 2012:304).

Further, "the fourth national development plan (1981-1985) focused on the preventive health services and called for the establishment of a three-level healthcare service [i.e. comprehensive health centres – to serve the communities of above 20,000 persons; primary health centres – to serve communities of 5,000 to 20,000 persons; health clinics – to serve 2,000 to 5,000 persons]" (Scott-Emuakpor, 2010:56). As comprehensive as the policy appeared to be, unfortunately, the government was not able to implement it effectively because it was the period of economic crisis, and when SAPs were imposed on the country (among other developing nations around the world). As noted earlier, generally, spending on healthcare reduced and campaign for privatisation and monetisation became intense. This led to the stoppage of free healthcare and the introduction of user-fees. For Adésínà (2012:286), "1980-1985 was a period of policy transition while post-1985 prompted a process of institutional decay and erosion of social trust". The incidence compelled the government to reduce health spending and paved the way for private health investors to provide healthcare services in the country. In specific terms, the third and fourth development plans were faced with the challenge of funding (Ikeanyibe, 2009:201).

1.1.2.3 1988 National Health Policy and Strategy to Achieve Health for All

"The National Health Policy and Strategy to Achieve Health for All Nigerians promulgated in 1988 was the first comprehensive national health policy (NHP) in Nigeria" (Nigeria Federal Ministry of Health, 2004). This featured the launch of primary healthcare plan premised on the values of the Alma Ata declaration. For effective implementation, "the National Primary Health Care Development Agency (NPHCDA) was set up in 1992 to extend healthcare delivery

services to the rural areas" (Omuta *et al.,* 2014:25). However, the policy suffered "major infrastructural and personnel deficit as well as public health management" (Welcome, 2011:473).

1.1.2.4 2004 National Health Policy

In 2004, "the national health policy of 1988 was revised" (Okafor, 2016:3). The policy was mainly based on the outcome of "a 1995 National Health Summit of experts, leaders, policymakers, healthcare providers and planners, administrators and many other stakeholders (local and international) convened to examine the factors that have militated against the improvement in Nigeria's health status" (Nigeria Federal Ministry of Health, 2004:2). A series of review followed this, and the policy document was endorsed and released in 2004. The document gave attention to "HIV/AIDS, malaria, immunisation, reproductive health, health management information system, population, traditional medicine etc." (Nigeria Federal Ministry of Health, 2004: iii). Despite the health objectives contained in the policy and initiatives, "efforts at health system strengthening have not had the desired effect, resulting in limited healthcare coverage and persistently poor health status of the population" (Nigeria Federal Ministry of Health, 2018:1).

To further improve the healthcare system, health reform was made as one of the social sector reforms of the National Economic Empowerment and Development Strategy (NEEDS) launched in 2004 (Suleiman *et al.,* 2017:10; Ajala & Alonge, 2009:45; Anaemene, 2016:57). Broadly, the strategy aimed to "empower the people, promote private enterprise and change the way government does it works but the focus was limited to HIV/AIDS, malaria, tuberculosis and reproductive health in the healthcare sector" (Nigeria National Planning Commission, 2004:x). Thus, "it did not make a significant impact on the health and standard of living of the majority of the people" (Bambale, 2011:15). Generally, the health policy did not record a significant achievement, and therefore in 2016, the 2004 national health policy was revised.

1.1.2.5 2016 National Health Policy

The national health policy of 2016 emerged as a revised version of the 2004 national health policy. With a period over a decade (between the two policies), most of the challenges of the Nigerian healthcare system documented in the 2004 national health policy (and promised to be tackled) are clearly highlighted in the national health policy of 2016, unresolved and perhaps, getting worse. In clear terms, the federal government noted that the new policy was necessitated by indicators such as "weak healthcare system, the almost total absence of financial risk protection, inequity in access to services, weak governance, low confidence of consumers in

services provided (especially in public health facilities), lack of proper coordination between public and private sectors, poor referral systems etc." (Nigeria Federal Ministry of Health, 2016: xiv). Hence, the "policy was introduced to strengthen Nigeria's health system, particularly the primary healthcare sub-system, to deliver effective and comprehensive healthcare services to all Nigerians" (Nigeria Federal Ministry of Health, 2016: xiv).

Essentially, other significant attempts towards health reform in Nigeria include the National Health Insurance Scheme Decree (1999), Health Sector Reform Plan (2004-2007), and the First National Strategic Health Development Plan Framework [2010-2015] (Welcome, 2011; Nigeria Federal Ministry of Health, 2009; Ugal, 2013:4; National Bureau of Statistics, 2015). Also, in 2014, the National Health Act was enacted. The "Act (2014) is the first legislative framework for the health system, though, it has not properly addressed the gaps in the constitution" (Nigeria Federal Ministry of Health, 2016:12). More so, "the basic health care provision fund [BHCPF], mandated by the National Health Act of 2014, is meant to provide the needed financing so that all Nigerians may access a Basic Minimum Package of Health Services [BMPHS]" (Hafez, 2018: ix). This was recently set-up by the government. Put together, these strategies and plans are yet to bring about a significant transformation in the health sector.

1.1.3 Health Insurance in Nigeria: an insight

Health insurance has been under consideration in Nigeria for some time before it was finally implemented. The initial effort at introducing NHIS was in 1962, but the effort was not followed through (Awosika, 2005:42; Nnamuchi, 2009; Onyedibe *et al.*, 2012:5). However, in 1984, the federal government constituted a committee to work on an alternative method of health financing, and it recommended the introduction of health insurance (Itavyar, 1987b:310; Ibiwoye & Adeleke, 2008:220). Indeed, the adoption of health insurance in Nigeria is a result of the structural adjustment programme that severely retrenched public funding of healthcare. In the 1970s, healthcare was funded through the fiscus. "Per capita health expenditure increased from US$18.4 in 1975 to US$61.3 in 1981, but by 2004 it had declined to US$1.42" (Scott-Emuakpor 2010:59). There was no indication that healthcare cost was considered unsustainable in 1981. The critical question has always been: if Nigeria could afford universal access to healthcare in the 1970s, why is it a major problem in the 21st century when Nigeria is a far richer country than in the 1970s?

The formulation of the National Health Insurance Scheme (NHIS) commenced in 1993. Eventually, the Federal Government established it in 1999, and it became operational in 2005

(Nnamuchi, 2009). As opposed to the tax-funded health system, the NHIS programme requires the policyholders to pay premiums (with co-contributions from employers for those in the formal sector). The claim made is that the programme was implemented to deliver affordable healthcare services to all Nigerians (formal and informal sectors) through various prepayment schemes.

However, the programmes developed for different segments of people in the society have been ineffective in solving the problems of accessing quality healthcare and catastrophic health expenditure (Fonta *et al.*, 2010:122; Welcome, 2011:473; Olakunde, 2012:6; Chubike, 2013:357; Bamidele & Awobimpe, 2013:2; Asakitipi, 2016:30; Ezeama, 2016:17; Edeh & Udoikah, 2017:2384). The Nigerian NHIS has not covered up to 5% of the population since its establishment, and rural dwellers are yet to benefit from the scheme (Ejughemre *et al.*, 2015:6; Oreh, 2017:160; Nigeria Federal Ministry of Health, 2018:37; Ibrahim, 2018). The relative success recorded is among federal government employees. However, "some enrolled federal government workers have not begun to pay their employee contributions to health insurance" (Nigeria Federal Ministry of Health, 2016:16). Also, many state governments are yet to enrol into the scheme, and over 70% of Nigerians are in the informal sector (PharmAccess Foundation, 2015a:19; Ejughemre *et al.*, 2015:7; Hafez, 2018: ix). The NHIS makes no explicit provision for Nigerians in abject poverty – who cannot raise fund for feeding much less for healthcare. Among the enrollees, there are complaints about double deduction from government-employed couples and those without children complain about over-deduction because they do not have children to fully utilise the package (Nnamuchi, 2009:18).

Due to the slow pace of coverage by the NHIS and efforts to achieve universal coverage, "the Community-Based Health Insurance Scheme (CBHIS) was introduced under the NHIS in 2010" (Dutta & Hangoro, 2013:1). The CBHIS is designed for providing basic healthcare services, particularly, among the rural dwellers and those in the informal sector. It is designed as "a non-profit programme for a cohesive group of households/individuals or occupation-based groups, formed based on the ethics of mutual aid and the collective pooling of health risks, in which members take part in its management" (Nigeria NHIS, 2018).

However, before the NHIS implemented its CBHI policy in 2010 (Dutta & Hangoro, 2013:1), the Kwara State Community-Based Health Insurance Scheme became operational in 2007, as a joint project of the Kwara State Government and the Dutch Health Insurance Fund through the PharmAccess Foundation (in the Netherlands), and Nigerian-based health maintenance

organisation, Hygeia Nigeria Limited. It is claimed that the partnership was to implement a donor-subsidised health insurance scheme to bridge the gap between rural and urban dwellers. The initial agreement expired in 2013, and a new agreement was signed to span 2014 and 2018. The Kwara State government was lauded for the effort and received various awards for the programme: OECD Finalist Award, Saving Lives at Birth Award, FT/IFC Transformational Business Award etc. It was also recognised by the World Economic Forum (WEF) as an effective model for improving access to healthcare (PharmAccess Group, 2016:9). However, in less than a decade of existence, the programme has come to a halt. Therefore, this study seeks to examine the factors behind the collapse of the community-based health insurance programme in Kwara State, Nigeria.

1.2 Statement of the Problem

The current promotion of CBHI as an effective and appropriate healthcare financing strategy to be adopted across Nigeria requires a critical view. The Kwara CBHI is one of the first in Nigeria. At inception, the programme seemed to be thriving with the provision and extension of healthcare services in the rural communities. However, at some points, the programme faced challenges that threatened its sustainability and growth. Adenusi (2011) identifies inadequate enrolment, inability to pay the premium by enrollees, and insufficient healthcare providers and quality of service as problems of the programme. Also, there are problems of affordability and substandard healthcare facilities (Opowoye, 2014). Specifically, Christian Aid (2015) raises concern on the sustainability of Kwara CBHI as a donor co-funded programme. This is because of the common trend in donor-funded programmes (which are North to South aids) where the donors stop contributing after some time with the expectation that the local partner will continue to finance the programme.

Also, enrolment into the programme stopped in December 2015, and the enrollees enjoyed the services till the end of 2016. This incidence has seemingly left the enrollees in considerable despair in terms of access to affordable healthcare services. More than 70% (30 healthcare centres) of the programme facilities were established between 2014 and 2015, which is an indication of expansion. However, the expansion seems to have been in the period that the state political leaders were campaigning for re-election. McConnell (2010:350) noted that the "choices of government (including the timing of decisions and the symbolism of particular action or inaction) have consequences for the reputation and electoral prospects of politicians and their capacity to manage political agendas".

Between 2007 and 2016, the programme had enrolled about 140,000 people, and the state government provided a part funding of 1.1 billion Naira for the programme (Ahmed, 2018). Meanwhile, in 2014, the partners (implementing the programme) renewed their agreement which places more financial responsibility on the government. For instance, the government was required to contribute 60% of the premium subsidy for 2014, 70% for 2015 and 80 % from 2016 to 2018 – approximately 7 billion Naira for the 5-year health plan (see Framework Agreement on Kwara State Community Health Insurance Programme, 2014). Recently, the state government launched the Kwara State Health Insurance Scheme (KSHIS) with claims of 'replacing' the CBHI with a state-wide programme (Ahmed, 2018). The new KSHIS involves a multilateral partnership of the state government, the federal government, the Dutch government and the World Bank. Though it is claimed that the scheme will cover all residents in the state, but the experience with the CBHI programme seems to raise concerns about the new programme to attend to the healthcare requirements of the people effectively.

Unfortunately, the considerable investment in the Kwara CBHI programme is not commensurate with the outcome. Also, worrisome is the low enrolment figure for nine years (2007-2016), which was 139,713 – an average of 15,524 persons per year. Thus, the coverage was 4.41% of the state population (estimated at 3,166,513 by the National Bureau of Statistics at the end of 2016) when the programme was terminated. This implies that at that pace, it would take a very long time (203.9 years) to attain universal coverage in Kwara through CBHI even if it is still operational.

Most of the studies on Kwara CBHI are filled with optimism about the efficiency of the programme (see Babatunde *et al.,* 2011; Hendriks *et al.,* 2013; Akande, 2015; Odusola *et al.,* 2016; Brals *et al.,* 2017). Though, some of the studies identify areas in need of improvement, only a few (see Adenusi, 2011; Opowoye, 2014; Christian Aid, 2015) gave adequate attention to identifying the challenges capable of impeding its service delivery. Since the collapse of the programme, no conscious attempt has been made to investigate the reasons for the sudden stoppage of healthcare service delivery. There are many lessons to learn from policy failures as are from policy successes. Hence, this study seeks to explain the collapse of CBHI in Kwara State Nigeria, essentially, from a political-economic perspective not only for understanding the healthcare system but also to examine the various narratives that shape the health policy-making.

1.3 Research Objectives

The main objective of the study is to examine the collapse of Community-Based Health Insurance in Kwara State, Nigeria. The specific objectives are:

(i) To explore the perceptions of members of the communities about the CBHI programme in Kwara State Nigeria.

(ii) To examine the various elements (actors, content, context and process) that influenced the design and implementation of the CBHI programme in Kwara State Nigeria.

(iii) To assess the funding mechanisms of the CBHI programme in Kwara State Nigeria.

(iv) To identify the factors that led to the collapse or stoppage of the CBHI programme in Kwara State Nigeria.

1.4 Research Questions

(i) What are the perceptions of the community members about the CBHI programme in Kwara State Nigeria?

(ii) What are the various elements (actors, content, context and process) that influenced the design and implementation of the CBHI programme in Kwara State Nigeria?

(iii) What were the funding mechanisms of the CBHI programme in Kwara State Nigeria?

(iv) What are the factors that led to the collapse or stoppage of the CBHI programme in Kwara State Nigeria?

1.5 Limitation of the Study

The study covered 11 communities (out of the 43 communities where the programme was operational) sampled across the three (3) geopolitical zones in the State. The researcher did not cover the whole population because of time and financial constraints. However, the methodology (i.e. mixed-methods) choice is towards making the findings representative of the entire population. This would be discussed further in the methodology chapter (Chapter 4) of the thesis.

1.6 Significance of the Study

There have been contributions to the literature on CBHI in Nigeria. However, this kind of study is rare in Nigeria and has not been carried out in Kwara State. Accordingly, this study contributes to the literature and existing debate on CBHI programme in the developing

countries and Nigeria in particular. While most available studies appear to focus on 'success' and sustainability issues, this study fills the gap in knowledge regarding the failure of CBHI programme. In specific terms, it broadens understanding about the failure of CBHI in Kwara State.

At the level of policy, this study drives the consciousness of policymakers towards issues that are left out of the debate with a view to identifying and adopting a more effective health financing strategy. The study also assists policymakers and other stakeholders (e.g. academia) in policy planning and implementation. Also, most of the studies on CBHI are carried out using solely quantitative or qualitative method. However, the researcher adopts a mixed-method approach in carrying out this study.

1.7 Chapter Outline

Chapter 1: Introduction

The chapter provides a general background to the study. It also discusses the healthcare reforms in Africa since 1980. It further traces reforms in the Nigerian health sector from the colonial period to date and gives an insight into the emergence of health insurance in Nigeria. Essentially, the implementation of health insurance in Nigeria was due to the cut in public spending on social services. Besides, the chapter contains a statement of the problem, research objectives, research questions, limitation of the study, the significance of the study and chapter outline.

Chapter 2: Literature Review

The chapter examines the main health financing mechanisms that have been adopted around the world over the years to understand the emergence of the CBHI policy option. It also critically reviews the healthcare reform process and healthcare financing strategies in Nigeria. The review reveals that there is poor coordination in the healthcare policy space in Nigeria with the possibility of veering from the fundamental policy objectives due to external interference. Further, it presents a critical analysis of the CBHI programme in Nigeria as well as the Ghanaian and Rwandan CBHI Experiences.

Chapter 3: Conceptual Framework

The chapter contains the conceptual framework adopted in the study. The Walt and Gilson (1994) health policy triangle helps to examine health policies in developing countries. The

framework argues that to understand a health policy better, there is a need to critically examine the policy content, context, process and actors.

Chapter 4: Research Methodology

This chapter discusses the methodology adopted for the study and the theoretical underpinnings behind the mixed-methods approach used in the study. Specifically, the chapter details the main research paradigms and locates this study within the mixed-methods approach. Further, it describes the sampling techniques, the research site, instruments employed for data collection and how the data were collected. Again, it addressed the validity and reliability concerns in the study. Likewise, the chapter details the quantitative and qualitative data analysis techniques. It further includes the ethical considerations, reflexivity and fieldwork challenges encountered by the researcher.

Chapter 5: Design and Implementation of the CBHI Programme

This chapter focuses mostly on the technical issues in the design and implementation of the programme. It commences with the examination of the healthcare situation in rural Kwara before the introduction of the programme. It also discusses the design of the CBHI programme detailing the healthcare benefits package offered. The chapter further examines the roles of the main actors in the implementation of the programme. The main actors were the Kwara State Government, the PharmAccess Foundation and the Hygeia Nigeria Limited. Also, it explores the process of implementation of the programme. This includes piloting and provision of healthcare facilities, sensitisation and enrolment into the programme, expansion into communities, engagement of healthcare providers, capacity building for healthcare workers, monitoring and evaluation of the programme as well as decision-making. Finally, it discusses the main achievements of the CBHI programme in rural Kwara.

Chapter 6: Perceptions and Experiences of Community Members about the CBHI Programme

The chapter reflects on the perceptions and experiences of the community members about the CBHI programme in Kwara State Nigeria. It examines the level of awareness among the people about the programme. Specifically, the majority of the people became aware of it through family and friends. The community leaders were also enjoined to endorse the programme and encourage their people to enrol. This approach enhanced the interest and trust of the people in the programme. Besides, the chapter discusses enrolment in the programme

detailing the reasons for enrolment and non-enrolment in the programme. It also examines how the non-enrollees catered for their healthcare needs when the programme was operational. Further, it discusses the delivery of healthcare services under the programme by analysing the conduct of the healthcare providers, quality of care, a combination of alternative/traditional care and CBHI care, as well as knowledge of the CBHI health benefits package among the former enrollees. Though there were complaints, most of the former-enrollees in the study were satisfied with the conduct of the healthcare providers and the quality of service.

Chapter 7: Funding Mechanisms of the CBHI Programme in Kwara State

This chapter focuses on the funding strategies adopted for the implementation of the programme. Notably, it examines the sources of fund for the programme, affordability of the enrolment premium and capacity of government to provide free healthcare services. The primary sources of fund for the programme were contributions by the partners (i.e. the Kwara State Government and the Dutch Health Insurance Fund) and the premiums paid by the enrollees. On affordability, the study found that the majority of the community members could not afford the enrolment premium. Further, the majority of the respondents noted that the government has the capacity to provide free healthcare for the people.

Chapter 8: Stoppage of the CBHI Programme in Kwara State Nigeria

The chapter focuses on the stoppage of the CBHI programme in Kwara State. It examines the challenges and moral issues in the programme as it relates to the roles of the state government, the health maintenance organisation and the healthcare providers. The challenges include stock-out of drugs, reduction in health benefits, inadequate enrolment coverage, low capitation, clash of interest between the health maintenance organisation and the healthcare providers, long waiting period, preference for non-enrollees, foray of healthcare providers in enrolment exercise and abuse of care by the former enrollees. Though the stoppage stemmed from these challenges, the chapter further traces the main reasons behind the collapse of the programme, namely: non-payment of counterpart fund by the state government and poor management. Finally, the chapter examines the healthcare situation in the rural communities in the post-CBHI period.

Chapter 9: Politics of Healthcare Reform: A Case of the CBHI in Kwara State Nigeria

This chapter discusses the power relations around the introduction and implementation of the programme. Notably, it explores how the CBHI policy was offered to the Kwara State Government, the alliances between the foreign partners and local actors and how the policy

was accepted for implementation in the State. Also, the chapter shows that the policy space was dominated by the international partner at the stages of design and implementation. Further, the chapter reveals that, to an extent, the stoppage of the programme influenced the outcome of the 2019 general elections in the State, particularly in the study communities – with the loss of power by the then ruling party. Lastly, the chapter argues for a need to repurpose the role of the State (i.e. government) to attain universal health coverage.

Chapter 10: Conclusion

This chapter summarises the major findings from the study. In addition, it offers policy recommendations and concludes with suggestions for future research.

1.8 Conclusion

The chapter provided a detailed introduction to the study. It explained how neoliberalism crept into the policy space in the developing countries, especially as it affected the healthcare sector. In addition, the chapter examined the healthcare reforms in Africa since 1980 and the healthcare reforms in Nigeria from colonial era to date. It also gave an insight into the emergence of health insurance in Nigeria. Further, the chapter covered statement of the problem, research objectives, research questions, limitation of the study and the significance of the study. Finally, the chapter provided a map of the thesis by detailing the content of each chapter.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Healthcare financing appears as a major challenge for many developing countries in Africa and Asia. Community-based health insurance which is being advanced as an effective model for financing healthcare, has generated a series of debate regarding its efficiency in improving access to healthcare and achieving universal health coverage. To understand how CBHI became a health policy option in Nigeria, this chapter analysed the main health reform models that have been adopted across the world over time, the process of healthcare reform in Nigeria and healthcare financing in Nigeria. More so, the review paid attention to the neoliberal forces behind the various health reform programmes in Nigeria. Also, this chapter examines CBHI as a policy with a critical look at the experiences of Nigeria, Ghana and Rwanda.

2.2 Healthcare Financing Reform

The main "objectives of the healthcare system are to enhance the quality of care, health outcomes, equity in access as well as to contain costs" (Or *et al.,* 2010:271). Specifically, the core functions of the healthcare system are stewardship, resource generation, service provision and financing (WHO 2000 cited in Cuadrado *et al.,* 2019). Different countries embark on healthcare reforms at various points in time to achieve these functions. As noted in Chapter 1, healthcare reform became necessary in the LMICs, especially in Africa in the 1980s as a result of the SAPs that necessitated a cut in social spending. Meanwhile, the focus was more on financing reform – leading to consideration of introducing prepayment and risk-pooling mechanisms, among other options – because it is crucial to the overall success of any reform.

Healthcare financing refers "to the mechanisms used for raising the money that pays for the activities in the health sector, including taxes, insurance, and direct payments by the patients" (Blas, 2005:11). Also, Obansa & Omisan (2013:230) defined it as the "collection of funds from various sources (e.g. government, households, businesses, and donors), pooling them to share financial risk across larger population groups and using them to pay for services from public and private healthcare providers". Basically, health financing reform is the strategy adopted for sourcing and allocating fund for the healthcare sector. More so, the nature of health financing in a country determines the quality of care and behaviour of different stakeholders in the healthcare system (Essien *et al.,* 2014:10572).

There are different models of healthcare financing reform that have been adopted over time towards achieving the objectives of the healthcare system. Essentially, the main differences in the various models relate to "how benefits are assigned, how providers are organised, and how services are purchased and paid" (Giedion *et al.*, 2013:2). While they are numerous, historically, the main models of healthcare financing reforms across countries are social health insurance model, tax-based health insurance model, private health insurance model, national health insurance, and the out-of-pocket model (Magnussen *et al.*, 2009:9; Reid, 2009 cited in Batalden, 2018; Shimazaki, 2013; Lopez-Casasnovas *et al.*, 2015). Though the classification may not be perfect, it assists with a better understanding of various financing options that have been adopted over the years. As such, the models are further categorised as private mechanisms [private insurance and direct out-of-pocket payments] and public mechanisms [tax-funding, national and social health insurance] (Beattie *et al.*, 2016:15; WHO 2019:3).

More so, there may be variation in their implementation from one country to the other. This is because the suitability of each model or mechanism is based on the context of each country (KPMG International, 2017:16; van der Zee & Kroneman, 2007:1) and in some cases, features from different models are combined to come up with a new desired model. For instance, Thailand finances the healthcare of those in the formal sector through statutory health insurance and those in the informal sector are covered from general taxation (Beattie *et al.*, 2016:35; Witter *et al.*, 2017:7). Further, Mathauer *et al.* (2019:3) noted that "prepayment systems of healthcare financing can be broadly distinguished along with institutional design aspects of pooling arrangement: nature of pooling (compulsory/automatic versus voluntary) and the structure of pooling (single versus multiple pools)". They added that "these two key design aspects determine the redistributive capacity of those funds to support access to needed services with financial protection, and they have important implications for efficiency". The main models are, therefore considered as follows:

2.2.1 Social Health Insurance Model

The Social Health Insurance System (SHI) started in Germany in 1883 by Otto von Bismarck to offer healthcare services to the citizens through insurance and co-paid by employers and employees based on payroll deductions (Batalden, 2018). It emerged from various sickness funds that were already existing, in the wake of rapid industrialisation. This model of the healthcare system was implemented to improve the well-being of the people in the area of healthcare. The earliest beneficiaries were employees at railways, power plants, metal works,

shipyards, etc., and it was extended gradually towards covering the entire population (Bump, 2015:32; Merrill, 1994:171). Enrolment is mandatory and often employment-based.

The Bismarck system provides healthcare to all citizens, and the government acts as a regulator (Choi *et al.*, 2016:432). Precisely, the state is responsible for those who are not in employment, the homeless and the immigrants through general revenues (Savage *et al.*, 2011:27; Gaeta *et al.*, 2017:114). The core principles of the SHI-type healthcare systems are "plurality, liberty and solidarity" (Fredriksson *et al.*, 2018:2) which allow the users to choose providers and also grant the provider the right to practice as they wish, to some extent. Other countries that have adopted this model in various forms include The Netherlands, France, Japan, Belgium, Indonesia, Nigeria, etc.

The supporters of this model claimed that it offers a variety of providers and an abundance of choice to the users (see Or *et al.*, 2010:270). Also, the nature of pooling is compulsory, and it makes the overall risk profile of the population to have financial sustainability (Mathauer *et al.*, 2019:3). Additionally, it has less dependence on budgetary allocation for healthcare, and it is highly redistributive among participants (Gottret & Schieber, 2006:87). However, opponents of the model maintained that it fails to control cost [with negative consequences on equitable access] (Or *et al.*, 2010:270: Razum & Va'zquez, 2017:959) and selective purchasing (Savage *et al.*, 2011:29). Also, "introducing SHI in economies in which most of the population is in the informal sector runs the great risk of widening existing disparities in access to care and financial protection" (Kutzin *et al.*, 2009:549). The fact that it is mainly employment-based shows the tendency of relative exclusion of those in the informal sector – partly due to the sustainability challenge.

For instance, recent reforms in Germany have shifted the costs to users through "user-fees or co-payments although the fees are lowered or exempted for those with chronic illnesses, low-income earners and citizens under 18 years" (Savage *et al.*, 2011:28). While coverage of those without employment or income may not be a major problem in the developed nations, it constitutes a significant source of concern in the LMICs. Beyond the situation where some countries (e.g. Nigeria) are yet to cover the formal sector – after many years of implementation; in the LMICs, SHI tends to focus resources on those in the formal sector – that are economically advantaged at the expense of the larger population (Kutzin, 2013:606).

2.2.2 Tax-Based Health Insurance Model

The tax-based health insurance refers to a system where "public sector, including the central and local governments, directly provides medical services financed through taxation" (Shimazaki, 2013). Put differently, Savedoff (2004:3) defined it as a system "in which more than half of public expenditure is financed through revenues other than earmarked payroll taxes, and in which access to publicly-financed services is, at least formally, open to all citizens". This model originated in the United Kingdom and known as the Beveridge model. It was named after William Beveridge whose report formed the basis for implementing the policy in 1942. It emerged from the agitation of the trade union for a better social protection system since industrialisation could generate the needed financial resources (Bump, 2015:34).

In the Beveridge model, the government has the responsibility to provide and finance healthcare from the state's budget through general taxation (Batalden, 2018). The model, also known as National Health System (NHS), is not based on profit-motivation, and the government provides coverage to those who are not in employment (Gaeta *et al.,* 2017:114). In other words, it is a system whereby the government provides healthcare coverage for all citizens and financed through tax payments (Choi *et al.,* 2016:432). The government has greater regulatory power in the sector. The core principles common in these countries are "universality and plurality" (Fredriksson *et al.,* 2018:2). The model has been implemented in other countries like Cuba, New Zealand, Denmark, Finland, Ireland etc.

Its promoters argued that it ensures equitable access and minimises cost, adverse selection and cost-shifting by the insurers and the providers (Or *et al.,* 2010:270). Additionally, it appears more progressive because payment is based on income (Magnussen *et al.,* 2009:9) and funds are generated from other revenue sources from virtually all the citizens through value-added taxes, import duties etc. (Savedoff, 2004:3). However, the system has been criticised that it offers a limited choice for patients and long waiting times (Or *et al.,* 2010:269). Also, the effective implementation of this model in the LMICs will be difficult because general government revenues are crucial for attaining universal health coverage (Kutzin, 2012:867). Meanwhile, most of the people in these nations are in the informal sector.

2.2.3 Private Health Insurance Model

Private Health Insurance (PHI) model is a profit-oriented model that is often linked to the formal sector and offered by multiple insurers that compete for clients (Mathauer *et al.,*

2019:8). The healthcare providers fix premium based on their assessment of the risk level (Asomani, 2014:4). In PHI, health insurance coverage may be purchased from commercial insurance firms; not-for-profit or community insurance entities; and voluntary self-employed insurance fund (WHO, 2019:4). The prominent features of this model are private ownership of health sector inputs, voluntary, competitive and employer-based or individual purchase (Gottret & Schieber, 2006:104; Schieber *et al.*, 2006:226). PHI is exemplified by the USA where apart from the Medicare scheme for the elderly (based on social insurance model) and the Medicaid scheme for the poor (funded by taxes), healthcare financing is left to the private sector (Shimazaki, 2013).

PHI is common and often co-exists with other models such as the tax-funded healthcare system in some countries. Though operated in different ways, PHI is allowed as an additional financing mechanism in countries such as the UK and Canada (Gillies, 2003:57) and many other countries. The model provides good benefits and protection for those who can afford it, especially if it can exclude individuals with high risks (Kutzin, 2013:606). It also diversifies the risk of medical expenses through private insurers (Shimazaki, 2013). Further, it allows individuals to opt for elective services at their convenience (Gillies, 2003:57) and boycott possible delay that is common with the public health system.

In contrast, the model has a common challenge of adverse selection which tends to exclude individuals with high risk. This has implication for equity because the excluded individuals may experience inadequate access and high cost of care etc. (Gottret & Schieber, 2006:107). More so, due to competition, premiums are based on illness or relative risk rather than income or ability to pay (Evans, 2002:37). Though it exists on a small scale in some LMICs, including Nigeria, it appears not suitable for them because of the level of poverty in the countries.

It is also partly in conflict with the overall objectives of UHC because it provides access to few fractions of the population at the expense of others (Kutzin, 2013:606; Beattie *et al.*, 2016:35). For instance, PHI accounted for over 20% of the healthcare spending in the Bahamas, Brazil, Namibia and Botswana in 2016 (WHO, 2018 cited in Mathauer *et al.*, 2019:8-9). Also, "40% of total health spending in South Africa is to the benefit of 16% of the population through employment-based medical cover" (Kutzin, 2013:606). Also, it becomes a duplication in countries where people have access to a publicly-financed healthcare system (Mathauer *et al.*, 2019:8).

2.2.4 National Health Insurance (NHI)

In this model (also known as a single-payer model), services are mostly delivered by private healthcare facilities and a government-run insurance agency regulates and facilitates the collection of funds and payment of bills (Lopez-Casasnovas *et al.*, 2015:153; Batalden, 2018). With compulsory or automatic coverage, healthcare services are financed using a single national pool by the government through income or general revenues (Econex, 2011:2; Choi *et al.*, 2016:433; Mathauer *et al.*, 2019:5). Therefore, entitlement to healthcare services is not dependent on citizen's capacity to contribute (Cuadrado *et al.*, 2019). Countries such as Canada, Australia and Turkey have implemented this model. Among the LMICs, Indonesia has implemented a single-payer system to provide some services for its large population in the informal sector (Beattie *et al.*, 2016:36).

The NHI depends mainly on state participation and regulation (Cuadrado *et al.*, 2019). Mathauer *et al.* (2019:5) explained that the pooling arrangement might take two forms: (i) the health ministry pools the fund into the healthcare budget and then allocates to the healthcare providers (HCPs) who are to provide equitable access to all with not clear purchaser-provider split – examples are Malta and Swaziland; (ii) a separate pooling and purchasing agency manages the single national fund with purchaser-provider split – examples of this are Costa Rica, Mongolia and Estonia.

Supporters of this model argued that it offers efficiency in ensuring maximum capacity for cross-subsidisation towards providing coverage for all with some support from the rich (Beattie *et al.*, 2016:35; Mathauer *et al.*, 2019:4). Also, it offers universal coverage of the population – right from the start – and a simplified mode of governance with potential for administrative efficiency (Gottret & Schieber, 2006:76-78; Econex, 2011:3). However, the model has been linked with challenges of cost containment and a long waiting period (Savage *et al.*, 2011:24). For example, some services are unavailable in the Canadian NHI culminating in extra costs and less satisfaction (Econex, 2011:7). Nevertheless, these could be resolved as the healthcare system expands and grows. For this model to be effective in the LMICs, the government must have an ideational commitment and also institute plans to raise sufficient fund for healthcare because of the financial crisis that is common with these countries (Gottret & Schieber, 2006:73-74).

2.2.5 Out-of-Pocket Model

Out-of-pocket (OOP) refers to the "payments made by users for healthcare services at the point of use" (Witter *et al.,* 2017:6). The OOP model requires each user or citizen to "pay for the medical/health services and products they receive out of their savings [pockets]" (Choi *et al.,* 2016:433). According to Gilson and McIntyre (2005:762), "OOP payments (which include user fees at public sector facilities) are more regressive than any other method of financing health care, capturing a higher proportion of income among poor households than wealthier ones". It places the burden of payment on the individual who seeks healthcare service, at the point of need (McIyntre, 2012:4). The out-of-pocket (OOP) model according to Batalden (2018), exists in countries that do not have an organised system of paying and providing healthcare services, where individuals pay for most or all of their healthcare. It appears that no country consciously adopts this model of health financing. Still, it emanates from a weak healthcare financing system, leaving citizens with no other option than paying out-of-pocket to access healthcare.

Since the imposition of SAPs, this system of health financing is common in the LMICs such as India, Nigeria - where the healthcare systems are not viable enough to protect the majority of the people. This is because those who cannot afford to enrol in prepaid schemes or where the needed care of enrollees are not covered, they have to pay OOP to access healthcare services (Gottret & Schieber, 2006:92). In other words, "in systems where there is no universal coverage, the portion of the population that is uncovered or only partially covered has to pay out-of-pocket for medical services" (Econex, 2011:3). The OOP model may take any of the following forms: "individual payment for a visit to a private doctor; official user-fees or co-payments; payment paid in public facilities to healthcare workers; and payments for drugs and other supplies for treatment" (WHO, 2019:3-4).

This model is the worst because it is based on purchase power of individuals and thereby creates a disparity in access and utilisation of healthcare services among the people (McIyntre, 2012:4; Deo *et al.,* 2018:45). In 2007, "OOP payments accounted for more than 50% of health expenditure in 33 LMICs" (WHO 2010 cited in Asante *et al.,* 2016:2) and its impoverishing effects necessitate the adoption of pre-payment mechanisms for healthcare financing in many developing countries (Mejia, 2013:232). This model has catastrophic health expenditure and has negative consequences for equity in access (Evans *et al.,* 2010, cited in Cuadrado *et al.,* 2019). The non-suitability of these various financing models for the socio-economic realities

in the LMICs led to the introduction of the CBHI option. This is discussed further in the proceeding sections of this chapter.

2.3 Healthcare Reform Process in Nigeria: Behind the Scenes

Health reform "deals with a fundamental change of processes in policies and institutional arrangement of the health sector, usually guided by the government" (Sein, 2000:1). Cassels (1995:331) noted that health sector reform involves "defining priorities, refining policies and reforming the institutions through which those policies are implemented". However, "existing institutions and interest groups often have both the reasons and the resources to oppose change vigorously. As a result, it often takes some sort of political or economic shock to begin the health sector reform process" (Roberts *et al.*, 2003:4). Also, health reform can be blocked or slowed down by issues "relating to control over financial resources (at federal, state and local levels), weak regulatory capacity and poor coordination" (Ananaba *et al.,* 2018:1). These partly explain the lack of capacity by the Federal Ministry of Health to efficiently supervise the healthcare sector in Nigeria because the Nigerian constitution places healthcare on the concurrent legislative list. Meanwhile, one of the rationales for decentralisation of responsibility is to bring "decision-making nearer to the grassroots and allow those who 'understand' the problems to be directly involved in the planning and execution of programmes meant to benefit such communities" (Obansa & Omisan, 2013:227).

In Nigeria, "there is poor coordination between government, development partners and Non-Governmental Organisations' (NGOs) activities, as well as poor alignment to national priorities and programmes" (Ananaba *et al.,* 2018:12). For example, Shaw *et al.* (2015) [cited in Ananaba *et al.* (2018:12)] revealed that "in 2011, 57% of total external financial assistance for the health sector was for sexually transmitted diseases and HIV/AIDS. Meanwhile, Nigeria's burden of diseases associated with HIV/AIDS/TB was estimated to be less than 5%". This amounted to misplacement of priority. It was also noted that Nigeria's health policies do not give adequate attention to the various ways of seeking healthcare (e.g. traditional or spiritual healthcare) among the people thereby compromising the principles of equity and coverage (Asakitikpi, 2019:10).

According to Mirzoev *et al.* (2015), "the achievement of robust health policy reform process is determined by policy context; the Ministry of Health's leadership and governance; involvement of policy actors; the role of evidence; and effective use of available resources for policy processes". They argued that "these five determinants are related, and capacity needs

exist in relation to each determinant". Usually, the process for developing healthcare reform or national health policy in Nigeria is "initiated by the FMOH through consensus-building among stakeholders" (Nigeria Federal Ministry of Health, 2016: xiv). After that, a Technical Working Group (TWG) was established, comprising the "relevant officials of FMOH and its various agencies, representatives of the development partners, private health sectors, civil society organisations (CSOs), regulatory bodies, ministries of health from the states and the FCT (Federal Capital Territory) and the academia" (Nigeria Federal Ministry of Health, 2016: xiv). The involvement of the various stakeholders is to ensure broader consultation and emergence of a robust and comprehensive policy. The group, therefore, meets to examine the achievements, weaknesses and challenges of the previous health policies or plans to chart a way forward through the development of new policy.

The implementation of healthcare reform takes the form of introducing necessary health plans or programmes. As such, the national health policy document represents "the point of reference in providing a sound foundation for the planning, organising and managing of the nation's overall health system" (Nigeria Federal Ministry of Health, 2004:v). Further, it constitutes a "suitable framework for the design and successful implementation of government-led comprehensive health sector reforms in the country" (Nigeria Federal Ministry of Health, 2004:v). Ogundana (2012:440) noted that the 1988 national health policy was implemented through "initiatives such as the national health plans, the outcomes of the National Vision Committee, the Health Sector Development Framework and Reform Initiative, including the efforts made at pursuing the Millennium Development Goals (MDGs)". In fact, between 1960 and 2009, Nigeria adopted over 24 sub-sectoral health policies (Nigeria Federal Ministry of Health, 2009:19).

Besides, the 2004 "revised national health policy was operationalised through the National Health Sector Reform Programme (2004-2007) and the National Strategic Health Development Plan (2010-2015 but extended till 2016) and other annual operational plans" (Nigeria Federal Ministry of Health, 2016:1). Other sub-sectoral health policies or plans are "Reproductive Health Policy, National Health Promotion Policy, Health Financing Policy, National Human Resources for Health (HRH) Policy and Plan, and National Strategic Plan of Action for Nutrition etc." (Nigeria Federal Ministry of Health, 2016:12).

Furthermore, the 2016 national health policy is being operationalised through "the National Strategic Health Development Plan II (2018-2022) which recognises Nigeria's aspiration to attain Universal Health Coverage (to have one functional Primary Health Clinic per ward) as well as consideration for expanding the pre-payment social health insurance, unfinished business of the Millennium Development Goals, the Sustainable Development Goals and the Global Post 2015 Development Agenda, the renewed Global Commitment for countries to progressively attain Universal Health Coverage, the National Health Act, the Economic Recovery and Growth Plan (2017-2020) and the National Vision 20:2020" (Nigeria Federal Ministry of Health, 2018:i). For oversight and monitoring of the programmes, the responsibility rests in the "National Council on Health, Health Partners Coordinating Committee (chaired by the Minister), the Development Partners Group for Health and other technical/task groups" (Nigeria Federal Ministry of Health, 2016:12). However, there is often duplication of functions due to poor coordination among the various groups (African Development Fund, 2002:5). This is a significant impediment limiting the success rate of the reform programmes.

Notwithstanding the importance of broader consultation in policymaking, where it exists, it is imperative to ensure that the ideational basis of the reform is not eroded to achieve positive results. More comprehensive consultation in the policymaking process might be reasonably based on trust mainly, to make the best decisions. Groenewegen *et al.* (2019:1) emphasised that the smooth functioning of healthcare systems requires mutual trust between parties involved. That is, there must be unity of purpose without ulterior motives. However, in general terms, "neoliberalism is more expressive in SSA because the region continues to offer a fertile ground for experimentation of policies for contending ideologies of international and multilateral agencies" (Ichoku & Ifelunini, 2017:490).

Specifically, Odutola (2003) [cited in Ajala and Alonge (2009:41)], maintained that donors, multilateral and bilateral organisations see health sector reforms or health policymaking as a project to "rationalise health programmes, emphasise basic and population health, promote economic efficiency and rein in public sector spending while promoting increasing privatisation". Also, Gautier and Ridde (2017:2) argued that "global health decision-making primarily involves a wide variety of donors including bilateral, multilateral agencies, and international financial institutions (IFIs), as well as non-state actors (i.e. non-governmental organisations and private-for-profit entities) and as such, the political voice and power of developing nations' governments tend to be limited".

For instance, Cali *et al.* (2018:137) noted that "since 2010, United States Agency for International Development (USAID) has been involved in the development of health financing strategies or reforms in eight countries (Bangladesh, Botswana, Cambodia, Haiti, Nigeria, Senegal, Tanzania, and Vietnam), with the Health Financing and Governance Project (HFG) participating in seven countries and Health Systems Strengthening Plus (HSS+) involved in Senegal". Also, "the United Kingdom's Department for International Development (DFID) played significant roles in the policy dimensions of programmes such as the Partnership for Transforming Health Systems (PATHS) and the Programme for Reviving Routine Immunisation in Northern Nigeria –Maternal, Newborn and Child Health (PRRINN-MNCH)" (Ananaba *et al.,* 2018:1). Apparently, this provides an avenue to influence the decisions in the reform.

Mostly in the guise of financial and technical support, it appears that Nigeria has not been able to insulate its policy initiatives from external interference consciously. According to Ogundana (2012:444), "the evolution of the 1988 National Health Policy was indirectly initiated by the World Bank and its implementation had been in collaboration with external funding agencies such as the World Bank, USAID and UNFPA, among others". Due to high level of influence, "some of these development partners finance health independently and not in accordance with governments' policy thrust leading to inefficient use of scarce resources and duplication of efforts" (Uzochukwu *et al.,* 2015:443). Moreover, "total aid financing in Nigeria is less than 5% of total health expenditure" and is mainly channelled through vertical programmes for tackling specific diseases (Ananaba *et al.,* 2018:1). However, vertical approach to healthcare is inimical to the principle of comprehensive healthcare being sought by Nigeria or as enshrined in the Alma Ata Declaration.

Furthermore, the 2004 NHP was framed within the scope of the Health Strategy of the NEPAD, MDGs and NEEDS (Nigeria Federal Ministry of Health, 2016:5; Ewurum *et al.,* 2015:198). However, the NEPAD and NEEDS' frameworks are products of the neoliberal ideology (Adésínà, 2004:142; Obansa & Omisan, 2013:235) and therefore could not provide a solution to the challenges of the healthcare sector or cater to the healthcare requirements of the Nigerian people. Unfortunately, in Nigeria, neoliberalism has significant implications for government policies by de-emphasising favourable government policies and encouraging free-market methods (Ogundana, 2012:439). Notwithstanding, there are other factors related to the inefficiency in the Nigerian healthcare system. At times, elected and unelected public

officials or local actors tend to "deviate significantly from national policy initiatives" (Gros, 2016:3).

Also, the 2016 NHP was based on the need to "develop a health policy that would reflect new realities and trends, including unfinished agenda of the Millennium Development Goals (MDGs), Sustainable Development Goals (SDGs), emerging health issues (especially epidemics), the provisions of the National Health Act 2014, the new Primary Health Care (PHC) governance reform of bringing PHC Under One Roof (PHCUOR), and Nigeria's renewed commitment to UHC" (Nigeria Federal Ministry of Health, 2016: xiii). Meanwhile, the relevance of some of these global policies to the Nigerian realities is an issue of contention. More so, a study by Mirzoev *et al.* (2014) indicated that international agencies greatly influence health policy decisions using 'evidence'. According to Abbasi (1999) [cited in Blas (2005:11)], "blueprints for reform, such as the one presented in the World Development Report in 1993 can be, and often are, prepared at a drawing board without adequate empirical evidence". Thus, these agencies tend to direct policy decisions and implementation towards their interests. Generally, health sector reforms cannot be very effective without the needed leadership and institutional structures (Blas, 2005:93; Obansa & Omisan, 2013:226-227; Saka *et al.*,2012:54; Jowett *et al.*, 2016:3).

2.4 Healthcare Financing in Nigeria: An Overview

Over time, various governments have paid lip service to improving the healthcare system in Nigeria without sufficient financial commitment. Within the "Sub-Saharan African region, countries such as South Africa and Angola spend seven and three times more per capita on healthcare, respectively than Nigeria does. The per capita expenditure on healthcare in Nigeria pales into insignificance when compared with some developed countries like the United States that spends an average of 7,000 US dollars per capita; Switzerland, which spends about 6,000 US dollars per capita; or an average of 3,600 US dollars per capita among developing countries in Europe" (World Bank, 2013 cited in Ejughemre, 2014b:14). This is not a new trend in Nigeria. Specifically, concerning the third and fourth national development plans, only 1.6% and 4.4% (with populations of 75 million and almost 90 million) of the total proposed expenditure were committed to health, respectively (Scott-Emuakpor, 2010:59). Also, "an average of 5% was allocated to the health sector between 1995 and 2010, indicating a slight increase from the allocations in the 1980s and early 1990s" (Okafor, 2016:3).

Also, since 2000, the federal budget for healthcare stands at 7% (Nigeria Federal Ministry of Health, 2016:14; Hafez, 2018) and has not exceeded 6% since 2010 (Nigeria Federal Ministry of Health, 2018:38), far less than the African Union standard of 15%. This is because "the percentage of public expenditure on health stood at 5.4% in 2011; 5.8% in 2012; 5.7% in 2013; 6.0% in 2014 and 5.5% in 2015" (Nigeria Federal Ministry of Health, 2015 cited in Okafor, 2016:3). Worse still, the share of recurrent expenditure in the inadequate allocation is usually higher than capital (Ogundana, 2012:442) and often, the amount released falls short of the approved budgetary allocation (Nigeria Federal Ministry of Health, 2018:38). Consequently, many Nigerians are subjected to out-of-pocket (OOP) and catastrophic health expenditure.

Most health policies and plans in Nigeria usually contain healthcare financing because of its critical position in the healthcare system. Specifically, the 2006 health financing policy has an "overall goal of ensuring that adequate and sustainable funds are available and allocated for accessible, affordable, efficient, and equitable healthcare provision and consumption" (Uzochukwu *et al.*, 2015:438). It, therefore, becomes worrisome that despite the existence of this policy, among others, Nigeria still faces the problem of healthcare financing.

Nevertheless, it is important to note that the imposition of the SAPs was ideological, and it negatively impacted the Nigerian health system, particularly in the area of financing. Ikeanyibe (2009:201) noted that "SAPs underscored a shift from project-based to the policy-based planning system and emphasised a private-sector-led economy rather than the prevailing public-sector-led philosophy" that was in existence in Nigeria. This led the government to retrench public spending on healthcare; and also, the 'undoing' of what government has built over decades (Fox & Reich 2015:1024). Consequently, "health spending as a proportion of federal government expenditure shrank from an average of 3.5% in the 1970s to less than 2% in the late 1980s" (Ogunbekun, 1991:423). There was also "a drop in the quality of care in public health institutions and gradual abolition of free medical services through the introduction of cost recovery mechanisms at all levels of healthcare delivery" (Anaemene, 2016:56).

Arguing in favour of privatisation, Ogunbekun (1991:424-425) stated that tax-based financed health services (i.e. through general taxation by the government) are at risk in a period of recession and foreign aid is an unreliable source of funds. He added that the competition between the private contractors would lead to better quality service, and it will widen

consumers' choices. Consequently, private sector participation in the healthcare system was approved, and efforts continued towards introducing health insurance which also became operational in 2005.

In contrast, Alubo (2001:313) contended that the argument of those canvassing for private medicine is weak, ignoring Nigeria's political and economic processes as well as the health-seeking behaviour of the people. He added that though private medical enterprise was helpful, its feature as a business enterprise serves as a significant impediment to the expected goal in service delivery. Evidently, privatisation of healthcare provisioning did not end the health system crisis in Nigeria because it appears to address, to an extent, the problem of availability and access with no effective solution to the problem of affordability and inequity among others. More so, "the free-market health financing implemented in Nigeria is devoid of safety nets as it is in the United States of America [Medicare] and Singapore [3M programs]" (Essien *et al.*, 2014:10573). Also, market systems are characterised by price gouging, unnecessary or harmful care as well as weak government regulatory capacity (Lagomarsino & Kundra, 2008:6).

Consequently, Asakitipi (2016:33) notes that "the way paved for privatisation marked the advent of a highly stratified health system in Nigeria and challenged the role of the government as a problem-solving entity". However, apart from the challenge of cost for the poor, the private sector was not able to fill the vacuum created in the health sector. Further, "most of them were poorly equipped and lacked essential supplies and qualified staff" (Anaemene, 2016:59). Besides, "the poor provision and delivery of public health services and the attendant user-fee for almost every item of treatment in the public health system has encouraged the explosion of private medical practice in Nigeria" (Ichoku & Fonta, 2006:3). Till date, the trend and situation have not changed for good within the healthcare system.

Ogundana (2012:443) argued that "the recognition that health systems are not just to improve people's health but to protect them against the financial cost of illness partly informed the government about the need to alleviate the burden of user-fees (i.e. out-of-pocket payment for health) by introducing resource-pooling mechanisms or prepayment schemes". It, however, appears that the shifts from state-dominated to a market-driven paradigm of healthcare provisioning led to the implementation of health insurance in Nigeria. Unfortunately, "both measures which were driven by neoliberal frameworks [privatisation of healthcare services – such that the masses could not afford; and introduction of health insurance – which was mainly

employment-based], have negatively impacted the health-seeking behaviour of most Nigerians and widened the gap between the haves [elites/upper class and the working class] and the haves-not [lower class and the rural masses]" (Asakitikpi, 2019:5).

The healthcare reform process, which allows for the participation of 'development partners' makes the health reform programmes susceptible to 'hijacking'. Gautier & Ridde (2017:5) found in their study that donors influenced the emergence of health insurance in West African countries, even if it happened within government structures. Specifically, they also found that "government ownership of the NHIS programme at the policy formulation stage was mixed: there was a clear leadership at the highest level of power (at least for user-fee exemption policies and health insurance in Nigeria), but the State's ability to engage the technical and operational levels of government was ineffective, and the State's coordination efforts when designing the user-fee exemption policy was limited".

Further, Pettigrew and Mathauer (2016:15) contended that the policy objective of voluntary health insurance in Nigeria is for private sector growth. Onoka *et al.* (2015:1113) argued that the contributions of the partners to the design of the NHIS were negative because the programme was structured in a way that gave preference to private health insurance and promoted purchaser/provider split. He added that the policy favoured the Health Maintenance Organisations (HMOs) at the expense of the NHIS managers. Also, parading CBHI as a financing mechanism towards achieving UHC has the potential to distract the government from expanding publicly-financed coverage and increase general health expenditure (Pettigrew & Mathauer, 2016:15). Perhaps, these negative influences are perpetuated in connivance with some local stakeholders for personal gains.

According to Obansa and Omisan (2013:231), Uzochukwu *et al.* (2015:437), Eboh *et al.* (2016:24) and Anaemene (2016:57), the significant sources of healthcare financing in Nigeria are government budget, health insurance (NHIS, CBHI and PHI), OOP (payments for health services at the time of illness), foreign aid and debt relief (i.e. heavily indebted poor countries [HIPC] initiative). Hafez (2018:24) however reported that "government and the NHIS make up only 17.2% of total health financing and OOP spending accounts for 75.2% of total health expenditure, making it one of the highest in the world". This is a significant indication of the weakness of the healthcare system and little impact of the government's efforts. Apart from a lack of political will and neoliberalism, Ejughmere (2014b:15) suggests that macroeconomic and fiscal instability also account for inadequate public financing of the health system in

Nigeria. This is because where macroeconomic policies downplay the need for social service provisioning, they also "undermine the microeconomic basis of growth, with tendencies of weakening the social and political basis of sustainable economic growth" (Adésínà, 2007:26). Though, it can be argued that the economic challenge is a result of the neoliberal policies imposed on Nigeria; yet, the need for an effective healthcare financing strategy for improving the healthcare system is essential.

According to the Health Strategy and Delivery Foundation (2019), health financing comprises two main functions: "resource mobilisation mechanism (raising money for health) and financial management (efficient management of resources)". Besides, Jowett *et al.* (2016:7) opined that budget allocations to health reflect political commitment but effectively spending those funds to strengthen the health system requires a particular focus. This is confirmed by Obansa & Omisan (2013:229) that in Nigeria, "increased financial resources for health do not necessarily translate into improved health due to poor financial management, weakly coordinated pooling mechanisms, poor intra-sectoral coordination, lack of strategic purchasing, and unsustainable risk pools", among others.

Generally, McIyntre and Kutzin (2016:7) explained the important role of the political-administrative structure in health financing, "particularly the extent of decentralisation within government and the decision-making responsibilities held at different levels. They added that if there is a federal structure whereby states or provinces have considerable decision-making authority, the extent to which public spending on health is prioritised will be heavily influenced by decisions made at this level". In the case of Nigeria, Obansa and Omisan (2013:230) confirmed that "the share of the federal government from the federation account creates a lopsided budgeting allocation amongst the three tiers of government and this equally affects the allocation from lower tiers of government to the health sector". This is because the federal government can only enjoin but cannot compel other tiers of government on how to spend their health budgets.

For instance, due to weak revenue mobilisation efforts, the 2016-2017 economic recession in Nigeria (because of decline in oil price) negatively affected States' and LGAs' funding for healthcare because they still rely heavily on allocations from the Federal Government (Nigeria Federal Ministry of Health, 2018:5). Meanwhile, "the federal government is responsible for the collection of nine taxes, States are responsible for collecting 25 taxes and levies, and local governments are responsible for collecting 21 taxes and levies" (Hafez, 2018:26-27). All of

these have not been able to ease the healthcare financing burden in the country because of the ineffective tax system. Notwithstanding, the Nigerian healthcare system suffers several obstacles, especially at the local government levels (Welcome, 2011:476).

Asakitipi (2016:37) noted that "although user-fee for health has a long history in Nigeria, the idea of paying in advance for health services in the form of insurance is certainly novel and thus needs careful planning and implementation in achieving the desired goal for universal health coverage". For instance, if the insurance option does not provide coverage for the entire population, it becomes difficult to attain UHC. Though "understanding the fiscal context of a country is essential for understanding the viability of various reform options, particularly those involving new or increased mechanisms of contributions for health" (McIyntre & Kutzin, 2016:7). Importantly however is that achieving UHC requires the ideational and financial commitment of the government to healthcare service provisioning. As such, effective health reform and financing will give equity and universality clear priorities from the onset such that those living in poverty can benefit.

2.5 Community-Based Health Insurance: A wider view

The main motive behind the various healthcare reforms around the world is to "improve the functioning and performance of the health systems" (Lambo & Sambo, 2003:1) as well as develop a very reliable model of accessing quality healthcare services. Health financing has been a bane of the health sectors in most developing nations due to the neoliberal-inspired shift towards market provisioning of healthcare. And as discussed above, successful implementation of the various health financing models may be difficult in these nations. Instead of considering the option of publicly-funded healthcare services provisioning, it was however argued that attention should be given to people's demand for healthcare rather than focusing on their perceived needs (see World Health Organization, 2000:xiii). The neoliberals believe that the state should not be involved in the management of the "affairs of men" [i.e. people] (see Lippmann, 1937:267). For them, it is not a question of affordability but keeping the state from matters of social provisioning.

Hence, the state should merely "determine, arbitrate, and enforce the rules of the game" (Friedman, 1962:31). While arguing for economic freedom, Hayek (1944:40-100) recognised that competition could hamper the provisioning of some social services but contended that people should be 'freed' and granted the right to decide among available choices in a competitive society. Particularly on healthcare, Friedman (1962) argued that the exit of

government from healthcare provisioning would 'immensely' enhance service delivery in terms of quality, professionalism, choice and business (e.g. charging consumers "separate fees for separate services"). This ideological drive necessitates healthcare reforms around the world.

To this end, the option of health insurance – through different models – has been aggressively promoted as an effective solution to the problem of healthcare and achieving universal health coverage (WHO, 2010). The new definition of UHC by WHO suggests that the goal is to be pursued in a way that people are financially protected. UHC connotes that "all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship" WHO (2018a). Meanwhile, there have been debates among scholars as to the right healthcare financing model to be adopted towards the provision of equitable and accessible healthcare services.

Those promoting health insurance policies believe that the responsibility is too much for the government to bear given the global financial instability; hence, the need for a health insurance system. For them, healthcare financing systems through health insurance is an effective strategy to attain universal coverage and financial protection against catastrophic healthcare expenses (Carrin *et al.,* 2005; Schellekens *et al.,* 2007:4; Fonta *et al.,* 2010:109; Devadasan *et al.,* 2010; Spaan *et al.,* 2012; Giedion *et al.,* 2013; Fadlallah *et al.,* 2018). Examples of such countries are Germany, the United Kingdom, Sweden, Norway, Switzerland, France, Belgium and Japan.

Given the concerns about the suitability of some health insurance models (discussed above) for the LMICs, specifically, scholars such as Wiesmann and Jutting (2000), Bennett (2004), Lagomarsino and Kundra (2008:66), Badacho *et al.* (2016), Ezeama (2016:14) and Ahmed *et al.* (2018:13) contended that CBHI is appropriate to cover persons who are in the informal sector and in the LMICs, where public revenue is inadequate with extensive reliance on OOP (out-of-pocket) expenditure. Gustafsson-Wright and Schellekens (2013:13) also claimed that "CBHI policy is an effective instrument towards universal coverage and better alternative against out-of-pocket and catastrophic health expenditure through risk-pooling to improve access to health care". Binnendijk *et al.* (2012:68) opined that CBHI is effective in "keeping transaction costs low and tailoring the benefits to suit local needs".

Some of the countries that have adopted CBHI for healthcare financing are India, China, Bangladesh, Afghanistan, Nepal, Guinea, Benin, Ethiopia, Burkina Faso, Cameroun, Mali, Cote d'Ivoire, Kenya, Ghana, Rwanda, Nigeria, among others. In line with earlier submissions, Odeyemi and Nixon (2013:12) noted that the policy serves to guarantee "access to basic healthcare services for most people in rural areas". Similarly, Jacobs *et al.* (2008) believed that CBHI could guarantee better-quality services and bring about more accountable healthcare providers. Sekhri and Savedoff (2005:127) also argued that it could assist developing countries in developing mechanisms, institutions and capacities for attaining UHC. In this context, UHC is understood as one 'ultimate goal' in the healthcare system towards which CBHI can contribute. Thus, this policy is seen as a shortcut for providing healthcare cover for the informal sector and rural dwellers and also a route to attaining UHC.

In an empirical study, Spaan *et al.* (2012) found that the services rendered under CBHI are of moderate quality. Studies conducted by Carrin *et al.* (2005) and Weinberger & Jutting (2000) also revealed that CBHI programmes could assist in reducing OOP and enhancing access to healthcare services. Further, Adebayo *et al.* (2015:4) found a high level of willingness to pay (WTP) for CBHI in LMICs. WTP refers to the readiness to give up a particular amount of money to access healthcare services (Lawanson & Ibrahim, 2015:4) under a health insurance programme. The high rate of willingness might be due to anticipated protection against OOP after enrolment. Purohit (2014:1237) also found in India "that CBHI schemes have proved to be effective in reducing catastrophic health expenditure of the people".

Since the 1990s, CBHIs have been implemented in several African countries, including Burkina Faso, Ghana, Rwanda, Senegal, Tanzania etc. (Odeyemi, 2014). Kebede *et al.* (2014:263) and Minyihun *et al.* (2019:1) reported 80% and 77.8% willingness to pay in Northwest and Northeast Ethiopia, respectively. Generally, in Africa, Rwanda and Ghana have been recognised as nations being able to scale-up from CBHI towards universal coverage. Specifically, "Rwanda is the country with the highest enrolment in health insurance in Sub-Saharan Africa" (Chemouni, 2018:1). This feat was achieved through the implementation of mandatory enrolment by all citizens in the programme. Kalisa *et al.* (2015:11) reported that CBHI coverage of the Rwandan informal sector rose from less than 7% in 2003 to 74% in 2013. Also, in 2004, the Ghanaian health system scaled-up to National Health Insurance Scheme (NHIS) from the various existing CBHIs or Mutual Health Organisations (MHOs). The scheme is financed from a single source. As of 2014, the NHIS

covered 40% (10.5 million) of Ghana's population (Wang *et al.*, 2017:1). I will take up a more in-depth discussion of CBHI in Rwanda and Ghana in the next section.

In Nigeria today, some CBHI schemes exist across various states in the country (Kwara, Lagos, Ogun, Anambra, Akwa Ibom, Delta states, etc.). Many studies conducted around the country (even where the programme is yet to exist) indicate readiness among the people to enrol. Nura *et al.* (2017) observed the potentials of CBHI in reducing OOP expenditure and increasing utilisation among Nigerians. Onwujekwe *et al.* (2011a:3) found a very high (98.3%) acceptability of CBHI as a means of paying for health in a study carried out in South-Eastern Nigeria, and Banwat *et al.* (2012:54) found a very high (93.6%) willingness to pay for CBHI in North Central Nigeria. Also, Falaki *et al.* (2017) found 75% willingness to pay for CBHI among respondents in Katsina State. Most of these studies examined readiness to pay for CBHI if introduced.

Whereas, there is evidence of mixed reactions among respondents in some studies. Oriakhi and Onemolease (2012:95) found in a study in Edo State that 60% of the respondents expressed willingness to pay. In contrast, those not willing to pay gave reasons such as "lack of trust in the scheme administrators and government policies (which are considered very unstable)". However, among artisans in Osun State, Bamidele and Awobimpe (2013:1) found 82.4% willingness to pay out of which 74% preferred that the government organise the scheme. This signifies a variation in the level of trust in government by different people, perhaps, based on previous experience with intervention programmes.

Nevertheless, the willingness to pay studies may not be a suitable premise to float a CBHI scheme. On this, Udeh *et al.* (2016:11) advised that "determining threshold premium (the maximum level of premium that a given proportion of the population covered by the scheme will be able to afford based on a pre-determined capacity to pay) gives a clearer picture of the affordability and capacity to enrol than a willingness to pay". This is because the willingness to pay is quite different from the ability to pay. A good understanding of this helps in the decision to establish CBHI programmes in settings where most people cannot pay owing to the level of poverty in Nigeria. Thus, conducting studies on threshold premium makes the financial capacity of the people clear before the premium is fixed.

Regarding the CBHI programme in Kwara State, a study by Amsterdam Institute of International Development (AIID) in 2013 found that the programme enjoyed high enrolment and that it impacted positively on the health status of the enrollees. The study also found that

the programme protected the enrollees against OOP expenditure. The study further indicated that there were over 200,000 visits to the healthcare facilities out of which 70% were by women and children. Also, Babatunde *et al.* (2011) found a high level of willingness to pay among people in Asa Local Government of Kwara State. In addition, Ameen *et al.* (2016:1) found high level (80.4%) of willingness to participate among artisans in Ilorin Metropolis. In the same vein, Akande (2015:9) found a high rate (72%) of the utilisation of Kwara CBHI among pregnant women. Generally, the CBHI programme has assisted in building a more robust and cost-effective health system in the state (PharmAccess Group, 2016:13).

Similarly, Brals *et al.* (2017:990) found that the CBHI programme improved the choice of hospital delivery among women in some rural communities in Kwara State as a result of health facility upgrades. According to PharmAccess Group (2016:15), the programme led to an increase in hospital delivery from 50% in 2009 to 70% in 2013. More so, Hendriks *et al.* (2013:560) found an association between Kwara-CBHI and a significant decline in blood pressure among the enrollees. In a more recent study, AIID (2017:15) found that "the CBHI program increased healthcare utilisation and reduced out-of-pocket (OOP) expenditure among the enrollees". Studies conducted on the CBHI programme relating to hypertension and cardiovascular care in Bacita, Edu LGA indicated positive results (see Odusola *et al.*, 2011, 2014, 2015, 2016; Odusola, 2015). Precisely, Odusola *et al.* (2014) reported that the CBHI programme improved enrollees perception about medications. As claimed by PharmAccess Group (2017:4), "the lessons of Kwara CBHI have led to the development of health insurance laws in other 17 states in Nigeria". Invariably, the interest in the CBHI programme by those state governments was to adopt an effective policy with the potential of solving their healthcare challenges.

In contrast to the optimistic studies reported above, other researchers have raised some concerns about the appropriateness of CBHI for provision of healthcare services and achieving UHC. Generally, scholars inclined by Marxian analysis hold the view that the proposition of health insurance, including CBHI, is premised on the zeal and motive of the capitalists to generate profits. Collyer (2015:43) argued that "a social system should operate to satisfy human needs rather than producing profit and compelling individuals to become consumers of capitalist commodities". She added that "the replacement of publicly-provided or publicly-financed healthcare services by others owned or run by private, for-profit organisations presents a serious challenge to the governance of the state in its efforts to produce healthcare services based on equity of access, accountability, cost at the point of service and quality of

service". The "implications of commodification are greater inequality of provision and access, higher costs and the creation of new avenues for corruption" (Whiteside, 2015:392).

Despite some significant accomplishments in countries with strong national-government stewardship, most CBHI schemes have been limited in scope and success (Okunola *et al.*, 2016:1). Mulupi *et al.* (2013) argued against the workability of CBHI in nations with most people in the informal sector. This is because "those who cannot afford to pay premiums do not get enrolled, leaving the poor and many other vulnerable groups excluded" (Mathauer *et al.*, 2017:2). According to Woldemicheal *et al.* (2016:2), "the proliferation of CBHI schemes in many countries in Africa as mainstream healthcare financing mechanisms has triggered considerable analytical policy questions concerning its impact in providing access to healthcare services and protecting households from financial risks due to illness". In the same vein, Tabor (2005:5) argued that "CBHI should be regarded as a complement to, not a substitute for, strong government involvement in healthcare financing and risk management related to the cost of illness".

In addition, CBHIs "are usually small fragmented pools with little capacity for redistribution of risks" (Mathauer *et al.*, 2017:3). Thus, the reliance of some countries on CBHI as a core health financing mechanism might be inappropriate. Further, setting low premium to aid high enrolment tends to limit the capacity of CBHI to deliver high-quality service, thereby reducing the attractiveness of the programme and financial protection (Mathauer *et al.*, 2017). Members will then need to seek medical attention elsewhere for services which are not covered by the scheme.

Further still, Kutzin (2012:867) asserted "that no country has attained universal health coverage by relying mainly on voluntary contributions and payroll taxes towards insurance schemes regardless of the institution facilitating it; hence, general government revenue is essential for coverage of informal sector of the population". In other words, government involvement in the provision of healthcare should not be minimal because most of those in need of coverage are not in the formal sector. Further, "from the perspective of UHC, whether or not a financing scheme improves attainment of coverage objectives for its members is not intrinsically important; what matters is the impact of that scheme on the attainment of the objectives for the population and system as a whole" (Kutzin, 2013:607).

More so, empirical evidence has shown the challenges inherent in the CBHI policy option. Panda *et al.* (2016:1) and Ranabhat *et al.* (2019:4) identified inappropriate benefits package and stringent rules as part of the challenges of CBHI schemes in LMICs, which must be tackled. Otherwise, alternative health financing mechanism should be put in place. The design of CBHI programmes is such that the more extensive curative cares are not covered. For instance, dialysis and some other medical procedures are not covered by the CBHI policy. Acharya *et al.* (2012:51) examined "the impact of social and community-based health insurance" on the poor and near-poor, using utilisation, financial protection and health outcome. They found a high rate of use of CBHI with no evidence on the reduction in OOP expenditure and no significant improvement in health outcomes. This indicates that the programme did not impact the health status of the people positively. Apart from the challenge of capacity to pay for healthcare, the inability of the CBHI policy to provide a comprehensive health benefits package (i.e. access to all kinds of care) tends to alter the meaning and goal of UHC which seeks to facilitate access to all types of healthcare services at the point of need.

In a systematic review, Dror *et al.* (2016:2) found stringent rules, inadequate legal framework and inappropriate benefits package as barriers to the renewal of CBHI enrolment in LMICs. Also, Hounton and Newlands (2012:10) challenged the assumption that CBHI schemes are a potential means to improve access to healthcare in LMICs. This is because they found no "evidence of the cost-effectiveness of CBHI in Burkina Faso, using the net-benefit framework". Meanwhile, Ochoma (2009:208) and Hounton *et al.* (2012) argued that an effective CBHI scheme must be able to improve access to quality care, prevent OOP expenditure, reduce mortality and ensure sustainability. Thus, these barriers must be well addressed in an effective CBHI scheme.

Ekman (2004) noted that it is unclear whether CBHI schemes are sustainable in the long term; and its sustainability in Africa is strongly linked to the ability to pay (Ejughemre, 2014a:18). In some settings in Africa, enrolment and payment of premium for CBHIs are encouraged among farmers during harvest time before the earnings are spent on other purposes (Shimless, 2010). More so, "simply replicating an intervention from one setting to another is likely to fail without taking into consideration, the factors critical to its implementation and sustainability" (Edwards and Barker, 2014 cited in Fadlallah *et al.* 2018:2). Also, "many have questioned whether African countries have been too eager to adopt Western-styled policies that are not necessarily appropriate to their fiscal context" (Fenny *et al.*, 2018:2). In the African experience, Noubiap *et al.* (2014) found poor knowledge about CBHI among informal sector workers in Douala Cameroon. Also, low membership renewal rate was found in Ethiopia (Ethiopian

Health Insurance Agency, 2015: x) and Parma *et al.* (2012:1) found the problem of adverse selection in Burkina Faso.

In the same light, in Nigeria, Nura *et al.* (2017:118) raised concerns about CBHI's coverage of comparatively small proportion of the people "as well as inadequate funding, weak policy, lack of political commitment and inadequate infrastructure". Also, Aregbeshola (2017:43) associated CBHI in Nigeria with "poor coverage, poor quality of care, lack of trust and high rates of attrition". Further, Ejughemre *et al.* (2015:6) observed that "CBHIs are still rudimentary in Nigeria and are fraught with implementation challenges, including issues of acceptance by the people". They added that "exclusion continues to be of concern in the schemes despite high willingness to pay (WTP)". However, the experience with most CBHI programmes in Nigeria has not been able to positively inform the negative perception and lack of trust in the programme.

Often, reform programmes in Nigeria (including health reforms and CBHI) do not record appreciable success such that they can sustain the confidence of the public (Okonjo-Iweala, 2007 cited in Eneh, 2011). Studies in Lagos State revealed that most people do not have confidence in CBHI. In a recent study among pregnant women in Lagos State, Osakede *et al.* (2016:19) reported 65% willingness to pay; however, only 40% of them had trust in the programme. Thus, it appears that the remaining 60% who did not have confidence in the programme would not join if they have alternative access to healthcare. Regardless of trust, it appears that expression of willingness to pay for CBHI is high (as reported in some studies above) because the people are faced with the depleted public healthcare system and huge OOP. In other words, the researches were conducted in contexts suggesting alternative access to care for the people; thus, the findings are dependent on the context of the study. The outcome is likely to be different in the context of functioning and free public healthcare service. What is often not placed on the table in these studies is the question of the well-functioning publicly-funded healthcare system.

Further, on trust, in a more recent study by AbdulRasheed and Aladetohun (2018:19) among CBHI enrollees in Alimosho, Lagos State, more than 70% of the respondents did not have trust in the programme and believed that it was established as a means of enriching some few people. The study also reported that enrollees "were not satisfied with the quality of service rendered through the CBHI programme". In the same vein, Agbo *et al.* (2019:53) found that only a few people (22.1% and 10.6% in Surulere and Ikorodu respectively) had high

confidence in CBHI in Lagos. Meanwhile, trust and satisfaction are major factors in the acceptance and success of healthcare intervention programmes. Therefore, a shortfall in these is capable to negatively influence the decisions of prospective beneficiaries of the CBHI programme. Ogben and Ilesanmi (2018:57) found that almost half (44.9%) of the respondents "were not satisfied with the overall quality of care rendered" by a CBHI programme in the FCT (Abuja). Further, Collins (2015:11) identified low enrolment with the Akwa Ibom CBHI pilot scheme.

Onwujekwe *et al.* (2009:96) identified successful and non-successful CBHI schemes in Anambra State. They found that "enrolment was low (15.5%) in the non-successful community (Neni), and higher (48.4%) in a thriving community (Igbo-Ukwu), both less than half the target population, and contributions were regressive". Uzochukwu *et al.* (2009:31; 2015:7) analysed the challenges inherent in the Anambra CBHI programme. Community participation, power dynamics, the attitude of healthcare workers and drug acquisition and delivery are some of the factors affecting the programme (Uzochukwu *et al.*, 2010:1). Generally, Fonta *et al.* (2010:122) observed that the implementation of successful CBHI programme in Nigeria has been difficult. They, however, opined that the programme could be temporarily adopted for healthcare needs of the poor pending the full development of the NHIS. It, however, becomes worrying to note when NHIS will become effective after many years of existence. Yet, the NHIS involves a higher health insurance premium, which is a 'threat' to enrolment.

For financial sustainability, Onwujekwe *et al.* (2009:96) advised that subsidies from government and donors should supplement payments by enrollees particularly in "poor and rural communities in order to ensure equitable financial risk protection". This is concerning, considering the efficacy and suitability of CBHI. This is more so given the level of poverty in Nigeria and the financial resources that will be needed to subsidise the payment of the rural poor. Also, for improving access and achieving UHC, Onwujekwe *et al.* (2011b:54) canvassed the need to adopt various types of health insurance (SHI, PHI CBHI, etc.) concurrently. This suggests that there is a significant limitation in health insurance, especially when only a few types are available in a country. Moreover, the efficiency of deploying many types of health insurance is contentious.

Also, Vaughan *et al.* (2016:405) carried out a benefit incidence analysis on a CBHI scheme in Rivers State and found a shift in concentration from the poor to the rich enrollees. The same

anomaly was found in studies conducted by Asante *et al.* (2016:17) on the LMICs, Alkenbrack *et al.* (2013) in Lao PDR and Akazili *et al.* (2014:1) in Ghana where CBHI schemes were established in areas where there was relatively good quality of care. Meanwhile, CBHI programmes are primarily introduced to protect the poor and other vulnerable groups against OOP expenditure. Invariably, one of the main goals of CBHI to prevent enrollees from catastrophic health expenditure is defeated. All these tend to challenge the appropriateness of the health policy option.

The CBHI programme implemented in Lagos State for Market Women by the PharmAcess Foundation, alongside the Kwara programme, was faced with several problems which forced it to be phased-out in 2014 (Amsterdam Institute for Global Health and Development, 2015:10). "The main reasons for discontinuing the Lagos programme were overutilisation of services, increase in enrolment by high-income persons and administrative challenges" (AIGHD, 2015:10). Overutilisation is closely linked to adverse selection, and these tend to threaten sustainability; hence, the decision to wind-up the programme.

Likewise, Kwara-CBHI was not immune to certain difficulties. Adenusi (2011) found that enrolment into the programme did not grow as envisaged to achieve the universal coverage of communities where it existed. Recently, Gustafsson-Wright *et al.* (2018:42) reported that in one of the communities where the CBHI programme existed (Afon), enrolment between 2011 and 2013 was relatively stagnant. They added that new enrollees had replaced half of the people who were in the enrolment of the programme in 2011. This might be partially due to a lack of satisfaction with the quality of service provided. Similarly, Babatunde *et al.* (2016:26) concluded that the CBHI programme did not bring about a remarkable variation in the socio-economic status of enrollees and non-enrollees in Edu Local Government Area of the state.

In addition, Opowoye (2014:20) noted distance and inability to pay an increased premium from 300 Naira to 500 Naira as barriers. He added that inadequate staffing, substandard facilities, the gap in knowledge and skills of clinical and non-clinical staff are part of the challenges. The programme also faced the problem of adverse selection and administrative bottleneck (Lawanson & Ibrahim, 2015:11). More so, in a study on hypertension care within the Kwara-CBHI, Odusola *et al.* (2016) found inadequate human, material, and administrative resources as factors hindering the delivery of quality care. Equally, Bonfrer *et al.* (2015:144) reported decreased formal healthcare utilisation "among the non-enrollees with a high increase in the use of informal healthcare facilities as well as high OOP expenditure". They

found “evidence of crowding-out of the non-enrollees from formal care facilities” Bonfrer *et al.* (2015:144). This is a thing of concern and an indication that regardless of the acclaimed success, the policy came along with a negative consequence for the people.

Also, the ultimate goal of the programme was to expand to state-wide coverage. However, a study by Gomez *et al.* (2015:12) argued that the expansion was less feasible because of the inadequate health personnel and infrastructure in Kwara State. Though the premium was subsidised, they added that inability to pay among some households could hamper the expansion and sustainability of the programme. These suggest that the policy was not comprehensive enough to cater to the diverse healthcare needs in the State adequately. Further, “the delivery of quality healthcare services in rural areas, where the programme existed, was not guaranteed” (PharmAccess Group, 2015b:17) suggesting the possibility of ineffective monitoring and evaluation mechanism to measure the adequacy of implementation.

More so, Bonfrer *et al.* (2018:62) noted that “the use of government funding to subsidise the Kwara CBHI might increase inequity if the non-enrollees continue to pay OOP for healthcare and have limited access to necessary quality health services”. They concluded that “it is unlikely that this scheme can operate independently of the government funding, by leveraging on actuarially fair premium”. Meanwhile, PharmAccess Group (2015b:4) reported that starting from 2014, the Kwara State Government was finding it difficult to meet its financial obligations towards the programme. This might be a factor in the eventual collapse of the programme. The sudden stoppage of healthcare service delivery, therefore, threw the possibility of effective state-wide expansion into uncertainty or illusion.

Before the collapse of the programme, findings have identified areas requiring improvement for effective service delivery and satisfaction. For long-term care, as reported by Odusola (2015:155), there was a need to improve the financial and organisational structure of the CBHI programme. Specifically, he found the need to give adequate attention to “trust in the sustainability of care, treatment guidelines, tools for patient education, human resources, capacity building, (diagnostic) equipment and drugs, adequate care administration infrastructure, quality assurance monitoring, adequate provider payments benchmarking and good provider/enrollee relationships” for high-quality care.

Obamwonyi and Aibieyi (2014:41) identified improper policy formulation, lack of continuity and mechanisms for sustainability as some of the factors responsible for policy failure in Nigeria. Charan and Paramita (2016:1) argued that failure of health programmes could be

attributed to technical insufficiency, administrative inanity and operational incapacity. For Odeyemi (2014:1), failure of CBHI can be attributed to the "inability to engage and account for the real needs of the beneficiaries". Uche (2016:28-29) attributed the limited success of CBHI in Nigeria to weakness in design, implementation and management. She further argued that the sustainability of CBHI requires institutional capacity, effective management skills and technical expertise. These suggest that the adequate capacity and preference for the specific healthcare needs of each community or country are quite necessary for the success of CBHI programmes.

2.6 Community-Based Health Insurance in Ghana and Rwanda

2.6.1 CBHI: The Ghanaian Experience

Origin

In Africa, Ghana is one of the nations identified with the successful implementation of the CBHI policy. In the immediate post-independence, "Kwame Nkrumah's government ended payment for health at the point of use and provided some free healthcare services funded by general tax revenue" (Blanchet & Acheampong, 2013:2). However, economic crisis (due to the adoption of the imposed SAPs) led to the introduction of user-fees (cash and carry) in the 1980s to finance the provision of health services (Jehu-Appiah *et al.,* 2011:158; Fusheini *et al.,* 2012:1). "In the early 1990s, CBHI schemes were established in Ghana as a self-help initiative to meet the healthcare requirements of those in the informal sector" (Adomah-Afari, 2015:824) and eliminate user-fees. This initiative operated mainly, through collaboration among Catholic missions, health facilities and communities (Carbone, 2011:397).

After experimenting with the CBHI model in selected settings in the late 1990s, the Ghanaian health system scaled-up to NHIS in 2004, from the various existing CBHIs or Mutual Health Organisations (MHOs) towards achieving universal health coverage and to eliminate user-fees. Essentially, Ghana NHIS was influenced by politics. Specifically, it grew out of the electoral promises by the New Patriotic Party (NPP) to take an ambitious move towards implementing the programme (Brugiavini & Pace, 2016:4; Blanchet & Acheampong, 2013; Fusheini *et al.,* 2012:5). This grand vision clearly reflects the positioning of healthcare reform in the overall strategic direction of the government (Rahaman *et al.,* 2011:21), "reflecting the demand of the people for an alternative to the cash and carry system" (Owusu-Sekyere & Bagah, 2014:188). However, the eventual policy direction cannot be absolved of foreign intervention. For instance, the Ghanaian Ministry of Health leveraged on the 'supports' of USAID and Danish

International Development Agency (DANIDA) to increase the number of government-owned CBHI schemes from 4 in 1999 to 47 in 2001, 159 in 2002 and 168 in 2003 (Carbone, 2011:397).

Design and Implementation

The model of NHIS in Ghana involves "District Mutual Health Organisations (DMOs) for the informal sector, Private Commercial Health Insurance Scheme (PCHIS) for the formal sector and Private Mutual Health Insurance Scheme (PMHIS) for the affluent" (Fusheini *et al.*, 2012:7). The scheme is financed from a single source and aimed to cover all residents in Ghana, including non-citizens. Health services are "delivered by accredited public, and private providers who are reimbursed from a single national fund with no fees at the point of service and 90% of its revenue are generated from dedicated taxes [a portion of value-added tax and payroll]" (Blanchet & Acheampong, 2013:2). "The indigent, pregnant women, persons aged above 70, persons with mental disorders, and children under the age of 18 years are exempt from paying a premium" (Agyepong *et al.*, 2016:2). Others are required to pay a premium that ranges from GHC7.2 to GHC48 (1.9 USD – 12.3 USD) per head annually, depending on the relative development of the area of residence (Jehu-Appiah *et al.*, 2010:158; Amo-Adjei *et al.*, 2016:2).

The scheme allows for individual registration and does not mandate family registration (Agyepong *et al.* 2016:7). It claims to "cover 95% of common disease conditions in Ghana. It is also claimed to offer inpatient and outpatient services for general, and specialist care, surgical operations, hospital admission, maternity care, emergency treatment etc." (Association of Chartered Certified Accountants, 2013:7). The National Health Insurance Fund (NHIF) generates fund through contributions "from the National Health Insurance levy of 2.5% Value Added Tax (VAT) on most goods and services, 2.5% Social Security and National Insurance Trust (SSNIT) payroll taxes, NHIF investment income, donor funds and about 5% revenue through informal sector enrollees' premium payment" (Blanchet, & Acheampong, 2013:6).

Certain initiatives were put in place to address sustainability issues and strengthen the operation of the scheme and achieve universal health coverage. In 2007, "Information Communication Technology (ICT) was introduced to automate the service for easy access to health information" (Brugiavini & Pace, 2016:3) and Ghana-Diagnosis Related Groups was adopted in 2008 to reduce cost escalation (Andoh-Adjei *et al.*, 2018:2). In 2012, a new law (Act 852) was introduced to replace the earlier one (Act 650) enacted in 2003, to improve general administration and service delivery under the scheme. With the new law, operations of all the

District Mutual Schemes fall under the National Health Insurance Authority (Teye *et al.,* 2015:494) towards better services and centralisation.

Major Achievements

The Ghana NHIS no doubt, contributes to the health status of its enrollees. Indeed, the scheme has been studied and commended by many authors as well as international organisations recommending it to other LMICs for replication in their various settings (Carbone, 2011:393). It is claimed that the scheme provides healthcare coverage for 37% of Ghana's 27.4 million population (see PharmAccess Foundation, 2016:1) and operates in over 150 districts across the country (Alhassan *et al.,* 2016a:2). Wang *et al.* (2017:8) also claimed that health indicators of Ghana improved under the NHIS and outperformed the SSA average on life expectancy at birth, maternal mortality, total fertility and under-five mortality. Though contentious, it is further claimed that there is high utilisation of the programme among enrollees and it grants them financial protection as well as reduced OOP to 29% of total health expenditure (Blanchet, & Acheampong, 2013:2). In another study, Brugiavini and Pace (2016:3) found that the NHIS increases the chances of utilising healthcare facility for ante-natal and delivery services. Therefore, the scheme has improved health-seeking behaviour among the people.

Weaknesses and Challenges

Before the establishment of NHIS, the various CBHIs in Ghana have major challenges of "small size, limited benefits package, inability to cover all sectors or groups" (Atim *et al.,* 2001: xvii) etc. All these challenges were anticipated to be resolved with the introduction of NHIS. Still, after the emergence of NHIS, there are various challenges such as equity, long-term sustainability, quality of care and coverage (Atim, 2011; Carbone, 2011:393; Blanchet & Acheampong, 2013:2). Besides, it appears that there is a dearth of accurate data on the coverage of the NHIS. For instance, Wang *et al.* (2017:1) stated that as of 2014, the NHIS covered 40% (10.5 million) of Ghana's population while Alhasssan *et al.* (2016b) claimed that as of 2016, the scheme covered 40% (26.9 million) indicating conflicting figures. On this, Oxfam International (2011:1) cautioned and noted the need for critical methods in calculating the coverage of the scheme to avoid inaccurate and misleading statistical data. However, based on the coverage, it may be rated as one of the best in Africa. More so, "under the NHIS amended Act 852 (2012), every Ghanaian is required to enrol in the scheme, but the constitutional provision is not effectively implemented due to large informal sector and weak administrative capacity of the National Health Insurance Authority [NHIA]" (Alhassan *et al.,* 2016b:2).

According to Yete *et al.* (2015:501), the Ghana NHIS programme is faced with UHC challenges, utilisation challenges and implementation or operational challenges. The UHC challenges entail the problems confronting the achievement of universal health coverage. These challenges include low enrolment, difficulty in registering individuals in the informal sector, the problem of identifying the 'indigents' etc. (Okoroh *et al.,* 2018). The scheme has been existing for more than 15 years, but there seems to be inadequate awareness and knowledge about it. For instance, Wang *et al.* (2017:22) found that "only 29% of NHIS enrollees are aware that pregnant women and children under the age of 18 are exempt from paying the premium and are not required to pay OOP". This might be due to inefficiency on the part of the government (i.e. NHIA) to provide adequate information to the people.

More so, studies carried out by Kusi *et al.* (2015:2), Kotoh *et al.* (2018:443) and Alesane and Anang (2018:2) confirmed that enrolment in the scheme is on the decline. Among other challenges, the decline is related to experience and perception about the scheme. This is because the difference between policy content and implementation affects enrollees' experiences of the scheme and determines their decision to enrol or stay enrolled (Agyepong *et al.,* 2016:7). Also, poverty dependency ratios were high and affected enrolment because some individuals cannot afford the enrolment premium (Agyepong *et al.,* 2016:7). Further, in their study which focused on enablers and barriers to enrolment, Agyepong *et al.* (2016:2) found that health insurance coverage was very slow in Volta region in Ghana because the premium was beyond the affordability of most people and that individuals below age 40 "were not enrolling because they felt their health risk was low". Similarly, a recent study by Seddoh and Sataru (2018:3) revealed that "respondents between the ages of 41-60 years were twice likely to enrol compared with the respondents between the ages of 21-40 years". This indicates that awareness and sensitisation efforts towards healthcare and enrolment are weak.

In addition, enrollees face specific challenges in utilising healthcare services. The challenges involve negative attitudes of healthcare providers, informal fees for health services, long waiting times, cleanliness of facilities, emergency services, discrimination in favour of patients who would pay out-of-pocket etc. (Dalinjong & Laar, 2012:9; PharmAccess Foundation, 2016:2). In principle, enrollees are not required to share costs, pay for services or pharmaceuticals, however, they are often written prescriptions to purchase non-available drugs (Wang *et al.,* 2017:20; Agyepong *et al.,* 2016:11; Yete *et al.,* 2015:504) at pharmacies. Therefore, enrollees tend to be disappointed and unsatisfied with the scheme, and these generally, influence non-willingness to enrol or renewal of enrolment. Okoroh *et al.* (2018)

found that 6% to 8% of enrolled households made catastrophic health expenditures. Also, "OOP payments as a proportion of total health expenditures remain high at 26%, exceeding the WHO's recommendation of 15% to 20%" (Okoroh *et al.*, 2018:1). This shows the level of the impediment in eliminating OOP payments, which is a barrier to access and utilisation.

Studies by Dixon *et al.* (2013:7) and Amo-Adjei *et al.* (2016:1) on the scheme indicated that most people have a negative perception of the programme. In most cases, this is usually linked to the quality of service rendered by the scheme. A recent study by Duku *et al.* (2018:8) on Ghanaian NHIS revealed that the enrollees have a negative perception of the programme because non-enrollees get better quality of healthcare. Further, it is believed that "the quality of service provided by the scheme is unsatisfactory" (Yete *et al.*, 2015:507). However, PharmAccess Foundation (2016:1) found that healthcare providers generally perceived healthcare services rendered to the enrollees as satisfactory (from a technical quality dimension) meanwhile, enrollees expressed disappointment in the quality of service provided. In most cases, the negative attitudes of healthcare providers stem from the increased workload of attending to many patients, majorly enrollees (Dalinjong & Laar, 2012:9). This is as a result of inadequate staffing that could match the high number of visitations. Expectedly, mobilisation for enrolment is to be matched with adequate provision of resources (human resources and facilities) to cater to the people.

As obtainable in Nigeria (see Onyedibe *et al.*, 2012:5), Agyepong *et al.* (2016:7) found that "SSNIT contributors (public and private formal employees) preferred to use private health facilities rather than government facilities because of quality of care". Even, "most premium exempt groups do not enrol and renew enrolment" (Agyepong *et al.*, 2016:2), perhaps, due to issues of quality and satisfaction. More so, "the claim by the decision-makers that the NHIS offers a 'generous' benefits package that covers about 95% of common diseases" (Amo-Adjei *et al.*, 2016:1) ends in mistrust when enrollees are not able to get the healthcare needed. For instance, it does not cover vision, hearing, orthopaedic and dental aids as well as antiretroviral drugs for treating HIV/AIDS (Wang *et al.*, 2017:20), amongst others. In another study, Brugiavini and Pace (2016:3) found that "the NHIS does not have a significant effect on the reduction of OOP expenditure at the extensive margin". This is partly because certain healthcare needs of the people are not part of the benefits package of the insurance programme.

Furthermore, the NHIS programme is faced with some problems (nationally) relating to policy design, implementation and administration. Despite the various reform efforts, the scheme is still faced with financial sustainability. As noted by Wang *et al.* (2017:1), the "total claims payments rose from GHc7.6 million in 2005 to over GHc1.07 billion in 2014 with an annual deficit of GHc300 million". This continues to be a major source of worry to the government. Even at that, the scheme is still faced with myriad challenges. Also, in the perception of healthcare providers, "satisfaction with timeliness of reimbursement decreased from approximately 14% in 2012 to less than 10% in 2014" (Alhassan *et al.,* 2016a:6). Also, as of 2013, "Ghana has about 11 doctors, nurses and midwives per 10,000 population, less than half of the number (23 per 10,000 population) recommended by WHO for attaining MDGs" (Association of Chartered Certified Accountants, 2013:18). This tends to limit the level of success of the programme because of the inadequate health workforce.

All these challenges tend to suggest a change of policy rather than a review that is characteristic of Ghana's NHIS. Consequently, Oxfam International (2011:1) argued that the healthcare system in Ghana is unfair and inefficient, and advised the government to "replace it with the tax-based system that would be free at the point of delivery for all, based on rights and not ability to pay". This is because "every Ghanaian pays for the NHIS through VAT, but over 80% of the people were excluded as of 2011" (Oxfam International, 2011:1). It is very clear that the population of enrollees exempt from paying premium is very high - 70% of total enrollees as of 2014 (Yete *et al.,* 2015:501; Wang *et al.,* 2017:1) yet, "the scheme has not been able to achieve one of its goal of eradicating inequities between the rich and poor in terms of access to healthcare services" (Association of Chartered Certified Accountants, 2013:17). Thus, the call by Oxfam International for free healthcare for all citizens seems achievable going by the cost incurred on those that are exempt from paying the premium in the existing policy (see Oxfam International, 2011:7).

The Ghanaian NHIS has financial and operational challenges ranging from "cost, political interference, corruption" (Fusheini, 2016:550), "technical capacity, the distribution of healthcare facilities and workforce, benefits package, community engagement, monitoring mechanism and exemption policy" (Alhassan *et al.,* 2016b:1). Given the various challenges, Mathauer *et al.* (2017:iv) suggested that "for countries with traditional CBHI schemes, an option is to integrate or merge existing schemes into a single national pool with decentralised arms or closely interconnected pools beyond the community level, which can provide similar

benefits packages and act – with national support – as strategic purchasers of health services while maintaining local accountability". Invariably, Ghana appears to have acted in line with this suggestion. However, the performance of the NHIS seemingly reveals that the suggestion might not effectively lead towards the provision of equal access to health and attainment of UHC (with adequate coverage of the poor and the vulnerable groups). The experience in Ghana "holds myriad lessons for countries striving to increase access to affordable healthcare, at national level financing and risk pooling; the merging of centralised authorities with decentralised administration and purchasing of health services from public and private health providers" (Blanchet & Acheampong, 2013:2).

2.6.2 CBHI: The Rwandan Experience

Origin

The first form of CBHI in Rwanda (Muvandimwe association) was established in 1966 in the former province of Kibungo for the purpose of attending to specific health goals (Kalisa *et al.,* 2015:15). As experienced in Ghana and many other African countries, the post-independence provision of free healthcare services in Rwanda was terminated by the IMF/World Bank imposed SAPs, and user-fees was adopted in the 1980s. After the 1994 genocide, which left the country with loss of lives and infrastructures, "mutual aid initiatives emerged in the health sector as a community response to user-fees in public and mission health facilities" (Diop & Butera, 2005:1). As part of efforts to revive and entrench the solidarity among the people, CBHI schemes were established in various communities in the country by community members.

The schemes continued to benefit members, "and in 1999, the CBHI also known as *Mutuelles de Sante* was piloted in three districts (Byumba, Kabgayi and Kabutare) with two control districts [Bugesera and Kibungo]" (Woldemichael *et al.,* 2016:5). It was established as a national policy in 2004 (USAID, 2016:1). Besides the need to provide healthcare for the people, especially the poor, the CBHI programme was also used as an instrument of social cohesion for promoting national reconciliation and reconstruction as well as promoting self-sufficiency (Antunes *et al.,* 2009:59). However, it is argued that the establishment of the programme is part of the strategies of the ruling party (Rwandan Patriotic Front) to bring development and foster regime legitimacy and deter possible challenge (Chemouni, 2018:93).

Design and Implementation

In Rwanda, apart from the CBHI schemes which cover individuals in the formal and informal sectors, other schemes include "Rwandaise d'Assurance Maladie (RAMA) for the civil

servants and employees of state-owned enterprises, Military Medical Insurance (MMI) for the military personnel and private health insurance schemes" (International Labour Organization, 2016:1). Majority of the people are enrolled in the CBHI programme, although, enrolment became compulsory in 2006. The programme is claimed to cover 90% of the healthcare costs at public and non-profit health centres (Rickard *et al.,* 2018:1604) and enrollees can access care anywhere in the country (i.e. patient roaming system) (Kalisa *et al.,* 2015:31). Other health insurance schemes are made to contribute financially to the CBHI programme. In policy decisions and implementation, the Rwandan government took control above foreign donors to the programme (Iyer *et al.,* 2018:204).

Before 2007, "enrolment was on a household basis, and since 2007, enrolment has been on an individual basis with each member paying a subsidised flat rate of RwF1,000 (USD1.5) per year and co-payment of RwF200 at clinics and 10% at hospitals per episode of illness" (Woldemicheal *et al.,* 2016:6). For financial sustainability, in 2010, a three-tier premium scaling system (called *ubudehe* classification) was introduced, following a revision of the CBHI policy, whereby households are assigned to one of six categories based on their income and assets, and premium ranges from RwF2,000 to RwF7,000 (ILO, 2016:2). This classification is further collapsed into 3 CBHI categories and Category I (those living in abject poverty and very poor) pays RwF2,000 (3 USD), Category II (poor and resourceful poor) pays RwF3,000 (4.50 USD). In contrast, Category III (food rich and money rich) pays RwF7,000 (10.50 USD) (Iyakaremye, 2012:17). The cost of care for Category I (vulnerable groups and the poor) "are fully covered by the government and development partners" (Kalisa *et al.,* 2015:30). In the enrolment, 24.8% are in category I, 65.9% are in category II, and 0.64% constitute Category III (Chemouni, 2018:93).

The CBHI programme delivers services at different levels of need. According to the policy, the health centres (provide primary and preventive healthcare as well as pharmaceutical and basic laboratory supports), the district hospitals (provide preventive, curative and promotional healthcare for patients referred from primary healthcare centres) and tertiary hospitals (provide specialised health services for patients referred from districts hospitals) (ILO, 2016:3; USAID, 2016:4). In contrast to the Kwara and Ghana CBHI, the Rwanda CBHI requires co-payment from enrollees.

Major Achievements

Chemouni (2018:1) noted that "Rwanda is the country with the highest enrolment in health insurance in Sub-Saharan Africa". Authors such as Lu *et al.* (2012:1), Sibomana (2014:38) and Jowett *et al.* (2016:14) commended the programme. In a study on the programme, Shimless (2010:14) found increased healthcare utilisation and reduced catastrophic health expenditure among the enrollees compared to the non-enrollees. Also, "between 2003 and 2007, the number of health centres increased from 88 to 403 across the country" (Kalisa *et al.,* 2015:26). The ILO (2016:1) claimed that "as of 2011, 96% of the Rwandan population was covered by health insurance and the CBHI had the highest coverage, rising from 7% in 2003 to 91% in 2011". However, Kalisa *et al.* (2015:36) reported that the CBHI coverage reduced to 74% in 2013.

Chemouni (2018:91) linked the increased coverage between 2006 and 2012 to "a grant of $34 million secured from the USAID's Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM)". This facilitated the enrolment of more people, mainly the poor. Furthermore, Rickard *et al.* (2018:1607) found in a recent study that patients enrolled in the CBHI programme had decreased the risk of catastrophic health expenditure for undergoing a surgical procedure (i.e. peritonitis). This feat was partly achieved through an increased financial commitment by the government and donors (Lu *et al.,* 2012:2) as well as community engagement and aggressive awareness exercise.

Weaknesses and Challenges

The Rwandan CBHI is also faced with a series of challenges. Most of the challenges identified in 2010 reviewed Health Insurance Policy are still evident and yet unresolved. Recent studies by Rubogora (2017:1), Chemouni (2018:92) and (Mukangendo *et al.,* 2018:3) revealed that the enrolment in the CBHI programme is decreasing. For instance, the coverage steadily declined to 79% in 2016, from over 90% in 2011 (USAID, 2016:4). This is partly due to an increase in premium and reduced quality of care (Rubogora, 2017:1). More so, recent finding by Chemouni (2018) that CBHI officials in Rwanda usually tamper with enrolment data to keep the figures high is another contentious revelation challenging the claimed 'huge success' of the programme.

Similarly, the CBHI Household Survey conducted in 2013 revealed that 67% of Category II enrollees did not find it convenient to pay premiums and 22% resolved not to renew enrolment in the following year (see Kalisa *et al.* 2015:38). Also, this category of enrollees often resorted to savings or sell household items to finance the premiums (Kalisa *et al.,* 2015:48).

Furthermore, 89% of the non-enrolled respondents in the survey were previously enrolled, and nearly all of them said they stopped because they could not afford the premiums (see Collins *et al.*, 2016:7). This is because, as of 2016, "38.2% of the Rwanda population live below the poverty line" (World Bank, 2020a). These question the CBHI's strength and ability to deliver UHC.

Although Woldemichael *et al.* (2016:3) admitted that the programme has significantly increased out-patient utilisation rates, they expressed some concerns that the subsidised premium was not affordable for most poor people, especially large families. On the evidence of improved healthcare service utilisation, Kutzin (2012:868) argued that "this is hardly news and could not serve as a veritable basis for CBHI policy recommendation because a programme can benefit its members at the expense of the rest of the population". Therefore, "the goal is to institute a health system that gives access to the entire population and deliver UHC" (Kutzin (2012:868).

The *ubudehe* system remains an imperfect mechanism for determining who the government pays their premium (Sibomana, 2014:41). The inaccuracy of this system has left some individuals uncovered, most of who belong to the low economic status and are not eligible for the public subsidy (Musabwasoni & Oudshoorn, 2019:60). Though the premiums are income-sensitive through the *ubudehe* classification, nevertheless, "co-payments which are determined by healthcare providers remain unaffordable for many poor people" (Wang *et al.*, 2017:368). In this regard, Chemouni (2018:95) found that enrolment subscription and co-payment are consciously retained by the ruling party and the government to configure the mindset of Rwandans away from 'culture of assistance' because free things are dangerous. Nevertheless, no matter how good, the country seems unripe for this policy decision due to its poverty rate and the much reliance on the programme on foreign aids. In a systematic study, Mebratie *et al.* (2013:17), found that "despite the avowed aim of social inclusion, the ultra-poor (exempt from payment) did not have access to the CBHI schemes because of inability to bear other costs (e.g. transportation) associated with accessing healthcare".

Experience at the healthcare facilities seems to be unsatisfactory. In most cases, enrollees complained about poor courtesy and quality of service, weak customer care, regular stock-out of drugs, embezzlement, over-charging and over-prescription (Habiyonizeye, 2013:30; Nyandekwe, 2014; Sibomana, 2014:42; Rubogora, 2017:2). Often, enrollees are sent to buy drugs at private pharmacies at a high cost (Kalisa *et al.*, 2015:42). Further, Woldemicheal *et*

al. (2016:17) found high spending on drugs among enrollees because not all drugs are covered by the CBHI programme. The programme which is aimed at expanding access to healthcare across the country has not done enough in terms of engaging qualified healthcare workers, especially in rural areas. For instance, "the number of people allocated to a nurse is an average of 1 nurse to 2,219 people" (Rubogora, 2017:2). Consequently, enrollees had to wake up very early and endure long queue hours before medical consultation and treatment (Rubogora, 2017:2).

Humuza (2011) and (Uche, 2016:35) decried the heavy reliance on government and donor contributions. Similarly, Iyakaremye (2012) and Mukangendo *et al.* (2018:3) expressed concerns about the financial sustainability of the programme. These concerns might be due to an inconsistent flow of fund from the government and donor agencies into the programme. Moreso, "as per many sub-Saharan African countries, Rwanda is highly aid-dependent" (Sekabaraga *et al.,* 2011:61). According to the USAID (2016:2), the programme is funded by 62% of foreign aid while 38% is generated from domestic sources, with premium providing only 18%.

There is also national advocacy of additional essential services yet to be included in the package (Nyandekwe, 2014). This is because there is still an array of healthcare challenges among the people that are not covered by the programme. The implication is that only citizens with financial capacity (outside the health insurance package) would be able to access healthcare. In contrast, others are left to adopt any other source of care. This, however, challenges the success of the CBHI policy.

2.7 Conclusion

Health reform is a continuous process across countries, and health insurance has been implemented for decades, mainly in developed countries. The various health insurance models appear not relevant to the realities of developing countries. CBHI is a relatively recent health financing strategy recommended for implementation in LMICs, mostly located in Asia and Africa. Specifically, it was employed and targeted towards achieving UHC. Over the years, the experience from implementation in some of these countries has generated mixed results (positive and negative).

In some cases, the coverage of the programme remains stagnant while it declines in other settings. The worse situation is the kind experienced in rural Kwara in Nigeria where a CBHI programme collapsed or ceased to operate. Hence, a need for a closer look at the policy to

examine its suitability for Nigeria and other developing countries. Thus, the chapter reviews the literature on the different health financing reforms options at the global level. It also examines the strengths and weaknesses of the CBHI model of health financing citing experiences from Nigeria, Ghana and Rwanda. Again, this review reveals the interplay of various forces involved in the shaping of the health reform programmes in Nigeria. Therefore, to have a clearer understanding, Walt and Gilson health policy triangle was adopted as a conceptual framework. The framework which is discussed in the next chapter will assist in understanding the relationships and roles of different stakeholders that implemented the programme in Kwara State.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

3.1 Introduction

The chapter deals with the conceptual framework adopted in the study. It serves as a guide for understanding and explaining the various narratives and discourses emanating from the data collected for the study. As noted in Chapter 2, health policy or healthcare reform involves a complex and contested process that requires careful and systematic analysis. The ideas and goals of actors with the 'strongest' ability to influence the process dominates. This, therefore, has implications for policy success or failure. Thus, the framework provides the basis to answer the research questions and helps to unpack the various elements that informed the design, implementation and stoppage of the CBHI programme in Kwara State Nigeria.

3.2 Walt and Gilson Model

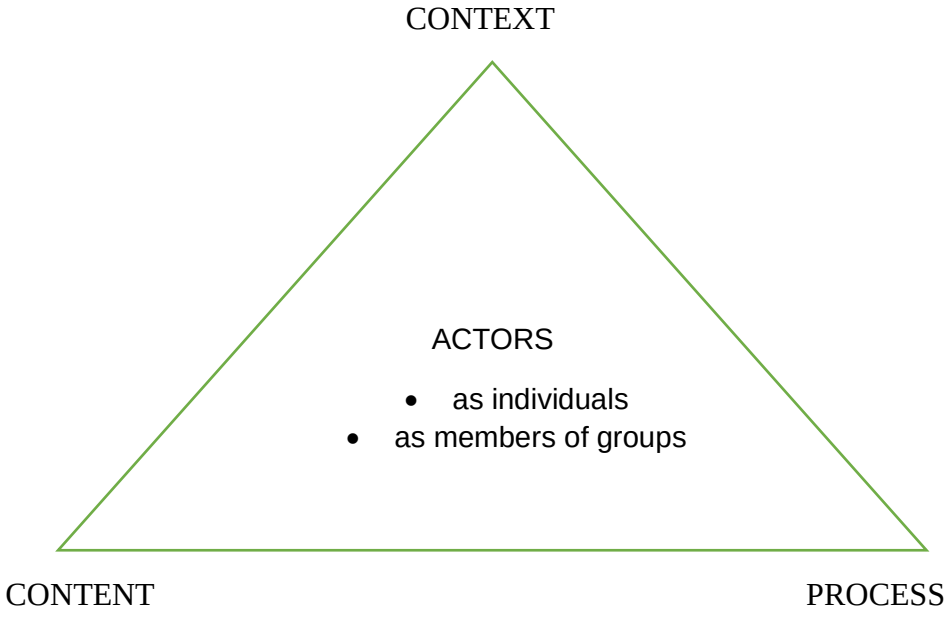
This study adopts a health policy triangle, a model developed by Gill Walt and Lucy Gilson, as a conceptual framework for framing and analysing the data we collected from the field. The model came into existence as a result of the growing crisis in the healthcare system and the neglect or limited application of health policy analysis in the developing countries. As a "simplified representation of policy reality" (Hagenaars *et al.,* 2017:2), it also seeks to provide a detailed analysis of health policy process and how it influences policy effectiveness (Walt & Gilson, 1994; Sanneving *et al.,* 2013; Juma *et al.,* 2016). For Alostad *et al.* (2019:3-4), the model is effective in investigating "the context within which the policy was developed (i.e. context for and reasons why the policy was developed); the policy process (i.e. how the policy was developed and is being implemented); the policy content (i.e. how the content was formulated); and the actors involved (i.e. who were they and what role they played in the process)". These various elements are interrelated and influence each other during the policy cycle.

The model is relevant to the study in that it was developed purposely for "health policy analysis in developing countries" (Walt & Gilson, 1994:353). "It acknowledges the non-linearity but incremental nature of policymaking and systematically explores the somewhat neglected place of politics in health policy" (Sanni *et al.,* 2019:377). Further, it gives "adequate attention to uncovering the reasons why particular policies are adopted at the expense of technically more efficient alternatives" (Smith-Merry *et al.,* 2007:2). It helps to understand policy success or failure. More so, it is partly designed "for analysing data produced in scientific research on health" (Alharbi *et al.,* 2016:234) and can be used "retrospectively – to understand the process

of health policy reform better – and prospectively – to plan for more effective policy implementation" (Walt & Gilson, 1994:355). In this study, however, it is used retrospectively, and it serves as a conceptual framework; not a theory because it offers a broad framework for understanding the study. Therefore, it is a conceptual device for organising the data obtained in the study.

According to Walt and Gilson (1994:354), "much health policy wrongly focuses attention on the *content* of reform and neglect the *actors* involved in policy reform (at international, national and sub-national levels), the *process* contingent on developing and implementing change and the *context* within which policy is developed". They further argued that "the traditional focus on the content of policy neglects the other dimensions of process, actors, and context which can make a difference between effective and ineffective policy choice and implementation" (Walt and Gilson, 1994:353). "The policy setting is ever-changing, as well as relationships between partners (including policy networks) and institutions because policy is a dynamic process" (Walt & Gilson, 1994:366; Gilson & Raphaely, 2008:295). Thus, there is a need to "pay attention to the processes of developing policy as well as how the policy issue arises, how decisions are made in the policy development and lastly, how the policy is implemented" (Taegtmeyer *et al.*, 2011:3).

Figure 3.1: Health Policy Triangle



Source: Walt & Gilson (1994:254)

The four dimensions of health analysis, according to them, are as follows:

Context: According to Exworthy (2008:319), "context is the milieu within which interventions are mediated; it therefore shapes and is shaped by external stimuli (policy)". Simply put, it involves the situational factors (national and international – events, agreements, treaties and resources) that affect health policies. They are historical (legacy of colonialism), social, cultural, political (governance structure, the system of accountability and power distribution), economic (macro-economic situation and policy), religious, structural, administrative (skills and structures), environmental factors (Walt & Gilson, 1994:361; Etiaba *et al.,* 2015:2; Gilson & Agyepong, 2018:38; Al-Ansari *et al.,* 2019:193; Sanni *et al.,* 2019:376) and other systemic factors that may affect the eventual policy content (Buse *et al.,* 2005:4; Hagenaars *et al.,* 2017:3; Mji *et al.,* 2017:5).

Put differently, Collins *et al.* (1999:72) explained that health policies are developed within a complex milieu and not in a vacuum, thus, understanding the context assists in the analysis of the "issues on the agenda and how the policies are formulated and implemented". Further, they summarised the "context of contemporary health policy reform" into six: "economic and financial policy; processes of social and economic change; demographic and epidemiological change; politics and the political regime; ideology, public policy and the public sector; and external factors". These factors may be formal or informal (Sumner *et al.,* 2011:5).

For instance, "the economic context involves the country's economic status as well as the global and local financial situation and conflicting development agendas" (Sanni *et al.,* 2017:376). Further, the socio-political context of a nation has "a significant influence over actors' values and interests, and consequently, their reactions to policies including their opportunities to participate in decision-making" (Gilson & Agyepong, 2018:37). Going further, the political context as described by Araujo and Filho (2001:207) is "the space in which the flow of power occurs amongst distinct groups in society". It accounts for "who is ruling, who is in support, who is in opposition, who is benefiting and who is losing throughout the policy process" (Araujo & Filho, 2001:207).

Context also includes the neoliberal policy framework that "introduced new tensions into the health policy domain" (Walt & Gilson, 1994:357) and mostly pushed through market-centric strategies. Hence, context can facilitate and constrain a health policy (Agyepong & Adjei, 2008:151; Etiaba *et al.,* 2015:8; Mirzoev *et al.,* 2015:62; Seale *et al.,* 2017:2). On health policy transfer, Walt *et al.* (2004:206) noted that complex policies (involving long and iterative

process) are often simplified and marketed across the world as 'global best practice' (especially, to countries with weak healthcare systems) by international agents through policy networks. They added, however, that "the process cannot be described as linear, rational, bottom-up or top-down, coercive or voluntary, but may display any of those characteristics at different points".

The policy transfers are usually easy to be orchestrated because the contexts provide the opportunities to do so. A common technique employed by international actors for influencing health reform is to leverage on their 'expertise' to justify and facilitate training programmes for policymakers usually channelled along 'desired' goals (see Reich *et al.,* 2016:214). This is done for a wide range of policymakers across the world, and they are lured into adopting particular policies when they embark on reforms.

In their work, Agyepong and Adjei (2008:151) noted that the individual characteristics of health policy actors (responsible for policy formulation) "such as their ideological predispositions, professional expertise and knowledge, feedback from similar policy situations, position and power resources, political and institutional commitments, loyalties and personal attributes and goals form part of the context of policymaking". This is because all these features tend to influence the understanding of the policy context, which is the basis for policy formulation. For instance, "the policy context may influence which policy ideas are dominant" (Sumner *et al.,* 2011:6) and find their ways into the policy content through the policy actors.

According to Collins *et al.* (1999:80), "the interpretation of context is not politically neutral - it forms part of the political character of the policymaking system". While interpretations based on scientific research evidence (mostly involving the epistemic community who may focus on issues of interest to the funders) often appear to be objective. Dobrow *et al.* (2004:213) argued that what constitutes evidence and how we utilise them are affected by both internal and external contextual factors. Ideology is given priority over evidence (Baum & Fisher, 2014:220). This includes the tactical use of the media to shape and influence the understanding and interpretations of policy problems (Katikireddi & Hilton, 2015:126; Etiaba *et al.,* 2015:8).

Consequently, once some actors can weave their preferred goals into the interpretation of the policy context, there is a likelihood that it will find its way into the policy content. Significantly, the policy context determines what eventually constitutes the policy content,

the roles that can be played or cannot be played by the policy actors, and the process that will characterise the policy from development to implementation and evaluation. Therefore, the context must be well-understood.

Actors: The actors are in the middle of the framework because they act as the drivers of other components in the framework. The framework explains that various actors play important roles ('interest-based') in formulating and implementing healthcare policies. The roles of these actors influence the other processes and outcome of the policy. Thus, success or failure of such policy is determined by the actions or inactions of the various actors. Araujo and Filho (2001:213) explained that "formulators, implementers, supporters or opposition add their ideological values, political views and practical proposals to the process and, by doing this they determine the course of a policy process".

The actors (state and non-state) include key decision-makers, individuals, organisations, politicians, professionals, policy entrepreneurs, global civil societies, networks or groups that are influential in decision making (Sumner *et al.,* 2011:5; Gilson & Agyepong, 2018:46) within the health policy space. Both for the for-profit private sector (multinational corporations) and the not-for-profit organisations are increasingly playing significant roles in the health policy arena (Walt *et al.,* 2008:309). According to Walt and Gilson (1994:362-3), among other actors, the role of civil service is quite instrumental in the policy arena because of the strategic position they occupy, as bureaucrats, in the implementation of reforms; and this makes it necessary to focus on the relationship between politicians and bureaucrats.

More often, health policy actors negotiate with a lot of actors at the local and foreign levels (Green, 2000:58; Exworthy, 2008:323; Gilson, 2012:29). At times, actors with related goals collaborate against other actors within the negotiation space (Liefeld & Schneider, 2012:741) to influence the policy decisions. Actors may also include 'experienced' individuals recruited by foreign actors from local health sectors to represent their agencies and foster their interests (Marchal *et al.,* 2009:3). However, the extent to which actors can influence policy depends on their interest, actual or perceived power [among other things] (Buse *et al.,* 2005:10; Lister & Lee, 2013:74; Katikireddi & Hilton, 2015:131). Moreover, it is quite difficult to assess the power of actors which can be tangible (financial, votes, organisational capacities etc.) or intangible (control of information, credibility, position etc.) (Bossert *et al.,* 2007:48).

Meanwhile, non-state actors (mostly international actors) often leverage on the use of their knowledge to advance their preferences during the policymaking process "in three ways:

instrumentally, conceptually and strategically" (Dolowitz *et al.,* 2019:3). Unfortunately, "international organisations and states are rarely challenged by domestic or state actors who are expected to alter the power relations towards national interest" (Dolowitz *et al.,* 2019:3). This is because in most cases, the domestic actors (i.e. government representatives and others) lack the technical know-how or pre-requisite knowledge – even in some developed countries as claimed by Howlett (2009:153). As is to be expected, this has a devastating effect on the entire policy cycle as it becomes difficult to negotiate gainfully with the other stakeholders involved in the policy design (Onoka *et al.,* 2015:1113; Alharbi *et al.,* 2016:236). As a result, stakeholders (civil society organisations including advocacy groups, donor agencies etc.) that should have limited roles appear to play outsize roles in policymaking (Lister & Lee, 2013:78) mainly because of their financial and epistemic powers (Khan *et al.,* 2018:218).

Individuals within the public service (politicians and bureaucrats) are very influential due to their positions and experience. While discussing policy failure and success in developing countries, Aryee (2000) [cited in Agyepong and Adjei (2008:152)], identified two kinds of unusual state actors (i.e. saints and wizards) that are capable of actualising policy success: "(i) progressive and committed politicians and bureaucrats (saints) (ii) supported by appropriate policy analysts with available and reliable information (wizards) to manage hostile and apathetic groups (demons) from infiltrating the policy arena". He explained that "demons are a very small set of public officials and individuals who engage in corruption or rent-seeking activities and they have to be neutralised" to achieve a meaningful result. Further, the demons include anyone who seeks to subvert the policymaking efforts at any point from agenda-setting to implementation and evaluation. Regarding resistance to health policy implementation, Gilson (2019:239) argued that "the task is well beyond the responsibility of health financing and policy analysis units in the public sector". Therefore, a well-constituted team (with the necessary expertise) in the public bureaucracy must be directed to develop political strategies for managing health policy reform. This shows the demanding nature of successful health policymaking.

Some domestic actors have, however, been able to limit the influence of international actors within their policy space in countries like Morroco, Tunisia and Rwanda (Allal, 2010 cited in Dolowitz *et al.* 2019:5; Chemouni, 2018) because they were able to focus on their desired goals. More so, Tantivess and Walt (2008:336) found in Thailand that the involvement of non-state actor (from national and international communities) in agenda setting, policy formulation and implementation yielded positive results. They, however, noted that this singular case does

not suggest a change in trend from the prevailing negative impact of policy interference, mainly by international actors. Besides, the Thailand programme is not a comprehensive national health policy reform but an interventionist programme to widen anti-retroviral therapy coverage. More often, international actors tend to 'dismember' and disorient the healthcare systems, especially in the LMICs.

Content: This refers to the actual policy being designed, including its identified goals. It focuses on the various units and elements that constitute the policy agenda. This element "is the substance of a policy which details its constituent parts" (Hagenaars *et al.,* 2017:3). Put differently, "content refers to the object of policy and policy analysis" (Janovsky & Cassells, 1996 cited in Exworthy, 2008:316) and policy can "be expressed in a whole series of instruments such as laws, practices, statements, regulations etc." (Buse *et al.,* 2005:8). Sanni *et al.* (2019:376) noted that "content examines the rationale for developing the policy, policy objectives, types of interventions (upstream, midstream, or downstream), population-level coverage (universal or targeted), implicit or explicit equity goals (improve the health of vulnerable groups, reduce health gaps between the most and least vulnerable groups, or flatten the social gradient in health across the entire population), and mechanisms through which the policy is actualised". More succinctly, Araujo and Filho (2001:205) noted that policy content details the problems aimed to be changed, programmes and projects involved, actions to be taken, as well as targets and resources required. Therefore, analysing the content helps to identify the "policy's perspective, impact and adequacy of its measures and resources" (Araujo & Filho, 2001:205).

Buse *et al.* (2005:54) argued that "part of the failure of health reform programmes is linked to the undue emphasis placed on the technical content of reform at the expense of the politics of the reform process". Equally, Beland (2009:712) submitted that with political support, ideational processes could assist in achieving positive policy outcomes because it helps to shape reform agenda, the content of reform proposal as well as reform imperatives and ultimately, "shape the ways actors perceive their environment and interests". Further, he argued that if the policy imperatives are well-framed and the inherent values are amplified, it becomes possible to take charge of the policy generation space. In some cases, the framing is done using mass and social media (see Katikireddi & Hilton, 2015:125) to build wide understanding and acceptance among the people.

More so, the quality and comprehensiveness of the health policy have significant implication for its effectiveness during implementation, notwithstanding the influence of other factors involved. It often evolves to resolve healthcare challenge or to improve the status quo. Key policy actors are responsible for what constitutes policy content. However, as a result of the complexity of the policy space, involving too many actors, it is usually not easy to precisely point out the weaknesses of a healthcare system (Marchal *et al.*, 2009:4; Szlezack *et al.*, 2010:1) to set the appropriate agenda for transformative health reform. Importantly, if the context is well interpreted there is a tendency that the policy content will be suitable.

Process: This refers to the various steps and stages involved in health policymaking. It consists of the formulation and implementation of health policy (Srivastava *et al.*, 2018:2), relationships among the various "levels of governments, strategies for policy implementation and resources implications" (Araujo & Filho, 2001:205). For Buse *et al.* (2005:13), "process refers to the way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated". In their work, Walt and Gilson (1994:366) contended that policy analysis must not ignore the *how* of policy reform to have a clear overview of the health policy landscape, most especially due to the technical orientation of the health sector. They further argued that regardless of the rational debates advanced by professionals or technocrats during the policy design, the adoption and implementation is mainly a political decision. This decision depends on who has the most influence among the various actors (which often include the international actors in developing countries in the forms of donors, technical partners/advisers, etc.). Therefore, "policy analysis cannot also continue to ignore the influence of values and group interests – the *who* of policy reform – on policy choice and implementation practices" (Walt and Gilson, 1994:366). Besides, this influence may involve "a variety of goals from the adoption of a new policy to minor adjustments to institutional arrangements in current policies" (Weible *et al.*, 2012:1). They are orchestrated often, in ways that the influence goes unnoticed. The influence or direct involvement of the donors in the nation's health policy priorities becomes highly significant if the countries rely substantially on external funding (Khan *et al.*, 2018:216).

The form of implementation might be top-down, bottom-up or combination of both (Araujo & Filho, 2001:205; Hardee, 2012:8); the stakeholders never lose focus on their interests. The policy process also relates to the bureaucratic and administrative responsibilities in policy planning and implementation. Therefore, the phases through which the health policy goes through determine the policy outcome (success or failure). Weible *et al.* (2012:6-7) argued

that understanding the policy process requires the ability to map out the policy sub-systems and macro-system. For them, the sub-systems would include the key stakeholders in the healthcare sector at various levels (community, local and national levels) who work interdependently.

On the other hand, the macro-system considers how the constitutional rules, structure and culture give room for changes in parts of the system or sub-system (Weible *et al.,* 2012:6-7). Therefore, this creates multiple access points for actors to influence health policies. For instance, those resisting change may lobby with actors constituting various sub-systems to oppose a change at the macro-level. In contrast, those working for change may frustrate the successful implementation of health policy in certain places to reveal the deficiencies in the status quo.

As part of the political motives of health policy, Ballart and Fuentes (2019:352) noted that "the interest could be electoral (e.g. where re-election of the incumbent party is dependent on demonstrating progress in the implementation or reversal of certain policies) and corporative (e.g. professionals affected by reforms or changes in the organisation of health services)". Notwithstanding the presence of scientific evidence supporting policy, it might still be resisted due to the absence of broad support from the public or actors whose interests are threatened (Brownson *et al.,* 2006:361; Bossert *et al.,* 2007:46). Also, Dolowitz *et al.* (2019:8) cautioned that delays in policy process can lead to 'policy contamination' and that "the more control one actor (or set of actors) has in the policy process and the better positioned they are to guide a preferred option through the policy process, the more likely the policy outcomes will be in their interest". Thus, local or state actors (government representatives) are required to be active to be in control of the policy negotiation space.

Given the above, Sanni *et al.* (2019:386) opined that it is better to use the word *Strategy* rather than *Process* to clearly expose "how the various stakeholders in health policy make intentional choices to maximise benefits in a given policy context and content". Okuonzi and Macrae (1995:122) concluded from their study that "while (at times) the content of international prescriptions to strengthen the health system may not be bad in itself, the process by which they are applied potentially threatens national sovereignty and weakens mechanisms for ensuring accountability". At the policy implementation stage, "some actors leverage on certain possible factors (i.e. ambiguous objectives, poor communication between responsible agencies, inadequate time and resources in implementation units, and problems in work

environments etc.) to adjust or influence or reject the policy" (Hudson & Lowe 2004 cited in Tantivess & Walt 2008: 330).

3.3 Application of the Framework

The framework assists in understanding how economic conditions, religion, politics and other situational factors affect the CBHI policy in Kwara State (context); helps to explain the roles of the Kwara State Government, Health Insurance Fund [that introduced the CBHI policy option], PharmAccess Foundation [the foreign implementing partner responsible for pushing the HIF agenda], Hygeia Nigeria Limited [the local implementing partner] etc. (actors); assists in examining the design and implementation as well as the strengths and weaknesses of the policy (content); and finally, helps in analysing the entire processes involved in the programme from agenda-setting to implementation (process). Further, the framework provides an understanding of the interplay between the various elements (concepts) concerning the collapse of the Kwara CBHI.

The framework was adopted by Green (2000) to explore health sector reform in Thailand, Peters *et al.* (2003) to assess the healthcare system in India, Khan (2006) to analyse health policy in Pakistan and May *et al.* (2013) used it in their study on palliative care in Ireland. Also, Gleeson (2011) used the model to explain the mutual impact between health policy and public health nursing in the UK. It was also used by Jardali *et al.* (2014) in a study on nursing practice in Lebanon; they found that the adoption of international policy recommendation may be risky especially without consideration for local stakeholders and contextual factors. In a comparative study, Muslim (2014) adopted the model to analyse oral healthcare policy development in Australia and South Africa; he found that the policy development structures in the countries are deeply rooted in their socio-cultural contexts. Further, Osore (2015) used it in analysing the implementation process of a healthcare programme in Botswana. He found that the government was highly committed but the programme failed due to poor coordination and some other sustainability challenges. More recently, the model was also used in healthcare studies conducted by Juma *et al.* (2016), Tesfazghi *et al.* (2016), Mukanu *et al.* (2017), Maluka *et al.* (2018), Mokitimi *et al.* (2018), Al-Ansari *et al.* (2019), Alostad *et al.* (2019) among others. Specifically, in Nigeria, Onoka *et al.* (2015) adapted the model in analysing the emergence of the NHIS and found that the pace of policy process and UHC-related achievements are largely contingent on the interest of political leaders. In essence, the framework is very relevant to this study.

3.4 Conclusion

The chapter discussed the conceptual framework guiding the study. It consists of four essential elements (context, actor, content and process). It draws attention to areas which are often neglected in the course of policy analysis but are necessary to be given attention. It also shows how the process of policymaking can be infiltrated (due to situational factors) using a series of channels and how the policy space can be convoluted by different actors who are pursuing different goals. Specifically, it helps to deconstruct the complexities around the introduction and stoppage of the CBHI programme in Kwara State Nigeria. It shows how healthcare policy can be understood and how to effectively implement by giving attention to important areas of the policy process. While this study adopts the framework for analysing a policy that was implemented (retrospectively), the framework also has the potentials for informing the planning of health policy for implementation (prospectively).

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 Introduction

The chapter covers the research methodology. It is the scientific study of the conduct of research. According to Kothari (2004:8), "research methodology is a science of studying how research is done scientifically, which equips the researcher with various steps that are generally adopted in studying research problems along with the logic behind them". Essentially, research helps in the discovery or production of knowledge. Often, the worldview of a researcher is greatly influenced by the paradigm (positivism, interpretivism or critical realism) to which they align themselves (Doyle *et al.*, 2009:176). However, the nature of a study plays a significant role in determining the paradigm to be adopted in the study. Thus, this chapter details the methodology that guides the research.

4.2 Research Paradigms

Research paradigm refers to "a set of beliefs or principles about the world that guide people's actions regarding how to go about their research" (Kivunja & Kuyini, 2017:26). According to Kuhn (1962) who originated the term, 'research paradigm', it is an analytical lens for viewing the world and a framework for understanding human experience. It is a general and established framework that guides the research process based on human beliefs and experience. For Greene and Hall (2010:121), it includes "the philosophical issues of ontology or what is the nature of the social world we study, epistemology or what counts as warranted knowledge, methodology or how to generate and justify such knowledge, and axiology or what is the nature and role of values in the social inquiry".

4.2.1 Positivism

According to Ferrante (2013:20), "the term positivism was coined by Auguste Comte (1798-1857) who used the word to advocate the development of sociology as a science, but in the context of a shift in societal belief systems from theological to metaphysical and finally, scientific". Comte was optimistic that sociology would become the 'queen of science' to gain recognition and universal status. Positivism is generally described "as an approach that seeks to apply the natural science model of research to investigating social phenomena" (Nudzor, 2009:116). Positivism offers unambiguous and accurate knowledge. Further, "it assumes that social reality is made up of objective facts that value-free researchers can precisely measure and use statistics to test causal theories" (Neuman, 2004 cited in Tuli, 2010). Positivists seek to formulate laws that serve as the basis for prediction and generalisation (Scotland, 2012:10).

Positivist sociologists argue that positivist methodologies should be adopted to "study social behaviour in ways similar to those used in the natural sciences to study behaviour in the natural world" (Livesey, 2006:2). They see the researcher as external to the research setting and often use a large sample from the population to test relationships among variables. They use "standardised tests, closed-ended questionnaires and description of phenomena using standardised observation tools" (Pring, 2000 cited in Shah & Al-Bargi, 2013:225) among others, for data collection while analysis is usually done using statistical tools.

However, this approach has been criticised of not having deep insight and knowledge of phenomena. Also, methods of data analysis are quantitative. In addition, Cohen *et al.* (2007:8) maintained that "the approach is nomothetic because it is characterised by procedures and methods which are designed to discover general laws". More so, no scientific evaluation or explanation of human behaviour is ever complete (Berliner, 2002:20). Instead, methods of human sciences require detailed understanding and interpretation (Dilthey, 1976 cited in Swingewood, 1984:130).

4.2.2 Interpretivism

The interpretivists "reject the methodological monism of positivism and refuse to view the pattern set by natural sciences as an ideal for a rational understanding of reality" (Nudzor, 2009:117). According to Tubey *et al.* (2015:225), "the nature of interpretivist inquiry is to understand a particular phenomenon and not to generalise findings to a population". In support of this approach, Appleton and King (2002) noted that numerous realities and diverse interpretations that are important might result from research endeavour. Some of these realities emerge during the process of research, and their interpretation will enrich the findings of the research. Thus, this paradigm enables research participants "to derive meanings from their own realities and contribute to knowledge production through practice" (Cohen *et al.*, 2007:10).

For interpretive sociologists, the social world is different from the natural world because it consists of and constructed through meanings (Livesey, 2006:4). Therefore, when studying social behaviour, it is appropriate to "describe and explain it from the point of view of those involved" (Livesey, 2006:4). More so, Danby and Farrel (2004:41) asserted that "interpretive researchers produce theorised accounts that represent participant's sociological understandings". In other words, the interpretive method "yields insight and understandings of behaviour and explain actions from participants perspective" (Scotland, 2012:12). However, the paradigm has been criticised in terms of validity, reliability and generalisability

(Chowdhry, 2014:434) and that it does not "provide any agreed doctrine underlying all qualitative social research" (Nudzor, 2009:118). Consequently, mixed-methods emerged as a result of the rivalry (paradigm war) between positivism and interpretivism.

4.2.3 Critical Realism

Critical realism seeks to harmonise the strengths of both positivism and interpretivism. It rejects positivism's tendency to confuse observation for reality, and relativism's tendency to claim that 'all' accounts of a phenomenon under study are equally valid. Critical realism "accepts that reality can best be understood by investigating the multiple outlooks" (Halcomb & Hickman, 2015:6). As such, it sees people's situations and their viewpoints as real phenomena that have causal interaction with one another (Maxwell & Mittapalli, 2010). Critical realists also hold the belief that "all theories about the world are grounded in a particular perspective and worldview, and all knowledge is partial, incomplete, and fallible" (Regnault *et al.*, 2018:3).

This standpoint helps mixed-methods researchers "to better understand the context of what they study" (Doyle *et al.,* 2016:625). Also, "it provides a philosophical stance that is compatible with MMR (Mixed-methods Research) in that it acknowledges the methodological characteristics of both qualitative and quantitative research and can facilitate communication and cooperation between the two" (Regnault *et al.,* 2018:3). In other words, it provides opportunities for quantitative and qualitative researchers to collaborate (Cresswell & Plano Clark, 2018). While noting its importance, Wong (2016:58) opined that researchers could begin a mixed-methods study with the "quantitative phase, and then collect more data in the qualitative phase" for a better understanding. Given the strengths of this epistemic standpoint (which allows researchers to combine qualitative and quantitative methods), this study is informed by critical realism.

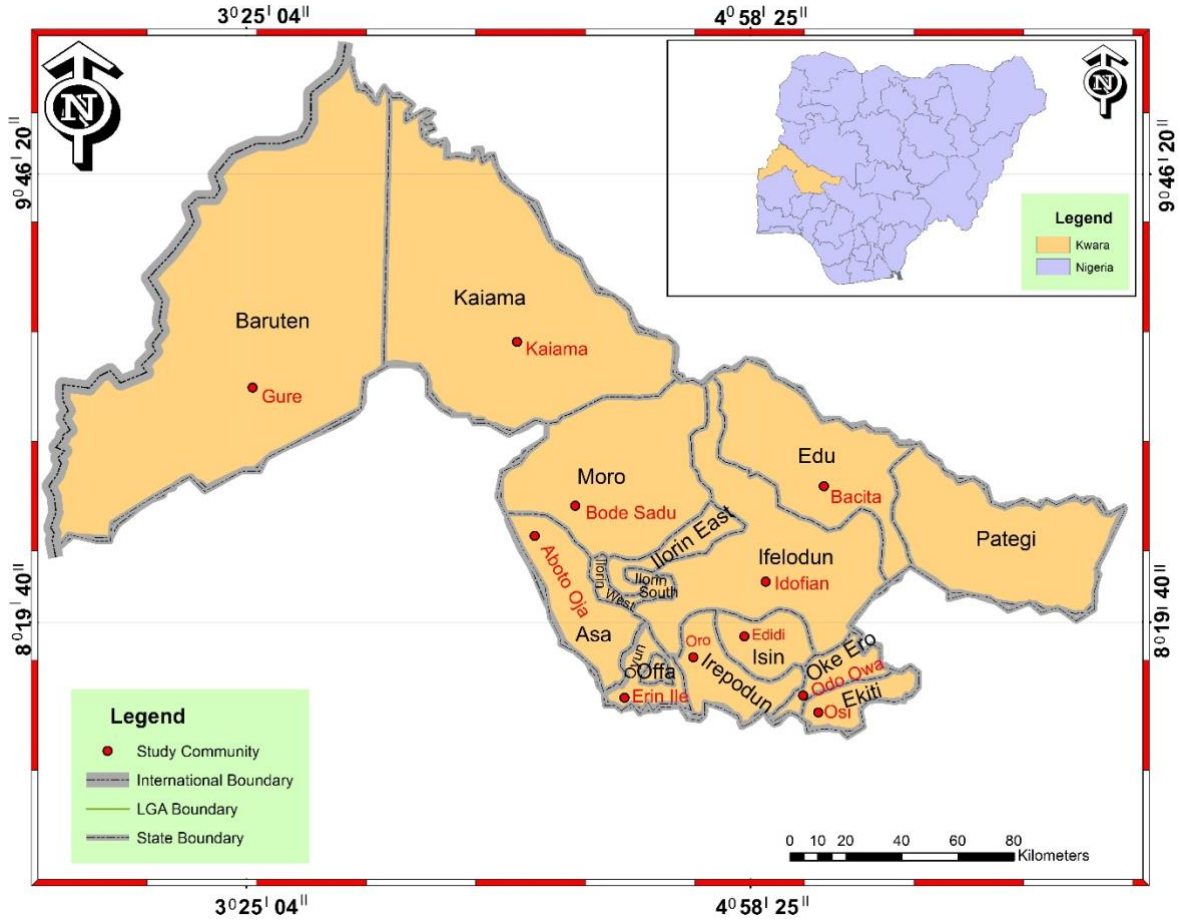
4.3 Research Site

The research was conducted in Kwara State, one of the 36 states comprising Nigeria and has Ilorin as its capital. It is geopolitically located in the North Central zone of the country and bounded by Benin Republic, Osun, Oyo, Ekiti and Niger states. The state comprises of 16 Local Government Areas (LGAs) delineated across 3 Senatorial Districts. Kwara State has both urban and rural areas, but the CBHI programme existed only in rural areas. As of 2016, the population of Kwara State is approximately 3.2 million (see National Bureau of Statistics,

2018:7). The elites mainly reside in the urban areas while the non-literates and semi-literates constitute the majority of the rural dwellers.

Agriculture is the primary source of income in rural Kwara. The principal cash crops are kolanut, palm produce, coffee and cotton. Agriculture keeps most people indigenous to the state in their rural communities. Meanwhile, some other economic activities drive the rural dwellers to migrate or regularly travel to urban areas. Inadequate access to healthcare is another factor that takes the rural dwellers to the urban areas for medical attention. The major languages spoken by the people of the state are Yoruba, Baruba, Nupe and Fulani while the majority of the people belong to Islam, Christianity and the traditional religion. There is limited access to quality healthcare, especially for the rural dwellers.

Figure 4.1: Map of Nigeria And Kwara State



4.4 Research Design

Research design refers to "how research can be conducted to answer the question being asked" (Marczyk *et al.*, 2005:22). For Yousaf (2019), it is a systematic approach adopted by a researcher for conducting a scientific study. It serves as the methodical plan for a study. Given

the philosophical stances discussed above and the need to adequately answer the research questions raised, the design adopted in this study is the mixed-methods approach.

4.4.1 Mixed-methods

As noted earlier (see 4.2 above), mixed-methods emerged as a result of the 'methodological harm' that can result from the alliance with only of the two paradigms (i.e. positivism and interpretivism); therefore, emerging as a third paradigm (Johnson & Onwuegbuzie, 2004). Specifically, the epistemic standpoint which informed the choice of mixed-methods approach adopted in this study is critical realism because it allows the mixture of both quantitative and qualitative methods in a research. It further allows the researcher to identify similarities, contradictions and variations as well as elicit a range of views from study participants based on the context of the study (Barbour, 2018).

Mixed-methods is "a process of research in which researchers rigorously integrate quantitative and qualitative methods of data collection and analysis to understand better a research purpose" (Guetterman *et al.,* 2019:179). Put differently, "it is a process of collecting, analysing and interpreting quantitative and qualitative data in a single study or in a series of studies that investigate the same underlying phenomenon" (Leech & Onwuegbuzie, 2009:265). Also, Cresswell and Plano Clark (2007) noted that mixed-methods have philosophical assumptions and methods of inquiry. For them, these assumptions guide how the methods are combined in one study through the stages of data collection and data analysis for a better understanding of research problems.

These philosophical assumptions are understood "in terms of axiology [role of values in research], ontology [what is considered real in the world], epistemology [how we gain knowledge of what we know], methodology, [process of conducting research] and rhetoric [language of research]" (Cresswell & Plano Clark, 2018). For instance, critical realism (adopted in this study) "integrates realist ontology [i.e. a real-world exists and independent of our constructions and perceptions] and constructivist epistemology [i.e. our understanding of the world is based on our perception]" (Cresswell & Plano Clark, 2018). Mixed-methods design also helps to tie several steps together in an evaluation process (Johnson *et al.,* 2019:143; Dopp *et al.,* 2019:3). Thus, in this study, mixed-methods allowed the researcher to use quantitative and qualitative methods iteratively.

Though there are arguments that the research paradigms are not compatible and would not be combinable for a single study (e.g. Crotty, 1998), Gorard and Taylor (2004:7) contended that

"while requiring a greater level of skill, the routine combination of methods create research with an increased ability to make appropriate criticism of all types of research". More so, Nudzor (2009) noted that "an appropriate methodological approach to social research is the one which gives pre-eminence to the purpose as well as the philosophical realm into which the issue under investigation fits". Further, Doyle *et al.* (2009:180) declared that "the product of combining qualitative and quantitative methods are more important than the process and therefore, the end justifies the means". However, Uprichard and Dawney, (2019:20) advised that "methods should be mixed in a way that has complementary strengths and non-overlapping weaknesses" for a meaningful outcome. The three overlapping spheres are quantitative, qualitative and mixed approaches to research, and the ability of mixed-methods to address complex research problems within a single study has led to its acceptability and application across disciplines (Plano Clark & Ivankova, 2016) and this particular study.

Weber (2004:vi) argued that the difference in the two methods does not affect the fundamental goals of their research because they tend to enhance the understanding of the world. In the recent times, mixed-methods research is emerging as a dominant paradigm in healthcare research because healthcare researchers are increasingly using it (Fetters *et al.,* 2013:2134; Guetterman *et al.,* 2019:179; Holtrop *et al.,* 2019:85). Recently, Alatinga and Williams (2019:82) canvassed for "the adoption of mixed-methods for studying health policy and specifically, health insurance, to enhance our understanding of the complex healthcare systems in Africa". This method is suitable for this study as it gave the researcher a synergistic understanding of the phenomena under study. It further allowed the researcher to collect data by recruiting respondents across identified geographical settings (quantitatively) and obtain detailed information (qualitatively) that are relevant to the study, from the participants.

Therefore, this study adopted quantitative-dominant mixed-methods research design which methodologically gives priority to quantitative approach compared to the qualitative**.** Mixed-methods enabled us to collect data from a range number of respondents to arrive at a reliable conclusion in the study. The study also adopted a concurrent triangulation strategy. This refers to the process whereby "qualitative and quantitative data are collected and analysed during a similar time frame" (Fetters *et al.,* 2013:2137). However, before the main data collection exercise, the study adopted a method called *building* - the method of "using the results of one form of data to inform data collection of the other, such as systematically using qualitative findings to develop a survey or instrument" (Fetters *et al.,* 2013:2140). Focus Group

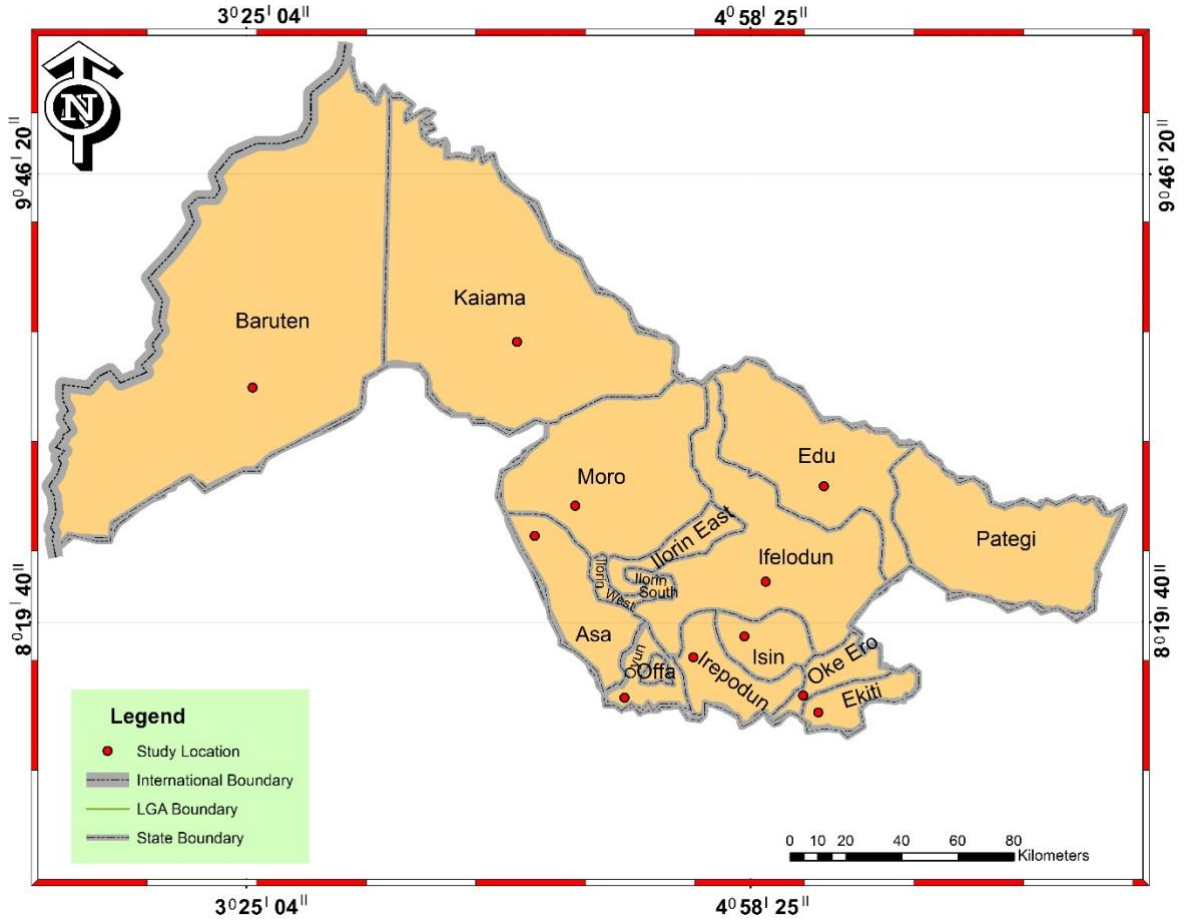
Discussions (FGDs) were conducted, and insights from the discussions were used to strengthen the questionnaires and In-Depth Interview guides designed for the study.

4.4.2 Sampling Techniques

The study adopted a multi-stage sampling technique and sampling was informed by the research questions. The study population consisted of residents of rural communities in Kwara State. The residents (former enrollees and non-enrollees) were important in this study because they are the ones the programme aimed to benefit. The sampling for the study involved the following stages:

Stage One: Purposive sampling was used to select the community with the highest enrolment from each of the 11 Local Government Areas (LGAs) hosting the programme. The communities are Aboto-Oja, Gure, Bacita, Osi, Idofian, Oro, Edidi, Kaiama, Bode Saadu, Odo-Owa and Erinle. Sampling across the various communities was to allow the researcher answer the research questions one (What are the perceptions of the community members about the CBHI programme in Kwara State Nigeria?), three (What were the funding mechanisms of the CBHI programme in Kwara State Nigeria?) and four (What are the factors that led to the collapse or stoppage of the CBHI programme in Kwara State Nigeria?) effectively.

Figure 4.2: Map of Kwara State showing Study Location



Stage Two: The total enrolment in the programme was 139,713, and the total enrolment in all the selected communities is 95,151. The sample size of 1,055 was proportionally taken from the former enrollees in the 11 selected communities (having a total of 95,151 enrollees), using the Survey System Sample Size Calculator at a confidence interval of three per cent (see www.surveysystem.com) as respondents for the enrollees' questionnaire. This is to ensure that the findings reflect the viewpoint of the entire population. Since the research questions sought to understand the perception of the community members about the programme, half of the total sample size of 1,055 (i.e. 528 respondents) was evenly selected among the non-enrollees for the study from the 11 communities. This is because there is no data available to determine the population of the communities for sampling purposes. Besides, all the communities had a very high number of non-enrollees; hence, they were allowed equal participation in the study (i.e. 48 non-enrolled respondents per community).

Stage Three: Systematic random sampling and non-systematic random sampling procedures were followed in the study. The primary aim was to systematically sample former enrollees

into the study from the enrolment registers and the non-enrollees from community registers. The researcher was, however, not given access to the enrolment registers and community registers were non-existent. Therefore, the respondents (former enrollees and non-enrollees) were recruited into the study based on households using systematic random sampling (i.e. using the *n*th number and selecting a sample at regular interval depending on the size of each community and needed sample). Scholars such as Kothari (2004:62), Degu and Yigzaw (2006:42), Kumar (2011) and Hibberts *et al.* (2012:58) suggested the need to determine the sampling interval based on the size of the population, select a random starting point and select every *n*th number into the study.

Operationalising the sampling procedures (in each community) with the assistance of community residents, each household in the community was allocated a number to create a households' register which served as the sampling frame. This allowed the researcher to determine the sampling interval for each of the communities depending on the number of households in each community and the number of respondents required among the former enrollees and non-enrollees. Thus, the sampling interval varied from one community to the other. After a random selection of the starting point from the register, the research team identified and visited the systematically selected households.

Since the study included the sampling of both formerly-enrolled and non-enrolled respondents in selected households, the first question was to determine if the household had a member that was enrolled or not enrolled in the programme. The response determined which sub-sample (enrollees or non-enrollees) the household falls into and the questionnaire to be used for collecting data. Thus, one respondent from a given household was selected into the study. Data collection for former enrollees and non-enrollees was carried out concurrently. However, in a particular community (Edidi) snowball sampling (a non-systematic technique) was used to identify some (4 out of 12) of the former enrollees because the enrolment population in the community was relatively low.

As proposed to reflect gender sensitivity, in each of the communities, 50% of the respondents (former enrollees and non-enrollees) were selected among males and females, respectively. Also, this is because the health requirements of men are different from women, especially for those in the reproductive age range. Further, individuals 21 years and above were selected into the study to ensure that respondents were at least 18 years (age of majority) by the time the

programme stopped in 2016. The former enrollees recruited into the study showed their registration cards as evidence of enrolment in each of the selected communities.

Also, the non-enrollees were selected among male and female heads of household (i.e. husband or wife) in the communities because of their roles in the decision about enrolment of members of the household in the CBHI programme. The experience of data collection exercise varied from one community to the other, especially with the dynamics (e.g. gender consideration) required for the sampling design. As such, in a few cases, preference was given to a particular gender (male or female) in selected households to fulfil the sampling requirement of equal participation for both male and female in the study.

Stage Four: Purposive sampling was used in selecting 22 participants (i.e. one male and female per community) for the In-Depth Interviews (IDIs) conducted in this study. Also, 32 Key Informant Interviews were conducted. The participants included: 11 community leaders, 12 healthcare providers (from healthcare facilities in the communities and referral centres), four policymakers (from the Governor's Office, State Ministry of Health and the NHIS's Office), two officials of the Health Maintenance Organisation (Hygeia Nigeria Limited) and two officials of the International Partners (PharmAccess Foundation and Health Insurance Fund) and one main researcher on the programme. Further, 12 Focus Group Discussions were conducted in six communities with the highest enrolment among the 11 communities selected (i.e. Aboto Oja, Gure, Bacita, Osi, Idofian and Oro). Two sessions (i.e. male and female) were conducted in each of the six communities while each session had between eight to ten selected participants (involving former enrollees and non-enrollees). All the participants in the Key Informant Interviews were sampled to provide answer to research questions two, three and four raised in the study while the participants in the IDIs were to provide further insights in answering research questions one, among others.

4.5 Data Collection

The research instruments used for data collection in the study are Focus Group Discussion, Questionnaire, In-Depth Interview and Key Informant Interview. The semi-structured format was adopted for the research instruments which allowed for relevant topics not previously considered to emerge organically from the discussion (Nicks *et al.*, 2017), and the qualitative data were tape-recorded. According to Kelly (2010), audio recording helps to eliminate frequent note-taking and facilitates interviews and discussions between the interviewer and the participant.

The researcher personally collected the qualitative data using a digital tape recorder and intermittently, also took the necessary field notes during and after each interview/FGD sessions on observations and thoughts that were useful for the data analysis. As recommended by Persaud (2010) and Kelly (2010), the researcher established rapport and familiarity with the study participants to gain their trust and elicit the information required for the study. Closure of the interview and FGD sessions were also done in a polite manner (Persaud, 2010).

4.5.1 Focus Group Discussion

Focus Group Discussion (FGD) was adopted to obtain a series of information on the general perception of the participants (community members) about the programme. Van Eeuwijk and Anghern (2017:2) noted that "focus group discussion is a qualitative research method and data collection technique in which a selected group of people discusses a given topic or issue in-depth, facilitated by a professional, external moderator". This instrument aims to "give the researcher an understanding of the participants' perspective on the topic being discussed" (Wong, 2008:256) as well as their emotional orientations and cognitive viewpoints (Lange, 2002).

For Rabiee (2004:656), it provides "information about a range of ideas and feelings that individuals have about specific issues, as well as illuminating the differences in perspective between groups of individuals". Also, "the information obtained from FGD can be used to identify potential areas of enquiry or to clarify the subject matter that may elude other research instruments" (Powell & Single, 1996:500). Essentially, FGD is an easy, fast, and effective technique of data collection from many participants in a short time (Krueger & Casey, 2000 cited in Onwuegbuzie *et al.*, 2009:2; Masadeh, 2012:64; Mishra, 2016:4).

Also, FGDs are very useful for programme evaluation (Heary & Hennessy, 2002:50), especially, health programmes to explore the perspective of patients and other groups in the healthcare system (Wilkinson, 1998:334; Tausch & Menold, 2016:1). FGD is often conducted among homogenous group primarily depending on the purpose of a study. However, some diversity in the composition of the group may enhance the quality of the discussion (Wong, 2008:257; Nyumba *et al.*, 2018:22). As such, the FGD sessions conducted in this study consisted of former enrollees and non-enrollees in the CBHI programme for a better outcome. Also, participants were recruited into the groups based on their relevance (Wong, 2008:257). For instance, the study sought the opinions of former enrollees and non-enrollees about the programme. Therefore, each session of the discussion consisted of 8 to 10 participants

(involving former enrollees and non-enrollees). This falls within an acceptable range for discussion (Morgan, 1997: 36; Masadeh, 2012:65; Connelly, 2015:369).

Powell and Single (1996:501) recommended between one and ten sessions for a study arguing that "since at some juncture, the group's discussion will simply replicate existing data, making further sessions unnecessary". However, the coverage and nature of this study (involving different communities) necessitated an increase. Consequently, 12 FGD sessions were conducted in the six (6) communities with the highest enrolment (i.e. Aboto Oja, Gure, Bacita, Osi, Idofian and Oro) among the eleven (11) communities where the study was conducted, and as such, covering more than 50% of the sampled communities. In line with the reason for conducting the sessions, the researcher was able to obtain series of information on the general perception of the participants about the programme and as well, draw insights from the discussions to strengthen the other instruments (Questionnaires, In-Depth Interview and Key Informant Interview) used in the study; and findings from the discussions were also used in reporting of results in the study.

4.5.2 Questionnaires

Questionnaires were used to collect the quantitative data. It is an instrument used in obtaining information from many respondents in a study. Kumar (2011:145; 2019:222) defined it "as a written list of questions, the answers to which are provided by respondents". Questionnaires are designed to obtain responses to "questions or reply to statements based on what people are (the characteristics such as age, gender, ethnicity etc.), how people think (their beliefs and attitudes), how people act (their behaviours) and what people know (their knowledge)" (Robbins, 2009:121 cited in Mangal & Mangal, 2013:337). To ensure that the instrument is well designed, scholars such as Stone (1993:1264), Jenn (2006:35) and Safdar *et al.* (2016:1274) advised that a questionnaire must be appropriate, intelligible, clear, unbiased, omnicompetent and well-presented.

A questionnaire can gather useful information from many people using limited time and resources to inform policy decisions, especially if the sample is large and widely dispersed. On this, Brace (2008:4) noted that "asking questions in the same way from different people is highly essential in a survey research". As such, the instrument helped in gathering data relating to the design, implementation, funding and collapse of the CBHI programme in Kwara State (from a wider number of respondents in the selected communities) within a manageable time.

The collection of quantitative data was carried out using enumerator-administered questionnaires by the researcher. This was facilitated with the support of experienced research assistants that were trained to assist the respondents in completing the questionnaires, with the supervision of the researcher. This form of questionnaire was chosen because most of the residents in the study area are non-literates or semi-literates; thus, the questions were asked in the local language (Yoruba Language – the most common language in Kwara State). More so, Bowling (2005:281) noted that this form of questionnaire administration is the least burdensome because it only requires the respondent to have the necessary verbal and listening skills; and respond to the questions asked. Further, this method helps to eliminate the possibility of misunderstanding the questions asked because there was room for seeking clarification where necessary, before responding. In this study, two (2) types of questionnaires were designed. The first type was used to gather relevant information from selected members of the communities who enrolled to benefit from the programme (former enrollees). The second type of questionnaire was designed to examine the perception of members of the communities who were not enrolled in the programme (non-enrollees).

Table 4.1: Selected Communities and Number of Questionnaires Administered

S/N	COMMUNITY	LGA	TOTAL ENROLMENT PER COMMUNITY	SELECTED SAMPLE		
				FORMER ENROLLEES	NON-ENROLLEES	TOTAL
1	Aboto Oja	Asa	11,993	133	48	181
2	Gure	Baruten	8,961	99	48	147
3	Bacita	Edu	6,731	74	48	122
4	Osi	Ekiti	24,550	272	48	320
5	Idofian	Ifelodun	11,009	122	48	170
6	Oro	Irepodun	12,306	137	48	185
7	Edidi	Isin	1,119	12	48	60
8	Kaiama	Kaiama	5,213	58	48	106
9	Bode Saadu	Moro	5,963	66	48	114
10	Odo Owa	Oke-Ero	1,682	19	48	67
11	Erinle	Oyun	5,624	63	48	111
	Total		**95,151**	**1,055**	**528**	**1,583**

4.5.3 In-depth Interview

In-depth interview (IDI) is "a qualitative research instrument used for collecting detailed information about people's knowledge, experiences, opinions or behaviour" (Pascale, 2015:7). For Rodríguez-Dorans (2018:747), it is an "encounter in which researcher and participant engage in an act of telling, listening, and meaning-making in order to understand aspects of a specific topic". IDI minimally structures how participants report their thoughts and feelings (LaRossa, 1989:228) and thus, "explores their viewpoints on a certain idea, program, or circumstances" (Boyce & Neale, 2006:3). Further, an in-depth interview helps to obtain understanding about the "lived experience of participants and the meaning they make of that experience" (Seidman, 2006:9).

Interviews in social research are seen as 'special conversations' (which has a specific agenda or purpose) therefore, the researcher must be equipped with adequate skills and techniques to elicit rich, detailed and accurate information from the participants (Kielmann, 2012:25; Serry & Liamputtong, 2013) as well as take note of relevant gestures, expressions and movements during the interview session (Mihnat, 2015:211). Importantly, IDI is highly crucial to health-related research because an in-depth understanding of the realities in the healthcare system can help to improve healthcare policy and service (Kelly, 2010). For a deep insight into the study, the researcher conducted IDIs with 22 community members that were enrolled in the programme. That is a male and female in each of the 11 communities selected for the study.

4.5.4 Key Informant Interview

Key Informant Interview (KII) helps to gather information from certain individuals with the requisite as well as relevant knowledge and experience about the phenomena under study. Rieger (2007:1) stated that KII involves a process where a "researcher employs interviewing of knowledgeable participants as an important part of the method of investigation". According to Cossham and Johanson (2019:2), "key informants are knowledgeable individuals who contribute a perspective on a research phenomenon or situation that the researchers themselves lack". In clearer terms, they explained that "key informants are usually not the core research participants (that is, they are not the main subjects of the research; they provide information about those subjects) but contribute to expanding a researcher's understanding and precise insights".

Marshall (1996:92) noted that "a key informant interview is an expert source of information and highly relevant to healthcare research". Marshall added that the personal skills and position make the informant suitable for providing deep insight into what is going on around them. O'Leary (2014) cited in Cossham and Johanson (2019:3) listed those who could be key informants: "a leader, the observant, experts (at the top of their field), insiders (in an organisation, culture or community), the highly experienced and those with secondary experience". The key informants in the study are categorised below:

Table 4.2: Key Informants Interviewees in the Study

Category of Participants	**Number**
Community leaders	11
Healthcare Providers	12
Policymakers	4
International Implementation Partners	2
Health Maintenance Organisation	2
Researcher on the Programme	1
Total	**32**

The selected key informants were very critical in the study because of their experience with the programme. For instance, the community leaders shared their views, and shed light on the perception of the generality of the people about the programme and how it impacted their healthcare status. This provides an avenue to obtain additional information (to the data collected via in-depth interview) on the community members' perspective of the programme. The healthcare providers are very relevant in the study because they were responsible for providing healthcare services under the programme. Also, the policymakers and the foreign implementing partners are relevant to the study because they introduced and implemented the programme.

Further, the Health Maintenance Organisation facilitated the implementation of the programme. It served as an interface between the collaborators that funded the programme and the healthcare providers, as well as the enrollees. Finally, the researcher (who carried out studies on the programme) was relevant to obtain a professional viewpoint based on experience with the programme. Goldman and Swayze (2012:232) observed that though it might be difficult to access most of the key informants because of their busy schedules owing to their positions, there are numerous advantages to interviewing them. The researcher was able to access all the participants except one healthcare provider who outrightly declined to participate after a series of visits to the hospital, scheduled appointments and follow-up calls. Whereas the researcher had also reached the information saturation point and his non-participation did

not affect the result of the study. Most of the key informants were still holding their positions while few had taken up appointments in other organisations.

4.5.5 Validity and Reliability

Zohrabi (2013:254) argued that "adopting mixed-methods is another way of ensuring the validity and reliability of a study". It provides the opportunity to assess the convergence or divergence in the findings of data collected through different techniques. According to Wium and Louw (2018:8), the main essence of validity and reliability in a mixed-methods study is to legitimise the research. For them, the overall essence of mixed-methods research is determined by three processes: methodological rigour, interpretive rigour and inference transferability. In other words, the rationale behind validity and reliability is to ensure that a study follows a carefully systematised rigorous procedure in reaching conclusions.

Validity "represents the degree to which a research instrument is able to measure what it is purported to measure in a study" (Cooper & Schindler, 2014, cited in Moazzam, 2015:89). Essentially, "validity is concerned with whether our research is believable and true and whether it is evaluating what it is supposed or purports to evaluate" (Zohrabi, 2013:268). Therefore, researchers are expected to identify means of assessing instrument validity that are suitable for the goals and objectives of the research (Hsu & Sandford, 2010). Accordingly, the instruments used in the study were designed based on the objectives. Wium and Louw (2018:9), explained that validity becomes increased when findings from FGD are used to strengthen the construction of the questionnaire (and other research instruments). As such, in this study (as noted in 4.5.1 above), the researcher conducted FGDs in six communities and insights from the discussions were used to improve the contents of the questionnaires and interview guides used in the study.

According to Mohamad *et al.* (2015:164) cited in Creswell (2005), "reliability means that the scores of an instrument are stable and consistent". For Tischler (2011:42), reliability holds that the findings of a study must be repeatable. Thus, the consistency in the findings from the various communities covered by this study proves its reliability. Relying on the works of Lincoln and Guba (1985) and Merriam (1998), Zohrabi (2013:259-260) asserted that a study can attain reliability through the use of three techniques: (i) the investigator needs to explain the different processes and phases of the research explicitly; (ii) the investigator needs to combine different techniques for data collection (triangulation); and (iii) the investigator needs to give a full description of data collection, analysis and how results are obtained. Therefore,

in this study, the researcher detailed the various processes and stages as well as the techniques for collecting and analysing data (in this chapter). Triangulation method was also adopted at the levels of data collection and data analysis to ensure validity and reliability. More so, the results from the quantitative data are consistent with the findings of the qualitative data. Generally, the research was carried out with a high sense of carefulness and rigour.

4.6 Data Analysis

According to Tischler (2011:39), data analysis is the "process through which large and complicated collections of scientific data are organised so that comparisons can be made, and conclusions drawn". Marczyk *et al.* (2005:198) noted that "the process of data analysis involves three steps: preparing the data for analysis, analysing the data, and interpreting the data (i.e., testing the research hypotheses and drawing valid inferences)". Data analyses in mixed-methods research are performed on the quantitative and qualitative data accordingly, based on the acceptable methods of analysis. However, the analysis plan must be aligned with the objectives of the study (Curry & Nunez-Smith, 2015). Hence, the methods of data analyses adopted in this study are as follows:

4.6.1 Quantitative

The data collected from the former enrollees and non-enrollees were sorted accordingly. After that, the data were given serial numbers and coded by the researcher (i.e. assigning values to responses in the questionnaires). It is on this basis that the data input was carefully done (according to a format designed by the researcher) using Statistical Package for Social Sciences (SPSS) version 25 (for analysis). Thereafter, a descriptive analysis was done using the SPSS software. Tischler (2011:109) explained that "descriptive statistics allow the researcher to describe the data and examine relationships between variables". Through this, the researcher generated frequency tables and percentages, and charts to show results from the data. Specifically, bivariate analysis and test of significance were adopted to examine relationships among variables.

4.6.2 Qualitative

According to Flick (2014:5), "qualitative data analysis is the classification and interpretation of linguistic (or visual) material to make statements about implicit and explicit dimensions and structures of meaning-making in the material and what is represented in it". The qualitative data were analysed with both manual and electronic methods. After translating the data obtained in the local language, all recorded discussions and interviews were transcribed and coded to yield major themes (Nicks *et al.,* 2017). Thematic analysis was used to identify the

relevant themes in the data. For Nowell *et al.* (2017:2), "this kind of analysis is appropriate because it is a useful method for examining the perspectives of different research participants, highlighting similarities and differences, and generating unanticipated insights".

Also, ATLAS.ti was used in the study to systematically organise and support the analysis of the qualitative data obtained. "ATLAS.ti is a Computer-Aided Qualitative Data Analysis Software [CAQDAS]" (O'Kane *et al.*, 2019:2). The "basic idea behind these programs is that using the computer is an efficient means for storing and locating qualitative data" (Cresswell & Cresswell, 2018:315). Particularly, ATLAS.ti helped the researcher to manage, extract, compare, and explore data within the texts which has meanings for the analysis (Mkwinda, 2013:3; Paulus & Lester, 2016:405; Brito, 2017). Excerpts from interviews conducted in the local language (Yoruba), other than in English, are presented in English with the original language included beside the translation (Roulston & Choi, 2018).

4.7 Ethical Considerations

According to Tischler (2011:44-45), sociologists must accept responsibility for recruiting research subjects in order not to become vulnerable as a result of their cooperation. Guillemin and Gillam (2004:263) distinguished between "two significant dimensions of ethics in research: procedural ethics and ethics in practice". According to them, "*procedural ethics* involves seeking approval from a relevant ethics committee or organisations to undertake research involving humans". On the other hand, they explained that "*ethics in practice* refer to the day-to-day ethical issues that arise in the doing of research". This shows an expectation from researchers to give optimum attention to ethical issues in conducting their research. Accordingly, this study adhered strictly with the ethical requirements for conducting research. After securing the ethical clearance of the Research Ethics Review Committee of the College of Human Sciences of the University, as a requirement, the researcher also obtained ethical clearance from the Kwara State Ministry of Health in Nigeria before embarking on the fieldwork.

As noted by Costley *et al.* (2010) and Høyland *et al.* (2015:226), in each of the communities, before commencing the study, the researcher met the community leaders (and other gatekeepers to access some key informants) and informed them, adequately, about the research. The respondents and participants were treated with respect. They were informed of the purpose of

the study and the relevance of their response. Participants were also allowed to dictate the convenient time and location for the sessions to hold (Pascale, 2015:12).

Also, they were assured of confidentiality and their anonymity preserved in the reporting of the findings (Bolderston, 2012:73; Minhat, 2015:211). They were also informed of their rights to refuse participation in the study, withdraw at any point in time, and refuse to answer any question about which they were not comfortable. Furthermore, the participants and respondents were notified that there was no financial benefit for participation; however, the findings of the study could aid improved access to healthcare in their communities. More so, they were informed and given assurance that there were no negative consequences for them in participating in the study. Also, the researcher reiterated that the data (digital and non-digital) would be kept safely. Apart from the verbal information, the participants and respondents were given printed copies of Informed Consent detailing all the information. After accepting to participate, consent forms were given to the respondents and participants to obtain their written consents.

4.8 Reflexivity

Begoray and Banister (2012:798) defined "reflexivity as the researcher's ongoing critique and critical reflection of his or her own biases and assumptions and how these influence all stages of the research process". In a qualitative study, researchers "reflect about how their role in the study and their background, culture, and experiences hold potential for shaping their interpretations, such as the themes they advance and the meaning they ascribe to the data" (Cresswell & Cresswell, 2018:301). Also, "this aspect of the methods is beyond advancing values and biases in the study, but how the background of the researcher may shape the course of the study" (Cresswell & Cresswell, 2018:301). In this study, however, the researcher was critically conscious to ensure that his values, experience and culture does not affect the research process. Maximum focus was directed to the research process, and the researcher displayed a high level of transparency throughout the study.

4.9 Fieldwork Challenges

The researcher was faced with some challenges during the fieldwork exercise. One, the research setting consists of communities drawn from different Local Government Areas in Kwara State. Thus, the researcher team had to travel to all the communities to collect data. Apart from the long-distance that characterised the trips, most of the terrains were very bad

and relatively not motorable; and the researcher had to visit some the communities twice for data collection (i.e. using FGDs and then, the other instruments).

During one of the trips in Kwara North, rainfall started suddenly, and the commercial vehicles could not continue with the journey; we resorted to hiring motorcycles to our destinations, which was more dangerous, to meet up with the scheduled appointment. The most terrible travel experience during the fieldwork was the trip from Kaiama (where the research team slept after data collection in the community) to Gure (to commence data collection in the community). The road was so bad that on several occasions the driver drove off the road and negotiated ahead through the bush because the 'main road' was not motorable. The road, we learnt had been abandoned for decades by successive state governments and not renovated. The driver explained that he could not continue to replace the shock absorber all the time; hence, as passengers, we were uncomfortably feeling the direct effects of the bad vehicle and poor road as we travelled. After the episode, the researcher had to suspend the fieldwork for a few days to take medications and adequate rest from the experience.

Two, the researcher found it difficult to access most of the key informants because of the nature of their positions and professions. There were several cases of failed appointments and rescheduling of appointments. However, as suggested by Shenton and Hayter (2004:226) that a researcher can rely on a past link, thus, the researcher leveraged on his previous familiarity with someone who was involved in the implementation of the programme to access the informants, and this yielded positive results. In some cases, apart from the informed consent that the researcher had, demands were made for formal letter to be written requesting participation in the study. The research did as demand, and the interviews were granted. Some of the interviews were conducted in the evening and during the weekends due to the tight schedules of the participants.

Third, in a particular community, most people (former enrollees and non-enrollees) initially showed disinterest in participating in the study based on their experience regarding the programme. However, when we convincingly explained the importance of the study and that it was for academic purpose, they agreed and participated in the study. In contrast, in another community, many individuals were ready to participate as they misconstrued the consent forms (which respondents completed) to be registration forms. We needed to take some time to address them and explain that we were conducting the study for academic purpose and that we were not enrolment officers for the CBHI programme.

4.10 Conclusion

The chapter centred on the research methods used in the study. It examines the major research paradigms and located this study within critical realism. An overview of the research site was discussed. Also, the researcher extensively discussed the research design as well as the sampling techniques used in the study. The researcher also gave a clear analysis of the methods of data collection, including the various techniques adopted and the reasons for the choices. The issues relating to the validity and reliability of the study were addressed in detail. Further, the procedures for analysing the quantitative and qualitative data collected, including the softwares used to aid the process were discussed. Lastly, the researcher addressed the issues relating to ethical considerations and reflexivity; and chronicled the fieldwork challenges encountered in the course of the study.

CHAPTER FIVE

DESIGN AND IMPLEMENTATION OF THE CBHI PROGRAMME IN KWARA

5.1 Introduction

The cut in public spending as a result of the SAPs in the 1980s negatively affected the provision of adequate healthcare services by the federal government. Consequently, it became burdensome for the governments at the state level to provide healthcare coverage for the entire population. Though it is worthy of note that there is also a relative lack of commitment by successive governments. The same thing goes for the healthcare system in Kwara State. This chapter is significant because it explores the context that led to the introduction of the CBHI programme as an alternative model for healthcare provisioning. Also, it examines the design in terms of health benefits involved. Further, it discusses the programme's implementation process and finally, reviews the success of the CBHI programme in rural Kwara.

5.2 Healthcare Situation in Rural Kwara: Pre-CBHI

The healthcare condition in Kwara State before the introduction of the CBHI programme was similar to what could be found in most states in Nigeria. This is because of the weakness of the national healthcare system, partly due to inadequate funding and ineffective policies. No remarkable achievement has been recorded up till date in the bid to provide adequate healthcare services across the country. For instance, the recent Nigeria National Demographic and Health Survey (2018) revealed that 59% of births are delivered at home, showing no significant departure from the trend since 1990. The Survey further found 512 maternal mortality ratio per 100,000 live births between 2011 and 2017.

In Kwara State, there was a general outcry about poor healthcare conditions in every part of the State (even when the programme was operational because it covered a few rural communities). According to Brals (2019:74), "the Kwara State health system is characterised by weak governance and legislation, inadequate government funding, and poor health infrastructure and service quality". Similarly, Musah and Kayode (2014:34) found insufficient healthcare personnel and poor quality of care in Ilorin Metropolis – the capital and economic centre of the State.

The Nigeria Malaria Indicator Survey (2015) reveals a 68% prevalence rate for anaemia among children (aged 6-59 months) in Nigeria, generally, and a 58% prevalence rate in Kwara State, specifically. The survey also showed a 28% prevalence rate for malaria among the same

category of children in Nigeria, and 27% in Kwara State. In the study, participants were asked about the healthcare situation in the rural communities before the implementation of the CBHI programme. Most of them indicated that the situation was awful, leading to loss of lives. Some of the participants stated that:

> Opolopo awon eyan ni won kori itoju gba; tiwon nilati lo si Ilorin fun itoju. Ki won to gbe elomi de Ilorin gaan, won a ti ku.
>
> Most people did not have access to healthcare; they had to travel to Ilorin for care. Some people even died on their ways to the hospital in Ilorin (KII, Community Leader, 01/07/2019, Aboto-Oja).

> Igbati won gbe Hygeia wa, o bo si asiko ti gbobgbo *community* yi ati awon to wa ni agbegbe, ti won *need* e; ti aisan po, ti kosi si owo nilu, ti kosi ise, ti ile ise kosi sise rara.
>
> Hygeia [i.e. the CBHI programme] was introduced at a time when the community and its environs needed it; there were so many cases of illness and the people had no money to pay for healthcare, and the industry [Nigeria Sugar Company] in the community has stopped working (Female FGD, 30/05/2019, Bacita).

A healthcare provider in one of the rural communities narrated how the collapse of an agro-industrial entity, the Nigeria Sugar Company, in the community deepened the healthcare challenges of the people, especially among the company's former employees. He explained that:

> The community is a rural community. In the heydays of the sugar company when it was fully operational. Then, most workers were enjoying some degrees of good healthcare under the auspices of the sugar company at much less cost, than it would have been necessary. It was highly subsidised and most times, even sponsored. So, when sugar was sugar, there was a good supply of multitude; and relatively, the degree of social welfare was going on because of the presence of the company. Once the company collapsed, virtually every other thing collapsed. Family life was in tension, and children suffered quite a lot. Malnutrition cases were rife, and there was social neglect. The people were financially disadvantaged, and so many goodies of life that were always harvested from expenditure were not possible. It was breeding its own frustration in its own way; and people had no choice than to resort to alternative medical practices, which at best were

> not satisfactory but that was the only recourse they had when NISUCO [i.e. Nigeria Sugar Company] collapsed. Also, because of the level of education around here, it was very easy to adapt to the low-level quality of life in every sphere (KII, HCP, 19/06/2019, Bacita).

Another healthcare provider added that:

> The people are 100% farmers, and if they fall sick outside the farming season, they don't want to visit the hospital because of the fund. To avoid loss of lives, they have to sell their farm produce in advance, and if they happen to sell everything to raise fund for healthcare, they would have nothing to harvest when it is time. For instance, if a sack of soya beans is sold for ₦12,000 during the harvesting period, they can collect ₦6,000 from the buyer with the promise that "when I harvest the produce, come and collect a sack"; meaning the farmer loses ₦6,000 (KII, HCP, 15/08/2019, Gure).

The prevalence of healthcare challenges in the communities was mainly due to the lack of clear healthcare policy framework exclusively designed for the State. Most of the health policies obtainable then were national policies which often stem from the declarations of global health organisations. Some of the key informants noted that there was no clear and specific healthcare policy in the State when the programme was operational. The government-owned healthcare facilities established in various parts of the State were poorly managed. Participants commented on the health policy in the State before the CBHI programme as thus:

> The health policy in the State was like that of many others since the government could not shoulder the burden of free healthcare; people were paying out-of-pocket (KII, Researcher, 30/07/2019, Ilorin).

> I know the policy was skewed to the urban area and those in the rural areas also needed access (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

The HMO officials added that:

> I think the state government had a lot of hospitals at the state level, Local Government Area level, dispensaries and health posts. That was how they were operating, but it was inadequate. They [i.e. health facilities] were not well staffed; especially the health posts, you don't have doctors there. Even hospitals in rural communities, they didn't have doctors; even if they had, they didn't come regularly. Probably they did not have a good

> monitoring system to know if people were doing their jobs (KII, HMO Official 2, 29/07/2019, Ilorin).
>
> The health policy in the State before the programme was similar to what was happening at the federal level. They were policies that supported other parallel programmes in the State such as Kick out Polio, Roll Back Malaria, subsidised care for women, and child health. Also, there was a funding challenge in government hospitals as well as policies implementation (KII, HMO Official 1, 26/07/2019, Ilorin).

The statements of the government officials substantiate the above submissions. They confirmed that there was no clear-cut healthcare policy in the State before the CBHI policy. Some of them noted that:

> Kwara did not have a clear-cut policy, but they had a policy on children under-5 welfare, which was a national policy as well, that every State had to follow (KII, KWSG Official 2, 24/07/2019, Ilorin).
>
> Before the programme, our health policy was nothing to write home about… There was no clear-cut health policy in the State (KII, KWSG Official 1, 20/08/2019, Ilorin).

Arising from the above, the healthcare system in the State did not enjoy adequate policy and financing attention before the emergence of the CBHI in rural Kwara. It was within the poor healthcare "context" that the CBHI programme crept into the policy landscape of the health system in Kwara State. Minkman *et al.* (2018:229) noted that policy transfer tends to flourish in the absence of alternative or competing policies. This is due to an impending need to solve identified challenges. In other words, where there is no better alternative, one is likely to take up an available offer.

It is, however, important to note a salient point about the submissions above. The memory time horizon from which these officials draw is the post-SAP experience of the retrenchment of public health funding and provisioning. Perhaps, they are unable to imagine a comprehensive publicly-funded healthcare system. Such system of public health provisioning – funded significantly from the fiscus – existed in Nigeria (and Kwara State) before 1985, when SAP was introduced (as noted in chapters 1 and 2). The refusal to countenance publicly-funded health system is part of the culture war of neoliberalism. That alternative exists and should be on the table for health systems reform in Nigeria.

5.3 Design of the CBHI Programme in Kwara State

The CBHI scheme in Kwara State "(otherwise called Hygeia Community Health Plan or Hygeia Community Health Care)" was established in 2007 (Gustafsson-Wright *et al.*, 2018:224) under a partnership "between the Kwara State Government and Dutch Health Insurance Fund [HIF]" (Gustafsson-Wright & Schellekens, 2013:14). The PharmAccess Foundation provided technical support, including monitoring and evaluation; and Hygeia Nigeria Limited was contracted as Health Maintenance Organisation to facilitate the provision of healthcare services in the programme. The long-term goal of the programme was to increase access to basic quality health services. According to Bonfrer *et al.* (2018:55), the Kwara CBHI "had two aims: (i) to provide access to a heavily subsidised voluntary health insurance scheme and (ii) to initiate quality upgrades in healthcare facilities".

The programme provided "coverage for medical consultations, diagnostic tests and drugs for all conditions that can be managed at a primary care level and limited coverage for secondary care services" (Brals *et al.*, 2017:991). The enrollees had the right to visit the healthcare facilities whenever they were ill. Enrollees also had up to 5 days hospitalisation (Humphreys, 2010) under the programme. The programme was flagged-off in Kwara North (Edu and Moro Local Government Areas [LGAs]) and expanded gradually to other parts of the State. Healthcare services were provided "through a network of contracted public and private healthcare facilities" (PharmAccess Group, 2017:15).

Specifically, the Health Insurance Fund financed the renovation and provision of many medical equipment and facilities while the PharmAccess Foundation provided clinical protocols, training, and quality monitoring (Lagomarsino & Kundra, 2008:34). As of 2015, the programme was operational in 43 healthcare facilities across 11 rural LGAs, and two tertiary referral centres within the state capital (Ilorin). Non-enrollees in the programme were also eligible to use the healthcare facilities by paying OOP for services (Gustafsson-Wright *et al.*, 2018:225). The programme existed in the three geopolitical zones in the State (i.e. Kwara South, Kwara North and Kwara Central) at varying levels. It was anticipated to cover 600,000 people by the end of 2017 (AIGHD, 2015:12). More details about the programme are discussed in the proceeding sections and chapters.

Specifically, "the primary and secondary care covered by the CBHI programme are:

(i) Inpatient care;

(ii) Outpatient care;

(iii) Hospital care and admissions;
(iv) Specialist consultation;
(v) Provision of prescribed drugs and pharmaceutical care;
(vi) Laboratory investigations and diagnostic tests;
(vii) Radiological investigations;
(viii) Screening for and treatment of diseases including malaria;
(ix) Minor and intermediate surgeries;
(x) Antenatal care and delivery;
(xi) Neonatal care;
(xii) Preventive care, including immunisation;
(xiii) Eye examination and care;
(xiv) Screening for and treatment of sexually transmitted diseases;
(xv) Annual check-ups; and
(xvi) Health education" (Amsterdam Institute of International Development, 2013:12).

The comprehensiveness of a CBHI benefits package is a determinant for enrolment among the poor (Schneider, 2004:353) as well as the success of the programme. But as noted earlier in chapter 2, that healthcare coverage of CBHI programmes usually does not include some critical needs of the enrollees; the Kwara CBHI programme was not an exception. According to Gustafsson-Wright *et al.* (2018:225), "the insurance does not cover high technology investigations (for example magnetic resonance imaging), major surgeries and complex eye surgeries, family planning commodities, treatment for substance abuse/addiction, cancer care requiring chemotherapy and radiation therapy, provision of spectacles, contact lenses and hearing aids, dental care, management of acute cardiovascular events other than admission to a hospital intensive care treatment such as dialysis".

This is, however, a substantial social policy concern which demands a comprehensive approach to social services provisioning, including healthcare. Dutta and Hangoro (2013:35), argued that "Nigeria cannot consider covering large numbers of citizens, especially the very poor, with a basic primary healthcare package using a patchwork of such schemes. It is also not clear how the very poor can participate in these schemes and access healthcare. Therefore, these schemes, despite the attention placed on them, do not obviate the need for investing in strengthening primary healthcare, eliminating user fees, and otherwise reducing out-of-pocket costs for the poorest citizens".

More so, the so-called pro-poor take on health provisioning is still trapped within the neoliberal echo chamber. The point of an expansive publicly-funded health system is to raise the tax to finance the health system from the citizens. The progressive nature of the tax system means that the marginal tax rates increases as the income level rises. This will allow for the coverage of everyone not just the 'poor'. In cases where 75% of the citizens live below US$3.10/day (in purchasing power parity terms) what is the point of targeting the poor? Finally, "separate discriminatory services for poor people have always tended to be poor quality services" as Richard Titmuss observed decades ago (cited in Shafik, 2018:7). When public health sector offers discriminatory 'free' services for the poor, the middle class tends to flee for the private healthcare sector, because in such scenario, the quality of services in the public sector declines overtime.

5.4 Programme Implementation

According to Mthethwa (2012:37), "policy implementation refers to the mechanisms, resources, and relationships that link policies to programme action". For Khan (2016:4), policy implementation refers to "a process, an output and an outcome, and it involves some actor organisations and techniques of control". Essentially, policy implementation is an activity or exercise that cannot be carried out in isolation but involves relationships among various actors. Thus, this section analyses the role of the various actors in the policy implementation, indicating their various levels of involvement, and the activities that constituted the implementation process. A participant gave a general idea of the activities entailed in the implementation of the programme as thus:

> On the demand side, there were awareness programmes in the communities, and we got philanthropists to enrol the indigents, we collected the premiums during rainy seasons when crops were harvested. We also created health posts, medical outreaches in the hard-to-reach communities. In these upgraded health facilities, the programme operated, organising mobile health exercises in collaboration with the UITH to solve some of the health problems. On the supply side, we had the structure of carrying out the quality assessment; we gave them some Quality Improvement Plans (QIPs) to improve the quality of service, we carried out train-the-trainers, training of medical staff on current evidence-based best practices, we carried out some advocacies to the stakeholders especially the government to make sure they paid their subsidy (KII, HMO Official 1, 26/07/2019, Ilorin).

Before delving deeper into the implementation process, it is necessary to understand the main actors involved in the implementation. This is because the positionality and ideational pre-disposition of actors have a bearing on policy design and implementation (Koduah *et al.*, 2015:3; Etiaba *et al.*, 2015:2; Campos & Reich, 2019:225; Araujo & Filho, 2001). Therefore, the main actors included: the Kwara State Government, the PharmAccess Foundation (representing HIF) and the Hygeia Nigeria Limited (HMO). Their involvement and roles are discussed below.

5.4.1 The Main Actors

The policy space for implementation of the CBHI programme involved three major actors, that is, two local actors (i.e. Kwara State Government and Hygeia Nigeria Limited) and one international actor (PharmAccess Foundation). The role of the actors are examined as follows:

5.4.1.1 Kwara State Government

The role of the Kwara State Government (KWSG) in the implementation of the programme was to provide an enabling environment for the programme to run and thrive smoothly. However, it had an agency known as CHIS (Community Health Insurance Scheme) created to represent it in the implementation of the programme. The agency played some roles through the government-owned healthcare facilities. Notably, the core responsibilities of CHIS was to ensure adequate staffing, procurement of drugs and smooth running of the healthcare facilities. All these were funded using the capitations that were due to the public facilities (KII, HMO Official 2, 29/07/2019, Ilorin).

One of the government officials explained that: initially, "the Kwara State Government was to give the will, support and enabling environment for them to thrive. The Kwara State Government at that point was providing facilities and security at the places" (KII, KWSG Official 2, 24/07/2019, Ilorin). With time, however, the involvement of the State Government became contributory when it requested for continuation and extension of the programme to more rural communities. Also, during the period of operation, the state government embarked on the renovation of 5 general hospitals and construction 15 primary health care centres (Boston Consulting Group, 2015:19).

5.4.1.2 PharmAccess Foundation

The PharmAccess Foundation (PAF) represented the Dutch Health Insurance Fund (HIF) in the design and implementation of the programme. The HIF, a Dutch Foundation, was established in 2006 as an agency under the Dutch Ministry of Foreign Affairs to provide the people in Africa with access to better healthcare (PharmAccess Group, 2018; Okoli *et al.*,

2016:2). According to the Boston Consulting Group (2015:14), "the HIF was founded to re-orient the healthcare market development towards effectiveness and sustainability, especially for low-income populations' access to affordable and high-quality care. The mission was to overcome the limitations of the prevailing paradigm and help replace it with a new one (that is transformative, long-term, locally owned, and private-sector inclusive) for sustainable healthcare system development". In other words, it aimed to strengthen the private sector's capacity towards improved access to quality care in the LMICs (PharmAccess Group, 2017:11).

This led to the release of "a grant of EUR 100 million by the Dutch Ministry of Foreign Affairs to HIF in 2006 (together with PharmAccess - a Dutch not-for-profit organisation, as executing partner) to launch community-based health insurance programmes in some African countries - Nigeria, Tanzania and Kenya" (Gustafsson-Wright & Schellekens, 2013:11). The HIF was exclusively represented in Nigeria by the PharmAccess Foundation. In pursuing its mission, the HIF seized the opportunity by leveraging on the existing links and reputation of PAF in many countries with private and public sector institutions; and this availed the Dutch government a suitable platform for executing its projects (Boston Consulting Group, 2015:15).

PharmAccess Foundation was established in 2001 with the primary focus on HIV/AIDS treatment, especially in Africa but expanded its focus to a general improvement of access to quality healthcare (Amsterdam Institute for Global Health and Development, 2017:9; PharmAccess Group, 2017:11), especially since its alliance with the HIF. The implementation was carried out by PharmAccess Foundation in collaboration with Health Maintenance Organisations (HMOs) that were considered reputable in the selected countries. In the case of Nigeria, Hygeia Nigeria Limited was the HMO engaged for the direct implementation of the programme in Lagos and Kwara states.

An official of the agency noted that: "PharmAccess Foundation is a not-for-profit entrepreneur organisation with its headquarters in Amsterdam, The Netherlands. We are supporting Sub-Sahara African countries in making health market work through our integrated approach" (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). Another participant noted that: "The role of PharmAccess Foundation was also to generate and regulate finances as well as develop financial strategies and plans. The Ministry of Foreign Affairs in Amsterdam was responsible for the financing provided through PharmAccess Foundation, serving as Fund Managers" (KII,

KWSG 2, 24/07/2019, Ilorin). The HIF through the PharmAccess Foundation provided the initial funding of the programme.

However, as noted in chapter 2, the idea to 're-orient the healthcare market' (claimed by the HIF above) is often promoted by taking publicly-funded health system off the policy agenda. This approach is firmly within the neoliberal policy frame: (a) get people to pay for their own healthcare, (b) take public spending off the table, and (c) reluctantly, only in demonstrable instances of inability to fund one's healthcare is public support to be provided. This is the quintessential case of stratified, segmented, and segregated social policy design (see Fischer, 2018). Thus, it appears that The Netherlands offered to replicate a poorer version of its own social insurance-based healthcare system.

5.4.1.3 Hygeia Nigeria Limited

The CBHI programme was implemented through the engagement of Hygeia Nigeria Limited. It was established in 1986, and it is one of the leading Health Maintenance Organisations (HMOs) in Nigeria and known as Hygeia HMO. Specifically, a new HMO was floated by the organisation, basically for the CBHI programme in Kwara State and named Hygeia Community Health Care (HCHC) to facilitate the implementation of the programme. More specifically, its role involved the "administration of the package and marketing activities for scaling up the project" (Gomez *et al.,* 2015:6).

The HMO was appointed by the PAF through a selection process midwifed by the PriceWaterhouseCoopers (AIID, 2013:11) and was provided assistance to improve its administrative capacity (England, 2008:58). One participant noted that: "Hygeia was the Health Maintenance Organisation engaged by the PharmAccess Foundation to assist in implementing the programme" (KII, KWSG 2, 24/07/2019, Ilorin). Another participant explained that "there was, however, a local implementing HMO designed strictly to oversee the local implementation of the scheme in Kwara State, Hygeia Community Health Care (HCHC) was seeing to the scheme's administration with the support of the committee set-up by the then governor to ensure that they worked hand-in-hand as a team to ensure that everything went on seamlessly" (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

Also, the HCHC served as an emissary of the partners in relating with the healthcare providers and as well, the enrollees. The HCHC also had the roles of quality assurance and claim management in the programme. Payment of capitation and fee-for-service to healthcare providers (private and public) were facilitated through the HCHC by the PharmAccess

Foundation. The HCPs were paid capitations in advance, in the first week of the month to allow them to purchase drugs and other requirements (KII, HCP, 20/06/19, Bode Saadu). Thus, the KWSG was hosting the programme; the PharmAccess Foundation was funding the programme while the mandate of HCHC was facilitating the implementation of the programme.

5.4.2 Implementation Process

The policy implementation process involved some critical activities. The main activities constituting the process are discussed in this section, critically reflecting the roles played by each of the main actors, though, most of the responsibilities were carried out by the HMO.

5.4.2.1 Piloting and Provision of Healthcare Facility

As noted earlier, the programme became operational in 2007 in Shonga, Edu LGA of the State. Two reasons informed the selection of the community for piloting the programme. One, there was large-scale commercial farming in the community by some Zimbabwe farmers. As such, it was necessary to provide accessible healthcare for them and the entire community to build a formidable workforce for the emerging agricultural industry. As one of the participants put it: "they [i.e. the partners] decided to take a holistic approach to have health insurance which was to start in Shonga, Edu LGA, an agrarian community where the Zimbabwean farmers were settled and at the same time, they used it as a pilot to provide health insurance in that community and improve agricultural production" (KII, HMO Official 1, 26/07/2019, Ilorin).

Moreover, health and economic development are intertwined. Two, it was easier to pilot the programme in Shonga because, the then State Governor and the Emir of the community are medical doctors, who know the importance of healthcare (KII, HMO Official 1, 26/07/2019, Ilorin). At this stage, the state government provided the healthcare facility and was responsible for the payment of staff salaries, but the facility was renovated and equipped by the foreign partner.

5.4.2.2 Sensitisation and Enrolment

The HCHC handled the responsibility for sensitisation and enrolment into the programme. The activities involved awareness creation about the programme and organising rallies as sensitisation fora for discussing health matters in the communities. Panda *et al.* (2015:1103) and Mekonen *et al.* (2018:11) concluded from their studies in rural India and Northeast Ethiopia respectively that awareness sensitisation efforts are crucial to enrolment and success of CBHI programmes. In Kwara, the HCHC had enrolment officers charged with the responsibilities of enrolling members of the communities (and environs) in the programme. These officers, in turn, worked with some community members to navigate and penetrate the

entire villages around the host communities, including the hard-to-reach (HTR) communities to widen the coverage of the programme.

For wider coverage, the enrolment officers moved door-to-door to articulate the programme to community members (Gustafsson-Wright *et al.*, 2018:225). Interested community members were registered on the payment of enrolment premium (which was ₦500 as at the time the programme stopped) and provided with enrolment cards. The enrolment card granted its holder the opportunity to access healthcare for a year in a designated healthcare facility. In the early years of implementation, in order to boost enrolment, community members were provided with souvenirs after enrolment (Female FGD, 30/05/2019, Bacita).

Also, given the influence that community leaders have on the people, they were given the mandate to mobilise members of their communities to enrol in the programme. Some community leaders explained that:

> Kosi *role* kankan fun *community* ju'pe won pewa pe, ki a *sensitise* awon eyan; asi *sensitise* won.
>
> There was no role for the community leadership other than sensitising the people [to enrol in the programme]; and we sensitised them (KII, Community Leader, 13/06/2019, Erinle).

> Won *encourage* wa wipe ka se *enlightenment*, wipe bi eyan ba se po si ti won gba *card*, oun ni kiniyen yi o se *work*.
>
> We were encouraged to enlighten the community members to enrol because the higher the enrolment, the better the programme (KII, Community Leader, 20/06/2019, Bode Saadu).

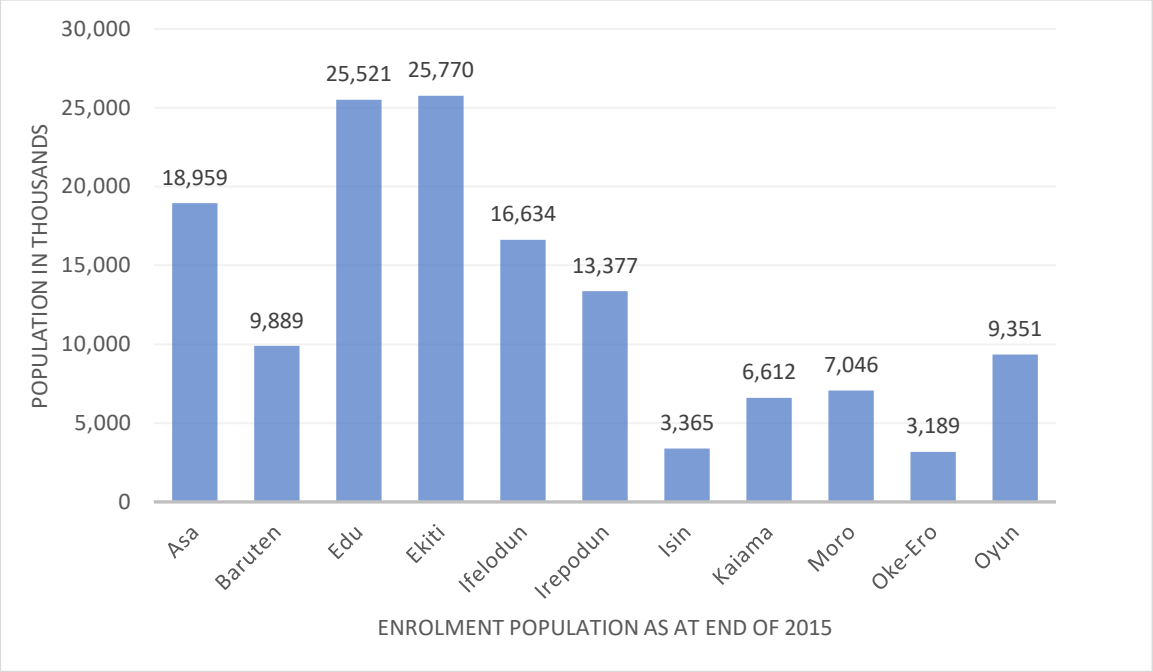
> Nigbayen, oba ilu gbe *microphone* fun awon eyan ki won fi kede kaakiri gbogbo igberiko.
>
> At that time, the King gave out the public address system to some people to publicise the programme in the community and its environs (KII, Community Leader, 03/07/2019, Gure).

The main actors were asked if they were comfortable with the enrolment coverage at the end of the programme, the government officials and the HMO were not satisfied while the officials of the foreign agency seemed to be satisfied. Some of the participants had this to say:

> We were not satisfied with the level of enrolment as at the end of the programme because we had our own targets (KII, KWSG Official 2, 24/07/2019, Ilorin).
>
> Our HMO was not satisfied with the active enrolment population as at the end of the programme in 2016 because we couldn't meet up with the target most of the time. As at then, the state population was about 2.6 million and the closing enrolment figure was about 139,000. By this, we did not do very well in terms of the coverage in 11 LGAs. We would have done more better (KII, HMO Official 1, 26/07/2019, Ilorin).
>
> PharmAccess Foundation was satisfied with the enrolment base as at the end of the programme in 2016…You know change is gradual, we could not cover more than that because it was difficult to get people convinced about the programme initially, but unfortunately, the programme stopped at a time when most people were convinced to enrol (KII, Foreign Agency Official 2, 02/09/2019, Ilorin).

As stated in Chapter 1, the fraction of enrolment coverage is insignificant in view of the rural population which constitute a larger part of the State's population (of well over 2 million people at that time). As indicated in Figure 5.1 below, at the end of the programme, the enrolment population was 139,713. Generally, "enrolment is one of the major impediments to the effectiveness of CBHI in Sub-Saharan Africa [SSA]" (Kalolo *et al.,* 2015) and the LMICs at large. Olowe (2019:3) noted that CBHI enrolment coverage in developing countries is often threatened by trust, implementation challenges and high enrolment dropout.

Figure 5.1: CBHI Enrolment Per Local Government Area

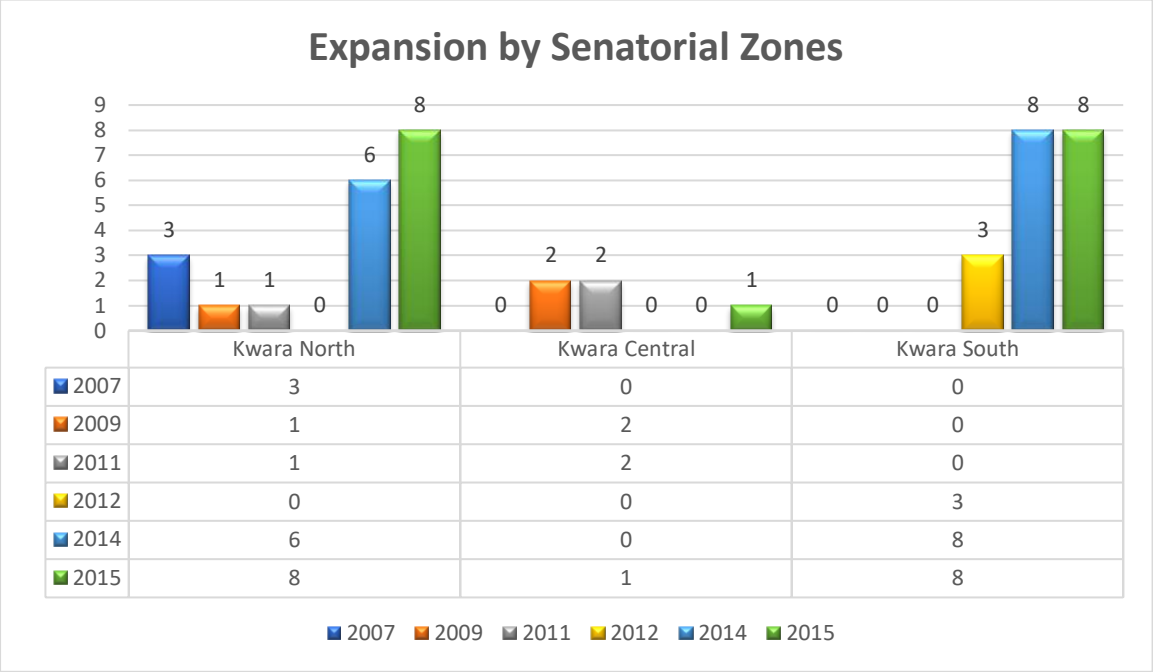


Source: Hygeia Community Health Care

5.4.2.3 Expansion into Communities

The feedback from the piloting phase of the programme gave the partners an impression that it was possible to use the programme "to improve access to healthcare in rural Kwara" (Hendriks *et al.*, 2016:478). Therefore, the programme extended from Shonga to some other parts of the State. Between 2007 and 2015, the programme was operational in 43 healthcare facilities (public and private) across the State. A participant noted that: "The aim was, for a radius of 5 kilometres, there must be a health facility in the area where people can access healthcare services" (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

Figure 5.2: CBHI Healthcare Facilities Distribution



Source: Hygeia Community Health Care

From Figure 5.2 above, the programme commenced operation in three healthcare facilities in 2007. It added three more facilities in 2009, three in 2011, three in 2012, fourteen in 2014 and seventeen in 2015. Thus, the programme operated in nineteen facilities each in Kwara North and Kwara South, and five facilities in Kwara Central senatorial zone; perhaps because there are more rural communities in the North and South compared to the Central, which has the State capital. The expansion was steady from 2007 to 2012 but took a more aggressive turn between 2014 and 2015. The partners were asked about the reasons for an expansive community entry between 2014 and 2015. Some of them noted that:

> The programme expanded to most of the communities in 2015 because enlightenment was high, and there was a lot of demand by the community leaders and willingness to participate was also high. That was the reason we had a major expansion in 2015 (KII, KWSG Official 2, 24/07/2019, Ilorin).

> When you start a programme, you pilot and move gradually. We started in Edu LGA in 2007, in 2009 we moved to 3 LGAs. The government at that time said they wanted to spread around the State (KII, Foreign Agency Official, 02/09/2019, Ilorin).

> The programme was extended to most of the covered communities in 2015 as part of the strategies towards UHC (KII, HMO Official 1, 26/07/2019, Ilorin).

Even at its most expansive reach, the CBHI programme covered only a small proportion (4.41%) of the total population of Kwara State. This exemplifies a typical phenomenon of CBHI programmes in Sub-Saharan Africa (Smith & Sulzbach, 2008:2461). The low rate of coverage over the nine-year period suggests that attaining UHC through CBHI would take a very long time.

5.4.2.4 Engagement of Providers and Capacity Building

After identifying communities where the programme would be extended, the healthcare providers in such communities were approached to participate in service delivery under the programme. This was usually preceded by carrying out a baseline assessment or medical due diligence on the facility, and each facility was expected to be well-staffed, especially the private facilities. The HCPs were selected by a team of PharmAccess Foundation and Hygeia HMO following the due diligence (England, 2008:59). After the assessments, HCPs were provided with Quality Improvement Plan (QIP) detailing the requirements across 13 key areas: "Management and leadership; human resource management; patients' rights and access to care; management of information; risk management; primary healthcare services; inpatient care; operating theatre; laboratory; diagnostic imaging; medication management; facility management; and, support services" (AIGHD, 2015:22). A follow-up assessment would be conducted (Bonfrer, 2018:56) before a provider was finally engaged under the programme.

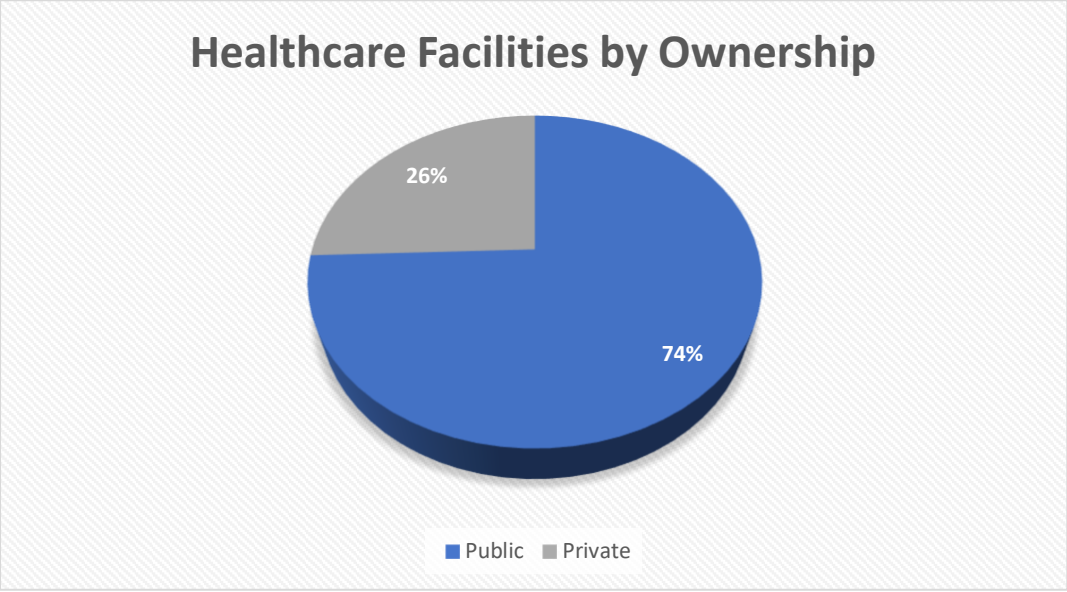
A private provider stated that: "We expanded our staffing from 17 to 75 before the programme collapsed" (KII, HCP, 19/06/2019, Bacita). They were also expected to have specific and separated departments or units to meet up with the operational standard. For instance, each facility was requested to have an ICT (Information Communication Technology) unit for capturing and transmitting the records of service delivery to the Programme Managers. Besides, the presence of many healthcare facilities in rural areas is uncommon because of the level of poverty and a high likelihood of not enjoying patronage. One of the healthcare providers recalled how he was approached. He narrated that:

> In 2006, when the CBHI was introduced here [i.e. Kwara State], it was unexpected and unplanned because nobody was thinking along that line. One day, a group came to my facility without prior information that they were coming, and they said they came to inspect the hospital. It was a crowd of people comprising white men, reporters and people from the Ministry of Health and Local Government Area officials, and so on. I was later informed that the inspection was to see a possible partnership on the CBHI

> programme…We were used as a regional referral centre to handle cases beyond primary healthcare facilities. We also became the primary provider (KII, HCP, 19/06/2019, Bacita).

Public healthcare facilities were used if they were suitably available in any community of interest. In that case, the management of such a facility would be under the CHIS (KII, HMO Official 2, 29/07/2019, Ilorin). Put differently, the HMO was in charge of the private facilities and the CHIS (the government agency) was in charge of the management of the public healthcare facilities. Figure 5.3 below shows that 74% (32) of the healthcare facilities were government-owned, while 26% (11) were private facilities. Payments were based on capitation for the healthcare services covered "while other types of care remained on a fee-for-service basis" (Bonfrer, 2018:56). The HCPs were given operational guidelines on how to deliver healthcare services under the CBHI programme. This is to positively influence the providers' behaviour and ensure efficiency and quality service delivery (Munge *et al.*, 2016:1).

Figure 5.3: Ownership of the CBHI Healthcare Facilities



Source: Hygeia Community Health Care

In addition, capacity building helps to lubricate the wheel of programme implementation for results. Thus, training and capacity building workshops were regularly organised for all categories of healthcare workers in the hospital to deliver standard service. Stakeholders were also often called to ruminate on issues regarding the status of the programme and way forward (HIF, 2012:4). A participant noted that: "They [i.e. Programme Managers] organised seminars

and training programmes for providers at different categories of staff for capacity building" (KII, HCP, 20/06/2019, Bode Saadu). A participant from a referral centre also testified that: "…They even brought equipment and trained us on best practices" (KII, HCP, Referral Centre 2 Official, 12/07/2019, Ilorin).

This indicates that the HCPs were exposed to standard and best practices in healthcare service delivery through trainings and seminars. This was confirmed by one of the implementing partners that: "We had capacity-building for healthcare workers across all cadres – medical doctors, nurses, midwives, laboratory scientists and technicians, pharmacists, pharmacy technicians etc." (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). However, more often, trainings and capacity building programmes are utilised by policy actors to enforce compliance, as well as introduce and instil the needed modus operandi in the healthcare providers (see Stone, 2004:556).

5.4.2.5 Facility Upgrade

In selecting communities during the expansion of the programme, the availability of a healthcare facility was considered. As such, it became necessary to renovate some healthcare facilities for implementing the programme. In other cases, facilities adjudged to be suitable for the programme were upgraded with the provision of equipment and other necessities to ease delivery of quality service. The funding was incurred by the international partner. One of the officials explained that:

> HIF financed the upgrade of many facilities, public and private. We had the Ogo-Oluwa Hospital in Bacita; it was a private hospital that benefitted immensely from structural and equipment upgrade (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

A provider who benefitted from the upgrade confirmed that: "They brought in some new equipment to improve quality of service…" (KII, HCP, 28/07/2019, Aboto-Oja). Some of the types of equipment given out were ambulances and ultrasound machines while other facilities further benefitted through a structural upgrade. The main funding of the facility upgrade was "by the Health Insurance Fund and partly by the Kwara State Government" (Bonfrer, 2018:57-58).

5.4.2.6 Monitoring and Evaluation

Monitoring and Evaluation (M&E) aimed to ensure "regular monitoring of the quality of care" (Schneider, 2004:353) and confirm that the implementation of the programme was carried out according to the established rules and guidelines. It was a quarterly exercise carried out in all

the facilities operating under the programme. The M&E was championed by the PharmAccess Foundation through SafeCare Healthcare Standards, an organisation dedicated to setting the standards for internationally acceptable healthcare service delivery. It consists of five components: "general training session; baseline assessment and gap analysis; initial feedback; improvement plan; and implementation assistance and feedback" (Dunsch, *et al.* 2017:7-8). The monitoring teams of the State's Ministry of Health and the HCHC were however carried along in the process, in attendance. The earliest M&E exercises were carried out in June 2007 and January 2008 (England, 2008:59). An official of the international agency commented on this when describing the roles of the organisation as:

> …improving quality using the SafeCare quality methodology designed by three organisations. JCI [i.e. Joint Commission International] of America, COHSASA [Council for Health Service Accreditation of Southern Africa] of South Africa and PharmAccess Foundation for resource-restricted settings in Africa (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

A government official added that:

> Basically, evaluation and monitoring of the programme were done by SafeCare Healthcare Standards to know if they met with standards…The evaluation was carried out quarterly. They gave a notification to providers on the things to be complied with. This included safety and clinical rules that needed to be complied with. It was a participatory thing, and they gave them a checklist on the things. It was not an exam, and it was like a way of life. The facilities used then were the best in standards (KII, KWSG Official 2, 24/07/2019, Ilorin).
>
> Kwara State Ministry of Health Monitoring Team in collaboration with the PharmAccess Foundation carried out an integrated inspection in the health facilities using SafeCare methodology to monitor their activities quarterly. The exercise was effective (KII, KWSG Official 3, 01/08/2019, Ilorin).

An HMO official also noted that:

> There was usually quarterly M&E conducted by the monitoring team that evaluated the programme, and there was also a team of doctors, we called them Care Coordinators that went to the clinics on a regular basis to monitor the delivery of care. The enrolment teams were also used to get feedback from enrollees. We also used the traditional rulers

and agents within the communities that tell us how things were run in the hospitals (KII, HMO Official 2, 29/07/2019, Ilorin).

Another way of monitoring the programme was through committees constituted in the communities to ensure proper implementation. A participant noted that:

> There was also a committee in each community for the programme involving traditional rulers, health workers and implementing partners to identify challenges and act to solve them. It was joint monitoring by all stakeholders (KII, KWSG Official 1, 20/08/2019, Ilorin).

A community leader added that:

> Ti a ba ni *complain*, a o pe *Enrolment Officer*, aade attend si wa. Igbaami, a tunle jo se *meeting* pelu awon *Health Committee* ati awon *health officials*. Emini *Secretary Health Committee.*
>
> Whenever we had a complain, we called the Enrolment Officer, and he attended to us. At times, we involved him in the meeting of the Health Committee [in the community] and the health officials [in the facility]. I am the Secretary of the Health Committee (KII, Community Leader, 15/06/2019, Edidi).

In addition, 9 out of 10 HCPs confirmed the effectiveness of the M&E. One of them noted that:

> There was effective monitoring and evaluation of the programme because they did evaluation every three months, and we usually prepared well for it so that we would not be marked down. I'll advise that the M&E be taken along any other programme that would come up. Enrollees were also given questionnaires to assess the quality of our service (KII, HCP, 13/06/2019, Erinle).

Furthermore, the majority of the community leaders (10 out of 11) and community members (20 out of 22) testified to the effectiveness of the M&E. In the same vein, the quantitative data in Table 5.1 below shows that the majority (87.1%) of the respondents believed that there were effective evaluation and monitoring of the programme. More so, the Table shows a statistically significant association between quality of service and monitoring and evaluation of the programme (χ^2 = 488.181, p-value = 0.001). The study also found a statistically significant association between conduct of the healthcare workers and monitoring and evaluation of the programme (χ^2 = 436.802, p-value = 0.001). These suggest that the M&E exercise played a

positive role to ensure that the healthcare workers conduct themselves properly and provide quality healthcare services to the enrollees.

Table 5.1: Effectiveness of the Monitoring and Evaluation

Response	**Frequency (N = 1,012)**	**Percentage**
Yes	881	87.1
No	131	12.9
Chi-Square Test of Association between Selected Variables and Effectiveness of the Monitoring and Evaluation System		
Variables	**Former Enrollees (p-value)**	
Quality of Care	.001	
Conduct of the healthcare workers	.001	
Note: 5% significance level		

Source: Fieldwork 2019

The respondents were not fully involved in the M&E exercise (i.e. some of them were interviewed as part of the process), but their perception as shown in the above Table indicates that the monitoring and evaluation of the programme were effective. However, the state government was not in the forefront of the exercise. Notwithstanding the level of response noting that the M&E was effective, there were a number of problems (discussed in Chapter 8) that tend to challenge the effectiveness of the exercise. Government officials were part of the M&E process "in-attendance" (KII, HCP, 27/07/2019, Oro) without significant contribution or influence. Mainly, the M&E focused more on healthcare service delivery "within the facility" without adequate attention to the administrative process of the programme at the level of HCHC and CHIS to checkmate their "excesses".

5.4.2.7 Decision-making

Decision-making in the policy space was greeted with a lot of contestation, with one party trying to dominate the other in exerting their influence. Promotion of personal interest is often the primary target of each party (Jones & Jenkins-Smith, 2009:45). In the case of Kwara CBHI, the findings reveal that decisions were jointly made. All (7 officials) that responded to the question noted that decisions were jointly made. For instance, an official of the foreign agency stated that: "Decisions were jointly made by the partners. The KWSG, HCHC and PharmAccess Foundation" (KII, Foreign Agency Official 2, 02/09/2019, Ilorin).

The submission was affirmed by the HMO officials and the researcher. One of them noted that: "Decisions were jointly made by the partners including on expansion and stoppage" (KII, HMO Official 2, 29/07/2019, Ilorin). Meanwhile, in a context of collaboration where a party owns the financial power and appears to possess better knowledge and expertise than the counterpart, joint decision-making is often passive and lack serious or adequate deliberation. This is reflected in the statements of participants. A participant noted that the foreign partner was always present in the State, and in fact, had an office in the State. This is to allow for close monitoring of the implementation of the programme, to their satisfaction. The participant explained that:

> Yes. Decisions were jointly made by the partners when the programme was operational. The government of the Netherlands were almost always here to have a discussion with the Kwara State Government. And they have their group here, the PharmAccess Foundation. They have their office in Kwara State here, and the State also has somebody, the Executive Secretary in charge of the health insurance scheme (KII, Researcher, 30/07/2019, Ilorin).

Kwara State Government official also confirmed that decisions were jointly made by the parties. However, they explained certain areas where decisions were solely made by the international partner. One of the officials stated that: "Most of the decisions were jointly made by the partners" (KII, KWSG Official 2, 24/07/2019, Ilorin). There are two areas identified regarding the programme that decisions were made by the international partner. First, is the choice of communities where the programme would be extended; second, is the decision regarding the standard of care given to the enrollees. The officials explained that:

> Decisions were jointly made by the partners. We agreed with their choice of communities to run the programme (KII, KWSG Official 1, 20/08/2019, Ilorin).

Regarding the choice of communities, the official added that:

> The foreign partners came by themselves and chose all the areas where they wanted the programme to be run. They would come here physically, drove around the whole State and found the areas where they felt the programme was highly needed. If it was the decision of the State Government, Bukola Saraki would have taken it to Agbaji [i.e. ancestral home of the then governor] or Ilorin something (KII, KWSG Official 1, 20/08/2019, Ilorin).

Another official pointed to the decision around the standard of healthcare. He explained that:

> Decisions were jointly made by the partners, but in terms of the standard of care, PharmAccess Foundation took upright decisions alone to ensure that quality was not compromised. Decisions about expansion benefits package, premium etc. were made together (KII, KWSG Official 2, 24/07/2019, Ilorin).

Based on the above discussion, like the policy design, the decision-making around the implementation of the programme was not totally made jointly. Some decisions were exclusively made by the foreign partner. This is inimical to the basic principles of partnership. However, programmes being pushed through "policy learning or policy transfer" are characteristically dominated by one party (the promoter) than the other, mostly, under the "guise" of technical know-how.

5.5 Achievements of the CBHI Programme

This section examines achievements and successes recorded by the CBHI programme within the period it was operational. As indicated in chapter 2, there have been concerns regarding the efficacy and success of CBHI as a policy or programme. In some cases, where CBHI programmes are implemented, there are implementation challenges stemming from the policy design. In other cases, where they are adjudged to be successful, they are faced with sustainability challenges. In the same light, the CBHI programme in Kwara State was viewed with concerns. An official of the state government shared his experience regarding the concerns people have about the workability and sustainability of the CBHI programme. He noted that: "The remarks about the programme had mixed feelings. At a conference at the Washington DC, there were debates that the national health insurance was not working well… I was able to showcase some data at the programme; even if we were on CBHI, it had fared very well within the State, and we had the records and data. At that point, some people were saying this is just one HMO programme, and you said it is thriving" (KII, KWSG Official 2, 24/07/2019, Ilorin).

It, however, recorded some level of success before its eventual stoppage. One of the participants explained that: "Some of the major achievements are a great improvement in the health indices of the State in the National Demographic Health Survey. The programme was pinpointed as the intervention" (KII, HMO Official 1, 26/07/2019, Ilorin). All the key informants (i.e. the researcher, HCPs as well as the officials of the HMO, International Agency, KWSG) argued that the programme met the healthcare needs of the former enrollees and that

it achieved some success. Another participant stated in general terms that: "The programme had multi-dimensional success. Access to healthcare by the people increased. The premium was just ₦200 for a whole year to access primary healthcare. The health facilities were upgraded. In terms of health status, the impact evaluation shows that the health status of the enrollees improved significantly. Preparation of health services also improved. It also had a touch on their socio-economic conditions since they would not have to spend much on healthcare, and they can spend on other things. The nutritional status of enrollees also improved" (KII, Researcher, 30/07/2019, Ilorin). Arising from the data, achievements highlighted by the participants are discussed as follows:

5.5.1 Benefits Package

All the HCPs claimed that the programme met the healthcare needs of the former enrollees and that the programme covered most of the diseases common in the communities. For instance, one of them argued that the readiness of the community members to enrol if the programme is re-introduced serves as an indication of the success of the programme. In justifying that the programme met the healthcare needs of the former enrollees, one of them pointed out that:

> …This is evident in the lamentation of the beneficiaries since the stoppage of the programme. There are now cases of people dying at home due to the challenge of the fund (KII, HCP, 28/07/2019, Aboto-Oja).

Similarly, another HCP contended that the programme met the healthcare needs of the beneficiaries because it covered most of the diseases in the community, and as such, it earned some international awards. In his words:

> The programme met the healthcare needs of the enrollees excellently to the extent that the Kwara State Government received international awards twice or thrice on the programme (KII, HCP, 19/06/2019, Bacita).

He continued that:

> The programme covered most of the diseases that are common in this community. This includes malaria, arthritis, measles, fever, malnutrition, anaemia and common surgeries like hernia, hydrolysis, appendicitis; and then, the obstetrics department which was the peak of it because many who would not come for ante-natal care would have died but they were coming on the platform of the programme, and they did not have to pay even if they delivered with surgery. The programme contributed to lowering the maternal

> mortality rate in this area when the programme was operational (KII, HCP, 19/06/2019, Bacita).

In addition, an HCP supported the above claim that: "The programme met the healthcare needs of the enrollees because some of them with chronic diseases could access regular care" (KII, HCP, 27/07/2019, Oro). He added that:

> The programme covered most of the diseases common in the community. Though, it didn't cover some geriatric conditions that require specialised attention. It covered what we can consider as the health body of that society (KII, HCP, 27/07/2019, Oro).

Another provider contributed that:

> The programme covered most of the diseases common in this community, to some extent. Malaria, maternal care, hernia, hypertension, and diabetes were covered hospital (KII, HCP, 20/06/2019, Bode Saadu).

In the same vein, an official of the international agency noted that:

> The benefits package was very robust involving some minor and intermediate surgeries such as caesarean section, appendectomy and many other intermediate surgeries. People could go to their farms to farm, people could go to their places of work and the economy of the populace was boosted because they were healthier (KII, Foreign Agency 1, 02/09/2019, Ilorin).

However, "most CBHI schemes offer limited benefits package that comprises of either one or a combination of services including outpatient care, surgery, deliveries, diagnostic test, referral to specialist hospitals and primary healthcare" (Chuma *et al.*, 2013:4). Likewise, as noted above, the Kwara CBHI covered primary and limited secondary healthcare services. As such, enrollees could not access services (e.g. dialysis in a case of renal failure) outside the benefits package without paying OOP. This tends to limit the interest of the people in enrolment in CBHI programmes (Panda *et al.*, 2016:58).

5.5.2 Increased Utilisation of Hospital Care

The key informants noted that the programme increased utilisation rate of hospital care services in the communities. This is attributable to the amount paid as premium for accessing care. A government official noted that: "People attended hospitals more and we had more volume of patients in the hospital, and since they were not paying anything it reduced mortality rate.

People were very healthy, including the workforce to help the economy" (KII, KWSG Official 1, 20/08/2019, Ilorin). Another participant made a comparison and narrated that:

> The CBHI achieved fantastic success in the State. The utilisation rate of the Comprehensive Health Centre in Shonga was very poor before the programme. Utilisation rate rose from 10 to over 200 cases daily. They could have up to 10 deliveries in a day, and that showed that there was a demand for healthcare, but people could not access due to many factors; our research showed that it was due to money, ill-equipped healthcare facilities (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

Some HCPs confirmed how healthcare service utilisation rose astronomically in their facilities. They stated that:

> The programme met the healthcare needs of the enrollees because the utilisation rate was very high (KII, HCP, 17/06/2019, Odo-Owa).

> At inception, drugs were available, and enrolment was very high, and the hospital was usually filled with patients, but suddenly, the standard dropped (KII, HCP, 02/07/2019, Kaiama).

> At some point in the programme, we had about 16,000 enrollees in our facility. That is enough evidence that we provided quality service (KII, HCP, 19/06/2019, Bacita).

> Many of the people did not go for an ultrasound scan or ante-natal care prior to the commencement of the programme. During the operational period, there was a high level of utilisation of care in the hospital (KII, HCP, 20/06/2019, Bode Saadu).

> As at the time of the close of the programme, we had about 25,000 enrollees which was the largest enrolment base in the State. People from other Local Government Areas, Oke-Ero and Isin, which had the programme were also coming to our hospital for care (KII, HCP, 21/06/2019, Osi).

From the foregoing, there was increased healthcare utilisation among community members when the programme was operational. This is aligns with studies conducted by Brals *et al.* (2017:999), AIID (2013:22) and AIGHD (2017:15); who found a high rate of healthcare utilisation among the enrollees in the programme. The testimonies of the first sets of enrollees served as the basis through which many other members of the communities enrolled and benefitted from the programme.

5.5.3 Reduction in Mortality Rate

One of the fundamental goals of healthcare programmes is a reduction in the mortality rate. Findings ('unverified claims') emanating from the study indicates that the programme reduced the mortality rate in the communities and increased life expectancy of the enrollees. An HCP noted that: "The programme met the healthcare needs of the enrollees because it reduced mortality rate" (KII, HCP, 13/06/2019, Erin-Ile). One HMO official recalled how some people named their children (as Hygeia) because of the standard of care received, leading to successful deliveries. He explained that:

> The programme was a great success because it was the first time the people would benefit from health insurance to the extent that people named their children delivered through CS [caesarean section] after the programme… (KII, HMO Official 1, 26/07/2019, Ilorin).

In support of the above, another participant among the HCPs narrated a specific case where a pregnant woman who was in a very critical stage of labour was referred to his facility. He explained that a caesarean section was successfully carried out and the baby was named after the programme, popularly called Hygiea. He elaborated that:

> The case of a pregnant woman whose baby is called "Hygeia Baby" today, was referred from Shonga to our facility because she had difficulty in delivering. We did CS, and the baby survived, and the baby was the first delivery under the programme free of charge. This boosted the population of the programme (KII, HCP,19/06/2019, Bacita).

In addition, a participant declared that:

> The programme had a huge success, and it overachieved the purpose for which it was established because the life expectancy of the people increased in addition to improved health-seeking behaviour. Maternal and infant, and aged mortality reduced. Chronic diseases such as diabetes and hypertension were well-managed by using standard quality operating procedure from the Dutch government, and all the hospitals followed the procedure (KII, HMO Official 2, 29/07/2019, Ilorin).

In support, some other participants stated that:

> Maternal morbidity and mortality reduced drastically, and productivity increased among the people. You know when there was no health insurance, we had a lot of farmers that had hernia (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

> It had a record of gross reduction of maternal and infant mortality rates, hypertension, diabetes, stroke etc. It improved the population rate and health status of the people (KII, KWSG 2, 24/07/2019, Ilorin).

5.5.4 Awards and Point of Reference

The programme won awards while it was operational regarding its performance, as noted in Chapter 1. One of the participants reiterated that: "The programme won both local and international awards, e.g. the Economic Development Award, Financial Times Award and the Ministry of Health also paid accolades to the programme. More so, representatives from different States came to understudy the programme based on its success. It also boosted the economic fortunes of the State through employment… Essentially, it brought Kwara State to the world map in terms of health improvement" (KII, HMO Official 1, 26/07/2019, Ilorin). Another participant added that:

> The international agencies commended the programme, and it received awards. The programme recorded huge success and helped the poor and vulnerable people in rural areas (KII, KWSG Official 3, 01/08/2019, Ilorin).

In addition, the programme was described as a viable model of health insurance that could be replicated in other climes. It was also reported that a former United Nations' (UN) Secretary-General endorsed the programme and recommended it for the adoption of other countries in Africa. A government official noted that:

> The most important thing is that the advent of the Kwara CBHI was the reason for the CBHI programme in other places in Nigeria. When they realised that it was thriving in Kwara, we were invited to come up with a model that can fit every other State in Nigeria. Because we gave them an argument that you cannot mandate health insurance policy in every state because each state has their own ways of managing it. Mr Ban Ki-moon, the then Secretary-General of the UN said, and I quote "the Kwara model is a model that can be recreated in all Sub-Saharan Africa" (KII, KWSG Official 2, 24/07/2019, Ilorin).

He added that:

> It became the only state that had a successful CBHI programme that became a tutorial centre for all other States to learn from. The States included Kaduna, Ogun, Delta, Ondo etc. Some people came in from Tanzania. Also, there are 40 international students who wrote their theses on the Kwara CBHI (KII, KWSG Official 2, 24/07/2019, Ilorin).

Another official remarked that:

> The programme was widely and worldly acclaimed as a very successful programme. It was commended by a former Secretary-General of the United Nations. Many other States came to understudy the programme based on its success. It was a very wonderful, remarkable and tremendous achievement (KII, KWSG Official 1, 20/08/2019, Ilorin).

Precisely, the programme won the "Saving Lives At Birth (SLAB) Award in 2014; Finalist for the OECD-DAC's (Organisation for Economic Co-operation and Development-Development Assistance Committee DAC) Prize for Taking Development Innovation to Scale by the World Economic Forum in 2014; Financial Times/International Finance Corporation's Transformational Business Award in 2016" (PharmAccess Group, 2016:6) etc. The CBHI programme also emerged as a point of reference for other States in the federation to "emulate" in terms of the provision of healthcare services. The United Nations (UN) former Secretary-General, Ban Ki-moon remarked about the programme in 2011 that: "The ground-breaking Community Health Insurance Scheme of the Kwara State Government is another hopeful example…This is exactly the kind of innovative partnership that we should replicate - here in Nigeria and beyond" (Ki-moon, 2011).

Quite worrisome at this point relates to the "lessons" learnt from the Kwara CBHI programme and the indication of interest by many states of the Nigerian federation. This is because it is claimed that 17 out of the 36 states have come up with health insurance laws based on the experience and ideas from the Kwara programme (see PharmAccess Group, 2017:5). Although there are huge lessons to be learnt but introducing health insurance in settings where only a limited part of the population can afford to pay tends to exclude the majority. In the same vein, this outcome challenges the ideational basis of this kind of policy, in spite of the stated achievements. Meanwhile, effective social provisioning towards development is "based on visionary agenda-setting, capturing a wider vision of society for long-term benefits" (Adésínà, 2011:464).

5.6 Conclusion

The chapter discusses how the context of healthcare in Kwara State led to the emergence of the CBHI programme. It shows the vulnerable nature of the State in agreeing to the launching of the CBHI programme. The chapter also shows how CBHI got onto the policy landscape in Kwara State. There was, however, no effective policy in place to improve and attend to the healthcare needs of the people. Consequently, it became easy to propose and implement the

CBHI policy in the State by international actors, with no input in the policy content from the local actors or policymakers.

The domination by the international actors was possible because of their possession of the fund and technical know-how. The main actors in the policy implementation were examined in relation to their roles. The programme was however implemented through the engagement of a local HMO by the international actors, and it directs it on how to implement the programme. The chapter further examines the achievement of the programme from the perspective of the key informants. The next chapter, however, comprehensively examines the perception of the community members about the programme. As such, areas of convergence and divergence will be noticed consequently enriching our understanding of the programme.

CHAPTER SIX

PERCEPTIONS AND EXPERIENCES OF COMMUNITY MEMBERS ABOUT THE CBHI PROGRAMME

6.1 Introduction

This chapter examines the perceptions of community members about the CBHI programme during the time it was operational in the various communities. This forms an important aspect of the study because it provides insights from the community members about the programme. Put differently, it reveals the insights of the people about the programme and the understanding of its success-level from the standpoint of the beneficiaries. Specifically, it discusses the demographic features of the respondents. Also, the awareness and interest of community members in the CBHI programme were interrogated. Issues regarding enrolment, healthcare service delivery and benefits package of the programme were also discussed.

6.2 Socio-Demographic Characteristics of Respondents

This section deals with the socio-demographic features of the respondents (former enrollees and non-enrollees) in the study. This is summarised in Table 6.1 below.

Table 6.1: Socio-Demographic Characteristics of Respondents

Variable	**Enrollees (N = 1,055)**		**Non-Enrollees (N = 528)**	
Gender	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Male	527	49.95	264	50.0
Female	528	50.05	264	50.0
Age	**Frequency**	**Percentage**	**Frequency**	**Percentage**
21 – 25	94	9.7	69	15
26 – 30	193	20.0	127	27.6
31 – 35	127	13.1	64	13.9
36 – 40	135	14.0	50	10.9
41 - 45	85	8.7	40	8.7
46 – 50	106	11.1	41	8.9
51 -55	43	4.5	19	4.1
56 – 60	73	7.6	10	2.2
61 and above	110	11.3	40	8.7

Variable	**Enrollees (N = 1,055)**		**Non-Enrollees (N = 528)**	
Education	**Frequency**	**Percentage**	**Frequency**	**Percentage**
No Formal Education	215	20.9	74	14.4
Primary School Education	197	19.1	98	19.0
Secondary School Education	303	29.4	202	39.2
ND/NCE/Tech. School	201	19.5	92	17.9
HND/University Graduate	115	11.2	49	9.5
Religion	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Islam	629	61.7	306	59.4
Christianity	388	38.0	207	40.2
African Traditional Religion	1	0.1	1	0.2
Other	2	0.2	1	0.2
Marital Status	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Married	886	86.9	528	100.0
Divorced	4	0.4	0	0
Single Parent	4	0.4	0	0
Widow	120	10.6	0	0
Single	6	0.5	0	0
Household Size	**Frequency**	**Percentage**	**Frequency**	**Percentage**
1 – 3	165	20.4	74	21
4 – 6	435	53.8	180	51
7 – 10	174	21.5	76	21.5
11 and above	35	4.3	23	6.5
Occupation	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Farmer	118	11.7	72	14.1
Trader	409	40.8	164	32.0
Technician	109	10.8	78	15.2
Civil Servant	166	16.4	59	11.5

Variable	Enrollees (N = 1,055)		Non-Enrollees (N = 528)	
Others	208	20.6	139	27.1
Income per month (USD)	**Frequency**	**Percentage**	**Frequency**	**Percentage**
₦3,000 or below (8.2 and below)	61	7.7	33	8.7
₦3,001 – ₦6,000 (8.2 – 16.5)	137	17.3	74	19.5
₦6,001 – ₦9,000 (16.5 – 24.8)	47	5.9	17	4.5
₦9,001- ₦12,000 (24.8 – 33.1)	158	19.9	65	17.1
₦12,001 – ₦15,000 (33.1 – 41.4)	53	6.7	33	8.7
₦15,001 and above (41.4 and above)	337	42.5	158	41.5

Source: Fieldwork 2019

As shown in Table 6.1, 1,583 respondents took part in the study. The study had equal participation for both male and female enrolled and non-enrolled respondents in the study to reflect gender sensitivity. Specifically, male respondents among the former enrollees were 527 (49.95%), and female respondents were 528 (50.05%). For the non-enrolled respondents, 264 (50%) were males, and 264 (50%) were females. Further, the mean age of the enrolled and non-enrolled respondents is 41.7 and 37.8 years, respectively. This signifies that the majority of the respondents were in their youth. Also, over 60% per cent of the total respondents had a minimum of secondary school education signifying that most of them acquired some forms of formal education. However, those with no formal education are more among the formerly-enrolled (20.9%) compared with the non-enrolled (14.4%) respondents.

Also, most of the respondents were Muslims because of the dominance of Islam in the study area. While the non-enrolled respondents were purposively taken from the married men and women in the selected communities, more than 80% of the formerly-enrolled respondents were also married. This indicates that the majority of the total respondents in the study were married. Further, the household size of the majority of the respondents falls within the range of 4-6 for

both the formerly-enrolled and non-enrolled respondents. More so, most of the total respondents were traders. While farming is common in the rural areas, only a few indicated that they were farmers. This might be because most people in the rural communities merely engage in subsistence farming while they combine it with other occupations (such as trade) to generate income.

Furthermore, half (50.8%) of the former enrollees and half (49.8%) of the non-enrollees earned monthly income of ₦12,000 (33.1 USD) or below. This suggests that most people in the rural communities earn slightly above one-third of the recently approved minimum wage of ₦30,000 (82.8 USD) per month. The income level of most of the respondents shows that they are 'petty traders' or engaged in small scale businesses in the rural communities. The finding reflects the income status of most people in Nigeria. The low income is similar to the finding of Ameen *et al.* (2016:5) among artisans on awareness about CBHI in Ilorin metropolis, whereby 41.1% of the respondents earned below ₦20,000 (55.2 USD) monthly. Also, Ogben and Ilesanmi (2018:56) found in a CBHI study in Abuja that over 60% of the respondents earned less than ₦18,000 (49.7 USD) monthly. Further, Agbo *et al.* (2019:52) found in a study of willingness to pay in Lagos that 48% and 95.8% of the urban and rural respondents earned monthly household income of less than ₦20,000 (55.2 USD) respectively.

6.3 Awareness about the CBHI Programme in Kwara State

As stated earlier in the preceding chapter, the CBHI programme became operational in 2007 and started in Shonga, Edu Local Government Area of Kwara State. The commencement was supported with strong awareness efforts to ensure the acceptance of the programme through massive enrolment. As a result, many people who lacked affordability and those who never considered receiving healthcare in the hospital as a necessity had the opportunity of enrolling in the programme. This section examines the sources of knowledge about the programme and interest of community members to enrol in the programme.

6.3.1 Source of Knowledge About the CBHI Programme

The respondents became aware of the CBHI programme through various sources. These strategies provided an opportunity for publicising the programme across the rural communities where it was introduced. Table 6.2 shows the various sources through which the respondents knew about the programme.

Table 6.2: Sources of Knowledge about the CBHI Programme

Source of Knowledge	Former Enrollees (N = 1,111)		Non- Enrollees (N = 527)	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Mass media	141	12.6	60	11.4
Family & Friends	421	37.8	214	40.6
Community meeting	393	35.3	157	29.7
Sales Agent	28	2.5	8	1.5
Mosque/Church	10	0.9	1	0.2
Healthcare facility	23	2.07	5	0.9
Association meeting	1	0.09	0	0
Awareness programme	0	0	7	1.3
Others	94	8.5	75	14.2

Source: Fieldwork 2019

Table 6.2 shows the predominant sources of information among the respondents were family & friends and community meetings, suggesting that there was a good level of social interaction and communication among the community members. This is a common feature of rural communities, known for a relatively high level of collectivism. The qualitative data aligns with the above results. A community leader during an interview noted that:

> Akoko, nigbati *information* ko *go round*, odape oje ajoji si *community* yi, *but with the efforts of* awon *indigenes*, ti won *go round*, ti won *enlighten* awon eyan, wipe: *this is what the government is trying to do.* O *make* e *easy*.
>
> Initially, when information about the programme did not go round, it was seemingly strange to this community, but with the efforts of the indigenes that went around to enlighten the people, that: this is what the government is trying to do. It made it easy for the programme to gain a high level of acceptance (KII, Community Leader, 20/06/2019, Bode Saadu).

Another community leader stated that:

> Ape *meeting* gbogbo awon ara ilu, ati gbobo ilu towa ni *surroundings* wa, won sin *brief* wa 'pe nti wongbe bo niyi, asi tewo gba.
>
> We called a meeting of all community members, including people from the neighbouring communities. Then, we were briefed about the programme and we embraced it (KII Community Leader, 01/07/2019, Aboto Oja).

A community member also pointed out that religious institutions assisted in increasing awareness about the programme. He explained that:

> I became aware of the programme in the hospital, though the community also sensitised the people through the mosques and churches. This sensitisation exercise improved the level of participation in the programme because more people became aware and enrolled (IDI, Male, 19/06/2019, Bacita).

Another community member noted that:

> I heard about it from a family member, but there was also awareness efforts carried out in the community (IDI, Male, 03/07/2019, Gure).

Some other sources of information that enhanced awareness about the programme were radio programmes and signboards. According to some community members:

> Akoko, mogbo nipare l'ori afefe, tianpe ni *redio*; elekeji, mogbo nipare lati enu awon ebi mi; eleketa, mo gbo nipare nibi *community meeting*. Awon ona yi jeki opolopo eyan kopa nibi eto na.
>
> First, I heard about it through the radio; second, I heard about it through my family members; third, I heard about it at the community meeting. These media encouraged most people to enrol in the programme (IDI, Male, 13/06/2019, Erinle).

> *Sanboodu* lari. Bi ase lo *konfaamu* niyen, wonde ni beeni.
>
> It was the signboard about the programme that we saw. We went to confirm, and they said it was real (IDI, Female, 17/06/2019, Odo-Owa).

More so, community leaders were given the mandate of informing and urging their community members to enrol in the programme, and this strategy also yielded positive results. Some of the community leaders discussed their role in the programme as thus:

> Won ni ki awa asiwaju ilu maa se alaye fun awon eyan pe kiwon maawasi odo won. The community leadership was requested to sensitise and enlighten the community members to enrol in the programme (KII, Community Leader, 02/07/2019, Kaiama).
>
> Awa asiwaju ilu'nfun awon ara ilu ni idanileko wipe kiwon losibe, 'pe kosi ifoya. The community leadership enlightened the community members to enrol in the programme that there was no cause for alarm (KII, Community Leader, 21/06/2019, Osi).

Table 6.3: Chi-Square Test of Association between Selected Variables and Knowledge about the CBHI Programme

Variables	**Former Enrollees (p-value)***	**Non-Enrollees (p-value)***
Gender	.080	.525
Education	.215	.242
Age	.669	.054
Occupation	.028	.013
Note: 5% significance level *Two-tailed test		

Source: Fieldwork 2019

Table 6.3 above reveals that the study did not find a statistically significant association between gender and knowledge about the CBHI programme among the former enrollees (χ^2 = 6.746, p-value = 0.080) and the non-enrollees (χ^2 = 2.235, p-value = 0.525). This might be linked to the high level of awareness and sensitisation efforts for the programme. The study did not also find a statistically significant association between educational status and knowledge about the programme among the former enrollees (χ^2 = 15.512, p-value = 0.215) and the non-enrollees (χ^2 = 14.990, p-value = 0.242). Similarly, Banwat *et al.* (2012:56) found no statistically significant relationship between educational status and knowledge about CBHI in North Central Nigeria, the same region where Kwara belongs.

Further, it found no statistically significant association between age and knowledge about the CBHI programme among the former enrollees (χ^2 = 20.482, p-value = 0.669) and the non-enrollees (χ^2 = 36.096, p-value = 0.054). In the same vein, Noubiap *et al.* (2014) found no relationship between age and knowledge about CBHI in Cameroun. However, the study found a statistically significant association between occupation and knowledge about the CBHI programme among the former enrollees (χ^2 = 22.955, p-value = 0.028) and non-enrollees (χ^2 = 25.321, p-value = 0.013). This might be related to the methods of publicising the programme. For instance, rallies and meetings were organised in the community markets. A community leader explained that:

Inu *big market* wa ni won ti bawa so'ro. *Everybody* sin jade si'ta.	We were invited to our big market where they introduced the programme to us, and everybody was present (KII, Community Leader, 03/07/2019, Gure).

The submission of the various participants indicates that the spread of information and awareness about the programme was due to the combined efforts of those implementing the programme and the community members, most notably, the community leaders and religious leaders. However, there was "poor awareness and paucity of information" about the CBHI programme in Lagos (AndChristie Research Foundation/Centre for Public Policy Alternatives, 2014:15). Also, studies by Abdulrasheed and Aladetohun (2018:18) and Bamidele and Adebimpe (2013:9) in Alimosho Lagos and Osun South-Western Nigeria respectively, found poor CBHI awareness among the respondents. The high level of awareness found in this study can be attributed to many media and channels employed in creating awareness about the programme.

Table 6.4: Multinomial Logistic Regression on Knowledge about the CBHI Programme

Variable	Former Enrollees				Non-Enrollees			
	Coefficient	**Wald ratio**	**P-value**	**Odds ratio**	**Coefficient**	**Wald ratio**	**P-value**	**Odds ratio**
Mass Media Intercept	1.649	4.349	.037		1.143	1.317	.251	
Gender	-.237	.666	.414	.789	-.357	.878	.349	.700
Education	-.168	1.909	.167	.846	.375	3.939	.047	1.455
Age	-.110	3.620	.057	.895	-.129	2.113	.146	.879
Occupation	.040	.123	.725	1.041	-.505	11.011	.001	.604

Family & Friends Intercept	2.823	16.897	.000		2.193	7.412	.006	
Gender	-.123	.239	.625	.884	-.476	2.577	.108	.621
Education	-.165	2.469	.116	.848	-.039	.076	.783	.961
Age	-.108	4.765	.029	.897	-.045	.491	.483	.956
Occupation	-.069	.470	.493	.933	-.086	.581	.446	.918
Community meeting Intercept	3.922	32.522	.000		2.339	8.001	.005	
Gender	-.602	5.674	.017	.548	-.594	3.717	.054	.552
Education	-.283	7.208	.007	.753	.001	.001	.997	1.001
Age	-.103	4.266	.039	.902	.011	.028	.866	1.011
Occupation	-.100	.983	.322	.905	-.254	4.613	.032	.776
Note: 5% significance level Reference Category: Others								

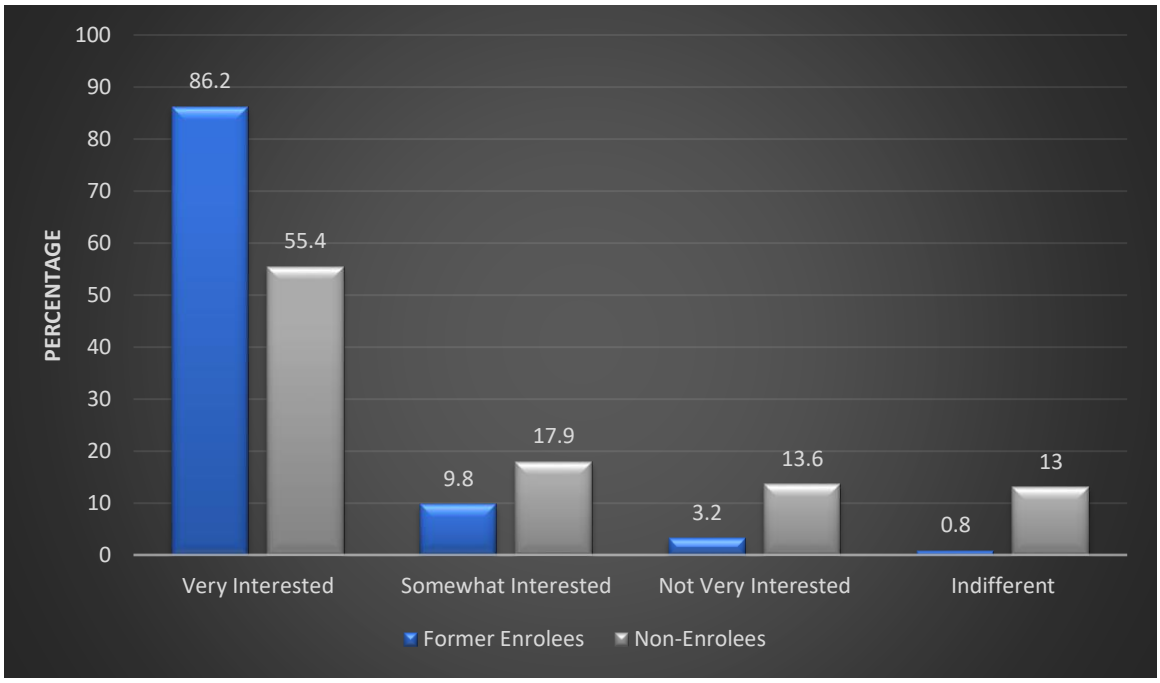
Source: Fieldwork 2019

The result in Table 6.4 above shows a comparison of each of the means of knowing about the CBHI programme against the Reference Category (Others – those who knew about the CBHI programme through other means) for the enrollees and non-enrollees. The first set of coefficients indicates that only education (b = 0.375; 0.047) and occupation (b = -.505; 0.001) among the non-enrollees were significant predictors though occupation had inverse relationship. Also, the second set of coefficients indicates that only age (b = -.108; 0.029) among the former enrollees was a significant predictor. However, the third set of coefficients reveals that only occupation was not a significant predictor among the former enrollees but found as a significant predictor among the non-enrollees.

6.3.2 Interest and Trust in the CBHI Programme at Inception

The introduction of the CBHI programme attracted most of the community members because it came with an opportunity of access to healthcare. Some people saw it as an opportunity while some other people felt the package was too good to be real. As noted earlier in Chapter 2, trust is one of the challenges of enrolment in CBHI programmes. This study also found that some people were sceptical about the efficacy of the programme. Therefore, some community members decided to wait while others enrolled to ascertain the genuineness of the claims regarding the benefits of the programme.

Figure 6.1: Interest in the CBHI Programme among Respondents



Source: Fieldwork 2019

Figure 6.1 shows that most of the respondents were interested in the CBHI programme. This indicates that the community members were delighted with the claims (during awareness programmes) that the programme would provide financial protection and improve their healthcare status. The qualitative findings of the study affirmed the results. All the interviewees (community leaders and community members) in the communities were delighted with the introduction of the programme. A community member gave a similitude of how happy she was, as thus:

> Odabi eni tolosinu orun ni, ti orun tipaa toti feeku; towade tangbe Maltina tutu fun komu.
>
> It was like someone who had been under the sun and about to die due to the hotness of the sun; and was given a very cold drink to take (IDI, Female, Odo Owa, 17/06/2019).

Some other participants noted that:

> Inumi dun nigbati wongbe eto na wa nitori wipe opolopo nikoni alafia ti won'o delowo lati fi toju arawon.
>
> I was very delighted with the introduction of the CBHI programme because many people were not healthy and had no money access care (IDI, Male, 15/06/2019, Edidi).

Another community member stated that:

> Nigbati won gbe eto naa wa, inuwa dun wipe won ma toju wa.
>
> We were happy when the programme was introduced, hoping to receive quality healthcare (IDI, Female, 12/06/2019, Idofian).

A community leader noted that:

> Nigbati agbo nipa eto naa, inuwa dunsi. Awon osise won niwon wasi aafin obawa nibi, won salaye. Kabiyesi si salaye fun gbogbo awa oloye, awan salaye fun awon eyan.
>
> We were delighted when we heard about the programme. The organisers came to this palace to inform the King, he informed us [the chiefs], and we also informed the community members about the programme (KII, Community Leader, 17/06/2019, Odo-Owa).

However, regardless of the level of interest, some people were still very reluctant to accept the programme. A participant explained that:

> Hygeia wa *very interesting* toripe opolopo eyan mi tiokin losi *hospital*, igbayen ni won ni *access; mean* 'pe ofe ni. Orisi nkan tikoda ni awon eyan nso nigbayen *until* ti awon kan sope eje ka *try* rewo.
>
> The programme was very interesting because most people that were not receiving hospital care had access to care because it was free. People were insinuating all sorts of negativities about it at inception until when some people decided to give it a try (IDI, Female, 21/06/2019, Osi).

Another participant noted that:

> The programme was superb and interesting. Initially, we did not trust the programme, but gradually we started to find it interesting when we were hearing about what was happening in the hospital (IDI, Male, 19/06/2019, Bacita).

A participant also commented that:

> Igbati won koko *introduce programme* yen siwa, tikotii bere, arope *fake* ni *because* iye
>
> When the programme was introduced then, before it commenced, we felt it was

tiwon ni kamaa san nigba yen okere si itoju tiwon ni amaari.	fake because the premium was low compared to the benefits package that was promised (IDI, Male, 20/06/2019, Bode Saadu).

The finding of this study that some community members were sceptical about the efficiency of the programme is confirmed by the outcome of a systematic review conducted by Adebayo *et al.* (2015:1) which found "lack of trust as one of the main reasons for low coverage of CBHI in the LMICs". As shown in Table 6.5 below, the study found no statistically significant association between gender and interest in the CBHI programme among the former enrollees (χ^2 = .762, p-value = 0.858) but found a statistically significant association between gender and interest in the CBHI programme among the non-enrolled respondents (χ^2 = 8.244, p-value = 0.041). This shows that the interest in the programme among the former enrollees was beyond gender considerations. This is confirmed by Figure 6.1, showing that interest was higher among the former enrollees compared to the non-enrollees.

The high level of interest in the programme is in tune with the study conducted by Haile *et al.* (2014:6) in Southwest Ethiopia where 77.8% of the respondents were interested in enrolling in CBHI programme. In the same vein, Kibret *et al.* (2019:1) found that 81.5% of respondents were interested in enrolling in the CBHI programme in Northwest Ethiopia. The association between gender and interest in the programme among the non-enrolled respondents suggests that certain factors influenced their interest in the programme. For instance, this might include considerations of affordability and thoughts of who (in terms of gender) was mostly in need of healthcare coverage in the household.

The study also found no statistically significant association between age and interest in the programme for both the former enrollees (χ^2 = 26.184, p-value = 0.344) and the non-enrollees (χ^2 = 33.160, p-value = 0.101). This indicates that most of the respondents did not give consideration to age regarding their interest in the programme. Often, the aged and children appear more vulnerable, however, no one is immune to illness. More so, the healthcare programme was accessible to all upon enrolment and regardless of age group. The finding is against the outcome of a recent study by Garedew *et al.* (2020:45) in Ethiopia which found an association between age and interest in CBHI programme.

Further, the study found no statistically significant relationship between education and interest in the CBHI programme among the formerly-enrolled (χ^2 = 14.793, p-value = 0.253) and non-enrolled (χ^2 = 15.917, p-value = 0.195) respondents. This shows that the respondents understood the importance of access to healthcare regardless of their educational status and that creation of awareness about the programme was done among the people using their local languages for better understanding. However, this is not in tune with the findings of studies conducted in Nepal (Ko *et al.,* 2018:58), North Central Nigeria (Banwat *et al.,* 2012:57) and Southeast Nigeria (Azuogu & Eze, 2018:3) that found association between education and interest in CBHI.

In addition, the study found a statistically significant relationship between occupation and interest in the programme among the former enrollees (χ^2 = 23.813, p-value = 0.022) and the non-enrollees (χ^2 = 22.335, p-value = 0.034). This might be related to the risks involved in some occupations. For instance, hernia was common among the farmers in the rural communities (Female FGD, 30/05/2019, Bacita; KII, HCP, 20/06/2019, Bode Saadu). Similarly, Ahmed *et al.* (2016:1) found an association between occupation and willingness to enrol in a CBHI programme in Bangladesh.

Furthermore, it found a statistically significant association between income and interest in the CBHI programme among the formerly-enrolled (χ^2 = 48.175, p-value = 0.001) and the non-enrolled (χ^2 = 28.289, p-value = 0.020) respondents. This may be related to the financial capacity of the respondents. Table 6.1 (above) shows that most of the respondents earned ₦12,000 (33.1 USD) or below and the majority were traders who may not have consistent or guaranteed income but desired healthcare coverage against catastrophic OOP. Likewise, previous studies by Gobir *et al.* (2016:8) and Bamidele and Adebimpe (2013:1) found an association between income and interest in CBHI programme in North-Western Nigeria and South-Western Nigeria, respectively.

The study also found a statistically significant association between source of knowledge about the programme and interest in the CBHI programme among the former enrollees (χ^2 = 18.232, p-value = 0.033) and the non-enrollees (χ^2 = 57.301, p-value = 0.001). This might be linked to the various strategies and methods adopted in creating awareness for the programme. Table 6.2 reveals that the majority of the people knew about the programme through family and friends and community meetings. Thus, the endorsement of the programme by the community

leaders as well as the bond shared with family and friends may have influenced the interest of the community members in the programme. As explained earlier in Chapter 5, community leaders and religious leaders were involved in the sensitisation efforts for the programme (KII, Community Leader, 11/07/2019, Idofian; KII, Community Leader, 20/06/2019, Bode Saadu). A male community member in Bacita noted that: "The programme was publicised through health talks in the markets, churches, mosques and other parts of the community…" (IDI, Male, 19/06/2019, Bacita). All of these were contributory to the high level of interest in the programme in the communities.

Table 6.5: Chi-Square Test of Association between Selected Variables and Interest in the CBHI Programme

Variables	**Former Enrollees (p-value)***	**Non-Enrollees (p-value)***
Gender	.858	.041
Age	.344	.101
Education	.253	.195
Occupation	.022	.034
Income	.001	.020
Knowledge about CBHI	.033	.001
Note: 5% significance level *Two-tailed test		

Source: Fieldwork 2019

Further, Table 6.6 below on multinomial regression logistic shows a comparison of each level of interest in the CBHI programme against the Reference Category (Indifferent) for the enrollees and non-enrollees. The first set of coefficients indicates that only income (b = .912; .044) among the former enrollees was a significant predictor of association. Similarly, the second set of coefficients indicates that income among the former enrollees (b = .988;.031) and non-enrollees (b = -.411; .003) were significant predictors. However, the relationship was inverse for the non-enrollees. The third set of coefficients reveals no significant predictors for the non-enrollees but indicates for age (b = .216; .044) and knowledge about the CBHI programme (b = -.746; .010) for the non-enrollees.

Table 6.6: Multinomial Logistic Regression on Interest in the CBHI Programme

Variable	Former Enrollees				Non-Enrollees			
	Coefficient	**Wald ratio**	**P-value**	**Odds ratio**	**Coefficient**	**Wald ratio**	**P-value**	**Odds ratio**
Very Interested Intercept	4.865	1.949	.163		4.774	12.650	.000	
Gender	.182	.029	.864	1.200	-.130	.102	.750	.878
Education	.424	.632	.427	1.528	-.069	.128	.721	.934
Age	.005	.000	.984	1.005	.057	.394	.530	1.059
Occupation	-.434	1.129	.288	.648	.024	.025	.874	1.024
Income	.912	4.072	.044	2.490	-.123	.931	.335	.884
Knowledge about the CBHI	-.938	1.981	.159	.391	-.896	13.895	.000	.408
Somewhat Interested Intercept	3.215	.814	.367		1.691	1.316	.251	
Gender	.113	.011	.917	1.120	.502	1.192	.275	1.652
Education	.189	.120	.729	1.208	.408	3.477	.062	1.504
Age	.077	.117	.733	1.080	.139	1.901	.168	1.149
Occupation	-.486	1.335	.248	.615	-.121	.475	.491	.886
Income	.988	4.669	.031	2.687	-.411	8.608	.003	.663
Knowledge about the CBHI	-1.069	2.460	.117	.343	-.508	3.674	.055	.602
Not very Interested Intercept	4.545	1.532	.216		1.542	.905	.342	
Gender	.109	.009	.923	1.115	.391	.610	.435	1.478
Education	.256	.205	.651	1.291	.015	.004	.950	1.015
Age	-.202	.714	.398	.817	.216	4.068	.044	1.241
Occupation	-.527	1.478	.224	.590	.116	.375	.540	1.123
Income	.731	2.466	.116	2.077	-.259	2.980	.084	.772
Knowledge about the CBHI	-1.132	2.565	.109	.322	-.746	6.592	.010	.474
Note: 5% significance level Reference Category: Indifferent								

Source: Fieldwork 2019

6.4 Enrolment in the CBHI Programme

Generally, decisions to enrol or otherwise are often premised on specific reasons. Participants in the study identified various reasons that informed their enrolment and non-enrolment in the CBHI programme. The reasons among the former enrollees are detailed in Table 6.7 below.

Table 6.7: Reasons for Enrolment among the Formerly-enrolled Respondents

Reason	Frequency (N = 1,043)	Percentage
Illness	195	18.6
Affordability	169	16
Benefits package	501	48
Testimony of others	161	15
Maternal Care	1	0.9
Others	16	1.5

Source: Fieldwork 2019

Table 6.7 shows that most (48%) of the respondents enrolled because of the benefits package offered by the programme. This implies that the respondents understood the importance of utilising modern healthcare services and the need for financial protection. The results were substantiated by the qualitative findings showing that almost half (10 of 22) of the participants in the IDIs were prompted to enrol by the benefits package. Other participants identified affordability of enrolment premium, maternal care, access to quality healthcare etc. A community leader noted that:

> Most of the community members were prompted to enrol based on the benefits (KII, Community Leader, 11/07/2019, Idofian).

Some community members disclosed that:

> Nkan to *prompt* mi lati *register* ni'pe won sofunwa 'pe leyin ₦500 tiaba ti san nigbayen fun *enrolment*, 'pe odun kan gbako laafi je anfani eto ilera ofe laisan kobo.
>
> What prompted me to enrol was that we were told at that time that after paying an enrolment premium of ₦500, we would benefit free access to healthcare for a whole year without paying a dime (IDI, Female, 26/06/2019, Oro).
>
> Mo wa ninu oyun nigbayen.
>
> I was pregnant at that time (IDI, Female, 13/06/2019, Erinle).
>
> Mogba *kaadi* nipa 'pe itoju to peye ni won ose fun awon eyan.
>
> I was prompted to enrol with the believe that good quality of care would be provided for the enrollees under the

programme (IDI, Male,15/06/2019, Edidi).

Another community member explained in detail that:

> I was prompted to enrol in the programme because I saw people who benefitted and confirmed that it was real. There were many healthcare challenges in this community that required treatments. I then decided to enrol my entire household, and my wife was within reproductive age. However, I would not have enrolled if I was not prone to sickness (IDI, Male, 19/06/2019, Bacita).

From the findings, the main prompts for enrolment among the respondents/participants were the benefits package and illness. Similarly, Kotoh *et al.* (2018:443) reported that "health benefits are enablers of enrolment in the Ghanaian health insurance programme". Also, Mahmood *et al.* (2018:8) found that "individuals with chronic disease were likely to enrol in a CBHI programme in rural Bangladesh". However, those who did not enrol in the CBHI programme have their reasons as follows:

Table 6.8: Reasons for Non-Enrolment among the Non-Enrolled Respondents

Reasons for Non-Enrolment	**Frequency (N = 511)**	**Percentage**
Financial Constraint	98	19.2
Enrolled in another health insurance scheme	25	4.9
Lack of trust	52	10.2
Lack of interest	135	26.4
Not fully around in the community	145	28.3
Late Awareness	23	4.5
No belief in hospital care	5	1
Spiritual healing	1	0.2
Always healthy	8	1.6
Misinformation that it is meant for the aged	4	0.8
Negative feedback from former enrollees	2	0.4
Distance to a healthcare facility	1	0.2
Others	12	2.3

Source: Fieldwork 2019

Table 6.8 reveals that even with the awareness programmes carried out in the communities, some people did not have confidence in the programme. Thus, apart from a common challenge of affordability of enrolment premium, other reasons were accountable for non-enrolment in the CBHI programme among the respondents. Findings from the qualitative data corroborate this result. Out of the twenty-nine participants that reacted to the question during the FGDs conducted, twelve noted that they were not around in the community when the programme was active; six claimed that they were not aware of the programme and three participants each identified lack of interest and non-satisfactory conduct by the HCPs as their reasons for non-enrolment. One of the non-enrolled participants in an FGDs explained that:

> Though, I did not register but had the intention to register. However, after a while, they started removing some services from the coverage of the programme. With this, some people became discouraged and did not enrol (Male FGD, 30/05/2019, Bacita).

Other participants stated their reasons that:

Mi o gba *kaadi* nitori 'pe miosi ni'lu n'igba na.	I did not enrol because I was not living in this community when it was operational (Female FGD, 31/05/2019, Aboto-Oja).
Mi o darapo mo eto na nitori wipe mio gbo nipa re.	I did not join because I was not aware of the programme (Male FGD, 27/05/2019, Osi)
Mi o darapo mo eto na nitori wipe eto itoju won ko t'emi lorun.	I did not enrol because I was not satisfied with the services rendered (Male FGD, 29/05/2019, Idofian).

While stated by some respondents through the questionnaire, none of the participants in the FGDs and IDIs gave financial constraint as the reason for non-enrolment as indicated by the quantitative data. If it was part of the reasons for non-enrolment of any of them, perhaps, they were not comfortable to state it. For instance, one community member in Bacita noted that:

Mio darapomo eto na lati ara ailakasi abi airaye nitori moni awon eyan legbemi ti won darapo mo.	I did not enrol due to my nonchalant attitude or busy schedule because I have

close associates who were enrolled (Female FGD, 30/05/2019, Bacita).

The decision to enrol and not to enrol in CBHI programmes are many and vary from one situation to another. However, in this study, the main reasons were: not fully resident in the community during the period, lack of interest and financial constraint. This partly aligns with the finding of AIGHD (2015:55) on the same programme indicating that non-enrolment, late renewal of enrolment and decision to enrol selected members of households are linked to financial constraints. Also, the finding on lack of trust and interest in the programme aligns with the finding of the study by Adewole *et al.* (2015:650) in South-West Nigeria where "most of the respondents were sceptical with the involvement of government in the provision and management of health insurance programme".

Table 6.9: Chi-Square Test of Association between Selected Variables and Enrolment Decision

Variables	**Former Enrollees (p-value)***	**Non-Enrollees (p-value)***
Gender	.990	.222
Age	.001	.424
Religion	.636	.016
Note: 5% significance level *Two-tailed test		

Source: Fieldwork 2019

Table 6.5 focuses on the interest of the respondents in the programme. Table 6.9 therefore sheds light on the actual decision to enrol or otherwise among the respondents. As shown in the Table, the study found no statistically significant association between gender and enrolment decision among the former enrollees (χ^2 = .260, p-value = 0.992) and the non-enrollees (χ^2 = 8.227, p-value = 0.222). This suggests that the decisions to enrol or otherwise were taken without gender considerations. Previous study by Parmar *et al.* (2014:76) in Burkina Faso also found no association between gender and enrolment in CBHI programme. However, Dror *et al.* (2016) found that gender and age were related to CBHI enrolment in the LMICs.

Further, the study found a statistically significant association between age and enrolment decision among the formerly-enrolled respondents (χ^2 = 75.407, p-value = 0.001). This supports the finding of Adhikari *et al.* (2018:378) that households with persons above 60 years

were likely to enrol in a CBHI programme in Nepal. The study however found no statistically significant association between age and enrolment decision among the non-enrolled respondents (χ^2 = 49.213, p-value = 0.424). This indicates that the decision not to enrol in the programme among the non-enrollees was not determined by age. Similarly, Schoeps *et al.* (2015) found no association between age and enrolment in CBHI in rural Burkina Faso.

Further, the study found no statistically significant relationship between religion and enrolment decision among the former enrollees (χ^2 = 9.774, p-value = 0.636). This may be related to an understanding of the distinction between the roles of modern healthcare and religious belief system. It however found a statistically significant association between religion and enrolment decision among the former enrollees (χ^2 = 33.089, p-value = 0.016). This is confirmed by the submission of a participant in Bacita. She stated that:

Mi o darapomo eto na nitori'pe iyawo *pastor* ni mi, asi ni gbagbo ninu adura. A n gba'dura Olorun si n gbo.	I did not enrol because I am a pastor's wife, and we believe in prayer. We pray, and God has always answered us (Female FGD, 30/05/2019, Bacita).

Further, Table 6.8 shows preference for spiritual healing and lack of belief in hospital care as part of the reasons for non-enrolment in the programme. Similarly, Reshmi *et al.* (2018:312) found an association between religion and CBHI enrolment decision in South India. I will take up further discussion about factors that influenced enrolment in the CBHI programme in the next Chapter (section 7.3).

6.5 Non-Enrollees and Access to Healthcare

The submissions by the respondents and participants above indicate that some community members enrolled in the programme and that there are also others who were not enrolled. Meanwhile, illness is relatively inevitable. Therefore, it is necessary to know how the healthcare needs of the non-enrolled respondents were met, and also how the formerly-enrolled respondents catered for the healthcare needs of their non-enrolled household members during the operational years of the programme. The respondents indicated their means of attaining healthcare needs in Table 6.10 as thus:

Table 6.10: Management of Illnesses of Non-Enrolled Household Members

Management Option	Former Enrollees (N = 812)		Non-Enrollees (N = 495)	
	Frequency	Percentage	Frequency	Percentage
Out-of-pocket payment	526	64.7	298	60.2
Traditional Medicine	80	9.9	55	11.1
Self-medication	121	15	98	19.7
Adequate rest	0	0	1	0.2
Enrolled in the NHIS	0	0	7	1.4
Prayer for healing	0	0	1	0.2
Everyone was enrolled	49	6	0	0
I was the only one around	4	0.5	1	0.2
Always healthy	6	0.7	15	3.0
Others	26	3.2	19	3.8

Source: Fieldwork 2019

From Table 6.10 above, the majority of the formerly-enrolled (64.7%) and non-enrolled (60.2%) respondents managed the healthcare needs of their non-enrolled household members through OOP. As revealed in Table 6.7 earlier, this confirms that most of the respondents knew the importance of mordern healthcare services. The qualitative data corroborate the above finding as the majority (11 out of 19) of the participants in the IDIs confirmed that they catered for non-enrolled household members through OOP. Some community members stated that:

> Awon tio darapo mo eto na ninu ebi mi nlo si *hospital*, asi san'wo.
>
> Non-enrolled members of my family received healthcare at the hospital, and we paid OOP (IDI, Female, 15/06/2019, Edidi).

> Asan'wo ni fun itoju awon tio darapo mo eto na ninu ebi.
>
> We paid OOP for treating the non-enrolled household members (IDI, Female, Odo Owa, 17/06/2019).

Another participant explained that:

> Like half of the non-enrollees in the community still used hospital care, but they paid higher while the other half resorted to the use of herbal care and self-medication (IDI, Male, 19/06/2019, Bacita).

Table 6.11: Chi-Square Test of Association between Selected Variables and Management of Illnesses of Non-Enrolled Household Members

Variables	Former Enrollees (p-value)*	Non-Enrollees (p-value)*
Occupation	.012	.012
Income	.151	.684
Household size	.431	.180
Education	.261	.068
Note: 5% significance level *Two-tailed test		

Source: Fieldwork 2019

According to Table 6.11, the study found a statistically significant relationship between occupation and management of illnesses of non-enrolled household members for both the former enrollees (χ^2 = 31.427, p-value = 0.012) and the non-enrollees (χ^2 = 25.535, p-value = 0.012). This indicates that the occupational experience of the people might have influenced the healthcare option adopted for treating the ailments of non-enrolled household members. For instance, farmers who are familiar with the use of herbs and roots may opt for herbal care instead of visiting the hospital for care. Equally, a systematic review by Arbesman and Mosley (2012) partly found a link between occupation and management of illnesses.

However, the study did not find a statistically significant relationship between income and management of illnesses of non-enrolled household members among the former enrollees (χ^2 = 26.447, p-value = 0.151) and the non-enrollees (χ^2 = 11.930, p-value = 0.684). It also did not find a statistically significant relationship between household size and management of illnesses of non-enrolled household members among the formerly-enrolled (χ^2 = 12.190, p-value = 0.431) and the non-enrolled (χ^2 = 12.624, p-value = 0.180) respondents. These may be related to the importance attributed to the need to provide access to care for the affected household members regardless of income and size of the household. This is affirmed by the submission of a non-enrolled participant that:

Gegebi eniti kodarapo mo eto na, mo man'lo *family doctor* wa, asin'san wo.	As a non-enrolee, I patronised our family doctor and we paid OOP (Female FGD, 28/5/2019, Oro).

Further, the study found no statistically significant relationship between educational status and management of illnesses of non-enrolled household members among the former enrollees (χ^2 = 19.147, p-value = 0.261) and the non-enrollees (χ^2 = 19.934, p-value = 0.068). This suggests that irrespective of the level of education, the respondents had tendencies to attend to the healthcare needs of their non-enrolled household members when necessary.

Apart from improving access to care, protection of community members from payment of OOP was one of the reasons for the introduction of the programme. Meanwhile, the attainment of this goal optimally was affected by the non-enrolment of some members of the communities. Table 6.10 which shows that more than 60% each of the formerly-enrolled and non-enrolled respondents managed the illnesses of non-enrolled household members through OOP payments indicates that illnesses of non-enrolled household members were mainly treated at the hospitals. However, this questions the level of protection which the programme was able to provide for the communities against catastrophic health expenditure. The finding is substantiated by the finding of Cleary *et al.* (2013:42) in South Africa that there was a high rate of borrowing and asset sales to cater to healthcare service costs, especially among the rural dwellers.

This also supports the finding of a study conducted in rural Uganda by Dekker and Wilms (2010:375) where "people had difficulties in paying their health insurance premium and borrowed money or sold assets to pay". Also, they reported that only 37% of enrolled household heads (who should shoulder the responsibility of enrolling other household members) "were able to pay their premiums, and more than half of those enrolled (55%) borrowed money to pay". These support the findings of Dror *et al.* (2016:1) on CBHI in LMICs. Consequently, the high level of OOP reported in this study could be linked to sales of assets or borrowing. However, most of these people resorted to the use of hospital and paid OOP for care when their health conditions have deteriorated badly (KII, HCP,15/06/2019, Bacita; KII, HCP, 27/07/2019, Oro).

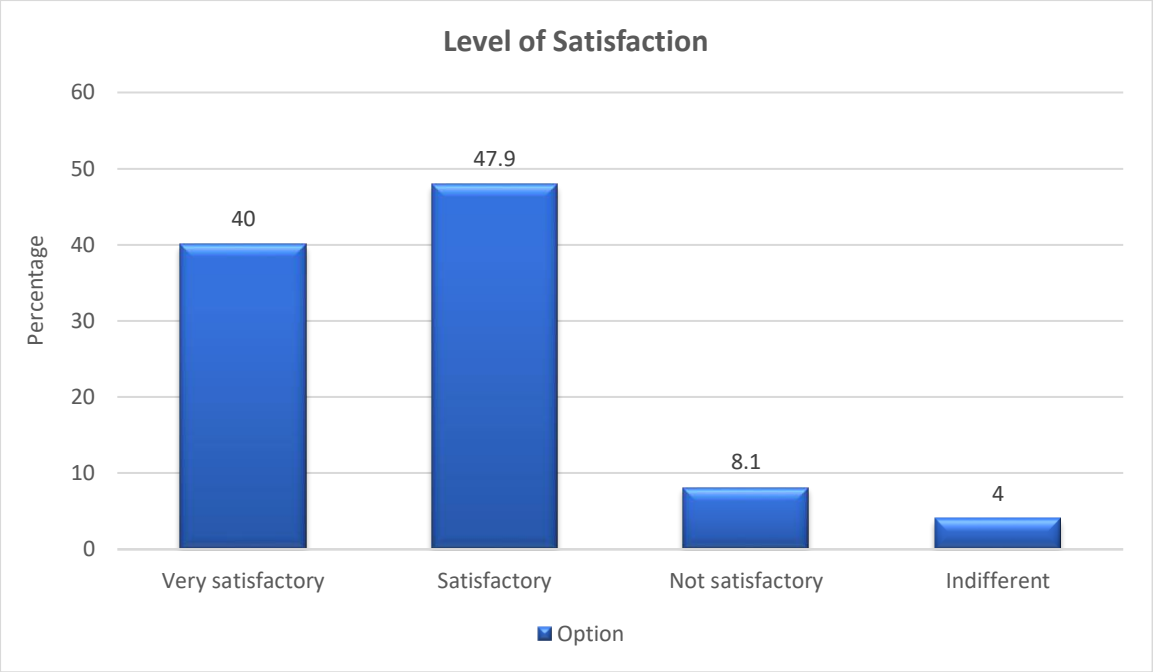
6.6 Delivery of Healthcare Services

Healthcare service delivery includes a range of issues. Essentially, improving healthcare delivery "requires a deliberate focus on the quality of health services, which involves providing effective, safe, people-centred care that is timely, equitable, integrated and efficient" (WHO, 2018b:11). In this section, the perception of community members, particularly, the former enrollees, were examined based on their experience with the programme when it was operational.

6.6.1 Conduct of Healthcare Providers

The conduct of healthcare workers forms part of the judgement about the quality of service rendered by a healthcare facility. This is because poor conduct by healthcare personnel is capable of deterring healthcare utilisation (Kotoh *et al.*, 2018:443). As such, the respondents' assessment of the conduct of the healthcare workers is presented in Figure 6.2 below.

Figure 6.2: Satisfaction with the Conduct of Healthcare Workers



Source: Fieldwork 2019

Figure 6.2 indicates that the majority (87.9%) of the formerly-enrolled respondents found the conduct of the healthcare workers to be very satisfactory and satisfactory. The qualitative data confirms the results because the majority (20 out of 22) of the interviewees stated that the healthcare workers attended to them very well. A participant noted that:

> Awon osise ile iwosan na ni oyaya, won kii foju paware. Bi aba sedesi nasen toju wa.
>
> The healthcare workers related with us [enrollees] cheerfully and with respect. They attended to us on a first-come-first-served basis (IDI, Female, 01/07/2019, Aboto-Oja).

Another participant explained that:

> Awon osise yen 'ofi ise sere rara. Won yoo tun bawa soro lori nti ale maaje taofi ni alafia.
>
> The healthcare workers did not joke with their jobs at all. They even advised us on what to eat to be more healthy (IDI, Male, 21/06/2019, Osi).

However, apart from the participants from Idofian who complained about the preference for non-enrollees as part of their non-satisfaction with the conduct of the healthcare providers, some participants during an FGD in Gure alleged that:

> Ti won ba ti ri'pe eni *kaadi* awon, won o ni tete dayin loun. Koda, ara ogun tiwon kowa ni wonfi ntoju awon eyan.
>
> If they realised that you had the enrolment card, the healthcare workers would not attend to you on time. They even used drugs meant for the programme in treating non-enrollees [who would pay OOP] (Male FGD, 03/06/2019, Gure).

From the preceding, majority of the respondents and participants were satisfied with the conduct of the healthcare workers. This is confirmed by Sarker *et al.* (2018:10) who found in a CBHI study in Bangladesh that enrollees were satisfied with the conduct of the healthcare workers. A study in Ghana by Kodom *et al.* (2019:579) reported that while some of the workers were rude, others were respectful and receptive. However, Olowe (2019:8) found the need to improve the conduct of healthcare workers towards CBHI enrollees in developing countries.

Table 6.12: Chi-Square Test of Association between Selected Variables and Satisfaction with the Conduct of the Healthcare Workers

Variables	**Former Enrollees (p-value)***
Gender	.048
Education	.001
Occupation	.015
Age	.497
Note: 5% significance level *Two-tailed test	

Source: Fieldwork 2019

As presented in Table 6.12, the study found a statistically significant association between gender and satisfaction with the conduct of the healthcare workers (χ^2 = 7.928, p-value = 0.048). This might be as a result of the difference in the healthcare requirements of the male and female enrollees. For example, women within reproductive age (who required ante-natal care) were likely to utilise healthcare services more frequently than their male counterparts within the same age bracket. As such, the level of satisfaction might differ. The study also found a statistically significant association between education and satisfaction with the conduct of the healthcare workers (χ^2 = 55.205, p-value = 0.001) as well as between occupation and satisfaction with the conduct of the healthcare workers (χ^2 = 24.915, p-value = 0.015).

These confirm the findings of Jadoo *et al.* (2012:976) in Turkey that gender, education, occupation and age were significantly associated with level of satisfaction with health insurance. However, this study found no statistically significant association between age and satisfaction with the conduct of the healthcare workers (χ^2 = 23.394, p-value = 0.497). The finding suggests that the attitudinal disposition of the healthcare workers tends to be similar towards all the respondents regardless of age bracket. This result is against the outcome of a study by Badacho *et al.* (2016) which found an association between age and satisfaction with a CBHI scheme in Ethiopia.

Table 6.13: Multinomial Logistic Regression on Satisfaction with the Conduct of the Healthcare Providers

Variable	Coefficient	Wald ratio	P-value	Odds ratio
Satisfactory Intercept	-.996	6.525	.011	
Gender	.430	8.509	.004	1.537
Education	-.012	.036	.849	.988
Age	-.039	1.671	.196	.962
Occupation	.108	3.475	.062	1.114
Very satisfactory Intercept	-1.028	2.266	.132	
Gender	.367	1.947	.163	1.443
Education	-.415	11.330	.001	.660
Age	-.030	.324	.569	.970
Occupation	-.059	.307	.580	.942
Not satisfactory Intercept	-1.723	3.411	.065	
Gender	-.237	.415	.519	.789

Education	-.371	5.329	.021	.690
Age	.016	.049	.825	1.016
Occupation	.135	.977	.323	1.145
Note: 5% significance level Reference Category: Satisfactory				

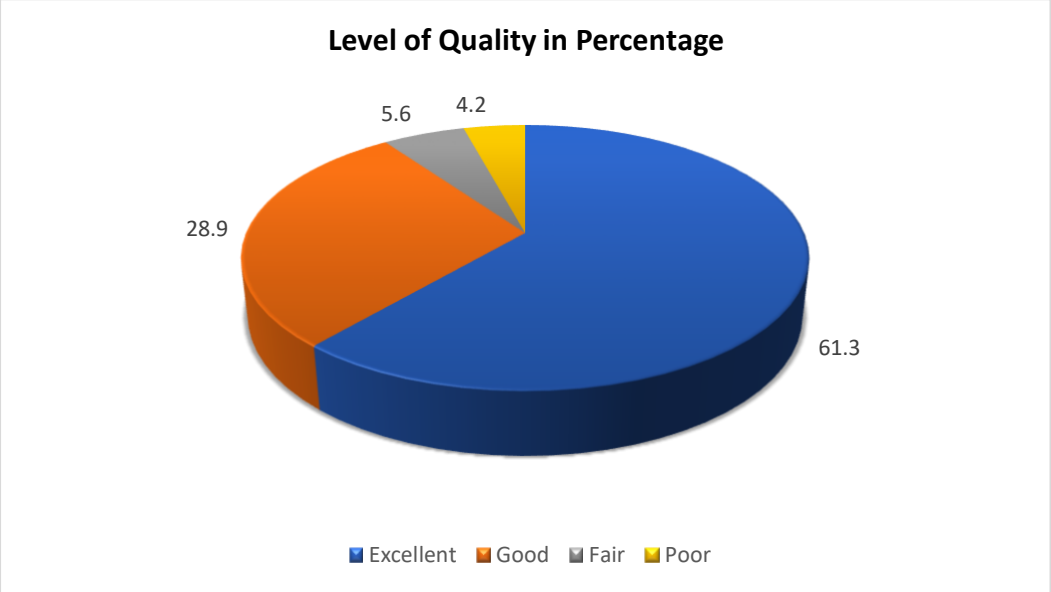
Source: Fieldwork 2019

The result in Table 6.13 shows a comparison of each level of satisfaction with the conduct of the healthcare providers under the CBHI programme against the Reference Category (Satisfactory) for the former enrollees. The first set of coefficients shows gender (b = .430; .004) as the only significant predictor of association. Also, the second and third sets of coefficients indicate education (b = -.415; .001 and b = -.371; .021) as significant predictors though with negative relationships.

6.6.2 Quality of Care

The CBHI programme was a voluntary healthcare service provided in selected rural communities. Mostly, a critical factor in the decision to enrol or renew enrolment was hinged on the perceived quality of service. Consequently, respondents and participants were questioned about the quality of care rendered under the programme.

Figure 6.3: Rating of Quality of Care by the CBHI Programme among Former Enrollees



Source: Fieldwork 2019

Based on Figure 6.3 above, the majority (61.3%) of the respondents believed that the quality of care was excellent and acceptable. The qualitative findings confirm the results that most of the former enrollees received good quality of care. Majority of the community members in the IDIs (20 out of 22) and FGDs (8 out of 12 sessions) noted that the programme rendered good

quality of service. Also, almost all the community leaders (10 out of 11) believed that the programme provided quality healthcare service. One of the former enrollees who enjoyed the programme stated that:

The quality of service was good under the programme (IDI, Male, 03/07/2019, Gure).

Some other participants testified that:

Itoju towa labe eto na gbopan. Emi funrami ni aisan *ulcer*. Gbogbo igba to'ba ti de simi, tinba tide'be, won a *treat* mi. Mo sin man *siiki*, bi iba; igbaa mi, won a *admit* mi. Won a fami simi lara, won a fun mi loogun. Tiaba sisetan, an lo'le lofe. Elekeji, omomi kan wa l'Eko. Eru nbawon lati se *operation* fun. Mowa ni ki won maa gbebo, asinti *register* re nibi. Biwon sede, won se *operation.* Lalafia l'omo lole laisan kobo.	The quality of care under the programme was good. Personally, I am an ulcer patient and each time I got there with the crisis, I was treated. I often fall sick with malaria. I was subjected to hospital admission in some cases and given drips and drugs; and after the full treatment, I would go home without making any payment. Secondly, I have a child who was sick in Lagos State. They were afraid of subjecting her to a surgical operation. I then told them to bring her here, meanwhile, I had enrolled her earlier. When they arrived, she was successfully treated under the programme through the surgical operation without paying a dime (IDI, Female, 19/06/2019, Bacita).
Inu gbogbo ara ilu dun si itoju towa labe eto na.	Community members were happy with the quality of care given under the programme (IDI, Female, 13/06/2019, Erinle).
Itoju to pe'ye ni owa ni abe eto na nitori'pe awon eyan nwa lati Aala ati Opanda lati wagba itoju. Inu awon eyan si dun si itoju na.	The quality of care was good because people came to receive care from as far as Aala and Opanda. People were happy with the healthcare services they received (IDI, Male, 15/06/2019, Edidi).

Also, some laboratory tests were covered by the programme. Therefore, whenever it was necessary, tests were carried out on enrolled patients to have a better understanding of the ailment before treatment. Some community members noted during IDIs and FGD that:

> *Quality of service* ti won *render* nigbayen odaa 'tori kosi eniti olo si *hospital* yen ti won o daa loun. Won o se *test* fun won, won o si fun won loogun.
>
> The quality of service rendered at that time was good because no one went to that hospital who did not receive medical attention. They conducted the test on them [i.e. the enrollees] and gave them drugs (IDI, Female, 20/06/2019, Bode Saadu).

> Gbogbo *test* ti oye kiwon *carry out* ni won se koto di 'pe won ma fun yan ni *treatment*.
>
> They conducted all relevant tests before giving treatment (IDI, Female, 21/06/2019, Osi).

> Nigbayen, elomi wa ti aisan mi wa lara e tiomo. T'oba ti de *Hygeia* tanba ti test e ni aisan yen mayoju, won a de *treat* e.
>
> At that time, there were some people with other ailments but were not aware. It was after they went through tests at the hospital that the ailments were discovered and they were treated (Female FGD, 31/05/2019, Aboto-Oja).

Further, community leaders affirmed that the programme provided a good quality of service. According to some of them:

> Itoju to pe'ye ni won fun awon eyan. Gbogbo aare tiwon gbe losi General Hospital n'Ilorin naani won *treat* nibe, ti awon eyan o fe ranti 'pe General Hospital nbe n'Ilorin gaan ma. Kosi itoju ti won kii toju eyan nibe.
>
> The healthcare services rendered to the enrollees were of quality. All the healthcare cases that were usually taken to the General Hospital at Ilorin were treated at the hospital [under the programme in the community] to the extent that people do not really remember that the General Hospital was still existing. There was no healthcare need that they didn't attend to at that hospital (KII, Community Leader, 01/07/2019, Aboto-Oja).

Itoju t'owa labe eto na pe'ye *to the extent* wipe opolopo eyan 'o lo *hospital* mi' ma ju Health Centre ti won gbesi lo.

The quality of care provided under the programme was efficient to the extent that most people neglected other hospitals in the community, to enrol in the programme at the Health Centre where it was operational (KII, Community Leader, 15/06/2019, Edidi).

Emi gegebi enikan, mogbadun *Hygeia* yen, 'tori iyawomi kan bimo laarin time yen. Mio san ₦1 leyin *kaadi* ti amuwa t'ofi gba itoju. Bi ara awon omo kobade ya, tan ba losibe won o dawon loun.

Personally, I benefitted from the programme because I have a wife who gave birth under the programme. Apart from presenting the enrolment card, I didn't pay a dime for the treatment. My children were also given medical attention whenever they were ill (KII, Community Leader, 03/07/2019, Gure).

Itoju to gbopan daada lowa labe eto na 'tori opolopo eyan pelu orisirisi aisan niwon toju.

The quality of care under the programme was very good because most people with different cases were treated (KII, Community Leader, 17/06/2019, Odo-Owa).

The findings from the respondents indicate that the programme rendered good quality of service. This supports the findings of Brals *et al.* (2017:999), Odusola *et al.* (2015:182) and PharmAccess Group (2016:15) on the quality of service under the programme. However, the experience differs across the communities. For instance, the experience in Idofian signifies a marked difference from most of the other communities. The community members relatively did not enjoy the programme and rated the quality of service under the programme as poor. A community member in Idofian remarked that:

Eto *Hygeia* nilu yi, kose daada to. Agba *kaadi* ni ₦500, igbati abama de *hospital*, won ko funwa loogun. Won ni kasanwo ni. Awa sije koyen won wipe kiniyi kiise alejo wa, won se ni Edu Local

The CBHI programme in this community was not good enough. We enrolled with ₦500. Whenever we got to the hospital, we were not given drugs but requested to pay OOP. We however told them that the programme was not new to us because it was also operating in Bacita, Edu Local

Government, t'oje ilu Bacita, ti won *treat* eyan lofe.	Government Area where enrollees were given free treatments (IDI, Male, 12/06/2019, Idofian).

He added that:

Awon eyan nlo'be lairi itoju gba. Eminaa lo, won o fun mi ni itoju. Molowo *B.P.* mi nijoyen ni. Won wo tan, won ni owoda. Mo ni *Hygeia* ni. Won ni *Hygeia* kini; won ni se awon loun r'ogun fawon ni. Igbati mowa kin funwon, *at the end of the day,* won sa fun mi ni *paracetamol* ₦5. Emeta ni molo'be.	Enrollees were visiting the accredited hospital without getting treated. I also went there and I was not treated. I went to check my BP (Blood Pressure) on that day. After the check-up, they requested me to pay, and I said I was a CBHI enrollee. I was told which CBHI; are they [the Programme Managers] the ones buying them drugs. I expressed my anger towards them, and at the end of the day, I was given paracetamol worth ₦5. I went there thrice (IDI, Male, 12/06/2019, Idofian).

Other enrolled community members disclosed that:

Nigbati itoju tiwon fun mi ose, emi o dohun mo.	Since the quality of care given to me was inefficient, I stopped going to the hospital for for treatment (IDI, Female, 12/06/2019, Idofian).
Molo lakoko, gbogbo ibitin dun mi ni mo salaye fun won, *paracetamol* ni won ko fun mi; otun d'elekeji na, *paracetamol* naani; igbati od'eleekeeta, *paracetamol* naani, moni otogee bahun.	On my first visit, I explained all my health challenges, and I was given paracetamol; on my second visit, I was still given paracetamol; on my third visit, I was further given paracetamol, and I said enough is enough [i.e. decided not to go again] (Female FGD, 29/05/2019, Idofian).

The above submissions revealed the odd side about the quality of care given to enrollees under the programme. While there might be a pocket of cases in other communities, the gross dissatisfaction expressed by enrollees in Idofian is unwholesome. Adebayo *et al.* (2015:11)

found that "poor quality of service could manifest in terms of non-availability of drugs and other medical supplies, the attitude of healthcare workers, waiting period and efficiency of treatment". The perceived poor quality of care reported was the reason for non-enrolment of some (4 out of 5 non-enrolled participants in the male FGD session) community members in Idofian. A participant lamented during a session that:

> Igbati molo, o tie re mi die ni, mo complain gbogbo oun t'on semi lara. Won fun mi ni *paracetamol* ati *flagyl*. Won ni ki n pada wa nijo keji sugbon mi o lo. *Although*, maa mi ni *luck*, won gba'bere, nitori 'pe iyawo omo won kan wa nibe.
>
> When I went there during a brief illness; after my complaint, I was given paracetamol and flagyl. I was told to come back the following day, but I did not go. Although, my mother was lucky to be treated with an injection because one of the staff was like her daughter-in-law to her (Female FGD, 29/05/2019, Idofian).

Table 6.14: Chi-Square Test of Association between Selected Variables and Perceived Quality of Care

Variables	**Former Enrollees (p-value)***
Gender	.820
Education	.001
Occupation	.001
Age	.426
Note: 5% significance level *Two-tailed test	

Source: Fieldwork 2019

As indicated in Table 6.14, the study did not find a statistically significant association between gender and perceived quality of care (χ^2 = .921, p-value = 0.820) among the respondents. Meanwhile, in a cross-sectional study, Teunissen *et al.* (2016) found a relationship between gender and percieved quality of care during hospital stay. The study also found a statistically significant association between educational status and perceived quality of care (χ^2 = 88.089, p-value = 0.001). This suggests that the level of education of the respondents influenced how they rated the quality of care received under the programme. In other words, those with high level of education (and having knowledge of healthcare standards) tend to rate the quality of care to be low if it appears to be inadequate.

It further found an association between occupation and perceived quality of care (χ^2 = 41.094, p-value = 0.001) among the respondents. This upholds the finding presented in Table 6.12 showing that satisfaction with the conduct of the healthcare workers is associated with education and occupation. Further, the study found no statistically significant relationship between age and perceived quality of care (χ^2 = 24.629, p-value = 0.426). This also affirms the finding in Table 6.12 which shows a lack of association between age and satisfaction with the conduct of the healthcare workers. It indicates that the quality of care received by the former enrollees were similar across all age categories.

The experience of the former enrollees in Idofian, however, challenged the effectiveness of the monitoring and evaluation (M&E) exercise carried out while the programme was operational. Though the experience is unique and peculiar, an effective M&E in the community might have allowed the community members to benefit from the programme. From the above narratives, it is clear that the majority of the former enrollees across most of the communities received good quality of care under the programme while a majority of the people that enrolled in one particular community (Idofian) did not receive a good quality of care under the CBHI programme.

Table 6.15: Multinomial Logistic Regression on Perceived Quality of Care

Variable	Coefficient	Wald ratio	P-value	Odds ratio
Good Intercept	-.333	.667	.414	
Gender	.041	.071	.790	1.042
Education	-.078	1.367	.242	.925
Age	-.023	.507	.476	.978
Occupation	-.057	.906	.341	.944
Fair Intercept	-2.300	8.158	.004	
Gender	-.050	.027	.870	.952
Education	-.154	1.429	.232	.857
Age	.061	1.006	.316	1.063
Occupation	.037	.098	.754	1.038
Poor Intercept	.253	.079	.779	
Gender	.119	.112	.738	1.127
Education	-.872	16.602	.001	.418
Age	-.003	.002	.965	.997
Occupation	-.491	6.860	.009	.612
Note: 5% significance level Reference Category: Excellent				

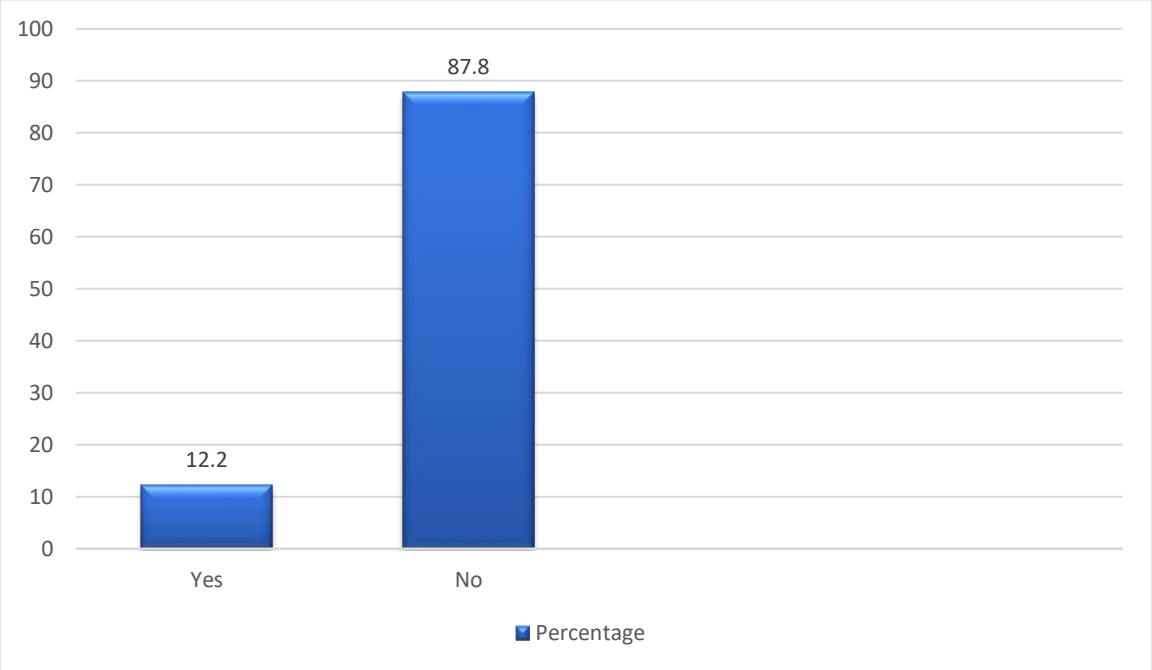
Source: Fieldwork 2019

The result in Table 6.15 above shows a comparison of each level of perception about the quality of care delivered under the CBHI programme against the Reference Category (Excellent) among the former enrollees. The first and second sets of coefficients show no significant predictor. However, the last set of coefficients indicates education (b = -.872; .001) and occupation (b = -.491; .009) as significant predictors though with inverse relationships.

6.6.3 Combination of Alternative Care with CBHI Care

The act of combining orthodox and alternative treatments for healthcare is a common phenomenon across Africa and particularly in Nigeria. Perhaps, due to the belief that some ailments are better treated using alternative medicine (Robyn *et al.*, 2012:162). The formerly-enrolled respondents were asked if they combined alternative healthcare with the care accessed under the CBHI programme, and their responses are presented as thus:

Figure 6.4: Combining Alternative Care with CBHI Care



Source: Fieldwork 2019

According to Figure 6.4 above, only 125 (12.2%) combined alternative/traditional care with the CBHI care while 901 (87.8%) did not combine the CBHI care with other forms of treatment. Thus, the CBHI programme was able to cater to the healthcare needs of the enrollees. The qualitative data from the study supported the results. Participants noted that the combination of alternative and CBHI care was uncommon; since they would not be paying OOP, it was

easier for them to access care on time before the illness became worse. Excerpts from the interviews and FGDs are as follows:

> I don't think enrollees combined hospital care with traditional care. Personally, I did not do that (IDI, Male, 19/06/2019, Bacita).

Mio pa agbo 'pomo itoju *hospital* nitori 'pe mo ni anfani ati losi *hospital* laini sanwo, ki aare to wo ara.	I did not combine herbal care with hospital care [received under the programme] because I had the opportunity to go to the hospital for healthcare at the early stage of illness before it becomes serious, without paying OOP (Female FGD, 28/05/2019, Oro).
Awon eyan kii pa itoju *hospital* papo mo ti alagbo nitori itoju ofe. Ti eyan ba gbatoju loni, ti ara 'otii se daada, won otun toju eyan naani. Kojeki eyan maa lo ile alagbo laarin igbana.	Most community members did not combine hospital and herbal care because the hospital was always ready to treat enrollees until they fully recover. Thus, the use of traditional healthcare was very minimal in the community at that time (IDI, Female, 01/07/2019, Aboto-Oja).
Ki elomi t'oti *enrol* to losi *hospital*, oleti maa lo *herbal healthcare*, ti kobawa *cure* re, yoo wa losi *hospital*. Sugbon ni *family* temi o, *hospital* nikan lalo.	Some enrollees adopted herbal healthcare before going to the hospital and resorted to the hospital if it [herbal care] proved ineffective. However, my family used hospital care only (IDI, Male, 20/06/2019, Bode Saadu).

Table 6.16: Chi-Square Test of Association between Selected Variables and Combination of Alternative Care with CBHI Care

Variables	**Former Enrollees (p-value)***
Gender	.198
Age	.068
Education	.003
Quality of care	.001

Note: 5% significance level *Two-tailed test	

Source: Fieldwork 2019

Table 6.16 shows no statistically significant association between gender and combination of alternative care with CBHI care (χ^2 = 1.657, p-value = 0.198) as well as between age and combination of alternative care with CBHI care (χ^2 = 14.569, p-value = 0.068) among the respondents. These imply that gender and age were not determinants of combining alternative care with CBHI care. In other words, those who combined both cares might have done so because they believed in the efficacy of that approach regardless of their gender and age. However, the study found a statistically significant relationship between educational status and combination of alternative care with CBHI care (χ^2 = 16.237, p-value = 0.003). This implies that those with low level of education might do so due to an inadequate knowledge of the risks involved in combining both kinds of healthcare.

The study also found a statistically significant relationship between perceived quality of care and combination of alternative care with CBHI care (χ^2 = 91.074, p-value = 0.001) among the respondents. That is, enrollees who perceived the CBHI care to be inadequate might have combined it with alternative care. The qualitative data confirms that some of the participants in this study combined alternative care with the formal CBHI care. One of the few that combined alternative care with the CBHI care stated his reason that:

> Itoju t'owa labe eto na 'okun to fun awon to gba *kaadi*. T'obaye kan funyin ni ogun merin, meta abi meji ni won o fun yin. Oun lofaa ti awon eyan fin pa agbo po mo itoju *hospital*.
>
> The quality of care given under the programme was not good enough. If you were supposed to be given medication of four drugs, they would give you three or two. That was what led some people to seek herbal care in addition to hospital care (IDI, Male, 03/07/2019, Gure).

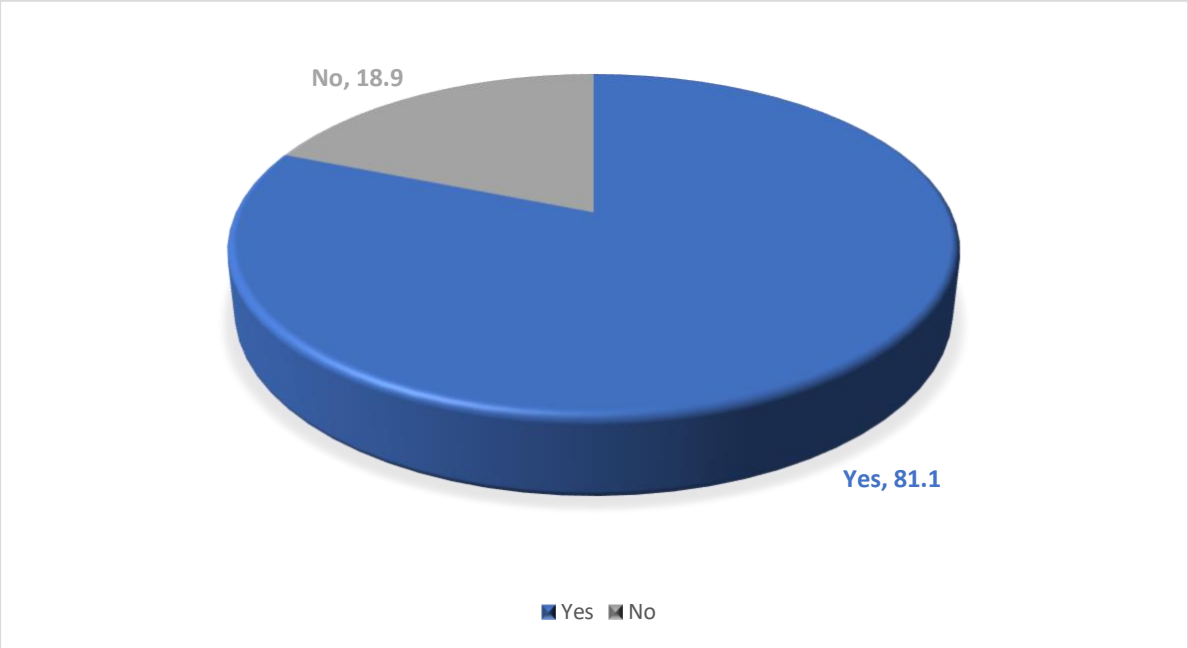
One of the goals of CBHI is to reduce alternative or traditional care adjudged to be mostly unregulated and risky. Thus, the above findings fall in line with the expected gains from a CBHI programme. Relevant examples are found in Burkin Faso. The finding of this study on non-combination of care is confirmed by the study of De Allegri *et al.* (2006:854) in rural Burkina Faso which reported that enrollees had a negative perception about traditional healthcare and viewed it as inadequate. Robyn *et al.* (2012:162) later found that

notwithstanding CBHI enrolment, enrollees in Northwest Burkina Faso continued to seek alternative healthcare through traditional healers. Perhaps, this might be due to the increasing challenges of CBHI sustainability in terms of quality of care and overall efficiency.

6.6.4 Knowledge of Benefits Package

As part of the implementation of a CBHI, adequate insurance education and sensitisation efforts are crucial for the smooth running of the programme. Figure 6.5 below shows that the majority of the respondents received prior information about the benefits package of the programme before enrolment.

Figure 6.5: Knowledge about the CBHI Health Benefits Coverage



Source: Fieldwork 2019

In the same vein, reactions from the majority of the participants in the IDIs (20 out of 22) aligned with the results, but there were divergent responses from the FGDs. Though, primarily, enrollees were to be informed about the coverage before enrolment; however, some of the enrollees got to know about the coverage at the hospital after enrolment. For those who confirmed that they were informed about the health benefits package of the programme before enrolment, the following are some of the excerpts from their interviews:

> Ko to di'pe mo dara po mo eto na, won salaye awon itoju t'opo ti *Hygeia cover*.
>
> Prior to my enrolment, I was informed about the various healthcare services covered by

Amo, won so'pe awon kan nbe ti *Hygeia* 'o *cover* o, kama rope gbogbo e yayan nlo *cover*.	the programme. However, they stated that some ailments were not covered so that we do not think it covered everything (IDI, Male, 01/07/2019, Aboto-Oja).
Won salaye awon itoju t'eto na ko sinu fun wa, ni *hospital*. Awon tiwon fun w ani *kaadi* so'pe o *cover* oloyun, omo ojo si odun marun, oni ifunpa ati *diabetes*.	We were informed at the hospital about the coverage of the programme. We were told by the enrolment officers that it covered maternal care, under-5 children, hypertensive and diabetic patients (IDI, Female, 13/06/2019, Erinle).

Contrastingly, some claimed that they were not informed about the benefits package. For instance, all the formerly-enrolled participants in the Male FGD in Bacita declared that they were not informed and the majority of those that participated during the Male FGD conducted in Idofian noted that they were not informed about the benefits package of the CBHI programme before enrolment. Some of the excerpts are as follows:

> The enrolment officers were not informing potential enrollees about the coverage of the programme before enrolling them (Male FGD, 30/05/2019, Bacita)

Won 'osalaye awon itoju ti eto na kosinu funwa.	We were not informed about the specific healthcare services covered by the programme (Male FGD, 29/05/2019, Idofian)

Incidentally, one of the participants who noted that they were not pre-informed was never disappointed because all his healthcare needs were within the benefit coverage of the programme. He stated that:

Won 'osalaye awon itoju ti eto na kosinu sugbon gbogbo aisan ti mo gbelo ni won toju.	I was not informed about the coverage of the programme, but I was treated for everything I complained about (Male FGD, 27/05/2019, Osi)

Procedurally, each enrollee was supposed to be informed before their enrolment. However, this was not the same. Some of those who confirmed that they were informed however noted the

possibility that other enrollees might not be informed as a result of the medium and method of passing the information. They noted that:

> Won salaye ibiti agbara *Hygeia* mon lati toju awon eyan. Nibi apejo tiwon 'pe ni wonti se alaye na. Eekan na ni won pe ipe na. Awa taa wanibe lalanfaani ati gbo.
>
> We were informed about the limits of healthcare coverage under the programme. This was explained during an awareness programme which was done once. Those of us that were present had the opportunity of knowing about the specific coverage (KII, Community Leader, 21/06/2019, Osi).

> Won salaye awon nkan ti *programme* na *cover* ni *meeting* ti won se ni aafin, sugbon awon kan lema gbo latari aisinibe.
>
> We were informed about the coverage of the programme at the meeting held in the palace, but some might not be informed about the coverage because of their absence (IDI, Male, 15/06/2019, Edidi).

Further, among those who claimed that they were informed, some of them argued that they were misinformed by the enrolment officers/sales agents that enrolment provides access to all kinds of care. One of them stated:

> Awon towa fun wa ni *kaadi* ni gbogbo oun toba tinseyan, kalo soun.
>
> The enrolment officers said that we [enrollees] were eligible to receive any kind of treatment under the programme (IDI, Female, 12/06/2019, Idofian).

The 'misinformation' or inadequate information could serve the purpose of attracting community members into the enrolment of the programme. Notably, in a case where prospective enrollee was deemed to be 'illiterate'; it became difficult to explain the coverage of the programme clearly. Thus, a quick but unethical way of getting them to enrol might be to declare that the programme covered all kinds of healthcare service. This served the interest of the HMO which was in-charge of enrolment and had targets to meet for each period in the communities.

As argued by some formerly-enrolled participants, some HCPs confirmed that the people were not well-informed about the benefits package. One of them noted that: "The health coverage

was not clearly spelt out for the enrollees to know and they continued to demand for what was not covered" (KII, HCP, 27/07/2019, Oro). Also, a participant clarified during an FGD that at the inception of the programme in her community, prospective enrollees were informed about the coverage. They were given pamphlets at the initial stage detailing the coverage of the programme, but this stopped after a while when it was extending to other communities in the State. She stated that:

> Nigbati won koko bere, ni Shonga, ibi ati Lafiagi, won se alaye sugbon nigba t'odi 'pe oun pinka pinka, boya owo 'ati *fund* re nio simo.
>
> When the programme commenced in Shonga, here [Bacita] and Lafiagi, they pre-informed prospective enrollees about the coverage of the programme. Still, when it was expanding across the State, perhaps, due to inadequate funding they stopped informing the people (Female FGD, 30/05/2019, Bacita).

Another participant emphasised that:

> Iwe kan wa nigbanaa ti won funwa, tiwon ko gbogbo ounti *Hygeia cover* si.
>
> In the beginning, they gave us a pamphlet containing all the healthcare services covered by the programme (Female FGD, 30/05/2019, Bacita)

Unfortunately, the downplaying of the importance of information about benefits package in enrolment and utilisation decisions led to a disappointment and disinterest on the part of most enrollees. A community leader confirmed this and remarked that:

> Opolopo eyan 'omo *cases* t'awon le je anfaani e. Tiwon ba debe ti won ni eleyi 'osi ninu *Hygeia*, oun *discourage* elomi. Won 'osalaye awon *cases* ti awon eyan le gbewa.
>
> Most people did not know the healthcare benefits covered by the programme. When they got their and were informed that the needed care was not covered, some became discouraged. They didn't explain the healthcare services accessible under the programme (KII, Community Leader, 20/06/2019, Bode Saadu).

Table 6.17: Chi-Square Test of Association between Selected Variables and Knowledge about the Programme's Benefits Package

Variables	Former Enrollees (p-value)*
Gender	.624
Age	.083
Education	.029
Occupation	.001
Note: 5% significance level *Two-tailed test	

Source: Fieldwork 2019

Table 6.17 reveals that the study found no statistically significant association between gender and knowledge about the benefits package (χ^2 = .241, p-value = 0.624). This implies that both the male and female enrollees had similar levels of knowledge about the benefits package. It also found no statistically significant relationship between age and knowledge about the benefits package (χ^2 = 13.948, p-value = 0.083). However, it found a statistically significant relationship between education and knowledge about the benefits package (χ^2 = 10.760, p-value = 0.029) as well as between occupation and knowledge about the benefits package (χ^2 = 24.834, p-value = 0.001). These suggest that those with high level of education and formal employment had the tendency to ask questions regarding the benefits package if they were given inadequate information.

Notwithstanding the high level of awareness about the programme, knowledge about the benefits package was low. Similarly, Olowe (2019:8) found poor knowledge of CBHI benefits package in developing countries. Ebrahim *et al.* (2019:139) also found poor knowledge about principles and high level of awareness about a CBHI programme in Ethiopia. Likewise, Kuwawenaruwa *et al.* (2019:20) found in Tanzania that "most of the enrollees lacked an understanding of the health insurance benefits package". The benefits package is one of the important determinants of enrolment decision. Most of the former enrollees believed that they were eligible to access all kinds of care under the CBHI, as a result of non or poor education of community members about the coverage of the programme. This might be the reason for the non-renewal of enrolment by some community members. Boston Consulting Group (2015:4) found relatively low renewal of enrolment in the programme. Specifically, the enrolment in

Asa LGA between 2011 and 2013 was relatively stagnant, and half of the enrollees in 2013 were new enrollees (AIGHD, 2015:27). This means that half of the enrollees in 2011 dropped-out of the programme, perhaps due to distrust or disappointment in the programme. Kebede and Geberetsadik (2020) concluded from their study in Ethiopia that proper education and information about benefits package should be given to the people to improve satisfaction in CBHI services.

6.7 Conclusion

The chapter provided an assessment of the programme from the perspective of the beneficiaries. It generally explored the perception of the community members about the programme. From the analysis, members of the communities were interested and delighted with the introduction of the CBHI programme. While the sources of information varied, there was a high level of awareness about the programme in the communities and their environs. Also, most community members were prompted to enrol to have access to healthcare without OOP payments. Those who did not enrol attributed it, mainly, to financial constraint, lack of interest, and not being fully resident in the communities during the period. They, however, paid OOP if they must utilise hospital care.

Furthermore, in terms of service delivery, the majority of the respondents and participants expressed satisfaction with the conduct of the healthcare providers and the quality of care provided. Though there were some cases of dissatisfaction. While most of the enrollees utilised hospital care to attend to their healthcare needs, others combined it with alternative care. Generally, the strength and aggressiveness deployed towards the enrolment process at inception dwindled with time, leading to improper education of prospective enrollees about the healthcare benefits package.

CHAPTER SEVEN

FUNDING MECHANISMS OF THE CBHI PROGRAMME IN KWARA STATE

7.1 Introduction

Funding is an integral part of any programme, most notably, intervention programmes. No matter how well-planned, the success of such a programme is contingent on the availability of fund or effective funding mechanism. This chapter is vital to the study because funding was an important part of the design and implementation of the Kwara CBHI programme. Thus, the first section of the chapter discusses the primary sources of fund committed to the implementation of the programme - counterpart fund by the partners and enrolment premium. Also, the second section examines the affordability of enrolment premium (which was one of the scheme's sources of funding) from the perspectives of the community members and other stakeholders in the implementation of the programme. Further, the third section discusses the capacity of government to provide free healthcare for the citizens. The final section concludes the chapter.

7.2 Financial Sources

The fund used in the implementation of the CBHI programme was generated through three primary sources. They are the financial contributions by the partners (i.e. the Kwara State Government and the international partner, Health Insurance Fund - through PharmAccess Foundation) and enrolment premiums. The funding requirements of the programme related to administrative and marketing expenses to manage the programme as well as facilities' upgrade and technical assistance (Brals, 2019). The funding mechanisms are discussed in this section as thus:

7.2.1 Counterpart Fund by the Partners

The CBHI programme was co-funded by the KWSG and the HIF. At inception, the programme was fully-funded by the international partner as a pilot in a Local Government Area (LGA) and extended to a second LGA after two years. However, like many other transfer programmes, the international partner offered to mainly finance the programme for the first five years of implementation with a view to reducing its financial commitment by 20% per annum in the subsequent years. The ultimate goal was that after at least ten years of implementation, the state government would take full ownership of the programme and continue to run it 'sustainably'.

Based on this arrangement, "the Kwara State Government was to increasingly take up the subsidy that made the initial insurance premium affordable, while the contribution of the Dutch HIF was to diminish gradually over the life span of the programme" (Amsterdam Institute of International Development, 2013:11). A participant noted that: "The initial agreement was that PharmAccess Foundation offered to make a complete payment of premiums for beneficiaries and then the PharmAccess had to withdraw gradually, and Kwara State Government took up the 100% responsibility of the premium payment" (KII, Foreign Agency Official 2, 02/09/2019, Ilorin). Another official gave a more precise insight and captioned it as thus:

> The MoU that was signed between Kwara State Government and the HIF is that since they [i.e. HIF] were paying full subsidy at inception - the first five years, it was fully paid; and there was an MoU that when we see how the scheme is running, the Kwara State Government would gradually take responsibility for subsidy payment for enrollees premiums such that at a point in time, the Kwara State Government would take full responsibility for sustainability because it was just a pilot (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

A government official corroborated the above and described how the funding responsibility was transferred to the state government on a sliding scale. He explained that:

> When the programme started, they [i.e. PAF] decided to fund it a hundred per cent. As the programme progressed, it was scheduled that they would be scaling down their funding by paying 80% and the Kwara State Government to pay 20%; the following year, they would pay 60%, and the Kwara State Government would pay 40% - in that order; until we would be able to own the programme. Such that their own funding would be 0% and Kwara State Government would be at 100% (KII, KWSG Official 1, 20/08/2019, Ilorin).

The agreement signed by the parties were not sacrosanct but reviewed based on necessity. A participant stated that: "There was a signed agreement which was subsequently reviewed based on need and demand. I think the first agreement was 5-year and funding was done 100% by the Dutch government" (KII, HMO Official 1, 26/07/2019, Ilorin). The state government was enticed with the financial relief enjoyed at the commencement of the programme, and the Governor requested that the programme be extended to another LGA in the State. This, therefore, pave the way for the foreign partner to introduce its conditionalities regarding

ownership of the programme, after a period. This is a common trend in transfer programmes **(**Dolowitz & Marsh, 1996, 2000; Stone, 2004; Fawcett & Marsh, 2012; Minkman *et al.*, 2018). Another government official narrated that:

> In 2009, the then Governor, Bukola Saraki requested an expansion to other LGAs and the PharmAccess Foundation said that if you need that, you must increase your commitment. So, the agreement had to change. You've not been having direct financial contribution; if you want us to do that, you must have a direct financial contribution. That was when the sliding scale agreement came in, such that the programme would be handed over to the Kwara State Government in 5 years (KII, KWSG Official 2, 24/07/2019, Ilorin).

The first "financial commitment by the Kwara State Government was for the period between July 1, 2010, to June 30, 2011" (AIGHD, 2015:11). Though the amount spent by the international partner was not disclosed, the amount spent, as part funding by the state government on the programme within the nine years of operation, was ₦1.1 billion [3.055 million USD] (Ahmed, 2018). A participant noted that the international partner was the main financier of the programme and confirmed that the state government indeed made financial commitments as well. She noted that:

> The funding of the programme was by the donor. Though, the Kwara State Government also tried by paying some of the counterpart funds. I don't know the commitment of the donor, but I know the Kwara State Government paid ₦60 million, ₦50 million, ₦100 million and ₦200 million at different times to the programme (KII, KWSG Official 3, 01/08/2019, Ilorin).

The Kwara State Government gave its counterpart funds to the international partner who would then disburse the fund to the HMO and the CHIS for implementation of the programme accordingly. In most sponsored or collaborative programmes, the partner with financial strength tends to direct the trend of policy design and implementation (Szlezak *et al.*, 2010:1; Koduah *et al.*, 2015:1; Storeng *et al.*, 2019:561). This, therefore, questions the level of control or ownership of the programme by the state government.

7.2.2 Enrolment Premium

The enrolment premium paid by the enrollees was another source of fund for the programme. At inception, the premium was fixed for ₦200 (1.26 USD) per annum per person. After a while, it was increased to ₦300 (1.90 USD), and it covered only 7% of the cost while the 93% balance

was covered by the state government and the HIF (Gustafsson-Wright & Schellekens, 2013). However, the premium was increased to ₦500 (3.13 USD) in 2013, and it was the amount paid to the end of the programme. Though the premium was only enough to print the enrolment card used for accessing care by the enrollees. As a participant puts it: "The ₦500 was a commitment from the beneficiaries. That amount usually served as the fund for printing out the ID cards. The actual premium as at that time was over ₦4,000" (KII, Foreign Agency Official 2, 02/09/2019, Ilorin). Thus, the premium paid by the enrollees was meagre; it was not significant in funding the programme.

7.3 Affordability of Enrolment Premium: Community Members and Other Stakeholders

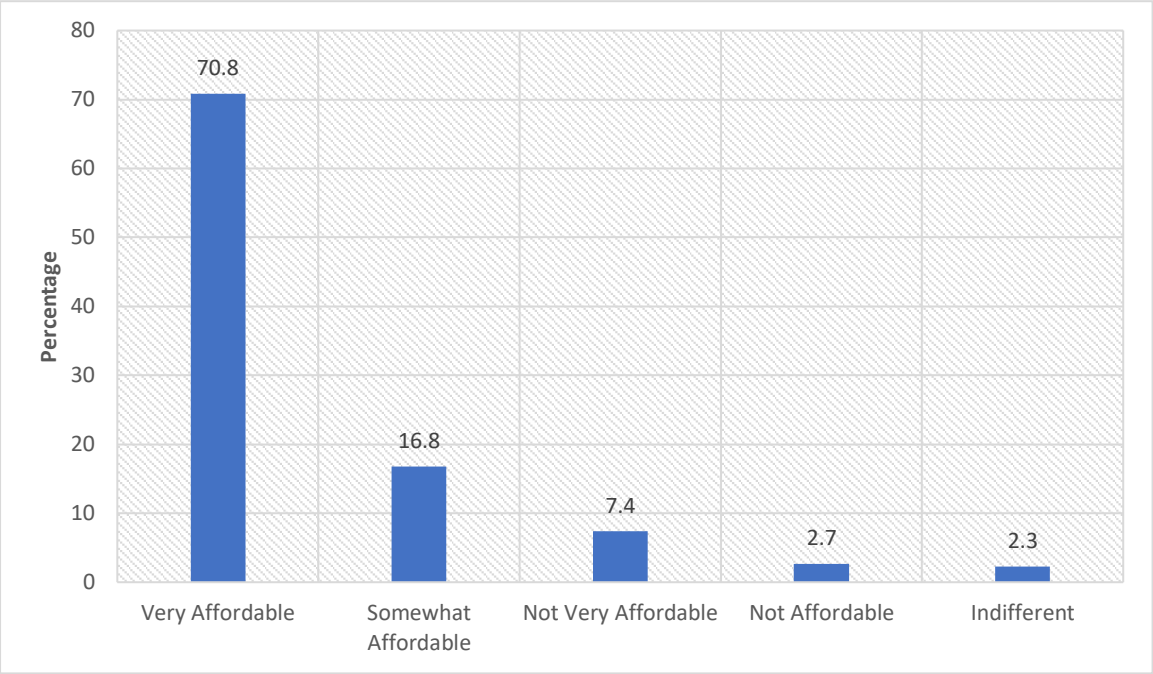
Affordability or ability to pay enrolment premium has always been a major challenge of a health insurance policy. CBHI, which is a smaller form of SHI, designed for rural community dwellers with a relatively lower premium. It was found in section 7.2.2 above, that enrolment premium contributed very little to the funding of the programme, yet, some people still battled the problem of affordability. This a source of concern on whether the enrolment premium can form a significant part of a sustainable funding mechanism for CBHI programme.

There is variation in the views of community members and other stakeholders (government officials, foreign implementing partners, HMO officials, and healthcare providers) involved in the planning and/or implementation of the Kwara CBHI programme regarding the affordability of the premium. Some participants noted the difficulty in paying the enrolment premium; some believed that the premium was significantly subsidised and made very affordable. For clarity, the views of the opposing sides are examined separately in this section.

7.3.1 Affordability of Premium: Community Members Views

Figure 7.1 shows that most (87.6%) of the respondents claimed that the premium at ₦500 per annum was very affordable and somewhat affordable. In the same vein, seven out of the eleven community leaders stated that the enrolment premium of ₦500 was affordable while the remaining four noted that it was not affordable.

Figure 7.1: Percentage Distribution of Affordability of Enrolment Premium



Source: Fieldwork 2019

However, the qualitative data reveals that their claims of affordability are in consideration of the benefits involved. For instance, a community leader stated that:

> Ti eyan ba feran ara re, ₦500 o po ju fun *anybody* lati san. Agbara opolopo eyan loka ₦500. Bi o ba ka, yio l'omo t'agbara re kaa *because* o mo ere tohun o je nibe. K'osan ₦500 *for 12 months*!
>
> If one loves him/herself, ₦500 is not too much for anybody to pay. It was affordable to most people in this community. If he/she cannot afford it, he/she would have a child who could afford to enrol him/her because of the healthcare benefits. To pay ₦500 for 12 months! (KII, Community Leader, 13/06/2019, Erinle).

Another community leader noted that:

> Agabra won ka. eni toba mo anfaani t'owanbe.
>
> The premium of ₦500 was affordable to most community members. Whoever appreciates the benefits of the CBHI programme would pay (KII, Community Leader, 03/07/2019, Gure).

Similarly, some community members shared their views about the affordability of enrolment premium. A female community member observed that:

Ti aba *quantify* owo ti won fi *register* pelu iwosan ti won gba, ₦500 ko je nkankan. O wa *affordable*.

If we compare the enrolment premium with the healthcare benefits, N500 was nothing. The premium was affordable (IDI, Female, 20/06/2019, Bode Saadu).

In contrast, some other participants argued that the premium was not affordable for most people. Participants in all the 12 FGDs conducted in the study concluded that the premium of ₦500 was not affordable for most community members. That is, some could afford but not the majority of the people. During a Focus Group Discussion in Gure, some participants linked inability to pay with poverty and large family size. They revealed that:

We are very poor here. Elomi fe gbaa sugbon agbara re 'okaa. Ati ri ₦500 gaan, onira.

We are very poor here. Some wanted to enrol but could not afford the premium. It was even difficult to earn ₦500 (Male FGD, 03/06/2019, Gure).

Agbara opolopo eyan 'oka latisan *because a family of* 30 masan ₦500 *times* 30, oje ₦15,000. Opolopo ninu wa *are poor farmers*.

Most community members could not afford the enrolment premium because a family of 30 would have to pay ₦500 in 30 places making ₦15,000. Most of us are poor farmers (Male FGD, 03/06/2019, Gure).

A female participant during a Focus Group Discussion in Bacita narrated the consequence of increasing enrolment premium to ₦500 in her community. She disclosed that:

Nigbati won so owo *kaadi* di ₦500, awon eyan bere sini diku die die. Oka awa naa lara 'pe won sodi apo meji abo. Sugbon awaro wipe, ti aba losi *hospital* omi, owo *kaadi* lasan 'wo ₦500, kotodipe won o *treat* eyan. Oun lafin lo.

When the premium was increased to ₦500, some people could neither renew nor enrol in the programme and enrolment in the programme started to reduce steadily. Though we were also not comfortable with the increment to ₦500 but we felt if we leave for another hospital, cost of obtaining a card only at another hospital was up to ₦500 before the cost of treatment. That was why I continued to renew my enrolment (Female FGD, 30/05/2019, Bacita).

Also, female participants in FGD in Aboto-Oja confirmed the difficulty in paying premium.

> Owo *kaadi* ₦500 ko ro'run fun opolopo awon eyan. Elomi ni omo merin si marun, osin ye ko gba *kaadi* fun gbogbo won.
>
> The premium of ₦500 was not affordable for most people in the community. Some people have four to five children, and they needed to enrol all of them (Female FGD, 31/05/2019, Aboto-Oja).

However, in the absence of a better alternative, some participants helplessly expressed readiness to strive and pay ₦500 premium should the programme is restored in their communities. According to them:

> Won ti fi towa lenu wo, an gbe oungbe re. Biwon ba gbewa ni ₦500 nisin, awon eyan ojade.
>
> We have experienced the benefits of the programme, and we are craving to have it back. If it is restored with a premium of ₦500, most people will enrol (Female FGD, 30/05/2019, Bacita).

> T'obaje 'pe ₦500 naani yoo je, kan gbewa, oni kaluku yoo wa.
>
> Even if the programme would require us to pay ₦500 premium, it should be restored. Everyone would source money and enrol (Female FGD, 31/05/2019, Aboto-Oja).

Further, more than half (10 out of 17) of the community members who responded to the question on premium affordability during IDIs asserted that the premium of ₦500 was not affordable to most members of their communities. A community member also explained a reason as thus:

> Agbara elomi 'oka lati san ₦500. Kosise kan taara nileyi ju kalo sa koro *cashew* lo.
>
> Some people could not afford the premium of ₦500. There is no major source of income in this community than to pick cashew nuts and sell (IDI, Male, 12/06/2019, Idofian).

Given the difficulty in paying enrolment premium, communities devised a means of enrolling indigent members through the art of philanthropism or politicians. A community leader noted that:

Anpe *attention* awon t'Oloun bun lati ran awon ti ko rolorun lowo.	We called the attention of the rich ones in the community to assist with the enrolment of those who could not afford to pay (KII, Community Leader, 01/07/2019, Aboto-Oja).

Also, some community members confirmed the non-affordability of the premium and explained how they assisted some few others with enrolment. According to them:

Mo *register* gbogbo idile mi ati awon ti won 'ole san'wo tanwa ni akata mi.	I enrolled everyone in my family, and I also enrolled people who could not afford the premium around me (Female FGD, 30/05/2019, Bacita).
Agbara awon 'mi koka ₦500 tori t'ebawo ilu yi, awon tio sise poju awon ti wonsise. Elomi, boya oko l'onda; kosi to ri nkan oko re, odigba ti nkan oko bata. Ni alafo igbayen, t'oba re, agbara re onika. Awon mi nranyan lowo. Emi gaan *register* eyan to mejo tiwon kii se malebi mi.	The premium of ₦500 was not affordable to some people. If you look at this community, those who are unemployed are more than those with employment. A person might be a farmer; he/she could only earn from it when it is ready for harvest. If he/she falls sick before the period of harvest, he/she would not be able to afford the cost of care. However, some people assisted with the enrolment premium of others. I also assisted in enrolling up to eight people who are not my relatives (IDI, Male, 13/06/2019, Erinle).

I was responsible for my first premium but the second one was paid by Senator Shaaba Lafiagi, a politician (IDI, Male, 02/07/2019, Kaiama).

These indicate that most people found it difficult to pay the enrolment premium based on their earnings. As a result, community members who could not afford the enrolment of their entire households had to enrol selected members. Also, some of the non-enrolled respondents were responsible for the enrolment of some household members who they deemed vulnerable. This is detailed in Table 7.1 below:

Table 7.1: Responsibility for other Persons' Premium among Respondents

Payment of Another Person's Premium	**Former Enrollees (N = 1,006)**		**Non-Enrollees (N = 500)**	
Yes	462	45.9	136	27.2
No	544	54.1	364	72.8
Number of Persons Enrolled by Respondents	**Former Enrollees (N = 359)**		**Non-Enrollees (N = 78)**	
1 – 5	288	80.2	57	73
6 – 10	65	18.1	19	24.4
11 and above	6	1.7	2	2.6

Source: Fieldwork 2019

Table 7.1 shows that less than half (45.9%) of the former enrollees could afford to pay the premium of other persons, mostly household members. Also, only a few (27.2%) of the non-enrollees were able to enrol members of their households while the majority could not afford to enrol themselves and members of their households. These indicate a high level of inability to pay enrolment premium (for others) among the respondents. Furthermore, the Table shows that out of those who 'strived' to enrol other persons, very few (less than 100) were able to enrol more than 5 persons in the programme. This also indicates that even while the programme was active, most people did not have financial protection and were still exposed to catastrophic healthcare spending because non-enrollees were meant to pay OOP for accessing healthcare (see Table 6.10). These support the finding of the WHO (2017) that as of 2010, "808 million people (11.7% of the world's population) incurred catastrophic spending at the 10% threshold" of income or consumption.

Table 7.2: Chi-Square Test of Association of Selected Socio-economic Variables with Affordability of Enrolment Premium and Reasons for Non-Enrolment

Socio-economic Variables	**Former Enrollees (p-value)***	**Non-Enrollees (p-value)***
Income	.001	.674
Education	.001	.696

Household Size	.008	.026
Occupation	.001	.048
Note: 5% significance level *Two-tailed test		

Source: Fieldwork 2019

For the former enrollees, the study found a statistically significant association between income and affordability of enrolment premium (χ^2 = 66.312, p-value = 0.001); education and affordability of enrolment premium (χ^2 = 41.997, p-value =0.001); household size and affordability of enrolment premium (χ^2 = 27.045, p-value = 0.008) and occupation and affordability of enrolment premium (χ^2 = 47.315, p-value = 0.001). Further, for the non-enrollees, it found a statistically significant relationship between household size and non-enrolment (χ^2 = 31.384, p-value = 0.026) as well as between occupation and non-enrolment (χ^2 = 36.619, p-value = 0.048). Meanwhile, there was no statistically significant relationship between income and non-enrolment (χ^2 = 26.025, p-value = 0.674) and also between education and non-enrolment (χ^2 = 20.010, p-value = 0.696) for the non-enrollees.

The study found a statistically significant association between income and affordability of enrolment premium among the enrollees but found no association between income and non-enrolment among the non-enrollees. A review of studies on the LMICs conducted by Umeh & Feeley (2017:304) indicated a direct association between socio-economic status and decision to enrol in CBHI. Also, Atnafu *et al.* (2018:3) and Jude *et al.* (2018:65) found an association between income and affordability of enrolment premium in CBHI studies conducted in Ethiopia and Cameroon respectively. The lack of significant association between income and non-enrolment in this study is confirmed by the results shown in Table 6.8 (see Chapter 6) where only 19.2% of the non-enrolled respondents indicated financial constraints as reasons for non-enrolment. Thus, for this category of respondents, income was not a significant factor for non-enrolment in the programme. Similarly, a recent study conducted by Atafu and Kwon (2018:902) on determinants of enrolment in Northwest Ethiopia did not find a direct association between income and non-enrolment in CBHI.

Moreover, findings from this study (as shown above) indicate that most community members cannot afford up to an annual premium of ₦500 (1.38 USD). Similarly, in Ethiopia, 49% of respondents could not effectively pay the premium, and this excludes the very poor that were

enrolled based on government subsidy (Ethiopian Health Insurance Agency, 2015:x). Also, Umeh & Feeley (2017:304) found that co-payment may discourage the poor from enrolling in CBHI, even if they can afford the premium. Palermo *et al.* (2019) found that premium waiver improved enrolment in health insurance programme in Ghana. Consequently, there is a tendency that some of the non-enrolled respondents would have been enrolled if the financial barrier was removed for them.

More so, the study found a statistically significant association between education and affordability of enrolment premium for the former enrollees but found no statistically significant association between education and non-enrollment among the non-enrolled respondents. In the same vein, Akazili *et al.* (2014:8) found in Ghana that "individuals with high educational attainment and white-collar jobs are likely to enrol in CBHI programme". This is because of the possible financial opportunities attached to them and making affordability easy. In this study, only 225 (14.7%) of the total respondents were civil servants (who were expected to earn steady salaries). In contrast, the income of others could be irregular, and this can affect enrolment decision.

Also, the study found a statistically significant relationship between household size and affordability of enrolment premium among the former enrollees as well as between household size and non-enrollment among the non-enrollees. This shows that there is a tendency that small households would find it affordable to enrol. Further, the association between household size and non-enrolment might be linked to the 'we-feeling' that is common in rural communities. This can necessitate the non-enrolment of an entire household if the household head is not capable of paying for all. According to an HMO official:

> It is difficult for a farmer with a household of 10 people to enrol all, and he may want to enrol some and leave others (KII, HMO official 2, 29/07/2019, Ilorin).

This confirms the finding of Kusi *et al.* (2015:4) in Ghana, where affordability of premium was "a burden on households with low socio-economic status and large household size". More so, Mba *et al.* (2018:271) recently found in a study on Nigeria that large household size increases the vulnerability of households. More recently, Taddesse *et al.* (2020:7) found that "household size was a determinant of enrolment in CBHI in Northwest Ethiopia".

Furthermore, this study found a relationship between occupation and affordability of enrolment premium among the former enrollees and between occupation and non-enrolment among the non-enrollees. The findings regarding occupation and enrolment confirms those by Atinga *et*

al. (2015:316) among urban slum dwellers in Ghana. Essentially, occupation is closely related to enrolment because there are very limited economic opportunities in the rural areas where the programme existed. Only those with better occupation were able to enrol. Similarly, Baloul and Dahlui (2014) found an association between occupation and enrolment in CBHI in Sudan. They also found an 80% chance of enrolment for civil service workers compared to those without employment.

Table 7.3: Multinomial Logistic Regression on Affordability of Enrolment Premium

Variable	Coefficient	Wald ratio	P-value	Odds ratio
Somewhat affordable Intercept	-.368	.537	.464	
Education	-.247	5.677	.017	.781
Occupation	.269	9.621	.002	1.309
Household size	-.031	.040	.842	.970
Income	-.286	18.133	.001	.751
Not very affordable Intercept	-.928	1.722	.189	
Education	-.092	.404	.525	.912
Occupation	.015	.014	.905	1.015
Household size	-.221	.996	.318	.802
Income	-.166	3.071	.080	.847
Not affordable Intercept	-.497	.156	.693	
Education	-.180	.414	.520	.835
Occupation	-.392	1.756	.185	.676
Household size	-.290	.513	.474	.748
Income	-.252	2.204	.138	.777
Indifferent Intercept	-3.610	11.968	.001	
Education	-.144	.482	.487	.866
Occupation	.159	.806	.369	1.172
Household size	.497	2.950	.086	1.644
Income	-.158	1.314	.252	.853
Note: 5% significance level Reference Category: Very affordable				

Source: Fieldwork 2019

The result shown in Table 7.3 above compares each level of affordability of the CBHI enrolment premium against the Reference Category (Very affordable) for the former enrollees. The first set of coefficients shows education (b = -.247; .017), occupation (b = .269 ; .002) and

income (b = -.286 ; .001) as significant predictors, with only occupation having a positive relationship. The second, third and fourth sets of coefficients have no significant predictor.

7.3.2 Affordability of Premium: Position of Other Stakeholders

The stakeholders in this regard, include the officials of government, HMO officials, foreign implementing partners and the healthcare providers. Many of these stakeholders held different beliefs from the community members about the affordability of enrolment premium. Specifically, the Kwara State Government and its international partner introduced a premium, which they believed was affordable to the community members. For instance, the premium of ₦500 was introduced with the belief that it was affordable. However, some participants, among other stakeholders, believed that the claim of non-affordability of the premium was due to misplacement of priority or that most community members gave priority to other things over their healthcare. Most of them argued given the health benefits package offered by the programme, as argued earlier by some community members in support of the ₦500 premium. One of the healthcare providers noted that the programme had at least one negative consequence for the people, that is, it made them dependent with no willingness to take up their 'personal responsibilities on healthcare'. The HCP added that:

> The premium was affordable to most members of the community except for those who did not know the importance of the programme (KII, HCP, 17/06/2019, Odo-Owa)

Another HCP argued that poverty did not deter the affordability of ₦500 premium if healthcare is given priority. She maintained that:

> The premium of ₦500 was not much, based on preference [of the community members on what to spend on]… Sincerely, ₦500 was affordable for health in this community even with the presence of poverty (KII, HCP, 20/06/2019, Bode Saadu).

One of them further explained that:

> The premium was extremely cheap, but most claimed they did not have enough money to enrol, but that was not correct because priority issues were involved. Most of those complaining about the increment of the premium to ₦300 and ₦500 is now ready to pay ₦1,000, and some will gladly pay ₦2,000 if the programme is re-introduced. The ₦500 is the amount to obtain card alone in private hospitals, and it was used to access care for a whole year under the programme (KII, HCP, 19/06/2019, Bacita).

He further argued the programme instilled poverty mentality in the community members. In his words:

> One of the negative parts of the programme was a poverty mentality that fostered a beggarly culture where people don't want to spend at all. They may spend money on ceremonies, but it's like a curse for them to spend on health. So, any amount spent on health-related issues pained them as if they were exploited or punished. For them, spending on health is not a priority (KII, HCP, 19/06/2019, Bacita).

Another participant corroborated this view that:

> The truth is that people don't take healthcare as their priority. They would instead use such money to buy Aso Ebi [cloths for attending ceremonies]. It's not about affordability but not having the will (KII, Researcher, 30/07/2019, Ilorin).

In essence, seven out of the ten HCPs noted that the premium of ₦500 was affordable to community members, while three noted that it was not affordable. One of the HCPs who believed the premium was not affordable stated that:

> Most people could not afford the premium, and some of them were assisted in paying their enrolment premiums (KII, HCP, 15/06/2019, Edidi).

Another participant buttressed that:

> Most people could not afford the premium, and that was the reason we involved donors in enrolling the indigent people, especially the minors (KII, HCP, 21/06/2019, Osi).

Meanwhile, two out of the seven HCPs who noted that the premium was affordable were not outright in their submissions. One of them stated:

> The premium was affordable to some extent, and some still found it difficult to pay (KII, HCP, 28/07/2019, Aboto-Oja).

The other participant pointed out a situation which necessitated non-affordability of the premium. He explained that:

> The premium was affordable to most members of the community. However, there were some challenges. It became a problem for people who intended to register members of their large households; and they only enrolled those that were vulnerable because the total amount was not affordable (KII, HCP, 15/08/2019, Gure).

Meanwhile, large households is a common feature of rural settings in Nigeria (Adebowale *et al.,* 2012:93) and it can limit affordability to enrol (Kebede *et al.,* 2014:263; Panda *et al.,* 2016:40). As noted by a participant:

> Olorun funwa ni ore ofe omo bibi ni'lu yi. Aman bimo gaan.
>
> God blessed us with fruits of the womb in the community. We give birth a lot (Female FGD, 30/05/2019, Bacita).

It can be concluded that only five out of the ten healthcare providers fully argued that the premium of ₦500 was affordable to the community members. More so, the inability to afford enrolment premium by the community members was confirmed by the HMO officials. They explained that the increment in enrolment premium affected the coverage of the programme because some community members could not renew their enrolment at the cost of ₦500. They explained that:

> The premium started with ₦200, increased to ₦300 and end with ₦500. The increments affected the coverage, given price sensitivity and economic situation of the country. Majority of the people live below one dollar per day. The issue of the increase in premium affected enrolment into the programme. People's health-seeking behaviour changed, and they had to return to what they were used to (KII, HMO official 1, 26/07/2019, Ilorin).
>
> Politicians and philanthropists had to pay the premium of some people. Affordability to enrol was higher when it was ₦300 (KII, HMO official 2, 29/07/2019, Ilorin).

Arising from the above, most of the stakeholders believed from experience, that the premium of ₦500 was not affordable to all the community members. Though, it may appear unbelievable - especially from afar, that the 'low' premium could be unaffordable to some people. Thus, the poor economic situation in the country and the communities, in particular, is a major impediment to the affordability of the enrolment premium. Hence, the need to revisit the CBHI or insurance approach to healthcare provisioning to be on track towards UHC.

7.3.3 Community-Level Affordable Amount as Premium

Though the premium of ₦500 paid by the respondents when the programme was operational appeared relatively small for accessing healthcare for a year, the data suggests that affordability was a challenge for most people in the communities. It was, therefore, necessary to know the actual amount in premium that could be affordable in the communities. A participant noted that: "Premium can only be determined through actuarial analysis" (KII, Foreign Agency

Official 1, 02/09/2019, Ilorin). However, some of the key informants suggested a premium ranging between ₦500 and ₦8,000. One HCP opined that:

> It is through a survey that the idea of affordability can be gotten but going by the current reality, the idea of ₦500 is no longer sustainable, and they [i.e. community members] should be thinking of between ₦4,000 and ₦6,000 and those who know the importance will pay (KII, HCP, 28/07/2019, Aboto-Oja).

Another HCP noted that:

> I believe if the premium is now fixed at ₦1,000 or ₦1,500, people will pay (KII, HCP, 15/08/2019, Gure).

Further, government officials stated that:

> I believe community members would be able to pay a premium of ₦1,500 (KII, KWSG Official 1, 20/08/2019, Ilorin).

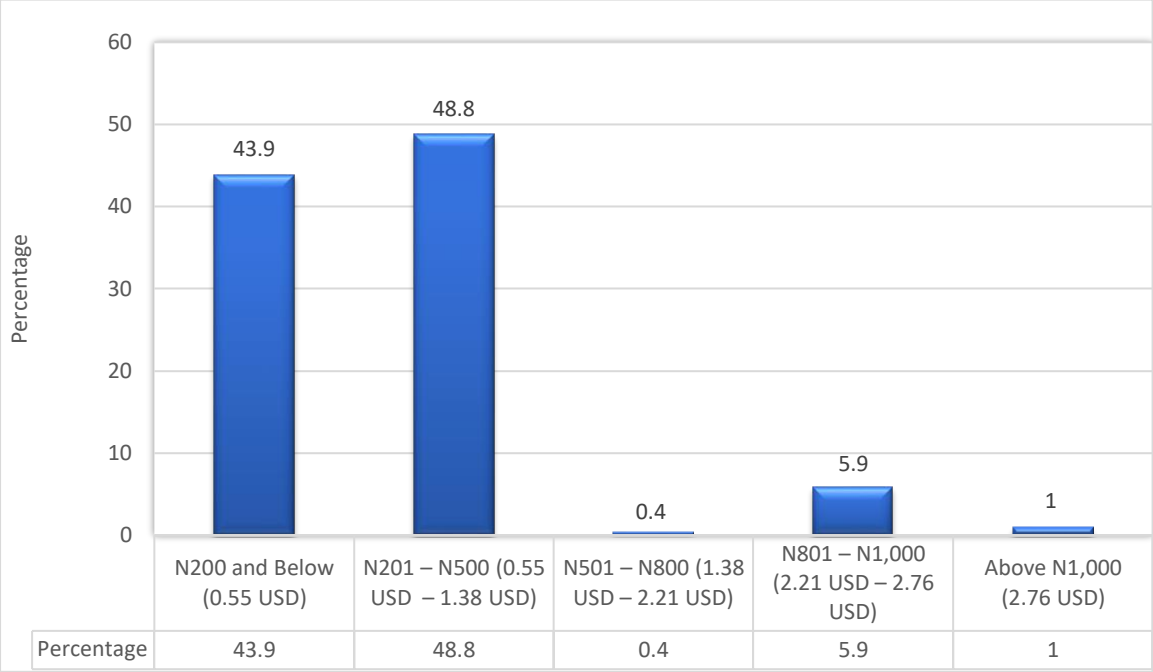
> Many factors are considered in determining the premium, but we can be looking at a premium of ₦8,000 per person (KII, KWSG Official 2, 24/07/2019, Ilorin).

Also, an HMO official commented that:

> Though it requires empirical test currently, the premium can still be affordable between ₦500 and ₦1,000 if there is a good quality of service based on trust (KII, HMO Official 1, 26/07/2019, Ilorin).

Perhaps, those recommending between ₦500 and ₦1,500 were doing so from the viewpoints of affordability by the community members. In contrast, those recommending above ₦1,500 were concerned with the economic reality of providing a reasonable benefits package. However, the amount indicated as affordable premium by the respondents is quite below the above amounts. Figure 7.2 depicts the amounts found to be affordable by the community members.

Figure 7.2: Affordable Amount as Premium by the Respondents



Source: Fieldwork 2019

Figure 7.2 shows that 92.7% of the respondents believed that the enrolment premium should not be more than ₦500. This includes those who wanted a premium of ₦200 and below (43.9%) and those who wanted a premium between ₦201 and ₦500 (48.8%). The responses were from the standpoint of an average community member and not based on the personal affordability of the respondents and participants. The quantitative data revealed that the average affordable amount as premium by the respondents is ₦383 ($1.6). Meanwhile, in all the twelve FGDs conducted in six out of the eleven communities covered by the study, the amount concluded by participants as an affordable premium for all is ₦200. For instance, one of the participants during the FGD conducted in Oro noted that:

Tiwon bale bawa faa wale si ₦200, gbogbo eyan ‘olesan.	The premium will be affordable to all if it is reduced to ₦200 (Female FGD, 28/5/2019, Oro).

Another participant stated that:

Tiwon bale bawa sesi ₦200, agbara opolopo yio kaa.	Most people in the community would be able to afford a premium if it is fixed at ₦200 (Male FGD, 03/06/2019, Gure).

Invariably, the ₦200 is like half (52.2%) of the average amount indicated by the quantitative data as affordable premium (i.e. ₦383) for most community members. Similarly, a recent study by Azuogu and Eze (2018:1) in Abakaliki, South-East Nigeria showed that respondents (artisans) were willing to pay premiums between ₦400 and ₦1,500 for healthcare that covers hospitalisation and surgery. The results from both settings mirror the socio-economic realities of the people in most parts of Nigeria.

While Udeh *et al.* (2016:10) found that high premium reduces the likelihood of enrolment among individuals in the lowest socio-economic quintile, they, however, noted that low level of literacy in the rural areas might be responsible for non-enrolment due to inability to weight the magnitude of health challenge and give priority to premium payment over other needs. This contrasts with the finding of this study which has high literacy level because only 20.9% and 14.4% of the former and non-enrolled respondents respectively had no formal education at all. Though, this study also reveals that access is likely to be challenging for individuals who fall within low economic quintile because of inability to pay for care. As such, "it is necessary to understand the socio-economic context of each setting through a careful analysis of spending on healthcare, including out-of-pocket payments to help determine the actual cost of healthcare versus the buying-power of the people" (United Nations Higher Commissioner for Refugees, 2012:7) especially, in the rural areas.

The premium may appear not too much, but the economic situation of a people can deny the ability to pay. For instance, approximately 50% of the total respondents earned ₦12,000 (33.1 USD) or below monthly (see Table 6.1), suggesting that relatively few people could earn above the recently approved minimum wage of ₦30,000 (82.6 USD). Consequently, subsidising this amount (₦383, i.e. average community-level affordability) is arguably as good as providing the care for free. This is because the "consequence of non-accessibility of healthcare can be enormous with poor health outcome, poverty, and sometimes death" (Adewole *et al.,* 2015:650). Moreover, recent findings revealed Nigeria as the world capital of poverty with close to half of its population trapped in poverty. According to the World Poverty Clock (2019), about 95 million people in Nigeria live in extreme poverty, with an estimated population of about 196 million people (World Bank, 2019). For instance, poverty grossly limits the access of women to maternal and pre-natal care in Nigeria (Ekpeyong *et al.,* 2019:1; Adedokun & Uthman, 2019:1).

Further, the discussion of affordability requires consideration of other costs related to healthcare. In clear terms, Russell (1996:222) explained that "healthcare could be considered affordable when utilisation is not due to financial reasons, and when the opportunity costs incurred do not cause levels of consumption and investment (e.g. on education) to go below minimum needs in the short run". This is because the cost of accessing care is more for some people beyond the enrolment premium. Moreover, the programme was designed to cover the host communities and their environs; consequently, the facilities were closer to some enrollees than the others, necessitating extra costs, including transportation. A participant explained that:

> The people in the Hard to Reach [HTR] areas wanted the programme in their environment because some had to spend ₦1,000 to travel to access care in this community, amount higher than the annual premium. The only time they got a vehicle to this community was on market day. So, if they needed to come on another day, they come by bike, spending between ₦300 and ₦500 and returned with the same amount (KII, HCP, 20/06/2019, Bode Saadu).

Another participant in Gure narrated a similar challenge of extra costs in accessing care. He noted that:

> For some [i.e. residents of distant communities], it was a problem to raise transport fare to Gure for care; that is if they can get the transport (KII, HCP, 15/08/2019, Gure).

This is consistent with the finding of Mahmood *et al.* (2018:8) that "distance between households and health facilities to access care plays a significant role in the decision to enrol as well as affordability, among the rural poor". The World Health Organization declared that "health spending is viewed as catastrophic when a household must reduce its basic expenses over a certain period to cope with the medical bills of one or more of its members" (see Kawabata *et al.*, 2002:612). More precisely, "catastrophic health spending is defined as out-of-pocket expenditures exceeding 10% of total household consumption or income" (WHO, 2017). Oriakhi and Onemolease (2012:98) found in a study on CBHI in Edo State Nigeria that 65% of respondents took credit facilities of averagely ₦8,000 within three months, to pay for healthcare. This shows the extent of the catastrophic expenses of people in accessing care.

It is crystal clear that fixing the health insurance premium is a polemic issue that requires consideration of many factors. However, the ability to pay determines the possibility or workability of any health insurance programme. Put differently, health insurance cannot work

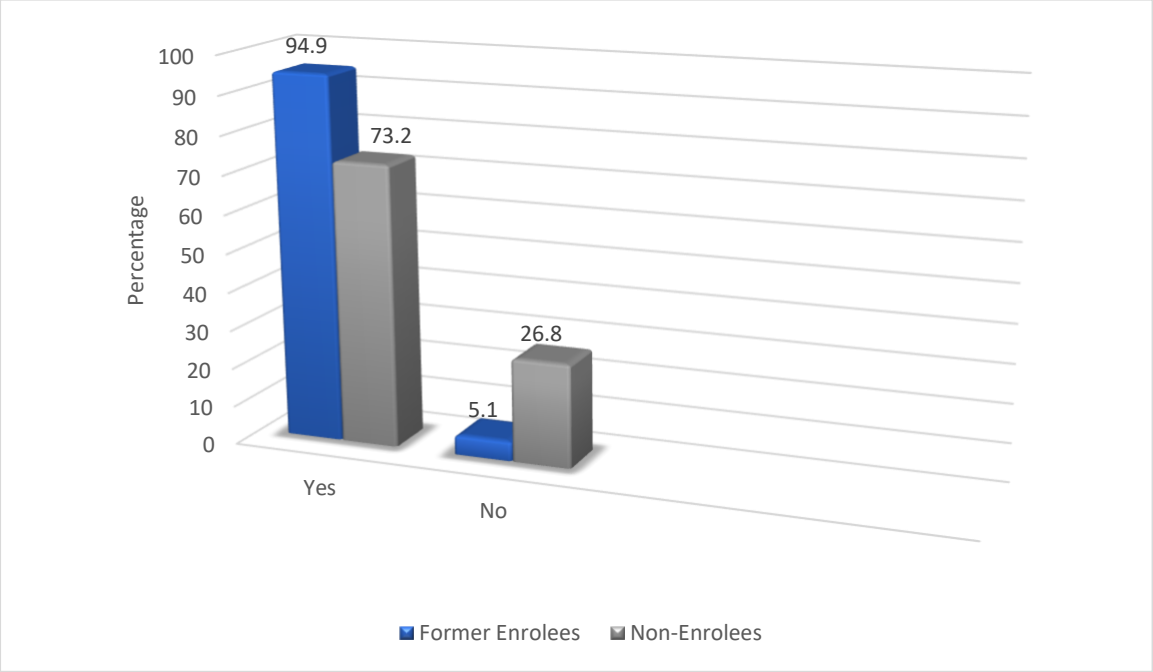
without the payment of premium; and this must be in tandem with the economic realities of the beneficiaries to achieve results. It is therefore imperative to examine the ability to pay of the beneficiaries. A participant concluded that: "Health insurance premium is a controversial issue because socio-economic status and cultural dynamics of the communities need to be considered given the cost of care and other sources of fund. It is the synergy of these that will assist in determining the appropriate premium" (KII, Referral Centre 1 Official, 30/07/2019, Ilorin).

Given these, Aggarwal (2011:1657) concluded from his study that "while CBHI may be used to reach the disadvantaged population, they cannot be considered as a substitute for government-created health infrastructure". More so, if the premium was so low that it only paid for the cost of producing enrolment card (as noted above), and the HIF expected the KWSG to assume hundred percent responsibility for financing the programme, then, it is no longer a social insurance. Thus, it may be necessary for promoters of CBHI to have a rethink and accept a publicly-funded (i.e. tax-based), universal healthcare system as a better alternative.

7.4 Capacity of Government and Free Healthcare

As highlighted in Chapter 2, the commodification of social services provisioning is one of the reasons for promoting health insurance as a means of accessing healthcare. However, the prevalent challenge of affordability of enrolment premium (see Workneh *et al.,* 2017:356; Fonta *et al.,* 2010:111) for many, prompted the need to revisit the capacity of government to provide free healthcare services to the citizenry as done in the past. Figure 7.3 below details the results from the respondents.

Figure 7.3 Government's Financial Capacity to Provide Free Healthcare



Source: Fieldwork 2019

Figure 7.3 above shows that most of the respondents, especially, among the former enrollees believed that the government could afford to provide free healthcare services for the people. This gives an insight regarding the people's impression of the government. Table 7.4 below give more insights into the results.

Table 7.4: Chi-Square Test of Association between Selected Variables and Belief about the Government's Financial Capacity to Provide Free Healthcare Services for the People

Variables	**Former Enrollees (p-value)***	**Non-Enrollees (p-value)***
Gender	.430	.527
Age	.270	.076
Education	.013	.281
Occupation	.848	.483
Note: 5% significance level *Two-tailed test		

Source: Fieldwork 2019

As shown in the above Table 7.4 above, the study did not find a statistically significant relationship between gender and belief in the government's capacity to provide free healthcare services among the formerly-enrolled (χ^2 = .623, p-value = 0.430) and non-enrolled (χ^2 = .401,

p-value = 0.527) respondents. The chi-square test also found no statistically significant relationship between age and belief in the government's capacity to provide free healthcare services for both the former enrollees (χ^2 = 9.931, p-value = 0.270) and the non-enrollees (χ^2 = 14.209, p-value = 0.076). These imply that both the male and female respondents across all age categories have same opinion about the government's ability to provide free healthcare services.

Further, the study found a statistically significant association between educational status and belief in government's capacity to provide free healthcare services among the formerly-enrolled respondents (χ^2 = 12.707, p-value = 0.013). This might be linked to their exposure to the 'huge' resources and or responsibilities of the government. However, it found no statistically significant association between education and belief in government's capacity to provide free healthcare services among the non-enrolled respondents (χ^2 = 5.064, p-value = 0.281). Furthermore, the study found no statistically significant association between occupation and belief in the government's capacity to provide free healthcare services among the formerly-enrolled (χ^2 = 1.376, p-value = 0.848) and non-enrolled (χ^2 = 3.467, p-value = 0.483) respondents. This suggests that occupation was not a significant factor in their belief regarding the government's ability to provide free healthcare services for the populace.

Table 7.5: Multinomial Logistic Regression on Government's Financial Capacity to Provide Free Healthcare

Variable	Former Enrollees				Non-Enrollees			
	Coefficient	**Wald ratio**	**P-value**	**Odds ratio**	**Coefficient**	**Wald ratio**	**P-value**	**Odds ratio**
No Intercept	-1.180	1.812	.178		.351	.364	.546	
Education	-.537	11.391	.001	.584	-.219	.977	.323	.803
Occupation	-.014	.013	.911	.986	.188	2.872	.090	1.207
Gender	.267	.613	.434	1.306	.107	4.448	.035	1.113
Age	-.217	8.451	.004	.805	.004	.002	.963	1.004
Note: 5% significance level Reference Category: Yes								

Source: Fieldwork 2019

The result in Table 7.5 above shows an assessment of government's ability to provide free healthcare services for the people against the Reference Category (Yes) among the respondents. The set of coefficients shows education (b = -.537; .001) and age (b = -.217 ; .004) as significant

predictors among the former enrollees but with negative relationships. However, gender (b = .107; .035) appears as a significant predictor among the non-enrollees with positive relationship.

In consonance with the quantitative results, the qualitative findings substantiate the trend of response. Majority of the participants noted that the government has the financial capacity to provide free healthcare services to the people. This includes ten out of eleven community leaders, all the participants in the IDIs (i.e. 24 out of 24 members of communities), nine out of ten healthcare providers and four out of eight officials of the implementing partners. Also, participants in ten out of the twelve FGDs conducted unanimously noted that the government has the financial capacity to provide free healthcare. A community leader argued, fundamentally, that provision of healthcare is a primary responsibility of the government to the citizens. According to him:

> The government has the financial capacity to provide free healthcare as part of the people's right to cover basic needs because this might be their only vivid benefit from the government as most people are restricted to their rural communities (KII, Community Leader, 11/07/2019, Idofian).

Some interviewees opined that free healthcare could be financed through government allocation to the health sector and internally-generated revenue (IGR). They noted that:

> *Government* ni agbara lati pese iwosan ofe fun ara ilu nitori 'pe won *vote* owo fun *health*, sugbon *selfishness* kole jeki won se.
>
> The government has the financial ability to provide free healthcare for the people because there is an allocation for healthcare. Still, selfishness would not allow them to offer it (IDI, Female, 20/07/2019, Bode Saadu).

Another participant in Bacita emphasised that:

> The government can provide free healthcare services to the people, and it should provide it. This is because the government can finance it from its revenue, and there are many resources in the State (Male FGD, 30/05/2019, Bacita).

Further, some of the participants contended that it is possible if the government has the political will and makes it a priority. They stated that:

Ijoba lagbara lati pese iwosan ofe fun ara ilu, ti wonba fe se.	The government has the financial capacity to provide free healthcare services to the people if they have the will (KII, Community Leader, 15/06/2019, Edidi).
B'ijoba ba fe se, ijoba lagbara e. Okan laafiile gbokan.	The government has the financial capacity to provide free healthcare service if it has the will. It is by making it a priority (KII, Community Leader, 13/06/2019, Erin-Ile).
Ijoba lese ju bee lo bi won ba fe se.	The government largely has the financial capacity to provide free healthcare service if it has the will (IDI, Female, 19/06/2019, Bacita).

Further, officials of government and the HMO added that:

> The government has the financial capacity to provide free healthcare to the people if they want (KII, KWSG Official 3, 01/08/2019, Ilorin).
>
> The government has the financial capacity to provide free healthcare, just that the political will is not there (KII, HMO Official 2, 29/07/2019, Ilorin).

Perhaps, due to the perceived lack of political will and bad governance, some participants (a community member and an official in a government-owned health facility) almost concluded that the government would never think in that direction. They declared that:

Ijoba ni agbara latise sugbon won 'ofe se, won 'ofe ran ara ilu lowo.	The government can provide free healthcare, but they don't want to do so or assist the masses (Female FGD, 30/05/2019, Bacita).

> I believe the government has the financial capacity to provide free healthcare to the citizens. Still, they would not do because they would claim that they have to spend on other sectors of society (KII, HCP, 15/06/2019, Edidi).

In most cases, healthcare providers, especially, the private providers, are found to resist the introduction of free healthcare services (Béland & Ridde, 2016:15) given how it might affect their businesses. Contrastingly in this study, as stated earlier, virtually all the HCPs (9 out of 10) noted that the government has the financial capacity to provide free healthcare services to

the people. Some of them felt that free healthcare could be provided if the government can re-organise the system of governance, block areas of wastage and then reprioritise its spendings. According to them:

> For the government to provide free healthcare, there is a need for restructuring in governance because the cost of the present presidential system of government is high. A lot of funds would be saved and channelled to the healthcare system in addition to the healthcare tax (KII, HCP, 28/07/2019, Aboto-Oja).

> Free healthcare is possible, depending on the commitment of leadership. There is enough wastage to address areas of the shortfall, and it can be diverted. (KII, HCP, 19/06/2019, Bacita).

> The government has the financial capacity to provide free healthcare services but lacked the political will. What is needed is to re-order their priorities (KII, HCP, 21/06/2019, Osi).

The above submissions are in line with the findings of Walker and Gilson (2004) and Zeidan *et al.,* (2004) in South Africa and Sudan respectively, where healthcare workers were in support of free healthcare (cited in Béland & Ridde, 2016:14). Also, Gilson and McIntyre (2005:762) stressed "the need for systematic removal of user fees in Africa because it's a significant impediment to access to healthcare, especially for the teeming poor". However, some participants were less optimistic and noted that if a policy on the provision of free healthcare services is introduced, a practical implementation may be challenging. Excerpts from their interviews are as follows:

Ijoba lagbara lati pese iwosan ofe fun ara ilu sugbon won 'oni se. Bi ijoba batie pase re loke, won 'onije kode 'sale.	The government has the financial capacity to provide free healthcare to the citizens but lacks the political will. Even if the top-level government approves it, it won't be implemented accordingly (IDI, Male, 17/06/2019, Odo-Owa).

> The government can provide free healthcare to the people because we are not as poor as a nation, but we do not have good managers (KII, HCP, 13/06/2019, Erin-Ile).

> The country and state have the financial capacity to provide free healthcare, but our problem is a mismanagement. Though health is not free anywhere, if it is properly managed; we can achieve it (KII, KWSG Official 1, 20/08/2019, Ilorin).

The worries of the participants were rife about the seemingly poor level of transparency and accountability in the government's dealings. Furthermore, those who argued that the government could not afford to provide free healthcare services attributed their concerns to the need for sustainability. They are, however, keenly, in support of health insurance such that enrollees pay for care as a form of appreciation. A community leader, an HMO official and an HCP shared similar view that:

> Ko *possible* fun ijoba lati pese iwosan ofe fun awon ara ilu. Nkan to wa ni *health*, opo koja kani *government* nikan loma mojuto alafia. Won 'oni agbara owo ati *staff* ti yoowa *sufficient*.
>
> It is not possible for the government to provide free healthcare service to the people. The responsibilities in the healthcare sector are beyond the ability of the government only. The government doesn't have the fund and staff strength to provide the service (KII, Community Leader, 20/06/2019, Bode Saadu).

> I do not support free healthcare in any form. People should appreciate by paying an amount for health (KII, HMO Official 1, 26/07/2019, Ilorin).

> The beneficiaries should be taught to appreciate what is done for them by making them pay a little bit more gradually in the reality of my rural community such that the programme can become sustainable…Even in Freetown, things are not free; somebody must have paid for it (KII, HCP, 27/07/2019, Oro).

He continued that:

> The government does not have the financial capacity to provide free healthcare for the citizens. Even the USA does not have enough resources to do so. Regarding health insurance, the government has resources if it is well managed (KII, HCP, 27/07/2019, Oro).

A government official who has the same opinion added that:

> Even if the government has the financial capacity to provide free healthcare for the people, it is not the best. It is always good to tailor it along with health insurance. In my hometown, there is a famous saying that "the medicine that is not paid for, is not usually potent". The people need to be financially committed but reduce their OOP payment drastically. There is no country where the government can sustainably take up the healthcare needs of the people 100% considering its other engagements (KII, KWSG Official 2, 24/07/2019, Ilorin).

Other participants added that:

> For some of us in healthcare financing, we don't believe in free healthcare because there's nothing free, it costs somebody something. And with the kind money available to governments, very few will be able to run free healthcare. Very rich governments, governments of the US, Britain and so on cannot run free healthcare, so how will we pretend in Nigeria to be running free healthcare. Our economy cannot carry the cost. Thus, the health insurance scheme is a way out (KII, Researcher, 30/07/2019, Ilorin).

> There is no free healthcare anywhere; one must contribute an amount, and if the need arises, he or she will be able to access care. The government cannot pay for everything. Even if the government has the capacity, individuals must also pay to make the programme effective (KII, NHIS Official, 01/08/2019, Ilorin).

> Free services are usually turbulent, but the government can provide affordable and efficiently subsidised healthcare. Providing free healthcare will need more. No free programme in Nigeria has outlived its originator or campaigner or administration (KII, Referral Centre 1 Official, 30/07/2019, Ilorin).

Meanwhile, from a social policy viewpoint, scholars such as Adésínà (2007; 2011; 2015) and Mkandawire (2010) have argued that provisioning of social services (including healthcare) is a fundamental responsibility of the government to ensure the well-being of the citizenry. Specifically, Adésínà (2007:20) argued that rather than adopting private sector-driven provisioning, the government needs to spend more on social services. As such, there is more to social policy than what the government is doing currently (Adésínà, 2011:455). For equality, "everybody deserves equal access to good quality essential services, so access should be free for all and not rationed by ability to pay" (Devereux, 2016:179). Also, the sustainability of

investment requires adequate ideational commitment with a focus on the goals and long-term developmental outcomes. Moreover, payment of subsidised CBHI premium does not guarantee the sustainability of health insurance programmes.

The officials of the foreign agency also admitted, partly, that the government can provide free healthcare services for the people if it has the political will. They, however, noted that this is not the 'right time' for the government to do so and that healthcare must be a shared responsibility between the government and the citizen. One of the participants stated that: "The FG was expected to commit at least 15% of the budget to health, but we've not been able to achieve 5%, not to talk of 15% which means that the government has other priorities and other sectors might suffer if the burden is pushed to government. Thus, I don't think this is the right time to make such decisions" (KII, Foreign Agency Official 2, 02/09/2019, Ilorin). Another participant argued that:

> When the government has the political will to do something, it would be done. However, the responsibility is not about the government alone; it is everybody's responsibility. The government would play their part; the citizens would play their part. Everybody has to take part. That's why the quickest and fastest way to attain UHC is through insurance. Donors can only assist if the government shows political will and trust (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

The spirit of interventionism and privatisation introduced to the healthcare system in the 1970s and 1980s, as discussed in chapter 1, has continued to linger with its consequent challenges on social services. The study found a disconnection between the economic realities of the people and the need for them to pay a premium to access healthcare. In other words, there was a clear threat to sustainability if one of the sources of the fund (i.e. enrolment premium) for the programme is weak. This wide gap needs to be filled if the rights of the citizenry must be protected. Thus, "the need to return to a wider vision of social services provisioning beyond narrowed social protection instruments" (Adésínà, 2015:100) such as CBHI. This is because if the plans towards providing accessible healthcare services for all is not revisited now, it becomes difficult to identify the appropriate time to rise with the idea.

7.5 Conclusion

Relying on empirical data, the chapter discussed the sources of fund for the CBHI programme. Most of the funds were generated through counterpart funding by the Kwara State Government (KWSG) and the Dutch HIF; these were complemented by the enrolment premium paid by the

enrollees. Also, from the perspectives of community members and other stakeholders in the implementation, the chapter explored the affordability of enrolment premium by the community members, since it was one of the sources of fund for financing the programme. The study showed that the premium was not affordable to most members of the communities. Going forward, the chapter also assessed the capacity of government to provide free healthcare for the citizens and majority of the respondents and participants held the belief that the government can provide free healthcare services for the citizenry.

CHAPTER EIGHT

STOPPAGE OF THE CBHI PROGRAMME IN KWARA STATE NIGERIA

8.1 Introduction

The establishment of the Kwara CBHI programme sought to extend access to healthcare service to the rural dwellers. However, the programme stopped 'abruptly' after less than a decade of implementation. One of the goals of this study is to examine the reasons behind the stoppage of the CBHI programme in rural Kwara. This chapter begins by examining the challenges that faced the CBHI programme, as they relate to each of the major actors in the implementation of the programme. Further, it discusses the reasons behind the stoppage of the programme, which were mainly non-payment of counterpart fund and poor management. Also, the healthcare situation in the communities in the post-CBHI era is examined. The community members and healthcare providers highly felt the resultant effects.

8.2 Challenges and Moral Issues in the Programme

It is necessary to note that "policies do not fail on their own merits" but dependent on the processes of implementation (Hudson *et al.,* 2019:1) as well as design. The stoppage of the CBHI programme was preceded by specific challenges which partly led to the eventual stoppage of the programme. However, challenges are never strange phenomena if there are adequate mechanisms put in place to tackle them as they arise. Table 8.1 details the challenges identified by the former enrollees, based on their experience with the programme.

Table 8.1: Challenges of the CBHI Programme by the Formerly-Enrolled Respondents

Challenge	Frequency (N = 811)	Percentage
Non-availability of drugs	33	4.1
Poor treatment	54	6.7
Poor attitude of healthcare workers	30	3.7
Distance	1	0.1
Request for Out of Pocket Payment	3	0.4
Long waiting period	122	15
Inadequate staffing	52	6.4
Increase in premium	4	0.5

Inadequate equipment/ facility	7	0.9
Inadequate benefits package	7	0.9
Funding challenge	35	4.3
Poor education on the benefits package	4	0.5
Poor management	22	2.7
Abuse of care	2	0.2
Lack of trust	8	1
No challenge	400	49.3
I don't know	27	3.3

Chi-Square Test of Association between Selected Variables and the Challenges of the CBHI Programme

Socio-economic Variables	**Former Enrollees (p-value)***
Conduct of healthcare workers	.001
Quality of care	.001
Note: 5% significance level *Two-tailed test	

Source: Fieldwork 2019

Table 8.1 above shows that slightly above half (52.6%) of the respondents did not identify any challenge with the programme. This might be as a result of their none or infrequent utilisation of healthcare under the programme because not all those that enrolled accessed care often while the programme was active. The Table also reveals a statistically significant relationship between conduct of the healthcare workers and the challenges of the programme (χ^2 = 527.036, p-value = 0.001). It also shows a statistically significant relationship between quality of care and the challenges of the programmes (χ^2 = 537.549, p-value = 0.001). These might be related to the various challenges mentioned by the respondents (see Table 8.1 above) which are mainly linked to the delivery of healthcare services under the programme.

The qualitative data indicates that most of the participants identified challenges with the programme (6 out of 11 community leaders, 16 out of 22 community members and 10 out of

12 FGDs). More so, the experience differed from one community to the other. The qualitative data gives a better understanding of the challenges presented in Table 8.1. As observed among the respondents in the above Table, some of the participants also noted that there was no challenge with the programme. One of them indicated that:

> Mio ri *complain* kankan nipa eto na. Igbati aari awon eleto na mo, ni won *complain.*
>
> I didn't observe any challenge in the programme. People only complained about the programme when it stopped (KII, Community Leader, 15/06/2019, Edidi).

However, other participants highlighted various challenges with the programme. These challenges range from the lethargy of the donors, low capitation, pressure on healthcare workers and facilities, long waiting period, poor knowledge of benefits package (KII, HCP, 21/06/2019, Osi), tribal issues (KII, KWSG Official 2, 24/07/2019, Ilorin), over-utilisation of services, non-renewal of enrolment due to the absence of sickness (KII, NHIS Official, 01/08/2019, Ilorin), inadequate human resources (KII, Community Leader, 11/07/2019, Idofian), insufficient research, inadequate funding (KII, HMO Official 1, 26/07/2019, Ilorin), among others.

A participant added that the problems included:

> Communication gap, inadequate advocacy, distribution of referral centres; UITH [University of Ilorin Teaching Hospital] is the only secondary-tertiary referral centre in the geopolitical zone. The distance between the UITH and the communities is far. The capitation given to HCPs is inadequate. I believe the enrollees and Programme Managers had their problems too (KII, Referral Hospital 1, 30/07/2019, Ilorin).

An HCP also recalled his experience with adverse selection when the programme commenced in his community, which stemmed from the poor healthcare situation in the State. He noted that: "There was the problem of adverse selection where the first set of enrollees were the chronically-ill with hypertension, diabetes, rheumatoid, arthritis, cancer and some other degenerative illnesses. Meanwhile, cancer was not covered. The HMO was not happy because they were paying more money than they were receiving" (KII, HCP, 21/06/2019, Osi). Generally, adverse selection is a common challenge in CBHI programmes, as found by Jembere (2018:1) in Ethiopia, Parmar *et al.* (2012:1) in Burkina Faso and Bodhisane and Pongpanich (2018:615) in Lao P.D.R. It tends to be more pronounced in places with a high rate of poverty and a weak healthcare system.

Taking a closer examination of the challenges beyond the responses in the questionnaire, the qualitative data relatively allows for classifying the challenges according to various actors or stakeholders, concerning how their actions or inactions constituted a challenge in the implementation of the programme. Thus, this section further examines the challenges of the programme as follows:

8.2.1 The State Government

The challenges of distance and stock-out of drugs, particularly in government-owned facilities, are attributed to the state government. Hence, that is the focus of this sub-section.

8.2.1.1 Distance

There was a problem of distance during the implementation of the programme, limiting the ability to reach people in many of the villages located around rural Kwara. Though efforts were made to contact them through the creation of health posts (KII, Foreign Agency Official 1, 02/09/2019, Ilorin), they were just too many and dispersed. This inability to extend healthcare services to them is partly due to the poor healthcare architecture and infrastructure in Kwara State which does not ensure that healthcare facilities are located within an accessible distance for various human settlements in the State. Consequently, those who intended to access care under the programme had to spend more to reach the facilities and access care. A community member noted that:

> Onira fun awon tanwa ni abule lati je anfaani eto na nitori ‘pe ojina siwon.
>
> It was difficult for dwellers of small villages in the hinterlands to benefit from the programme because of the distance (IDI, Female, 20/06/2019, Bode Saadu).

One of the HMO officials lamented because it was difficult for the enrolment officers to reach these settlements. He stated that:

> …Accessing hard-to-reach areas was another problem and distance to the health facility, on the supply side, was also a problem. Some needed to pay more than their premium for transportation (KII, HMO Official 1, 26/07/2019, Ilorin).

Another participant who identified poor road network as an impediment to access supported the above notion with an example from Asa LGA, as thus:

> For instance, there are a lot of interior communities in Asa LGA. I can mention more than 50 that are located far in the bushes. You can be going for like an hour in the bush without reaching the end (KII, HMO Official 2, 29/07/2019, Ilorin).

Further, a healthcare provider pointed out this challenge in Gure. He noted that:

> Complaints of enrollees under the programme were distance. The programme facility was in Gure. Places like Siya, Kosubosu, Yanrin, Yashikira, Chikanda etc., complained of distance including other villages in the bush where roads were not motorable. They wanted the facility closer to them (KII, HCP, 15/08/2019, Gure).

In this regard, the CBHI programme was not able to penetrate by establishing its presence beyond the use of few health posts in some places where they were available. Another healthcare provider observed this problem and noted that it is one of the reasons people eventually settled for patronising quacks when the programme was operational. She explained:

> …Some of them [i.e. rural dwellers] decided to patronise quacks around them and took wrong medications. It was only emergency cases they brought to the town because of distance (KII, HCP, 20/06/2019, Bode Saadu).

Another participant corroborated the implication and consequence of inability to access care under the CBHI programme due to distance. He concluded that:

> Where enrollees needed to spend more on transportation than premium, they felt its not worth it and settle for patent medicine shop for treatment (KII, Researcher, 30/07/2019, Ilorin).

At the policy level, the introduction of the CBHI programme could have considered the number of healthcare facilities that were available in the target areas, that is, the rural areas, to see how this could facilitate or inhibit enrolment and utilisation of healthcare services. Thus, even for CBHI to work effectively, there is a need to locate healthcare facilities within a considerable distance to the people. Unfortunately, however, some of those who should have enrolled and some enrollees in the programme submitted to the patronage of patent medicine vendors to buy drugs due to non-proximity of formal healthcare facilities. More painfully, for those who were enrolled, most of these medications were covered by the CBHI programme (Gustafsson-Wright *et al.,* 2018:249).

Dror *et al.* (2016) found distance as a common barrier to enrolment or utilisation of CBHI in LMICs. Also, Haven *et al.* (2018:5) found in Uganda that "individuals living in hard-to-reach areas were less than half likely to utilise CBHI services due to distance". Parmar *et al.* (2014:76) also found a similar level of utilisation among CBHI enrollees and non-enrollees who lived far from healthcare facilities. Cost of transportation is another burden for the rural dwellers. Masiye *et al.* (2016) found in Zambia that even with the removal of user fees at primary healthcare level, catastrophic healthcare expenditure was high among the poor due to the spending on transportation. The roll-out of the CBHI programme in rural Kwara was partly hampered by the 'unpreparedness' of the government concerning the non-availability of healthcare facilities within accessible distance to the intended beneficiaries. The number of facilities was never enough to reach the entire rural population in the State.

8.2.1.2 Stock-out of Drugs

One of the characteristics of the challenge of the programme was the non-availability of drugs. There were several instances where enrollees went to the hospitals for care, and they were told that the required drugs were not available. This was, however common with the public facilities under the management of the CHIS (the government's agency) because participants with this complain were receiving care in public facilities. As stated in Chapter 5, the agency was responsible for stocking the public hospitals with drugs from the capitation obtained on the enrollees. A participant cited an instance and noted that:

> Nigbati kosi ogun nile, won ni ki awon eyan pada wa.
>
> There was a time enrollees were told to go and come back for drugs because drugs were not available (IDI, Male, 15/06/2019, Edidi).

This was bolstered by a community leader who saw non-availability of drugs as one indicator that the programme would likely stop. In his words:

> Awon eyan *complain* nipa pe awon 'ori ogun gba. Lati ara aisi ogun latinri apere firifiri' pe eto na yio denukole.
>
> Some enrollees complained about non-availability of drugs. We observed traces that the programme would stop due to the non-availability of drugs (KII, Community Leader, 13/06/2019, Erinle).

The problem of non-availability of drugs and other materials was confirmed by an HCP who noted that:

> The challenges were stock-out of drugs, lack of delivery materials, no drugs for specific diseases and enrollees were told everything was free (KII, HCP, 02/07/2019, Kaiama).

Though the programme was jointly sponsored by the state government and the international partner, the use of government facilities provided the government officials with some influence on how the policy was implemented in the public facilities. A participant recalled that:

Policy kan wa lati Ministry of Health lori iye itoju tiwon lese lojumo laifi aye kale fun *emergency*.	There was a policy from the State Ministry of Health stating the number of cases to be attended to in a particular day without consideration for emergency cases (IDI, Male, 13/06/2019, Erinle).

Arising from the above, the implementation of the programme in public facilities was partly stalled with the stock-out of drugs and the general quality of care in private facilities was better than what was obtainable in government facilities under the programme. This partly informed the reason why enrolments were higher in private compared to the public facilities. This was confirmed by a study conducted by AIGHD (2015:37) on the programme which reported that in 2011, there was 39% enrolment in Aboto-Oja (private facility) and 26% in Afon (public facility) in the same LGA. Regarding non-availability of drugs, Kodom *et al.* (2019:576) reported a similar scenario in Ghana where enrollees were given only cheap drugs and directed to purchase the rest. Situations like these, obviously, limit the quality of care and expose enrollees to catastrophic healthcare spending, thereby altering the goals of CBHI. Generally, however, Mladovsky and Mossialos (2008) observed that corruption in government tends to affect the success of CBHI programmes.

8.2.2 The HMO

The challenges attributed to the HMO (HCHC) cannot be divorced from the international partner (PAF) because some of their decisions were based at the direction of the international actor. The following are some of the challenges of the programme attributed to the HMO.

8.2.2.1 Reduction in Health Benefits

The health benefits package was reviewed downward over time. In other words, some medical conditions that were covered, initially, were removed from the healthcare package. This was done as the programme expanded to more communities. The knowledge about the health benefits coverage became complicated with relatively frequent review in policy or operational guidelines, regarding the implementation of the programme. This included a reduction in the

benefits package of the programme. As a result, enrollees could no longer access some healthcare services under the programme, and they were not adequately informed. One reason most of the enrollees were not aware was that generally, the majority of the people utilised basic healthcare services. Some enrollees who required these services became enraged and confused about the programme's benefits package. For instance, a participant who was not affected by the reduction in benefits package noted that she was not informed about the removal of any care from the inclusion list. According to her:

> Won 'o salaye sugbon gbogbo igba ti mo ba ti lo naani won toju mi.
>
> I was not informed about the specific coverage of the programme, but I was treated for all the ailments I presented under the programme (IDI, Female, 03/07/2019, Gure).

The resultant effect of the reduction was felt most by the communities where the programme started early when they realised that they could no longer enjoy certain services under the programme. For instance, hernia was covered at inception, and it was one of the benefits enjoyed by former enrollees in Bacita (where the programme commenced in 2007). However, it's one of the ailments that residents of Bode Saadu (where the programme started in 2014) wished to be covered by the programme. During an FGD with female community members in Bacita, a participant commented on the coverage of the programme and stated that:

> Hygeia *cover hypertension, T.B.,* omo bibi, *operation*, paapa julo *hernia*. Oni ojo tiwon lakale fun *operation*. Won le bere lati *seven* laaro titi di *nine* ale.
>
> The programme covered hypertension, tuberculosis, maternal care, surgical operations, especially hernia. There was a particular day designated for different kinds of surgical procedures. They could start at 7 am and stop at 9 pm (Female FGD, 30/05/2019, Bacita).

Meanwhile, a participant in Bode Saadu suggested while discussing the challenges of the programme that:

> Koba daa, tiwon ba leje ko *cover g*bogbo awon ibi ti ko *cover* ninu aare, bi *hernia*.
>
> It would be good if the programme could be re-designed to cover some other

ailments such as hernia (IDI, Male, 20/06/2019, Bode Saadu).

This shows that the health benefits coverage of the programme changed at some point in time and it became disappointing to most of the enrollees. A community member recalled that, ironically, the reduction in benefits package was at a time when the premium was increased. According to her:

> Won *withdraw* awon itoju kan 'pe ko *cover* re mo. Anfaani taati wa je lalakoko taamo 'pe gbogbo e lo *cover*, won wa yoo kuro. Igbati awa nsan apo meji abo ni kowa *cover* nkan mii towa nibe tele.
>
> Some healthcare services were removed from the coverage of the programme. Some services that we had earlier benefitted from were removed. It was when the premium was increased to ₦500 that the health services were excluded (Female FGD, 30/05/2019, Bacita).

An HCP confirmed the reduction in the benefits package. She noted that:

> Before the programme was introduced in Bode Saadu, some people went to Bacita to enrol in the programme where all services were covered. By the time they were expanding the programme, they had put a limitation on cases, where excluded cases were treated through OOP. There were surgical cases excluded; as a result, people started to complain about the exclusion of some care. For example, the Programme Managers would not pay for surgical delivery of any woman who had previously delivered through C.S. (KII, HCP, 20/06/2019, Bode Saadu).

The exclusion of some benefits became challenging for the HCPs to relate effectively with the enrollees in situations where the needed care had been removed. An HCP confirmed the exclusion of some health benefits and recalled the challenge faced because enrollees became furious when asked to pay for any care that was not covered. She stated that:

> …Another challenge was that enrollees became furious whenever they were advised to pay for cares that were not covered by the CBHI programme (KII, HCP,15/06/2019, Edidi).

Another HCP supported the above submission while highlighting the challenges faced, and exposed the lapses of the HMO in the areas of enrollee education about the programme and how it affected their integrity as a provider. He narrated that:

> …There were also some areas which the programme did not cover in terms of treatment, and this also brought up some challenges. This was as a result of an information gap between the Programme Managers and the enrollees. The Managers, unfortunately, transferred some responsibilities to us, to educate enrollees about coverage and inclusion package, which was their duty. The gap was to the extent that some patients would come with ailments that were not in the inclusion package, but they assumed it was. By the time you treat and ask them to pay, they accuse you of double-dealing (KII, HCP, 19/06/2019, Bacita).

There seems to be more to what he regarded as information gap because the provision of inadequate or wrong information about the coverage might be deliberate (on the part of the HMO) considering the effect the information could have on enrolment decision. As a marketer of the insurance package, the HMO also had an 'ultimate' mandate of selling and expanding enrolment coverage; thus, they might have engaged in deceptive marketing. Meanwhile, misleading advertising in insurance "erodes social safety nets, corrodes trust and erases the potential of insurance as a mechanism of social solidarity" (Ericson & Doyle, 2006:993).

Primarily, the reduction of benefits package was due to the challenge of funding as it was difficult to sustain the initial package. An HMO official confirmed that the benefits package was reduced; "at some points, some healthcare services were removed from the coverage of the programme. Usually, the package was robust, but with time, funding and policy review led to the reduction of benefits package" (KII, HMO Official 1, 26/07/2019, Ilorin). He added that:

> Some of the benefit packages, too were not realistic. The benefits package did not match the fund available (KII, HMO Official 1, 26/07/2019, Ilorin).

According to the HIF (2012:11), the downward review of benefits package was necessitated by the need to ensure sustainability in terms of funding, by aligning the inclusion package to the health priorities of the target group. As much as this could sound rational, it appeared to have breached the trust of the community members or enrollees because sustainability has always been a bane of CBHI and this could have been adequately considered at the inception of the programme. This had negative consequences for the enrollees because they were only informed about the exclusion at the point of use and not at the point of enrolment or renewal of enrolment. Also, reduction in benefits tends to limit CBHI enrolment coverage (Akinyemi & Idowu, 2015) and expose enrollees to catastrophic health expenditure (Purohit, 2014:1242).

Aside from the reduction in the benefits package, further worrisome aspects of the CBHI schemes is the difficulty with accessing care for ailments that were usually not covered by the scheme such as chemotherapy, dialysis etc. There was no provision in place regarding financial protection for the healthcare needs of any enrollee whose ailment was not part of the benefits package, apart from a referral. An official of the foreign agency claimed that:

> In a few cases that tilted towards complications, we had an arrangement that they were properly referred to. UITH was our major referral centre, and they were referred to have a continuum of treatment (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

However, the submissions of other participants differ from the above claim. An HMO official noted that:

> Enrollees with ailments that were not covered were informed and taken to referral centres. At the same time, we rendered any support within our means to ensure they got treated. At times, we made special requests on why the enrollees should be assisted with financial protection for treatment. (KII, HMO Official 1, 26/07/2019, Ilorin).

More precisely, a government official submitted that:

> Enrollees were not treated for ailments that were not covered by the programme (KII, KWSG Official 2, 24/07/2019, Ilorin).

Also, a participant from a privately-owned referral centre confirmed that referred patients often complained of high cost of treatment. According to her:

> …They (enrollees) complained about our bills because they felt the treatment was free. Meanwhile, the CBHI was not paying their bills to us (KII, HCP, Referral Centre 2 Official, 12/07/2019, Ilorin).

These show that the referral system only served to guide enrollees to where 'quality' care could be accessed without adequate provision of financial protection. Fundamentally, promotion of CBHI policy is partly premised on the need to pool resources and improve access to care because most people die as a result of mild, preventable and manageable illness (Acharya & Ranson, 2005: Odeyemi, 2014); thus, where diseases are manageable, fund should not be a barrier to access. At the policy level, however, there is a huge concern about the benefits package as a component of the CBHI programme because it usually, states clearly, the specific healthcare services covered by the programme. This limitation usually placed on coverage

technically and subliminally ignores the other healthcare needs of the enrollees that are not covered by the CBHI programme. For example, Ayebazibwe (2019:12) found that a CBHI in Uganda did not cover high blood pressure and diabetes. Myint *et al.* (2019:2), argued that "a unified health insurance system providing the same benefits package for all, is the most efficient way to attain equitable access to health care". Meanwhile, the existence of CBHI programme tends to shift possible social policy attention of the government from adequate spending on healthcare to other sectors, denying the health sector the needed attention.

8.2.2.2 Inadequate Enrolment Coverage

Enrolment was a challenge in the programme. The enrolment coverage during the nine years (i.e. 2007 and 2016) was 4.41% of the State's population, though, the focus was on the rural areas which accounted for more than 70% of the entire population. One of the reasons attributed to the low level of coverage was the increase in enrolment premium (KII, HMO Official 1, 26/07/2019, Ilorin). Another participant linked inadequate enrolment coverage to non-engagement of adequate staff by the HMO to strengthen the enrolment drive. He stated that: "…For Hygeia, I believe the staff strength provided was not enough in terms of coverage of communities. We devised means of employing agents in the community, and we paid them a commission based on the number of enrolments" (KII, HMO Official 2, 29/07/2019, Ilorin). This was confirmed by a community member who noted that some surrounding communities were not reached in terms of awareness and enrolment efforts. According to him:

Enrolment yen ko *cover* gbogbo igberiko.	The enrolment efforts did not reach most of the small villages around here. (IDI, Male, 20/06/2019, Bode Saadu).

Instead of boosting enrolment through the improved workforce, the use of agents by the HMO was perhaps, a way of reducing expenses; and this took its toll on the programme in terms of enrolment coverage. Generally, achieving large enrolment base is a common challenge in CBHI programmes as reported by Adebayo *et al.* (2015) in LMICs, Aggarwal (2011:1657) in India, Mladovsky *et al.* (2014:18) in Senegal, Ajuaye *et al.* (2019:1304) in Tanzania and Odeyemi (2014) in Nigeria.

8.2.2.3 Low Capitation

One of the challenges identified in the programme is the payment of low capitation to the HCPs. Meanwhile, the HCPs are at the forefront of the CBHI programme implementation. Importantly, where health policy implementation process is poorly organised, without adequate consideration for the interest of the healthcare workers, the policy goal would be negatively

impacted (Béland & Ridde, 2016:16). Some of the HCPs lamented that the responsibilities and duties carried out under the programme were more than the remuneration they got. The capitation was not stable; it was reviewed continuously. Before the end of the programme, the capitation of private facilities was ₦180 while the public facilities were receiving ₦140 per enrollee (KII, HCP, 27/07/2019, Oro). One of the HCPs noted the inadequate amount while highlighting the process of getting capitation. She stated that:

> We complained that the capitation given to us was small compared to the huge amount of work. As providers, we were given capitation ahead of treatment, that was ₦250 or ₦350 per enrollee, in the first week of the month to purchase drugs. For government hospitals, they paid into the government coffers to purchase drugs for all government facilities. At the end of the month, the list of cases treated that were beyond capitation such as C.S. would be sent to the Programme Managers for claims (KII, HCP, 20/06/2019, Bode Saadu).

Another healthcare provider noted that the capitation was very low and concluded that it was the enrollees that bore the consequence. He stated that:

> The capitation was abysmally too low... In the end, the enrollees were the ones affected. Because of this, the HCPs could not improve their service because they were managing what they were given (KII, HCP, 27/07/2019, Oro).

Other HCPs added that:

> As time went on, they [i.e. the HMO] started reducing the number of cases they paid for. For instance, they stopped paying for surgery and evacuation and other fee-for-service illnesses outside capitation. The reason was that there was no money (KII, HCP, 15/08/2019, Gure).

> When the capitation was reduced, the dosage was also reduced, and the enrollees complained through the questionnaire, and we explained that it was due to low capitation (KII, HCP,13/06/2019, Erinle).

Being a public-private partnership programme, there was "an inherent contradiction between the quest for profits and the need to deliver quality healthcare services to the people" (see Romero & Gideon, 2019:11). The HCPs would not want to jeopardise their interests, and as such, the burden was transferred to the enrollees in the programme. The reduction in capitation that led to a reduction in benefits package was a serious flaw in the implementation of the

programme. It was also an indication of the non-sustainability of the funding requirements of the programme. Myint *et al.* (2019:1) noted that inappropriate payment mechanisms have devastating consequences for the quality of care. More broadly, Robyn *et al.* (2013:111) observed that inadequate payment of providers could hamper effective participation, quality and quantity of services, satisfaction, enrolment population and financial sustainability of CBHI programme. Thus, the role of HCPs is vital to the success of CBHI programmes.

8.2.2.4 HMO and HCP: Clash of Interest

HCPs often do not have confidence in HMOs regarding guaranteed payment of their entitlements (Mladovsky *et al.*, 2014:9). The HCPs in the Kwara CBHI complained about the constant change in policy. Notably, they complained about the introduction of fingerprint enrolment system, that they were wrongfully refused payment for errors made by the enrolment officers, who were staff of the HMO. One of the HCPs explained that:

> Change of policies, especially with the introduction of ICT software for fingerprint enrolment. This posed some challenges in terms of accepting or rejecting some enrollees or record multiple enrolments. In the process, healthcare providers were deprived of their entitlements because of the non-functionality of the software introduced by the Programme Managers [i.e. HMO]. Another problem was the inability to continue the programme, and there was poor financial will to sustain it at all cost. Also, there were no other financial commitments apart from the partners (KII, HCP, 28/07/2019, Aboto-Oja).

Another HCP who felt short-changed added with an example that:

> When the Enrolment Agents typing the names made mistakes, they transferred the blames to us, and we were not the ones doing the computation. For instance, if the gender of MUHAMMED FATIMA was mistakenly documented as male and if the person delivered a baby; they would say "How can a man deliver a baby?" That was atrocious and fraudulent because they were passing the blame on us, and we had nothing to do with the enrolment. There was usually gender error, age error, spelling error, and error while transferring data from one segment to another (KII, HCP, 19/06/2019, Bacita).

He continued that:

> All these were thorns in our flesh. We were short-changed of payments arising from the errors. Many times, they did not pay for such errors, and services had been delivered. There was a time we lost over a million naira to that errors. Of course, our IT Department

had their own issues because of the pressure of work on them but minimal (KII, HCP, 19/06/2019, Bacita).

Apart from the fund-related clash, an HCP complained about pre-authorisation before carrying out some treatments. She explained that:

> The problem we had with the Programme Managers was regarding pre-authorisation before carrying out the surgery, except emergencies. Some enrollees wanted it to be conducted as early as possible but won't be paid if it was not authorised. Then, enrollees became annoyed (KII, HCP, 13/06/2019, Erinle).

This suggests that the HMO did not have full trust in the HCPs, and the imbalance relationship tends to have adverse effects on the smooth implementation of the programme. For instance, seeking pre-authorisation before embarking on surgical procedure gives way for possible loss of life where there is a delay. Each party wanted to protect its interest. At the same time, the HMO acted to guard against 'unjustified' claims. The HCPs expected not to be 'wrongly' held accountable for lapses outside their purviews or incur a financial loss.

8.2.3 The Health Care Providers

HCPs are expected to understand the objectives of CBHI and appreciate their roles in the success of the programmes (Ndiaye *et al.,* 2007:160). However, in this study, the conduct of some HCPs posed specific challenges to the CBHI programme. While some of them greeted their grievances with the programme managers on the enrollees, others explored and exploited the loopholes in the CBHI policy to their own advantage.

8.2.3.1 Long waiting Period

The former enrollees complained about the long waiting period before accessing care in the healthcare facilities. This is a common glitch in the implementation of CBHI programmes (Adebayo *et al.,* 2015:1; Onwujekwe *et al.,* 2009:99; Mukagendo *et al.,* 2018:4). Though the HCPs might have their faults, this problem was partly because the programme was operational in selected and few facilities, leading to a hike in utilisation rate in the facilities. This was rife in government hospitals with inadequate staffing (IDI, Female, 13/06/2019, Erinle) and the government had the highest number of facilities in the programme (i.e. 32 out of 43). Typically, seeking healthcare should not be accompanied by stress or uncertainties. Still, in circumstances of this nature, some enrollees might not be able to endure the long wait to access care and would eventually return home without medical attention. With this in mind, some community members might have refused to enrol or renew enrolment. A participant explained that:

> I enrolled in the programme with my family, but I stopped using it for healthcare when I took my child to the hospital one day, and we were delayed for several hours without being attended to. We left them to receive treatment in another hospital (IDI, Male, 03/07/2019, Gure).

A community leader confirmed the problem and stated that:

> Opolopo ma n *complain* ‘pe *a lot of time* lawon lo nibe nitoripe eyan tipoju. Eleyi *discourage* opolopo eyan lati lo *hospital* na. Sugbon eniti obale ni suru, yio ri toju todaa gba.
>
> Most people complained that they spent a lot of time waiting to receive care. This discouraged most people from accessing care under the programme. However, those who could endure got quality care (KII, Community Leader, 20/06/2019, Bode Saadu).

A community member also noted that:

> The only challenge I saw in the programme is that you may get there and meet many people (IDI, Male, 26/06/2019, Oro).

Another community member confirmed that:

> Ero man po gaan ni *hospital*. Eyan de ma pe die.
>
> There was usually a high number of patients in the hospital waiting to receive care. One would wait for some time before getting medical attention (Female FGD, 27/05/2019, Osi).

Another participant shared his experience regarding the hardship that enrollees went through to access care. He explained that:

> I know of people who left their homes around 3:30 am to the hospital to access care because of a multitude of enrollees also seeking care. Many people wanted to be around before 7:00 am when the hospital would start consultation/treatment. Those who could not stay long might not be able to access care except those with cases of emergency (IDI, Male, 19/06/2019, Bacita).

This problem was confirmed by a researcher that: “some people complained about the long waiting period” (KII, Researcher, 30/07/2019, Ilorin). This finding is affirmed by the study

conducted by AIGHD (2015:54) on the same programme which found during the FGD that some enrollees refused to utilise the service because of overcrowding, which stemmed from understaffing in the facilities. The HCPs acknowledged the challenge and one of them remarked that:

> The complaints lodged by patients when the programme was active related to the long waiting period due to the high rate of utilisation. But generally, everyone was taken care of because we had enough doctors (KII, HCP, 21/06/2019, Osi).

Though, the problem of long waiting period could be partly blamed on the poor healthcare situation in the State, which had an inadequate number of healthcare facilities and personnel. Nevertheless, it was expected of the healthcare providers to ensure adequate staffing of the facilities and provide prompt services to the enrollees. The HCPs, however, saw it as a 'normal' phenomenon where there is a high utilisation rate. One of the HCPs who viewed it as normal noted that the utilisation could be very tiring and then, highlighted their efforts in militating the challenge. She explained that:

> Enrollees usually complained of waiting normal time, but then we had three doctors on the ground to attend to about 400 patients daily. In the morning, three of them would be on shift, one would be off in the afternoon, and two would be on call overnight. At times, when there were emergencies overnight, doctors may be tired in the morning, and patients would be complaining (KII, HCP, 13/06/2019, Erinle).

Another provider noted that: "Then, I had three to four doctors working with me. Despite that, patients complained that it took too long" (KII, HCP, 19/06/2019, Bacita). He argued that the problem could not be resolved in situations where there are high rates of utilisation by enrollees. According to him:

> By training, each patient must be given enough attention, but some of the enrollees complained about the long waiting period. Meanwhile, when it comes to their time, they want to spend as much as possible time with the doctor to be detailed enough in their consultation. There is no way such a problem can be divorced from massive turnout (KII, HCP, 19/06/2019, Bacita).

The HCPs could only improve the situation within the financial resources acquired through the programme. The challenge was a systemic problem, and it persisted with no clear solution. An official of the international agency also noted the challenge and stated that:

> The long waiting period was due to high utilisation rate, and as such, the manpower suffered (KII, Foreign Agency Official 2, 02/09/2019, Ilorin).

Thus, this questions the suitability of the CBHI policy option of healthcare services provisioning. It may not record appreciable success in settings without equal attention for healthcare infrastructural and human resources development for building a formidable healthcare system. Fundamentally, the government has the responsibility to make "direct or indirect investments in health and healthcare infrastructure" (Tuohy & Glied, 2011).

8.2.3.2 Preference for Non-Enrollees

There were complaints by participants that certain healthcare providers exhibited some unethical conducts while providing healthcare services under the programme. For instance, some enrollees complained that non-enrollees were given better attention over enrollees because non-enrollees would pay OOP. This was peculiar to some private healthcare providers. A community member recalled that:

> Igbati won koko bere, won toju eyan; igbati to ya, tieba ti so'pe *Hygeia* nioo, won o so'pe kelo joko na. Won o koko toju awon tofe sanwo na.
>
> The programme was very effective at inception, but later, the enrollees were not given prompt attention. Priority was given to those who paid OOP for care (IDI, Female, 17/06/2019, Odo-Owa).

Another community member noted while lamenting about the poor quality of care and preference given to non-enrollees that:

> Won sofun awon elomi kanlo m'owo wa.
>
> Some enrollees were asked to pay OOP for care (Female FGD, 29/05/2019, Idofian).

In another community, a participant recounted that:

> Kinikan wa tofe mu *confusion* wa nigba yen. Oun ni *time* tan fiile fun'toju awon toni *kaadi*, won o sope ise *government* ti pari. Seeri, ti eyan balo lataaro, toba tidi bi *two*, won oti *stop* ise. Ise owo loku tiwoon maase.
>
> There was something that was somehow confusing when the programme was operational. They had specified time to attend to enrollees; they would say that they were done with the government's work [i.e. the CBHI programme] for the day. See, they attended to enrollees from morning till around 2 pm, and they'll leave them for

attending to those who would pay OOP (Male FGD, 03/06/2019, Gure).

Another participant added that:

> Nigba taalo'be, enitoni *hospital* sofunyan' pe: toun o ba gba owo, awon omo tantele oun, kini won o je.
>
> When we went there, the owner of the hospital told people that: if he didn't collect OOP payment, how would he pay his staff (Male FGD, 03/06/2019, Gure).

The finding above is similar to the finding of in Ghana by Derbile and van der Geest (2013:590) that "healthcare workers abused poor enrollees with exemptions at the point of accessing care". Ayebazibwe (2019:15) also found that a CBHI in Uganda offered better services to patients who paid cash. In this study, the conduct is, however, inimical to the terms of their engagement in the programme. The idea was that the HCPs would be able to achieve their earnings through the provision of services, mainly to the CBHI enrollees since they were in the rural areas where healthcare utilisation is usually low. Still, it did not stop them from attending to non-enrollees but not at the detriment of those who were enrolled.

8.2.3.3 Foray of HCPs into Enrolment

Given the complaints by the private healthcare providers that the capitation given to them was low, some of them found a way of increasing their earnings within the available context of the policy. The HCPs colluded with the enrolment officers by providing fund for enrolling community members freely, to boost their enrolment base. This, in turn, would make them eligible to get capitation on the total number of enrollees registered with their facilities. For instance, if a facility has 10,000 enrollees, it would be entitled to ₦180 X 10,000 enrollees per month (i.e. ₦1,800,000 X 12 months, gives ₦21,600,000). One of the HCPs touched on this while complaining that poor capitation could stimulate sharp practices. He noted that:

> …As a result, it encouraged sharp practices where the HCP decided to use their funds to enrol some people, essentially healthy population who may not want to access the care to drive in more capitation to cushion their expenses (KII, HCP, 27/07/2019, Oro).

Also, an official of the international agency confirmed that the HCPs explored various opportunities to maximise their earnings from the programme, including giving 'unnecessary' treatments that could attract fee-for-service. She explained that:

> For facilities to make more money, they would always cut corners, and that was very eminent. There were different ways they were trying to manipulate the system. For instance, a facility would earn more based on the collection of fee-for-service as opposed to capitation (KII, Foreign Agency Official 2, 02/09/2019, Ilorin).

She continued that:

> When you increased the number of visits a patient has made, or a patient comes in for just malaria, and you treat him for something else because the drug implication for that particular treatment is higher. To manipulate the system, deliberately data are distorted so that this can happen; and for growth we need data, and that is why the need for technology is very eminent (KII, Foreign Agency Official 2, 02/09/2019, Ilorin).

Given the above, it is instructive to rethink and note two fundamental points regarding enrolment. One, the total enrolment coverage of about 140,000 enrollees at the end of the programme was partly motivated by this 'ploy'. Two, the submission of the respondents and participants, as presented in Chapter 7, regarding non-affordability of ₦500 premium is factual. This is because if the strategy was not deployed, the total enrolment might not be up to that. It is because of situations like this that Benatar *et al.* (2009:361) challenged the moral basis of the promotion of privatisation of healthcare services, in the recent decades, that it is detrimental to the goal of health for all or UHC. They noted that "it is becoming clear that our modern system of morals, with its emphasis on market values, the desirability and necessity of corporate power and their institutionalisation in bureaucratic processes promotes corruption and extreme forms of exploitation that are tantamount to slavery".

8.2.4 Former Enrollees and Abuse of Care

The art of managing enrollees also came up as a challenge under the programme, especially in their relationship with the HCPs. The conducts of some enrollees culminated in what could be called abuse of care. They capitalised on their enrolment cover to access healthcare at the slightest opportunity for the simplest complaints. Also, some of them did not have an understanding of how orthodox healthcare works and expected to recover from ailments almost immediately. A community leader observed that:

Elomi, ti aare bade arare yoosi fe kolo ni' sejukan. Aasese wa funwon ni suuru pe	Some enrollees expected to gain full recovery immediately after receiving treatment. We, however, educated them that

koda b'eyan bam' agbo na, koni sare *cure* re lesekan.	recovery would be gradual even if they were treating the ailment using herbs (KII, Community Leader, 01/07/2019, Aboto-Oja).

Using an example, a participant during an FGD in Bacita noted how some enrollees ignorantly accused the HCP because the medication given to them fell below their expectations. She recounted that:

Elomi je alainitelorun. Iyakan wa toun rojo nijokan 'pe ogun die ni won fun oun tiwon si di ogun to po fun awon kan. Mowani kile sope oseyin, oloun ni iba lomu oun, ori nfoun. Mowa sofun 'pe dede ounti yio wulo fun onikaluku ni won fun won. Iya yen pada rimi leyin bi ojoketa, owa dupe fun mi 'pe omo mi omaseun, wipe oun lo ogun na, ode se dede ara oun.	Some people were not contented. One day, there was a woman who was complaining that she was given a few drugs, while some other enrolled patients were given many drugs. I asked her of the ailment she took to the hospital, and she said malaria and headache. I had to educate her that each person was given what they needed. She later thanked me when we met about three days after that she had recovered using only the drugs (IDI, Female, 19/06/2019, Bacita).

Another strand of abuse among enrollees was to deceptively lodge a medical complaint at their healthcare facilities to obtain drugs, as a way of benefiting from the programme before the end of an enrolment year. A community member narrated that:

Elomi leso'pe: mii lori lodun ni oo, emi naelo, nre gboogun. Ati nkan se, ati nkan 'o se, won lawon osaa koo' le.	Some enrollees would say: I have not benefitted this year, I'll also go and collect drugs. Whether they were sick or not, they said they would keep it at home (IDI, Female, 13/06/2019, Erinle).

Some key informants confirmed that some enrollees lacked an understanding of the principle of insurance and were keen on benefitting from the programme within the enrolment year. They stated that:

> Some saw their premium as a contribution and wished they could collect a refund (KII, NHIS Official, 01/08/2019, Ilorin).

> Those who did not fall sick to use the care did not want to renew enrolment and wished to collect their premium (KII, KWSG Official 1, 20/08/2019, Ilorin).

Also, there were cases where some community members would not enrol until they needed to access healthcare. Meanwhile, the access rule is a month after enrolment to minimise adverse selection. A community leader who observed it stated that:

> Some people did not enrol until when they needed to access care (KII, Community Leader, 19/06/2019, Bacita).

Further, some healthcare providers shared their experience on the conduct of the enrollees in terms of abuse of access. One of them recalled that:

> The problem we had with enrollees was moral abuse. For instance, there was a day an enrollee came and was complaining about 'belching after eating', around 11 pm. Though, we appreciated if enrollees came for a check-up but not to abuse the access to care (KII, HCP, 13/06/2019, Erinle).

Though hospitals are expected to be open 24 hours a day and accept emergencies, regardless of the time of the day. Also, typically, healthcare workers on duty are expected to be available to attend to patients. However, another HCP recalled a case of abuse by enrollees. He explained that:

> You can imagine someone coming at 9 pm to check blood pressure without being a known hypertensive patient; when healthcare workers were to be relaxing. To such people, we told them, this is not the time you suppose to come… It was an abuse of process, and we wanted them to learn the right thing (KII, HCP, 27/07/2019, Oro).

A community member substantiated the assertion of the HCPs on abuse of care and cited an instance that:

> Elomi lede bayi koni oungbawe lataaro, oun sese sinu tan nisin, boun se j'amala gbona l'oru wa mu oun.
>
> An enrollee might come now and say he was fasting since morning; he just broke the fast by eating hot amala, and he's feeling the heat (IDI, Female, 13/06/2019, Erinle).

In the same vein, Garshong *et al.* (2001:23) reported abuse of care by exempted enrollees in Ghana. The latter returned to the hospital within a few days of treatment to obtain more medications while they were yet to consume the earlier ones dispensed to them altogether. As

a result of the interaction between the enrollees and the programme managers through various means, HCPs found it difficult to decisively deal with abuse of care because they might be reported to the programme managers. An HCP recounted how enrollees obtained drugs through the programme for non-enrolled relatives. She narrated that:

> Enrollees came to the hospital even with unnecessary cases, and we must give them drugs when they arrive. This is because there was a forum of enrollees and PharmAccess Foundation/Programme Managers where they interacted with enrollees and took up their complaints with the providers. Though, we didn't give drugs at times because not all cases required drugs (KII, HCP, 20/06/2019, Bode Saadu).

She added that:

> At times, enrollees came to the hospital to obtain drugs for their non-enrolled relatives and came back the following week for another treatment that the ailment was still persistent. We eventually discovered this prank because some came at a time when they should not have finished using the drugs given to them earlier (KII, HCP, 20/06/2019, Bode Saadu).

Though, not many, but there were cases of impersonation among the enrollees. An HCP noted that: "Impersonation wanted to come, but we prevented it" (KII, HCP, 13/06/2019, Erinle). However, it took place in another community, perhaps undetected. A former enrollee noted during an FGD while discussing the prompt for enrolment that:

> Igbat'okoko bere miogba *kaadi*. Owa re omomi okunrin kan nigbayen. Mowaya *kaadi* eyan kan, mofi gbatoju. Igbayen ni mowa ri 'pe *kaadi* yen ni nfaani pupo.
>
> I didn't enrol in the programme at inception. One of my male children then fell sick. I borrowed someone's enrolment card to access care. It was then that I realised that enrolment in the programme was beneficial (Female FGD, 31/05/2019, Aboto-Oja).

Abuse of care by non-enrollees is a peculiar problem in settings where healthcare is seen as an opportunity and privilege. This problem is less likely to be pronounced in places where the health policy allows easy access to healthcare. For example, it would not be necessary to obtain drugs and keep for future use or give to another person for consumption, if the health system is good. Also, there were cases where people came from distant locations, outside the spatial coverage of the programme, to access care under the programme. People that were resident in

neighbouring Ekiti and Kogi States (Male FGD, 27/05/2019, Osi) and Lagos State (Female FGD, 30/05/2019, Bacita) travelled to rural Kwara to access care. This shows the level of weakness in the Nigerian healthcare system, which is 'incapable' of easing access to healthcare for the people. Notwithstanding, the actions of these enrollees are condemnable.

8.3 Stoppage of the CBHI Programme: The Reasons

The respondents (i.e. formerly-enrolled and non-enrolled community members) were not in the forefront of the implementation of the programme and as such, might not be fully aware of the actual reasons that led to the stoppage of the programme. However, they shared their opinions based on their experience with the programme. Also, the stoppage of the programme was not accidental because the challenges discussed above are capable of crippling the success of a programme, especially when they are left unresolved. Consequently, some of these challenges form part of the perceived reasons advanced by the respondents, causing the stoppage or collapse of the programme. These are indicated in Table 8.2 below.

Table 8.2: Perceived Reasons for the Stoppage of the Programme

Reason	**Former Enrollees**		**Non- Enrollees**	
	Frequency (N = 860)	**Percentage**	**Frequency (N = 380)**	**Percentage**
Failure of the state government to pay counterpart fund	132	15.3	23	6.1
Non-availability of drugs	3	0.3	0	0
Poor treatment	30	3.5	3	0.8
Poor attitude of healthcare workers	9	1	1	0.1
Poor management	26	3	13	3.4
Lack of political will	1	0.1	5	1.3
Request for OOP payment	9	1	0	0
I don't know	425	49.4	218	57.4
New policy by the government	8	0.9	18	4.7
Inadequate staffing	2	0.2	0	0
Corruption	0	0	1	0.3

Inadequate benefits package	1	0.1	0	0
Poor enrolment	0	0	1	0.3
Funding challenge	135	15.7	60	15.8
Inadequate equipment/ facilities	10	1.2	0	0
Information gap	2	0.2	0	0
Bad governance	67	7.8	37	9.7

Source: Fieldwork 2019

As shown in Table 8.2 above, more than 50% of the total respondents did not know the reasons for the stoppage of the programme. This might be understandable because they were not at the forefront of the implementation of the programme. However, about 16% each among the non-enrolled and formerly-enrolled respondents pointed to funding as a challenge. In contrast, among the former enrollees, exclusively, 15% attributed the stoppage to failure of the government to fulfil its funding agreement to the programme. Also, the former enrollees who indicated funding challenge were indirectly blaming it on the government because it had a responsibility of providing fund for the programme. In essence, the main reasons given by the respondents are fund-related and bad governance. Similarly, Deo *et al.* (2018) concluded from a situational analysis that CBHI adopted in 1990 in Nepal eventually failed due to a myriad of challenges. This is because any observed shortcoming in the programme tends to decrease enrolment, which is a crucial factor in CBHI success.

Further, the qualitative findings provide better insights into the reasons, indicating that the main reason for the stoppage was funding. While most others did not know, three out of six community leaders, eleven out of twenty-five community members and six out of twelve FGDs concluded that the programme stopped due to non-payment of counterpart fund by the state government. Also, eight out of ten HCPs stated that the stoppage was as a result of the funding, specifically, the non-payment of counterpart fund by the state government. All the government officials confirmed this. Contrastingly, while the officials of the foreign agency acknowledged the challenge of non-payment of counterpart fund by the state government, they argued that the programme did not collapse but transitioned into a state-wide programme to cover everyone in the State.

Often, success or failure of public CBHI programmes is mainly attributed to the government and external donors (see Ranson, 2003:86) because of their crucial roles and level of

involvement. Findings from the qualitative data indicate two major causes of the collapse: non-payment of counterpart fund and bad management. While the non-payment of counterpart fund was attributed to the state government, bad management was assigned to the main actors in the programme at varying degrees – the HMO, the foreign partner and the State government agency. The main reasons are further considered as thus:

8.3.1 Non-Payment of Counterpart Fund

The success and sustainability of any policy programme are heavily reliant on the availability of fund. Given the heavy subsidy of the enrolment premium, Humphrey (2010) raised concerns about the sustainability of the programme because of the huge subsidy involved. As envisaged, the CBHI had a serious funding challenge. The state government was not able to fulfil the funding agreement signed with the international partner towards ownership of the programme. The counterpart fund was essential for the smooth running of the programme. However, after its financial commitment in December 2013 (PharmAccess Foundation, 2015b:3), the state government ceased to fulfil its financial obligation to the programme, and this posed sustainability challenges. One of the community leaders noted that: "The reason given was non-payment of counterpart fund by the state government" (KII, Community Leader, 11/07/2019, Idofian). Similarly, some community members noted that:

> Nkan taagbo nipe oni *counterpart fund* t' oye ki s*tate government* san. Igbati won 'o san, boya oun lofa ti won fi *stop programme* na.
>
> We learnt that the state government did not pay its counterpart fund. This might be the reason for the stoppage of the programme (IDI, Male, 20/06/2019, Bode Saadu).

> The reason was that the state government did not pay its counterpart fund. People were so disappointed in the state government and annoyed (IDI, Male, 02/07/2019, Kaiama).

Also, a healthcare provider noted: "Inability of government to pay their counterpart funds" (KII, HCP, 21/06/2019, Osi) as a reason for the stoppage. Other HCPs added that:

> We were informed that the programme would be winding up that the government was not paying its counterpart fund (KII, HCP, 15/06/2019, Edidi)

> The reason given was that funds were no longer available, essentially, from the state government side and not the donor (KII, HCP, 19/06/2019, Bacita).

He added with dismay that:

> It was the political will that made it possible in the beginning. It was the most meritorious work done by the government for not rejecting it. However, for not injecting their counterpart funding in the programme, they helped in its collapse (KII, HCP, 19/06/2019, Bacita).

Further, the HMO officials acknowledged non-payment of counterpart fund as a reason for the stoppage. They noted that:

> Fund was the major reason for the stoppage of the programme because it was not coming as expected, especially from the state government (KII, HMO Official 1, 26/07/2019, Ilorin).

> The reason for the stoppage of the programme was non-payment of counterpart fund by the Kwara State Government (KII, HMO Official 2, 29/07/2019, Ilorin).

In fact, all the government officials in the study affirmed that the collapse of the programme was due to non-payment of counterpart fund. They, however, blamed it on recession or decreased federal budgetary allocation to the State. One of them recalled that:

> When there was a drop in allocation from the federal government in 2015, and we were not able to pay counterpart fund, that was when we started having a problem. You know those people would not take any excuse. From their own side, they were very serious and very upright, but because of the problem of allocation, we were not able to meet their demands, and it was at that time that the programme wound-up (KII, KWSG Official 1, 20/08/2019, Ilorin).

Nonetheless, the drop in federal allocation to the State, the government could give the programme some priorities but failed to do so. The participant further linked the stoppage to the: "Attitude of the government by not wanting to spend money on anything. They underrate the benefits that the people would derive" (KII, KWSG Official 1, 20/08/2019, Ilorin). This is due to non-interest by the then government and lack of strategic policy roadmap for successive government to follow.

For clarity, the programme commenced during the tenure of Governor Bukola Saraki and the non-payment of counterpart fund was experienced during the tenure of his successor, Governor AbdulFatah Ahmed (who was also a senior official in the Saraki administration). Despite that, both of them belonged to the same political party (with campaign claims that Governor Ahmed was to continue the works of Governor Saraki) they had a different level of interest and

commitment to the programme making the signed agreement seemingly unreliable. Similarly, a CBHI programme in Anambra, South-east Nigeria partly failed because it did not get political and financial backing from the new government (Onwujekwe *et al.,* 2009:31).

There were concerns on whether the programme would outlive the tenure of the governor who signed an agreement with the foreign partner. According to Ayangbayi, "In five years' time, the person who promised [to pay the subsidy] today will not be in the government. So, who are you going to hold accountable?" (quoted in Humphreys, 2010). Generally, each leadership in power comes up with its template and policy plans. This approach is detrimental to meaningful development because it makes it difficult to implement policies towards success. Meanwhile, transformative social policy requires long-term plans, guarded by legislation, for implementation by successive governments. In other words, "social policy requires a democratic set up that embeds protection of human rights and civil liberties" (Lucas & Badubi, 2017:88), devoid of subversion (Adésínà, 2020:576).

Other government officials explained that:

> Fund was part of the reasons for the collapse of the programme (KII, KWSG Official 3, 01/08/2019, Ilorin).
>
> The major reason was finance because everything was in motion. The non-payment of the counterpart fund led the partner to pull out of the programme (KII, KWSG Official 2, 24/07/2019, Ilorin).

Further, the officials of the international agency confirmed that the state government could not pay its counterpart fund to the tune of ₦300 million. She explained that: "…Financing was also a challenge, especially when the Kwara State Government took over the programme and could not meet up due to economic recession" (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). She added that:

> Because of the economic recession in the country, for more than two years, the state could not pay counterpart funding of the programme which PharmAccess Foundation as an organisation was paying for the State. So, the State incurred a counterpart bill over ₦300 million (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

However, officials of the international partner only noted funding as a challenge but not the reason for the stoppage. They claimed that the programme did not collapse but was transitioning into a state-wide programme that would cover all residents in the State. One of

them noted that the stoppage of the programme was due to a need to expand the programme to cover the entire population in the State (KII, Foreign Agency Official 2, 02/09/2019 Ilorin). Further, while they agreed that the financial challenge was not totally resolved, one of the officials emphasised that the transition was a response to a global trend. In her words:

> By the year 2016, everything in the world was changing, and the narrative changed that we needed to have universal health coverage, everybody everywhere; no matter the status or location, you must have access to quality healthcare. So, the paradigm has to change that, community-based was strictly community-based; we needed to now have a state-wide…So, the CBHI began the journey of transitioning into a state-wide health insurance scheme (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

The claim that the programme was transitioned may not be tenable because: one, community members have been left without coverage since 2016 until the 'launch of the State-wide' programme in 2018. Two, transition ought to be seamless without a stoppage. Three, the state-wide programme (meant to restore the coverage of the former enrollees and further cover the entire population) was launched in 2018 without implementation. In other words, it took almost two years to launch the state-wide programme in 2018, after the stoppage of the CBHI in 2016. As of August 2020, it is yet to commence operation. An HCP also expressed that: "The transition period between the cancellation and start of a new one has been too long" (KII, HCP, 19/06/2019, Bacita). Notwithstanding the change in government, ordinarily, if a programme is transitioning, it would do so seamlessly without major glitch or stoppage for a protracted period. It is also not out of place to argue that the launch in 2018 was a mere 'political stunt', to show on record, that the state-wide programme was initiated by the immediate-past governor because there were no adequate structures and facilities in place for a smooth take-off of the programme.

Essentially, the transition to state-wide programme appeared to be an idea of the international partner (who felt a need for a paradigm shift – as quoted above). This is because the state government could not live up to its financial obligations to the CBHI with the claim that it had financial deficiency through dwindling federal allocation. Therefore it could not have thought of a state-wide programme which requires financial commitment far more than the community-based programme that was rural-centric. More so, availability of fund is a cornerstone in of public or social policy decision (Signe, 2017a:20). Perhaps, the international partner found Kwara State as a 'veritable site' for experimentation of health insurance models.

8.3.2 Poor Management

Efficiency in management is an essential factor for the success of CBHI programmes (Ranson, 2003:86). Bennett *et al.* (2008) however observed that "the main reasons in the past for failure of CBHI schemes have been managerial problems like poor design, mismanagement, lack of oversight mechanisms and corruption" (cited in Purohit, 2014:1241). Most of the participants commented that the programme was plagued with bad management. The problem ranged from misappropriation of the fund to several other forms of inadequacies. The collapse was linked to the mismanagement of fund by the HMO. One of its officials explained that: "The stoppage came to us as a shock, but the issue of funding and 'corruption' led to the stoppage with a re-bouncing effect on the people in the communities because they were dissatisfied. Corruption on the part of the government because there was an agreement to pay counterpart fund; there was integrity issue" (KII, HMO Official 1, 02/09/2019, Ilorin).

Contrarily, Some (3 out of 6) of the HCPs noted that the programme was characterised by bad management and misappropriation of the fund on the part of the HMO. One of them recalled that:

> One of the things that killed the programme was the administration of the fund. Some of us were unofficially privileged to have access to the evaluation report of the finance after the programme. About 50% of the fund was spent on administration without clear justification in terms of office keeping, salaries of Hygeia staff etc. How can the programme be sustainable? No reasonable planner of health insurance would allocate such amount to administration. The problem boils down to the fact that the Kwara State Government did not take ownership of the programme. It's like giving someone a blank cheque to write any amount they like (KII, HCP, 27/07/2019, Oro).

Another HCP stated that "It seemed they were using the bulk of the money to run the secretariat in Lagos and we only did as they wished" (KII, HCP, 15/08/2019, Gure). He added that:

> They were using most of the money on their own recurrent budget. Whenever the M.D. [Managing Director] came to Ilorin, they lodged in Kwara Hotel and other expensive hotels. The flights and hotel bills were paid from the fund meant for the programme. Some of their staff go on December holidays in the UK or the US, from the programme's fund. Therefore, the programme was characterised by bad management (KII, HCP,15/08/2019, Gure).

In addition to identifying poor funding and leadership with the collapse, an HCP noted:

> …Selfishness on the part of the Programme Managers. The money needed for people in rural areas is not much, but they fought for their own comfort at the expense of the enrollees. Some of the vehicles we asked for, to take healthcare to the people in the hard-to-reach areas were some of the ones they drove around (KII, HCP, 20/06/2019, Bode Saadu).

The HMO officials noted mismanagement of fund and submitted that:

> If we want to be sincere, in this part of the world, we have a lot of issues with leadership and management; and being proactive as well. If not for this, why would the programme have to stop if we were on top of our game? Saving for the rainy days was not put in place… There was a lot of mismanagement in the money that was gotten initially. It's supposed to be well-planned. When the programme started, there was a lot of funds to run it, and if it were appropriately managed and invested, the situation would not have gone this bad (KII, HMO Official 1, 26/07/2019, Ilorin).

> …I also feel that maybe some people were a bit extravagant. When you see the Dutch people funding the programme coming to Kwara, they would not use aeroplane but let the Hygeia people come from Lagos to Kwara; they came in an aeroplane (KII, HMO Official 2, 29/07/2019, Ilorin).

Also, as briefly noted earlier, the private facilities performed better compared to the public facilities. A participant noted that: "The private facilities performed better under the programme than the public facilities" (KII, HMO Official 1, 26/07/2019, Ilorin). Another participant expressed his discomfort with the management of the public facilities under CHIS (the government agency) and narrated how it affected the enrolment coverage of the programme. He recounted that:

> We had people that managed the scheme for the state government. The CHIS was in-charge of the state facilities in the programme. Part of the issues we had with enrolment is that all the state facilities except in Edu LGA were struggling. Majority of the state facilities could not perform to the level of the privately-owned facilities because sometimes enrollees would get there and there would be no drugs (KII, HMO Official 2, 29/07/2019, Ilorin).

He added that:

> Remuneration of staff was poor, especially those under CHIS. And when your staff are not motivated, they would also not perform (KII, HMO Official 2, 29/07/2019, Ilorin).

From the preceding, there is an indication that there was no smooth synergy between the two bodies in-charge of healthcare facilities – HCHC and CHIS. Each party seemed to have capitalised on pursuing their interests and overlooked the excesses of each other. A participant opined that the government could have curtailed mismanagement on the part of the HMO. He noted that: "If the Kwara State Government had been monitoring the HMO and obtained the quarterly report from them, it would have checkmated that much longer. However, the Kwara State Government did not have the moral right to do that because it did not pay its counterpart fund" (KII, HCP, 27/07/2019, Oro). On the other hand, a participant noted with worry that the HMO chose not to act on complaints about the public facilities. He stated that:

> Part of the issues with Hygeia [i.e. the HMO] was that complaints were coming to them about poor services in government facilities and no action was taken to tackle it. The complaints included mismanagement of resources, and there was nothing concrete to tackle it. Maybe it was because the state government was part of the funding of the programme (KII, HMO Official 2, 29/07/2019, Ilorin).

As noted in Chapter 4, policy arenas are often dominated by actors with various interests with each party ultimately pursuing their interests. In some cases, coalitions are formed among players with similar goals to take charge of the policy space formidably. As such, local policymakers must be fair and possess adequate understanding of the policy space and including the various actors; and manage the whole 'system' effectively for achieving the desired goals (Uzochukwu *et al.,* 2009:6).

8.4 Healthcare Situation in rural Kwara: Post-CBHI Experience

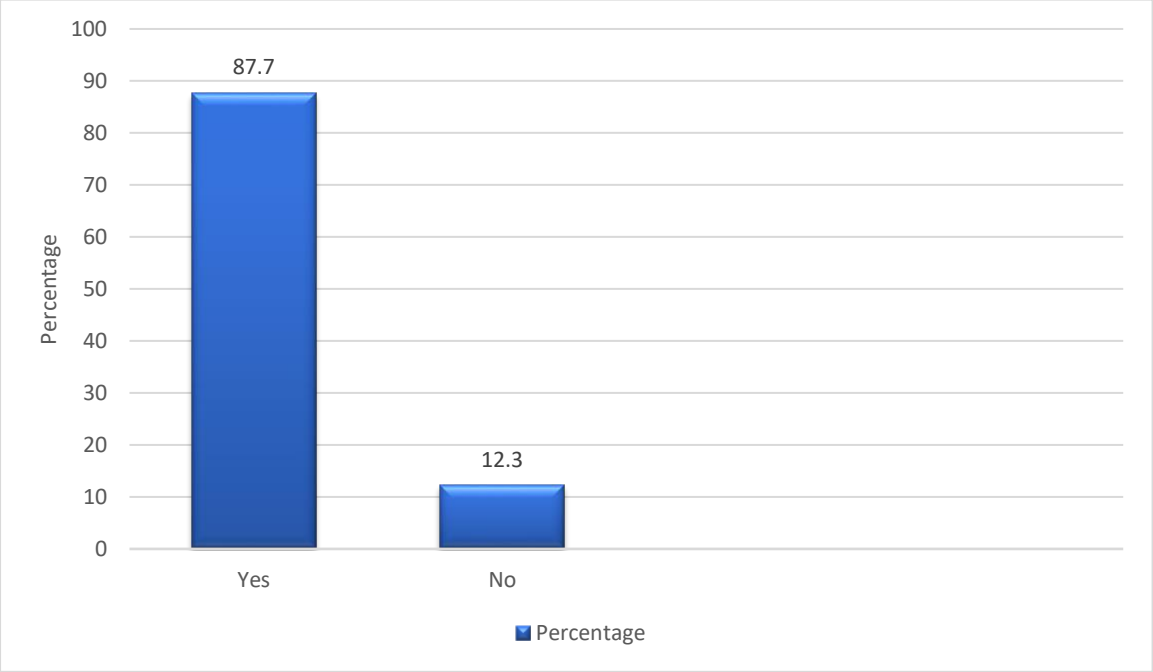
The collapse of the programme has implications for rural communities, specifically, the former enrollees and the healthcare providers. This section discusses the experiences of the community members and the healthcare providers since the collapse of the programme, in terms of its negative consequences.

8.4.1 Experience of the Community Members

The healthcare situation in rural communities after the collapse of the programme is highly devastating. However, most of the formerly-enrolled respondents still make use of hospital care. Figure 8.1 indicates that the majority (87.7%) have used hospital care since the stoppage of the programme, while only few (12.3%) have not utilised hospital care since the collapse of

the programme. The CBHI programme might have increased the acceptance of modern healthcare in rural communities because most of the people continued to receive healthcare in hospitals after the programme.

Figure 8.1: Utilisation of Hospital Care Since the Stoppage of the CBHI Programme



Source: Fieldwork 2019

Meanwhile, the qualitative data show that most people now go through hardships to access care because of costs. The use of self-medication and traditional healthcare has also increased astronomically, and the former enrollees were not happy with their situations. A healthcare provider painfully remarked on the situation of the people after the programme that: "The visit to the hospital has dropped because farming is not yielding enough profit for them [i.e. community members]. That's why they are looking for any cheap way of accessing care. They can buy ₦50 *gbobonise* [i.e. a multipurpose drug that cures all diseases] or go to medicine store to buy drugs according to their pockets, not according to their medical needs" (KII, HCP, 19/06/2019, Bacita). On how the community members felt about the stoppage, one of the implementation officials recalled how a former enrollee described it, as thus:

> Someone described it as 'It's just like giving a child a sweet, and the child is already enjoying the sweet, you now take it out of his mouth with a slap'. That's how he described how they feel about the stoppage of the programme. That to them, it was very painful, it was a rude shock to them, and they are not happy about the stoppage of the programme because they really enjoyed it (KII, HMO Official 1, 26/07/2019, Ilorin).

Self-medication and traditional healthcare are inimical and risky for the people, but they have become alternatives for the people in accessing healthcare. Asked about the healthcare measures adopted since the stoppage of the programme, the participants explained that most people have returned to their old ways of attending to their healthcare needs. A community leader noted that:

> Kaluku tun padasi ese aaro naani. Kaluku tun pada sibi agunmu abi agbo abi *general* abi *private hospital*. Emi o lo agbo oo; ijo t'oba ti rera, mounlo si *General Hospital* ni. Bayi nisin, b'owo o basi lowo, b'aare bade wahala de. Ole je k'elomi karibonu lati malo si *hospital*.
>
> People have returned to their old ways. People have returned to the use of herbal substances or concoctions, public or private hospital. Personally, I don't use herbs; whenever I fall sick, I proceed to the General Hospital. Now, if there is no money to pay OOP during illness, there would be a problem. It might deter someone from going to the hospital for treatment (KII, Community Leader, 13/06/2019, Erinle).

The healthcare situation was so bad to the extent that people cross the border to another country to access cheaper healthcare, for those who can afford. A participant explained that:

> Ki *Hygeia* to de, opolopo nlo *hospital* ni *Faranse* nitori 'pe o *cheap*; itoju tun dan manrain. Igbati *Hygeia* de, opolopo lo darapomo. Awon eyan tipada sibi *Faranse*. Emi naa manlo nida kookan.
>
> Before the introduction of the programme, people were receiving hospital care in the Benin Republic because it was cheaper and of good quality. They enrolled in the CBHI programme when it was introduced, but they have returned to hospitals in the Benin Republic with the stoppage of the programme. I also patronised them once in a while (KII, Community Leader, 03/07/2019, Gure).

With the cost involved, people were unable to visit the hospital regularly except when it is highly important. Some community members noted how they explore various options in treating illness before visiting the hospital. The most prominent among the options are traditional medicine and patent medicine. Meanwhile, patent medical vendors account for a

large fraction of OOP expenses in these communities through the sales of pharmaceuticals (Gustafsson-wright *et al.,* 2018:249). According to them:

Lati igbati eto na ti denukole, anlo si *hospital* amo keese gbogbo igba, nigba totidi t'olowo. Atipada sibi ogun ibile naani. T'aaba logun ibile tioba mun naa, ibe naa latun pada si.	Since the collapse of the programme, we still access hospital care but not at all times because it involves OOP payment. We have returned to the use of traditional healthcare. However, we eventually proceed to the hospital if the traditional care is ineffective (IDI, Female, 01/07/2019, Aboto-Oja).
Lati igbati *Hygeia* tiduro, ko *easy* oo tori kos'owo n'ilu yi. Opolopo ni aati koko ma ra ogun ni *chemist*. Ti kobawa mu mo, yoodipe gbogbo eyan ngbo.	Since the collapse of the programme, it's not been easy. Many people first engage in self-medication. By patronising the patent medicine stores to purchase drugs, but if the medicine fails to arrest the illness, then everyone would know that the person is sick (IDI, Female, 19/06/2019, Bacita).
Opolopo o gba itoju oo. Bii kanlo *chemist,* kanlo ra asapo, bii kanwa agbo; awon itoju ti kopeye ni onikaluku ndogbonsi tori owo. Elomi gaan, aare owa lara re, yoo ma paa mara latari 'pe won o lowo. Opolopo eyan o *really* lo *hospital* mo.	Most community members were not going for treatment. They have resorted to self-medication and herbal treatment as a remedy because they have no money. Even, some decide to inhibit their sicknesses and take no treatment because they cannot pay for healthcare. Most people don't receive care in the hospital nowadays (IDI, Female, 20/06/2019, Bode Saadu).
Lati igbati *Hygeia* ti denukole, elomi so'pe kosowo lowoun, agbo loun omu. Elomi losi *chemist* lati ra akape.	Since the stoppage of the programme, some claim they don't have money and resort to the use of herbs while others engage in self-medication (IDI, Male, 01/07/2019, Aboto-Oja).

Lati igbati eto na ti duro, oti *increase death rate*. Eniti ko ba lowo lowo'n kawo gbera ni. *Hospital* naani moun lo, mosin sanwo.	Since the stoppage of the programme, the death rate has increased. Those who cannot pay OOP now stay back at home with their illnesses. I still use the hospital, and I pay (IDI, Male, 21/06/2019, Osi).

The HCPs confirmed this, but they noted that the measures taken by the people are risky. They explained that:

> People have been catering to their healthcare needs indiscriminately and haphazardly. Indiscriminately because they explore the extremely low cost of care and complicate their health problems; haphazardly because they go to healthcare providers that are neither registered nor qualified, adding more to their problems and end up where they ought to have started. They use herbal care, self-medication, patent medicine, and engage in the indiscriminate use of drugs (KII, HCP, 28/07/2019, Aboto-Oja).

> Most of them have gone back to that stage where they use concoctions, spiritual powers, self-medication (i.e. over the counter drugs), birth delivery at home; and patronise semi-quacks and traditional birth attendants. It was a rewind of the clock back to the time before the CBHI programme came. The reason is that the economy has not improved in this locality, when the farmers labour so much, they don't get so much. They don't have the money to pay for care. The take-home pay of the civil servants is not enough to take them home, and the naira is a weak currency. Therefore, people gravitate on what is convenient for them economically, even if it is injurious health-wise (KII, HCP, 19/06/2019, Bacita).

> Since the stoppage of the programme, people have been attending to their health needs in bad ways. They cannot afford the cost of care, and some now go to the Traditional Birth Attendants (TBAs) [for delivery]. All she collects from them is the head and legs of the goats they slaughter for the naming ceremony. Even the wives of the so-called educated people use their services because there is no money to pay in the hospital. It has affected their healthcare sensibilities drastically (KII, HCP, 15/08/2019, Gure).

Further, an HMO Official explained that: "Since the stoppage of the programme, the health-seeking behaviour has changed because some people have turned to take local herbs while others seek financial assistance to access care and spiritual healing or self-medication" (KII, HMO Official 1, 26/07/2019, Ilorin). A government official added that: "People have been

paying OOP and those who do not have, have turned to the use of herbs and Traditional Birth Attendants and faced with much complication" (KII, KWSG Official 3, 01/08/2019, Ilorin). However, in contrast to other submissions, the officials of the international agency did not believe that community members have returned to their old ways. One of the officials noted that:

> There have been different means through which people can access care but majorly of course, out-of-pocket. We need to be scientific about whether it has pushed people into self-medication or alternative medicine. Probably, when a study is conducted, it would bring out the objective result (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

Given this notion, the international agency may likely misplace priorities if they have a further opportunity of influencing the decision in the Kwara State health policy arena. This is as a result of the marked difference in its position from the people, as well as the other key informants. This is not uncommon in cases of policy transfer, where the transferred policy is different from the policy requirement of the setting. As such, such policies tend to fail and fall short of achieving the desired results.

The main consequence of not seeking medical attention in hospitals is the loss of life, and the death rate is rising in the rural communities since the collapse of the programme. A community leader lamented on the stoppage of the programme and concluded that: "Currently, those who cannot afford any kind of treatment will either remain with the sickness or die. However, those using herbal care and self-medication have increased" (KII, Community Leader, 19/06/2019, Bacita). During FGDs, participants claimed that death rate has increased in their various communities, as follows:

Ati igbati eto yen tilo, iku ti *common* lagbegbe yi.	Since the programme stopped, the mortality rate has increased in this environment (Male FGD, 31/05/2019, Aboto-Oja).
Lati igbati *programme* yen ti *stop*, awon mi tiku, paapa julo, awon *pensioners* tiwon 'ori owo gba lati fi ra ogun.	Some people have died due to the stoppage of the programme, especially pensioners who were not paid and could not afford the cost of their medications (Female FGD, 28/05/2019, Oro).

Nigbati eto na *stop*, o *affect boda* mi debi ‘pe osalaisi, tori kos’agbara owo. Nigbati won da *Hygeia* le, owa *okay*, yoowa lati gba ogun lati Ilorin.	When the programme stopped, it affected my elder brother to the extent that he eventually died because he could not continue to enjoy the healthcare given to him under the programme, due to lack of money. When the programme was introduced, he was coming from Ilorin to receive care here (Male FGD, 27/05/2019, Osi)

Also, an HCP noted that: “The termination was so tragic for quite a number of them. Some of them relapsed, some of them stopped coming again, and some have died” (KII, HCP, 27/07/2019, Oro). He added with despair that:

> I remember a man we treat on the compassionate ground [i.e. since the stoppage of the programme] and I have not been seeing him again, meaning he might have died (KII, HCP, 27/07/2019, Oro).

Some other HCPs corroborated the ‘unverified claims’ on increase in mortality rate, especially among the older people, as thus:

> Many of the old ones who are hypertensive have died in the past four years. Some have been overpowered by stroke (KII, HCP, 19/06/2019, Bacita).

> Since the stoppage of the programme, many have died because they could not afford OOP (KII, HCP, 13/06/2019, Erinle)

Similarly, some officials of the HMO and KWSG submitted that:

> Feedbacks show that a lot of mortalities and morbidities have been taking place in the communities especially those that have chronic cases of hypertension and diabetes through complication (KII, HMO Official 1, 26/07/2019, Ilorin).

> Self-medication has sent many of them to early graves; there have been so many casualties (KII, KWSG Official 2, 24/07/2019, Ilorin).

Currently, the healthcare situation in the rural communities has degenerated to the bad state which is used to be; it might even be worse. Though the case of the former enrollees is regretted; however, if the programme did not stop, it would still not have covered up 10% of

the entire population. Meanwhile, the actual health policy requirement is one that is capable of covering the whole population. This might not be possible in a day, but it must be clear and well accommodated in the policy design.

8.4.2 Experience of Healthcare Providers

The healthcare providers, like the enrollees, have their significant share in the stoppage. The public facilities continue to operate, but utilisation has dropped because, as obtainable pre-CBHI, patients now need to pay for drugs and every other item needed for treatment such as a syringe, cotton wool, fluids, plasters etc. Also, there is a drop in human resources because the additional staffing provided by the CBHI programme is no longer in place. Thus, two main reasons are responsible for the reduced use of public facilities in the rural communities: one, the need to pay OOP for drugs and two, the inadequate human resources and facilities for quality treatment. It is quite challenging to get qualified and competent medical personnel to work in rural areas.

However, most of the private providers, who are incidentally, the majority in this study (9 out of 11) have been affected in terms of patronage and turnover. Expectedly, they all experienced a drastic reduction in patronage. For instance, 95% of patients that accessed care in one of the private CBHI-accredited facilities in Kwara North between 2010 and 2011 were enrollees (Brals, 2019). This indicates that the stoppage of the programme would leave the facility with very low patronage. For most of them, it became difficult to manage the expansions carried out during the operational period of the programme.

One of the HCPs explained that: “The challenges I faced included high personnel, overhead and maintenance costs because the programme demanded a high standard of service. So, when the programme stopped, it was difficult to finance these services, and it became a liability” (KII, HCP, 28/07/2019, Aboto-Oja). While some of them stated that they enjoyed a relative level of patronage compared to the Pre-CBHI era because the programme had exposed their competence to the people, others complained of very poor patronage. Those who noted better patronage explained that the programme allowed the people to see their efficiency. According to them:

> The stoppage affected our turnover but no too much because the programme exposed the people to our competence (KII, HCP, 21/06/2019, Osi).
>
> The programme affected our turnover, but it left us better than we were before the programme. Our capital base improved. It gave popularity to our facility, and the

> programme availed us the opportunity of enhancing the standard of service we provide. However, we aren't getting what we got when the programme was on (KII, HCP, 27/07/2019, Oro).

On the other hand, those who have been grappling with patronage explained that:

> The stoppage affected our turnover drastically because our enrollee-base was between 16,000 and 18,000, and the utilisation was around 1,200 per month. It has now reduced to far less than 10%, and patients only visit our hospitals when they have emergency conditions. They include emergency caesarean section, obstructed labour, typhoid, hypertensive crisis, diabetic crisis, sickle cell crisis and severe anaemia in children (KII, HCP, 28/07/2019, Aboto-Oja).

A provider noted that they had to lay-off some staff after a year of when the programme stopped. She added that:

> It has really affected our turnover. We just sit here watching television. Most times, we subsidise our salaries to ensure we don't close the hospital (KII, HCP, 13/06/2019, Erin-Ile).

Another provider explained that:

> During the programme, we saw as many as 500 patients in a month, but now, we hardly see 50 patients in a month coming to the hospital. The patronage has gone down drastically (KII, HCP, 15/08/2019, Gure).

From the preceding, the stoppage of the programme affected both the community members and the healthcare providers. Though unconfirmed, the participants claimed that death rate has increased in the communities, and the prevalent healthcare options are traditional care and self-medication. This is due to the inability to pay for healthcare. Also, most of the HCPs are faced with the challenge of poor patronage as a result of the stoppage of the programme. Therefore, the situation tends to reveal a policy gap or failure in ensuring adequate access to healthcare without the fear of cost.

Given some positive achievements that a policy might have recorded before getting to a halt, it may be unacceptable to outrightly declare that a policy has failed (McConnell, 2014:4). However, the success or failure of an intervention policy can be understood in terms of "whether the project's deliverables solve whatever problem originally motivated the project,

or if the project's deliverables were used, or fostered real development" (Andrews, 2018:13-14). The nature of success in the Kwara CBHI is small. It fits into what McConnell (2010:355) called precarious success whereby "initially government does fulfil some of its policy-making goals, but the costs of doing so become such that short-term success cannot be sustained". Meanwhile, attaining policy success is embedded in good policy design (McConnell, 2010:247) which considers the various dimensions of policy with an absolute focus on goals and required incremental outcomes. According to Adésínà (2008:12), "while policy learning from other parts of the world is important, more important is policy learning from within Africa itself not only in getting the attention of policymakers but in understanding that development is fundamentally about engaging with the local and learning to use what one has to achieve what one wants".

8.5 Conclusion

The stoppage of the CBHI programme was relatively abrupt, considering the agreement signed for an extension; though, it was characterised by a variety of challenges. Thus, this chapter examined the challenges and moral issues that permeated the programme when it was operational. These challenges were related to the action(s) and/or inaction(s) of the implementing partners. Due to the central role of fund in any programme, the shortage of fund and poor management were fundamental to the stoppage of the Kwara CBHI. Though the non-payment of counterpart fund was attributed to a cut in federal allocation to the state government. This was in addition to a lack of commitment on the part of the state government. It is claimed that since the stoppage of the programme, death rate in the communities have been increasing, and the healthcare providers are finding it difficult to continue to operate profitably because community members have significantly stopped using hospital care due to inability to pay.

CHAPTER NINE

POLITICS OF HEALTHCARE REFORM: A CASE OF THE CBHI IN KWARA STATE NIGERIA

9.1 Introduction

The chapter deals with the politics and powerplay that surrounded the introduction and implementation of the CBHI programme. The policy arena, more often, is characterised by politics of domination and influence by various actors on the policy scene (as noted in Chapter 3). Given the collapse of the programme, this chapter is important in examining the underlying politics in the design and implementation of the CBHI programme in rural Kwara. Thus, the first section discusses the emergence of the CBHI programme in rural Kwara. Specifically, it examines the process through which the policy was proposed and accepted, including the design and implementation of the policy. Further, it explores the link between the stoppage of the CBHI programme and the outcome of the 2019 general elections in the State. The last section draws on the Kwara experience and argues for a need to repurpose the role of the state (i.e. government) to improve social services provisioning, especially, healthcare services gainfully.

9.2 Emergence of the CBHI Programme in Kwara State: The Process

Arguably, "as the political economy changes, some policy contexts also change, in turn affecting which actors are involved, which policy decisions are made, and what processes take place at various levels, including the operational and service delivery levels" (Mthethwa, 2012:41). Also, "a policy is an output of a political process, and politics come into play at all stages of the policy reform process" (Fox & Reich, 2015:1021). As noted in Chapter 5, the poor healthcare situation in Kwara State, particularly in the rural areas continued until the emergence of the CBHI programme in some of the communities during the tenure of Dr Bukola Saraki as Executive Governor. As also noted earlier in some preceding chapters, the programme emerged from a partnership involving the Kwara State Government, PharmAccess Foundation and Hygeia Nigeria Limited to provide healthcare services to selected rural communities in the State. This section discusses how the programme emerged and the power relations that shaped it.

9.2.1 Policy Introduction and Offer

Social policy is often introduced to solve a particular social problem or improve a situation. Usually, the needs for a policy are justified, and the implication for adoption and/or rejection

is clearly stated. It is through the same process that transnational agencies transfer social policies to the global south. They are, however, cascaded in framings that make adoption convincing and urgent (Fox & Reich, 2015:1026; Storeng *et al.*, 2019:555: Stone *et al.*, 2020:5) as they are placed on the national agenda (Grindle & Thomas, 1989:221); at times, involving discreetly coercive process (Dolowitz & Marsh, 2000:11; James & Lodge, 2003:190). Similarly, the poor healthcare situation in rural Kwara and the need for a solution provided a basis for framing the need to adopt the CBHI model. Also, the general discussion around the time was on the need to strive towards achieving UHC, and to adopt alternative healthcare financing mechanisms (Gustafsson-Wright & Schellekens, 2013:2; WHO, 2010). Consequently, this window of opportunity was taken to develop and promote CBHI policy instrument.

The Dutch government proposed the Kwara CBHI programme through the HIF and PAF. The partners in the collaboration offered some explanations regarding the reason and how the programme emerged. Most of the participants noted that it was in a bid to improve the health status of the rural dwellers. An official of the foreign agency simply stated that: "The CBHI programme was a partnership between the PharmAccess Foundation and Kwara State Government to improve the health indices in the State." (KII, Foreign Agency Official 2, 02/09/2019, Ilorin). An HMO Official remarked that: "The motive of the programme was to make health accessible to the hard-to-reach communities especially due to the inability of the NHIS to cover the informal sector" (KII, HMO Official 2, 29/07/2019, Ilorin). In other words, another HMO official stated that: "The purpose of the programme was to improve the health indices in the State because before the commencement of the programme, the health indicators of the State were poor" (KII, HMO Official 1, 26/7/2019, Ilorin).

Also, a government official explained that:

> The initial motive of the programme was to see if health insurance could work in rural communities. It was also introduced to provide quality health services to the people in rural communities and see the possibility of using it to achieve UHC. The motive of the Kwara State Government was to ease the healthcare problems in the communities by getting them to participate by themselves at affordable cost and reduce OOP payments (KII, KWSG Official 2, 24/07/2019, Ilorin).

Put differently, he explained that:

> At the point, the State was trying to improve the health sector, and PharmAccess Foundation was also doing community entry in West Africa to assist people in attending to their health challenges. At that point, Kwara State was spotted as one of the communities where they could test-run the health insurance programme. The agreement was between the Kwara State Government, PharmAccess Foundation and the people (KII, KWSG Official 2, 24/07/2019, Ilorin).

Another government official corroborated this position that the programme was introduced to the state government and thus, not the state government's initiative. He recalled that:

> The programme was foreign-aided. Therefore, we were introduced and initiated into the programme by foreigners, particularly the Dutch. They introduced it, and we keyed into it; it wasn't our initiative. They were responsible for the initial take-off of the programme (KII, KWSG Official 1, 20/08/2019, Ilorin).

Also, an official of the foreign agency stated that:

> Our stay in Kwara State has been since 2007 when the then Governor of Kwara State, Dr Abubakar Bukola Saraki wanted to ensure that he improved the health status of the people in rural areas. The Dutch Ministry of Foreign Affairs through the Health Insurance Fund, an organisation under the Ministry, supported Kwara State in starting a community-based health insurance scheme focused on the rural areas in the State. That programme kicked-off in Shonga, Edu Local Government Area in 2007… It was a pilot to see how it would work in Africa, to see how people can have access to equitable, affordable and quality health services, and that was how it began. With the coming of HIF to Africa, the programme was first to Kwara State, in the whole of Africa. PharmAccess Foundation was implementing for the HIF on behalf of the Dutch government (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

The Health Insurance Fund claimed that the idea of the CBHI was motivated by the poor healthcare situation in most parts of Africa. The HIF (2012:5) summarised the motive as thus:

> The healthcare delivery system in sub-Saharan Africa is confronted with low supply and low demand for healthcare services. Among other constraints due to the high disease burden, limited financial resources, high out-of-pocket expenditures, lack of medical and financial data, inadequately trained personnel, insufficient operational capacity and quality, low trust in the healthcare system, and barely any investment in

> the healthcare sector. As a result of these constraints, many people still lack access to affordable quality health care and seek other means to solve their health problems due to high medical costs. The HIF supports the establishment of 'sustainable' systems of healthcare delivery and financing in sub-Saharan Africa by introducing voluntary health insurances for individuals and communities with low and middle incomes. The approach addresses challenges on both the supply and demand side of the healthcare system. The principle of insurance tackles the critical need for risk pooling and solidarity. By subsidising the insurance premium, health care becomes more accessible to low-income groups. For healthcare providers, insurance premiums offer a guaranteed income over a longer period, allowing them to invest in capacity and quality. This, in turn, will increase the trust in healthcare systems and clients' willingness to pay for insurance (Health Insurance Fund, 2012:5).

However, the above submission is a remarkably ahistorical account of health systems and health financing in post-colonial Africa. As noted in Chapter 1, many African countries ramped up investment in their health systems after formal colonial rule. According to Tidjani (2009:6), "these states, which are now discredited for their poor achievements, were perceived, in the1960s, as strategic actors in terms of economic and social policy". In a country like Nigeria, "the number of doctors per 1,000 of the population rose from 0.017 in 1960 to 0.050 in 1970, and 0.192 in 1985" – the year SAP was adopted (WHO's Global Health Workforce Statistics cited in World Bank, 2020b). If the growth rate for the period 1975 to 1985 had been maintained, the number of doctors per thousand population would have been nearly 0.45 in 1990. Rather, it was 0.192. In the 1970s, healthcare was universal and publicly-funded.

Thus, the story that the HIF tells above is the healthcare system after it was defunded and damaged by structural adjustment programmes – the same programme that European countries (such as the Netherlands) supported when it was imposed on African countries. The crisis with the narratives of Africa's failure is precisely this. Ignore the achievements of the pre-1980s, start history from 1985, when the 'pet policies' were imposed. Cast an eye on the ruined landscape created by the 'pet policies', then blame the failure on Africa and Africans, and then offer new rounds of proto-neoliberal[1] policy doses to address the problems they created in the first instance. Another example of such policies is cash transfer policy that is promoted for adoption across Africa, Asia and Latin America (see Foli *et al.,* 2018:114). Garcia and Moore

[1] Proto-neoliberal policies refer to the post-Keynesian regulatory policies.

(2012) [cited in Bender *et al.* (2014:6)] found that "as of 2012, cash transfer programs were discussed, planned or implemented in 35 out of a total of 47 countries in Sub-Saharan Africa". Thus, "the recent history of Sub-Saharan African states is strongly shaped by the transfer of policies produced elsewhere" (Tidjani, 2009:15).

Often, promoters of transferred policies and their agents come up with 'scary' problem definitions. They also introduce the policies as forms of 'best practices' and back them with research to drive acceptability (Stone, 1999:57; Signe, 2017b; Foli *et al.,* 2018:121; Stone *et al.,* 2020:2). At times, "these researches are produced in relatively insecure contexts and are marred with reliability issues" (Tidjani, 2009:11). The policies are, however, susceptible to failure if they are not in tune with the realities of the recipient country (Dolowitz & Marsh, 2000:17; Hare, 2017:2). Nevertheless, the claim on the sustainability of the CBHI model has been defeated with the stoppage of the programme. What is not on the policy table is universal, publicly-funded healthcare system. It is not 'free healthcare', someone is paying for it—through tax or sovereign wealth.

9.2.2 Alliance with Local Actors and Choice of Kwara

Policy transfers are often crafted in alliance with local actors "because non-state actors rarely operate without the consent facilitation of state actors" (Hanafi, 2020:8). In Kwara, the programme was characterised by three (3) primary levels of alliance. The first was between the Dutch government and the PharmAccess Foundation; the second was between the PharmAccess Foundation and Hygeia Nigeria Limited, and the third was the alliance of these actors with the Kwara State Government. Apart from the partnership with the Kwara State Government, other threads of the alliance in the communities included the engagement of healthcare providers, as well as community leaders and religious leaders (used as policy ambassadors) towards the implementation of the programme. In other words, the Dutch government (through the HIF) and PAF were the policy purveyors (i.e. actors behind the introduction of the policy); Hygeia HMO was a policy conduit (through which the policy was implemented); and the target of the policy was the Kwara State Government (in policy adoption). Further, the healthcare providers, community leaders and religious leaders were conduit belts for securing the implementation of the policy.

The first organisation to be identified in Nigeria by the PharmAccess Foundation was Hygeia Nigeria Limited (i.e. the implementing HMO). A participant noted that: "The Dutch NGO needed a local partner to work with and the partner they got in Nigeria was Hygeia HMO. Therefore, the programme had a tripartite arrangement including the Dutch HIF, Hygeia HMO

and the Kwara State Government" (KII, HMO Official 1, 26/07/2019, Ilorin). The HMO official further explained that the primary objective of the international agency was to attend to the HIV menace, but it changed to CBHI programme. The Dutch government relied on the wide engagement of PAF in Africa to sell its policy ideas. He added that:

> The then governor, Dr Bukola Saraki had a relationship with the Hygeia HMO in order to partner with a Dutch NGO to cater for HIV incidences in the State, but they decided to take a holistic approach to have health insurance (KII, HMO Official 1, 26/7/2019, Ilorin).

It was with the assistance of the HMO that Kwara State was identified and its government contacted. According to a participant:

> The CBHI Programme in Kwara State started with the late Prof. Lange [the founder of PharmAccess Foundation] in Amsterdam who had a lofty idea about HIV/AIDS and wanted to sell it to every part of the world. He sought to get the involvement of Nigeria in that, and he discussed with some other key stakeholders like Prof. Elebute, Chairman of Hygiea HMO then. They came up with the idea of having a broad programme and not just HIV/AIDS to allow people to have access to healthcare, and the idea of CBHI came up among the rural poor. They got in touch with Kwara State Government and the Governor then, Dr Bukola Saraki; and the three parties were very much interested and that kick-off the scheme (KII, Researcher, 30/07/2019, Ilorin).

As noted earlier, policy transfer involves an alliance with local actors, and therefore, the appointment of Hygeia Nigeria Limited by PAF was to ease the transfer process further. The HMO came on board because it was profitable for them. Also, the training and capacity building organised for the HCPs, discussed in Chapter 5, might be part of the efforts to align them with the goals set out by the policy promoters. Further, the network of alliances might partly be responsible for the non-curtailment of the excesses of the HMO in the implementation of the CBHI, as revealed in Chapter 8.

Further, the vulnerability of Nigeria and Africa at large with its weak healthcare system built the optimism of the international actors that the policy offer was going to be accepted on the continent. Perhaps, in Nigeria, the KWSG might have lost to any other State having a large rural population. However, it was able to 'clinch' the offer based on the influence and relationship of the then governor's father, Dr Olusola Saraki. According to a participant:

> The programme was initiated by the former governor, Dr Bukola Saraki due to the relationship between the Hygeia Group Chairman and the then governor's father, Dr Olusola Saraki; attracting the Dutch government to establish the programme in Kwara State. The Dutch government was looking for where to establish the programme in Nigeria, a state with a rural setting (KII, HMO Official 2, 29/07/2019, Ilorin).

9.2.3 Policy Acceptance

As stated earlier, the CBHI programme was a proposal by the Dutch government through the PharmAccess Foundation to the Kwara State Government. Four (4) main reasons informed the acceptance of the offer: the glaring poor condition of healthcare in the State; the lack of clear healthcare policy in the State; the political relevance of the CBHI programme; and the funding relief at inception, whereby funding was not a responsibility of the State government but that of the international partner. Consequently, the state government 'eagerly' accepted the partnership offer since the programme did not place many responsibilities on it.

As highlighted earlier, the general context of Kwara State (i.e. economic, social, cultural, environmental etc. – including the healthcare situation) was part of the reasons the programme was proposed and piloted in the State. One of the HMO officials explained that:

> It was an opportunity readily available, and the state government tapped into it. The Dutch government had a budget to develop some countries in Africa, and one of the targets was Nigeria, and Kwara State was identified as an enabling environment. The state governor was a medical doctor and the Emir of the community [i.e. Shonga] too; and that made it easy to implement the programme (KII, HMO Official 1, 26/07/2019, Ilorin).

However, an official of the international agency claimed that: "The Kwara State Government had a dream but did not have the fund, but the Dutch government supported the dream to come through" (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). This is the common narrative trend for policy merchants to 'conceal' their roles. According to Adésínà (2020:573), the current trend in policy merchandising or policy transfer is that policy promoters infiltrate the political setting and exert their influence on the political actors to adopt the offered policies. Put differently, they initiate the idea, sell it to the client, then turn around and claim they were only supporting the vision of the client. This is often complemented with other 'devices' such as fund, knowledge and data to foster the goals (Stone, 2001; Delvaux & Schoenaers, 2012:105). In the case of Kwara CBHI, the international partner had its goal and policy option

to be implemented, and the most powerful tool to actualise this was fund. With the fund, it was arguably certain that it would be able to push through its agenda. In most cases, policy offers are backed with funding to ensure acceptance (see Storeng *et al.*,2019).

Also, the initial acceptance of the state government to allow for the implementation of the CBHI programme in the State has political undertones. This is because politicians tend to use such programmes to legitimise and foster their stay in office (see Hunter & Power, 2007:1; Bohn, 2011:54; Sarwar, 2018). Also, with the poor state of healthcare in the State and absence of concrete policy plans for implementation (as discussed in Chapter 5), it was 'necessary' to accept such an offer. The establishment of the programme, expectedly, boosted the 'popularity' of the state government among the people; particularly, in the rural areas where the programme was operational. One of the government officials confirmed the political relevance of the programme and noted that: "It was in appreciation [i.e. of the programme] that the communities voted the administration in 2015 to return the favour" (KII, KWSG Official 2, 24/07/2019, Ilorin). He added that:

> It [i.e. the programme] was enough for anybody to vote somebody because it has so many political implications. As a politician, if anyone comes to you that their child or wife is sick, all you need to do is to enrol them in the programme. You can keep yourself happy; whenever they come up with such again, you can refer them appropriately. That was one of the beautiful parts of it; and politically, it was thriving. At that time, we even had some of our political leaders enrolling people in the project. What they used in enrolment was also cheaper than what they would need to spend for treating [medical] emergencies (KII, KWSG Official 2, 24/07/2019, Ilorin).

With these, it was easier for the international partner to lure the Kwara State Government to take ownership of the programme for onward implementation. In the early period of implementation, the programme started to get applauds and recognitions. Therefore, the KWSG requested an expansion to another LGA, perhaps, because of its political relevance. It was, however given a conditionality of financial commitment by the international partner (KII, KWSG Official 2, 24/07/2019, Ilorin). Therefore, the state government agreed to spend on the programme and had to accommodate it in the budget. Unfortunately, the KWSG did not take full ownership of the programme. In most cases, the common tactic used by donors and transfer agents is to give an impression that a proposed programme would not cost much in part-funding; conditionalities often follow acceptance by the government while refusal is followed

by ‘threats’ that may lead to the withdrawal of a whole network of supports (see Foli *et al.,* 2018:113; Dolowitz *et al.*, 2019:5).

9.3 Policy Design: “Who Pays the Piper Dictates the Tune”

The content of a policy instrument is a critical part of any programme. Generally, however, the design of social policies in Africa are influenced by interests, ideas, path dependence and international norms (Mkandawire, 2015:591). Primarily, the powerful player amongst policy actors tends to have the most influence within a policy environment. One of the officials of the foreign agency declared that: “The CBHI model was designed by PharmAccess Foundation” (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). The Kwara State Government was neither in-charge of the design of the policy nor given a space to have an input somewhat. Therefore, the policy instrument was like a ‘ready-made’ policy design implemented in the State without the input of the local policymakers and imposed in the form of ‘assistance’ or ‘support’. One of the government officials explained that: “They brought in the policy and said, can we test this here?” (KII, KWSG Official 2, 24/07/2019, Ilorin). He clarified that:

> The PharmAccess Foundation was responsible for the design of the programme’s policy content. They supported the State government in drawing up the policy on health management. It was part of their responsibilities in the MoU we had, that they were going to develop policies that were going to be of standard. (KII, KWSG Official 2, 24/07/2019, Ilorin).

Another official added that:

> …They [PAF] were also responsible for the policy design, operations and part funding. (KII, KWSG Official 1, 20/08/2019, Ilorin).

As discussed earlier in Chapter 3, one of the strategies being adopted by foreign policy actors to dominate the policy sphere is the technical know-know or expertise, which is ‘believed’ to be very limited in the developing countries. However, this provides an avenue for transnational organisations to take charge of policy decisions (Maluka, 2018:6; Le *et al.,* 2019:4; Jacquin, 2019). One HMO official explained that:

> The PharmAccess Foundation designed the policy because they had the technical know-how. The planning and implementation were done by the foreign partner, the Dutch NGO because they know what they wanted (KII, HMO Official 1, 26/07/2019, Ilorin).

All the healthcare providers, including the referral centres (i.e. 12 HCPs) noted that they were not involved in the policy design. They were just engaged and provided with operational guidelines on how the programme should be implemented. Some of the observations and suggestions of the HCPs on the programme were taken, while the others were not. An HCP explained that:

> We were not involved in the policy design. Whenever we had suggestions, we gave them; they might take it or not. (KII, HCP, 20/06/2019, Bode Saadu).

The healthcare benefits inherent in the proposed programme (at a lower cost) for the rural populace who were in dire of access to care beclouded the need to challenge the non-involvement of local policymakers or actors. Another healthcare provider noted that:

> nobody cared about who drafted the policy because it was seen as a help to the rural dwellers, and health is one of the key issues people deal with everywhere. It was like something given 'gratis' to operate (KII, HCP, 19/06/2019, Bacita).

Supposing the various relevant actors in the healthcare system took part in the design of the policy content, perhaps, it might have reflected more realities in the State in terms of the workability and sustainability of the programme. The healthcare providers were questioned about their thoughts regarding their non-involvement in the policy design. A participant explained that:

> It was not good enough not to involve the providers in the policy design. We told them that even if the programme belonged to them, they were using other people's facilities as providers; and we know what suites our communities and their people. It was improper to impose the policy on them, but because they funded it, it became 'whosoever pays the piper dictates the tunes' (KII, HCP, 20/06/2019, Bode Saadu).

Some other HCPs opined that:

> We were not involved in the policy design, and this also affected the performance and outcome of the programme. However, there was a tremendous achievement by the programme. If providers were involved, the policy would have been better (KII, HCP, 15/08/2019, Gure).

> We were not involved in the policy design, and there was a huge gap in that respect because HCPs were the ones on the ground whose advise and ideas would have been relevant in shaping the policy (KII, HCP, 27/07/2019, Oro).

> We were not involved in the policy design and this negatively impacted the programme because we only did the little we could do since we were not involved; it could have performed better (KII, HCP, 02/07/2019, Kaiama).

> We were not involved in the policy design, but it would have been better if we were involved, to enrich the entire package. Probably, it won't have suffered the way it did (KII, HCP, Referral Centre 1 Official, 30/07/2019, Ilorin).

These confirm that the healthcare providers were also not involved in the policy design and they were merely given directives on how the programme should be implemented regardless of their abilities to add value to the policy content and their experience about their respective communities. Also, as noted in Chapter 1, the CBHI programme in Kwara State was established before the NHIS came up with its model known as CBSHIP but then, the input of the NHIS in the policy design might have been useful before the implementation of the programme. However, the NHIS was relatively sidelined in the design and implementation of the programme, and its involvement was limited to facilities inspection. Very few (2 out of 9) among the participants (i.e. officials of the state government, international partner, HMO, NHIS, and the researcher) asked, claimed that the NHIS was carried along. An NHIS official noted that:

> The NHIS was carried along in the design and implementation of the Kwara CBHI in terms of inspecting the facilities used and quality of service rendered (KII, NHIS, 01/08/2019, Ilorin).

Another participant opined that the NHIS was involved in the design and implementation of the programme but did not state explicitly, the roles played, apart from giving its goodwill regarding the programme. According to him:

> Yes, the NHIS played a role in the programme. When the programme started, the NHIS was just coming up; the NHIS was launched in 2005. The first Executive Secretary explained the role that the NHIS played, giving the goodwill for the scheme (KII, Researcher, 30/07/2019, Ilorin).

In contrast, some other participants expressed that the non-involvement of the NHIS was exemplified by a clash of interest at some point when the two authorities were separately attempting to establish CBHI and CBSHIP in a particular community. The government officials explained that:

> There was a time we wanted to have a clash regarding the establishment of NHIS in Patigi. They were planning to start theirs, and it was also our own target. I was invited by the Governor, and he directed us to stay away since they wanted to help us care for the people... NHIS was not involved in the planning and implementation of the programme (KII, KWSG Official 1, 20/08/2019, Ilorin).

> They [i.e. the NHIS] were not involved in the policy design, planning and implementation; and no approval was taken from them. There was a time we wanted to expand to Patigi, and they were also planning to launch their CBSHIP in the area. The governor told us to leave Patigi for them so far it had a health insurance (KII, KWSG Official 2, 24/07/2019, Ilorin).

An HMO official corroborated the above that:

> There was a time both of us [i.e. the CBHI and NHIS' CBSHIP] were trying to occupy a Local Government Area. It wouldn't have been like that if we were working in synergy. It was obvious that they were not involved in the planning and implementation of the CBHI programme (KII, HMO Official 1, 26/07/2019, Ilorin).

Thus, the finding reveals that the NHIS, which is the regulatory agency for health insurance programmes in Nigeria, was not involved in the design and implementation of the programme. The imposition of the CBHI model on all other stakeholders became easy with the poor healthcare system in the State. A participant explained: "There was no home-grown health policy in Kwara State as at that time. Consequently, the Kwara State Government was spoon-fed by the foreign partner by bringing up a readily-designed CBHI policy" (KII, HMO Official 1, 26/07/2019, Ilorin).

9.4 Policy Implementation and Domination

Like policy design, policy implementation is a political process with complexities involving many actors (Campos & Reich, 2019:226) and partly influenced by ideas, knowledge, interests and motivations (Dolowitz & Marsh, 2012:341; Beland & Ridde, 2016:17). Also, in a policy cycle, actors with different ideas and interests are always involved in the politics of domination

and influence, especially during agenda-setting or policy formulation (Fox & Reich, 2015). Another window of influence often targeted by the dominated groups is the implementation stage to 'right the wrongs' by tilting implementation towards their interests. However, the CBHI policy space in Kwara relatively left no opportunity for such, especially for the local policymakers.

Though the KWSG (through CHIS) was responsible for overseeing the implementation of the programme in public facilities, as shown in Chapters 5 and 8. Nevertheless, the implementation of the CBHI programme was seemingly dominated by the international partner because of the resources brought to the policy space – idea, knowledge and fund. As explained in Chapter 7, when the involvement of the state government became contributory, the financial contributions of the state government were remitted to the PharmAccess Foundation (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). The Foundation was responsible for releasing fund to the HMO that was commissioned for implementing the programme (i.e. HCHC).

This suggests that the state government, in addition to its non-involvement in policy design, had a secondary role in the implementation of the programme. Also, as revealed in Chapter 5, some decisions were exclusively made by the foreign partner, especially regarding choice of the community for the programme and standard of care. These are often done with influence, expertise, skills and other resources (see Hussain & Cornelius, 2009:201) to shape the direction of implementation.

Further, the international partner was solely in charge of monitoring and evaluation of the programme, though, the Kwara State Government officials were always present but without a technical role in the exercise. For instance, a participant lamented that the State government did not have its teams that could allow it to match up with the level of involvement of the international agency as equal partners. He noted that "The government did not have its independent Quality Assurance Team apart from the HMO's that is privately-based; that could serve as checks and balances and as well, tame the excesses of the HMO (KII, HCP, 27/07/2019, Oro).

Same applies to the research conducted to carry out an impact assessment of the programme. Though a team of researchers was engaged from the University of Ilorin Teaching Hospital (UITH), they were seemingly less involved compared to the teams from Amsterdam (see AIID, 2013; AIGHD, 2015, 2017). Aside from the constraints that the engagement of 'foreign experts' place on the in-country consultants (Stone, 2001), more often, these pave the way for

the transnational organisations to generate an evaluation and research reports in ways that suit their interests. Two reasons pointed out that implementation of the programme was tuned to the interests of the international partner. One, the HMO was unilaterally engaged by the international partner. Two, the release of fund for implementation of the programme was through the international partner, notwithstanding the counterpart funding by the state government. According to Tidjani (2009:13), "this positioning of the experts includes the risk of leading governments to shed their responsibilities, owing to their intense workloads and the weakness of their capacities, thereby becoming secondary actors who merely endorse decisions that were taken at the technical stage, and which they cannot hope to change or shape". Contexts like this create opportunities for policy domination.

9.5 The CBHI Stoppage and 2019 General Elections: Any Link?

The political system in Kwara State is one that could be identified with godfatherism. Late Dr Olusola Saraki was a significant player on the political scene in the State. He was very influential to the extent of determining who emerged as governor or held political positions in the State, primarily, since Nigeria's return to democracy in 1999. For instance, Dr Saraki was instrumental in the emergence of Late Mohammed Lawal as the Kwara State governor in 1999, and he served till 2003 on the platform of the All Nigeria Peoples Party (ANPP). Lawal could not return to the office for another term of 4 years in 2003 as a result of a fall-out between him and his godfather, Olusola Saraki. This led to the emergence of Saraki's first son, Dr Bukola Saraki, as the governor in 2003, using the platform of the People's Democratic Party (PDP).

Dr Saraki ruled as governor between 2003 and 2011 before he was succeeded by one of his loyalists, AbdulFatah Ahmed, also on the platform of the PDP. This allowed the former governor to consolidate his power and influence in the State as he was arguably ruling by proxy, after his tenure. Still, under the aegis of the Saraki dynasty, Governor Ahmed got re-elected for a second term in 2015 through a newly-floated party in the country, All Progressive Congress (APC). In 2019, Dr Bukola Saraki and his followers returned to the PDP for the 2019 general elections. Both Saraki and Ahmed, and all other candidates from their political bloc lost massively in the general elections in the wave of 'Oto Ge' (i.e. Enough is Enough), the mantra demanding a change in the leadership and public affairs of the State by the people.

The trajectory highlighted above indicates that the Saraki family dominated the politics of Kwara State between 1999 and 2019. The CBHI programme was introduced during the tenure of Governor Saraki in 2007 and stopped during the tenure of Governor Ahmed in 2016. Asked

if there was any link between the collapse of the CBHI programme and loss of the election by the political bloc that was in government, 7 out of 13 participants did not rule out the possibility but opined that there were many other factors that influenced the outcome of the elections. This is because people all over the state were generally complaining about poor governance. Some HCPs noted that:

> I don't know if there is a causal relationship between the collapse of the programme and change in government because many factors went into that change (KII, HCP, 19/06/2019, Bacita).

> The pattern of voting in the last election was a conglomeration of many factors relating to poor governance. It may be one of the reasons but not the main reason (KII, HCP, 27/07/2019, Oro).

An HMO official added that:

> The collapse of the programme might play a role but not the sole reason for voting against the last government. Part of it was that the people were tired of the Saraki dynasty (KII, HMO Official 2, 29/07/2019, Ilorin).

A government official submitted that:

> I don't think the stoppage of the programme affected the decision to vote the last administration out of government (KII, KWSG Official 1, 20/08/2019, Ilorin).

Also, an international agency official and a researcher noted that:

> Some people believe that the CBHI programme was a political tool in 2015 which was not so, but we don't know if the stoppage eventually affected the voting decision in 2019 (KII, Foreign Agency Official 2, 02/09/2019, Ilorin).

> I don't think the suspension of the programme has anything to do with general elections. In civilised countries, that should have been major a reason why people would vote against their leaders. Most people in the State are not even aware of the programme anyway. There are several other reasons for voting out the formal government. It could be part of the reasons for the former enrollees (Researcher, 30/07/2019, Ilorin).

On the other hand, the remaining (6 out of 13) participants noted that the collapse of the programme influenced the members of the communities in voting against the ruling party in the State. A community leader stated that it was the community member's way of expressing

their dissatisfaction with the programme. He stated that: "I can't say that the stoppage of the programme did not affect the outcome of the 2019 general elections in the community, but the extent is what I don't know. This is because directly or indirectly, the voters have been denied continuous access to healthcare, and they are expected to react" (KII, Community Leader, 11/07/2019, Idofian).

Another community leader opined that the government failed to prepare an alternative for the people in accessing care. He noted that:

Idaduro *Hygeia* ni *effect* lori *election* 2019 tori'pe ani *Maternity* ni ilu wa nibi. Ko *function* daada, won 'ode tunse. Awon eyan ro'pe boya tanwon badibo f'elomi, *Hygeia* letun pada.	The stoppage of the programme had an effect on the outcome of the 2019 general elections in the community because the government was not proactive enough to refurbish government hospital in the community to become functional. People voted for the opposition with the hope that the CBHI programme might be revived (KII, Community Leader, 01/07/2019, Aboto-Oja).

Also, some of the participants in the implementation of the programme argued that the stoppage was partly responsible for the loss of the election by the PDP. According to an HCP:

> If the programme did not stop, the PDP would have won the 2019 general elections in the State (KII, HCP, 13/06/2019, Erinle).

An HMO official added that:

> Part of the reasons for the loss of the 2019 general elections by the PDP in the State was the stoppage of the programme because the communities were dissatisfied and the opposition used it to campaign against them on radio, while some people outrightly declared that they wouldn't vote for them (KII, HMO Official 1, 26/07/2019, Ilorin).

Also, a government official gave a more precise insight that the programme had always given the political leadership some advantages during elections because it was one of the 'beautiful things' happenings in the State. He submitted that:

> The programme had a link with the 2011 and 2015 general elections because it was an election-winning programme. The people never wanted the programme to be phased-out. Our advocacy then was that, if you have something beautiful happening in a place, you have to keep it up. The people were very anxious and happy with the programme. In all the areas where the programme was operational, we had bloc votes from them. It was the same thing that happened during the 2019 general elections because we were unable to operate and the people were not happy, all the areas we had bloc votes, we had zero votes. Because already, for 2 to 3 years after the programme, people were not happy. The people's reaction was that why did you give us the programme when you knew you couldn't sustain it, and we voted you for this (KII, KWSG Official 2, 24/07/2019, Ilorin)

The submissions above indicate that the stoppage of the programme, to an extent, had a link and was part of the reasons for the loss of the election by the political bloc that had led the State for almost two decades. This is because typically, the people have the power to decide their representatives in government (Raphael, 2014:385) through elections. McConnell (2014:2) noted that "policy failures can cause electoral and reputational damage to governments, and even lead to the downfall of public officials, politicians, governments and regimes".

9.6 Attaining UHC: Repurposing the Role of the State

The ultimate goal of every healthcare reform is the attainment of UHC. The level of development in Africa makes it vulnerable, and it is seen as a testing ground for all sorts of social experiments. Social experimentation and policy transfer have negative implications for the LMICs, especially Africa. It is one method of 'distraction' turning African countries away from adopting transformative social policies. Mostly, when hypotheses are tested, or experiments are conducted, there are chances that they may go wrong even if various kinds of precisions are considered.

All sorts of measures are therefore necessarily needed to be put in place to cushion eventual negative consequences. Fundamentally, policy options that are not home-grown or closely aligned with the realities obtainable in the recipient nations have high chances to fail (Dolowitz & Marsh, 2000:17; Kalu, 2012:66). It is as a result of this that ethics is increasingly gaining prominence in research around the world. To liken this analogy to the use of Africa as a testing ground for social policies or programmes, more often than not, the people of Africa are left to

their fates whenever these experiments (mainly promoted by the global North) go awful (see Andrianaivosoa, 2016).

The CBHI programme in Kwara State is a typical example because it was introduced and implemented without any input from the policymakers and other local actors. Though the programme was meant to enhance the people's state of health in rural communities; some participants noted that it was also a way of testing hypothesis. A government official stated that: "It was a way of testing hypothesis and at the same time, it became an institution of learning itself" (KII, KWSG Official 2, 24/07/2019, Ilorin). Another participant explained that the deficiency in technical expertise and financial resources, pave the way for the foreign partner to use the State as a place to test hypothesis and impose its policies of interest, without any resistance from within. According to him:

> It was clear that PharmAccess Foundation had an agenda, from a scientific point of view. Still, because we did not have the technical know-how and funding to match what they were bringing, everything they proposed was taken 'hook, line and sinker' (KII, HMO Official 1, 26/07/2019, Ilorin).

In fact, aside from the Kwara CBHI programme, other CBHI programmes sponsored by "HIF/PAF in Lagos (for market women and Computer and Allied Products Dealers Association), Kenya (for tea producers) and Tanzania (for coffee producers) collapsed as a result of financial sustainability and partly low enrolment" (Boston Consulting Group, 2015:20). This shows that the CBHI intervention programmes of the Dutch government in Africa have all stopped suggesting that the policy option is not appropriate. It is clear that CBHI is not new in the developing countries. However, the sustainability challenges of the health policy option appear to be a thing of concern to policymakers. Before the implementation of the Kwara programme in 2007, scholars such as Ekman (2004), Acharya and Ranson (2005) and Tabor (2005) have expressed serious concerns about its sustainability, especially in terms of funding and enrolment which were the leading causes of the HIF-sponsored CBHI programmes in Africa. Perhaps, the implementation of the policy had ideational underpinnings because these concerns could have been 'convincingly' addressed before implementation. Moreover, policy failures in Africa are closely related to "rent-seeking and neopatrimonialism, which leaves no room for learning or the interplay of ideas" (Mkandawire, 2015:598).

Notwithstanding the stoppage of the CBHI programme, the international partner was relatively still in-charge of the health policy direction in the State. With the stoppage of the CBHI

programme, mainly due to financial challenge; the state government yielded to the policy directive of the international partner and launched a state-wide health insurance programme to cover all residents in the State. While explaining that the state government eventually paid part of its counterpart fund for the CBHI, an official of the international agency pointed out that:

> When they paid the ₦200 million to PharmAccess Foundation, talking to Dutch Foreign Affairs now said, look, we are here to help you and not to take from you. We are keeping this fund, please go and set-up your state health insurance, set-up the funding, and make sure these criteria are met. That ₦200 million, we'll give it back to the State so that it can be used to pay the premium subsidy for those that are indigents (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

Apart from recommending the policy direction and ensuring that it was legislated, the international partner was in the forefront of the new programme with further conditionalities for the state government. The official added, regarding the role of the PharmAccess Foundation in the recently launched state-wide health insurance that: "PharmAccess Foundation was there and was able to support the State in the roll-out plan towards the state-wide health insurance programme" (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). She further stated that:

> PharmAccess Foundation helped to map out the poverty index tool to identify the indigents such that even at the point of registration, there is a poverty index tool that is used. That ₦200 million is sitting with PharmAccess, and over the years, it has even acquired interest. Once the state sets-up its health insurance programme, the money would be transferred to them for the payment of enrolment subsidy for the poor. For the scheme design, the roll-out and the rest, PharmAccess did not take a cent, not even a dollar (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

Further, for any partnership to be fruitful, each of the partners must share a common objective. One of the central goals of the international partner in the CBHI programme is inimical to statism or social provisioning of healthcare services. It is committed to making healthcare market work by giving more roles to the private sector (see PharmAccess Group, 2016; AIGHD, 2017; Boston Consulting Group 2015). One of the foreign agency officials noted that: "We are supporting Sub-Sahara African countries in making health market work through our integrated approach" (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). In the wake of neoliberalism and market-centric ideas, the international partner is committed to promoting private provisioning of healthcare services. She added that:

> "We are also involved in what we call 'Access to Finance Framework' because we understand that in Africa, there is a lot of financing challenges in the health sector. So, we play the role as guarantors to ensure that private facilities have access to a loan at a very affordable interest rate to support building their programmes, as the case may be" (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

Romero and Gideon (2019:1) noted that "an increasing role of the private sector in the provision of healthcare risks undermining social goals in favour of private profits". Given the experience in Latin America, they argued that "public-private partnership in the healthcare sector cannot deliver UHC and concluded that: it can be an expensive and risky business; there is no empirical evidence to claim that it delivers positive development outcomes; it can have negative impacts on the wider health system and on democratic governance". Meanwhile, in the LMICs, most international donors promote social policies that pave ways for free-market to thrive at the expense of the social provisioning of services. This tends to shift the state's attention from the likelihood of providing healthcare for the populace.

Generally, the social protection and social policy instruments 'enforced' in developing nations are distractive and largely non-progressive because they fail to offer a comprehensive model of solving the social policy problems. According to Adésínà (2020:565) "rather than the active social policy instruments concerned with enhancing productive capacity, employment, redistribution and degrees of collective social provisioning, what is offered is the primacy of the market in the allocation of resources and segregated public provisioning in addressing market diswelfares". Essentially, the CBHI programme like some other social policy options has a basis in neoliberalism and it is a ploy to ensure a policy shift from a comprehensive approach, backed by a normative commitment to 'make-shift' policies that would neither solve immediate nor long-term social problems.

Without delving deep into discussions on the dislocation between the socio-demographic and economic realities in the State (as shown in Chapter 7) and the newly adopted health policy programme - after the demise of the CBHI programme, it is necessary to note that situations like this (policy transfer and or policy domination), are likely to continue if most political leaders in Africa are not living up to their responsibilities. In other words, "the relationship between the citizens and the state" (Magashula, 2010:3) is a web of obligations and commitments. Those obligations need to be fulfilled to enjoy peaceful followership.

Precisely, the problem of healthcare, like other social services, were ravelling most African nations because the governments have not been working effectively. Thus, there is a need for a repurposed government especially in Nigeria whereby the objectives of the State would be directed towards catering for the social needs of the citizens as well as setting out a developmental agenda for the nation. Put differently, for meaningful development and to surmount healthcare challenges, it may be necessary for the government to be ideationally committed to a long-term effort. Moreover, "traditionally, social policy has been understood as a feature of increased social provisioning by the state for its citizen at a late stage in the development process" (Adésínà, 2008:3).

With this, in the end, it would be possible to provide social services, including free healthcare for the citizens as done in the past – before structural adjustment programmes were implemented. This is reflected in the views of participants. A community member rhetorically stated that: "If the government could provide free education in the past, why can't it provide free healthcare services. They can do it though. They don't want to do it" (IDI, Male, 19/06/2019, Bacita). An HCP added that: "In the 70s, health was free as well as education and financed by the government" (KII, HCP, 17/06/2019, Odo-Owa). Regaining these achievements may require commitment at every level of government, and the civil service need to have a sense of national mission.

One recent and ongoing incidence, which makes it imperative to repurpose the role of the state is the "coronavirus (COVID-19) pandemic which started in Wuhan, China in December 2019" (Wang *et al.*, 2020:1). The pandemic has claimed the lives of many around the world. As at 10 September 2020, "there were 27,668,740 cases and 899,315 deaths globally (WHO, 2020), with Africa having 1,095,829 cases and 23,466 deaths in 47 countries" (WHO Regional Office for Africa, 2020). Though "the pandemic has overwhelmed the capacity of many nations' healthcare systems" (Gilson & Muramatsu, 2020:1), some countries with good healthcare systems were able to respond more positively including those that were initially hard hit in the early months of the pandemic (Mehtar *et al.*, 2020). Notwithstanding the lower number of cases, many developing countries, especially in Africa, are faced with challenges of human and infrastructural resources to curtail spread and attend to the confirmed cases (Alegbeleye & Muhammed, 2020:7). This appears to be a wake-up call to the LMICs, including Nigeria, to commit adequate attention and resources to social services provisioning, including healthcare.

For meaningful improvement in global healthcare, as suggested by Benatar *et al.* (2009:361), there is a need to reconsider "our understanding of what it means to value human life, the role of the market and what is meant by development" towards a new vision, focusing on public goods. In other words, there is a need to unthink neoliberalism to rethink a new thing. Since the ability to pay for care is a significant impediment to access, it becomes necessary to adopt a more equitable and effective healthcare policy that will make healthcare accessible to all. For instance, the adoption of a non-fragmented health insurance system with a unified benefits package for all makes healthcare access and utilisation more equitable (Myint *et al.*, 2019:9). Regarding this study, the fund (₦1.1 billion [3.055 million USD]) committed by the KWSG as counterpart fund on the CBHI could have been directly invested on the sector based on state's envisioned agenda covering the entire population. Braveman *et al.* (2017:12) explained that "health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care".

The role of good leadership, at all levels, is critical to the success of social policies, including health policies (Isouard, 2010:23; McKee & Mackenbach, 2013:335). Ouma and Adésínà (2019) advised that ensuring appropriate problem definition is an essential factor in policy change. This is because once the problem is wrongly diagnosed, the policy design and implementation will be inefficient to achieve the needed results. The commodification of healthcare service provisioning serves as the major impediment to access healthcare by the majority of the people. Hence, a need for comprehensive and transformative social policies capable of performing multiple functions (Bond, 2007:241; Cook *et al.*, 2013:43) because active social policy is instrumental to overall socio-economic development (Mkandawire, 2007: xii; Adésínà, 2008:3; Adésínà, 2020:578) and overcoming neoliberal policies (Adésínà, 2015:114).

According to Duggal *et al.* (1995:834), "healthcare, like education, housing, old age security and other social provisions, has nowhere in the world been able to make an effective contribution without the active participation of the state. Even in the most advanced countries, the role of the state has been extremely critical in assuring that health care becomes universally and equitably available". Early examples of healthcare provision in this regard are the United Kingdom, and Germany and the governments are very much involved. This is because the state has the primary responsibility for the well-being of the citizenry (Mkandawire, 2007: xii).

9.7 Conclusion

Based on the empirical data, this chapter exposed the underlying goals behind the introduction, design and implementation of the CBHI programme in rural Kwara. It elucidated the process through which the policy was transferred and how the design and implementation were dominated by the foreign sponsor. It also revealed how the failure of the programme was partly instrumental in the ousting of a political bloc that had been in government for close to two decades in the State. Given the various findings, the chapter further argued that for a meaningful result in social services provisioning, repurposing the role of the state would be necessary with a view to ideationally taking full and decisive responsibility for community and national development.

CHAPTER TEN

CONCLUSION

10.1 Introduction

The chapter summarises the thesis. The focus of the study is to understand the reasons behind the stoppage of the CBHI programme that was operational in rural Kwara, Nigeria. The first section highlights a summary of the key findings and contributions of the study to knowledge. The second section provides a policy recommendation, and the last part covers a brief conclusion and suggestions for future studies.

10.2 Summary of Key Findings and Contributions

This section presents the key findings of the study based on the objectives of the study. The study sought to examine the perceptions of members of the communities about the CBHI programme, the factors that influenced its design and implementation, the funding mechanisms and the factors that led to the collapse or stoppage of the programme.

10.2.1 Short-term Policy and Temporary Outcomes

As evident in Chapter 6, one significant finding of the study is that except in a few cases, most of the former enrollees claimed that they were satisfied with the quality of service rendered by the programme as well as the conduct of the healthcare providers or workers. The CBHI programme improved the healthcare status of the former enrollees because most of them did not have access to modern healthcare. Those who enrolled could access healthcare, and this assisted in boosting their healthcare statuses. Also, given the right to visit the hospital to receive treatment for selected ailments after enrolment, the level of healthcare service utilisation rose during the operational period of the programme in the communities because it was easier to access hospitals for healthcare needs (see Chapter 5). Further, as shown in Chapter 6, enrolled pregnant women had the opportunity of receiving adequate ante-natal and post-natal care and enrolled infants could as well be taken to the facilities to receive care when necessary. These findings are consistent with previous studies (see Brals *et al.,* 2017; Odusola *et al.,* 2011, 2014, 2015, 2016; Hendriks *et al.,* 2013; Odusola, 2015) which were more focused on the gains of the programme. However, these benefits were limited to community members that were enrolled in the scheme.

Beyond the scope of the above studies, discussions in Chapters 8 and 9 evidently show that the CBHI programme was faced with sustainability challenges. This was also illustrated in the cases of Ghana and Rwanda in Chapter 2. As discussed in Chapter 8, the study participants

revealed that the benefits package did not cover some of the ailments presented by the enrollees which necessitated the payment of OOP. Also, findings in the Chapter show that healthcare benefits became reduced with time because some of the ailments initially covered were removed from the benefits package. For instance, hernia, which was part of the benefits package at inception of the programme in Bacita became excluded from the package by the time the programme extended to Bode Saadu. These findings run counter to the commonly expressed view that CBHI provides healthcare protection against most of the healthcare needs of the people and reduces OOP expenses (see Weinberger & Jutting, 2000; Spaan *et al.,* 2012; Carrin *et al.,* 2005; Odeyemi & Nixon 2013; Purohit, 2014).

Also, contrary to the claims of authors (e.g. Sekhri & Savedoff, 2005) who argued that CBHI could lead to UHC, the relative gains of the programme were short-lived with the sudden stoppage, leaving the beneficiaries unhappy (see Chapter 8). Thus, it can be concluded, in line with the position of scholars (Adésínà, 2007, 2008, 2020; Mkandawire, 2007; Bond, 2007; Aggarwal, 2011; Kutzin, 2012; Cook *et al.,* 2013; Romero & Gideon, 2019) that attaining UHC requires a far more commitment on the part of the government towards social provisioning of healthcare services for all. Regardless of the inherent challenges and weaknesses, evidences in Chapter 8 further indicate that the stoppage of the programme has exposed the former enrollees to healthcare challenges as they were before the introduction of the programme. Thus, the goal of the policy was temporary and short-lived. Yet, social policies ought to be to the benefit of all with long-term social advantage. This is to ensure that the entire society felt the outcomes.

10.2.2 Payment of Enrolment Premium and Affordability

Health insurance requires the payment of an amount as premium by enrollees to access care. As evident in Chapters 5 and 7, the programme did not cover all community members; it covered only those who could pay. Contrary to studies (e.g. Gustafsson-Wright & Schellekens, 2013; Lawanson & Ibrahim, 2015; Odusola *et al.,* 2016; Udeh *et al.,* 2016; Kakama *et al.,* 2020) suggesting that CBHI enrolment premium was affordable and that people in their spending did not give it a priority, majority of the study participants claimed that the enrolment premium was not affordable. As discussed in Chapter 7, some of the respondents claimed they were able to pay, while others said they were at the mercy of politicians or affluent members of their communities to join the programme. As such, premium was a hindrance to enrolment for those, who could not afford to pay. Even at the subsidised amount, many claimed that it was difficult for them to pay because of poor economic opportunities and high level of poverty (see Chapters 7 & 8).

It, therefore, becomes worrisome to note that the policy implemented to bridge the barrier of access to care in the rural communities left some people uncovered due to inability to pay. The existence of CBHI and other forms of health insurance, given the prevalent rate of poverty in the developing countries, are inimical to the current drive of the WHO towards attaining UHC. The WHO expects that everyone can access quality care without facing financial hardship (see WHO, 2017). This study argues that this goal would take a long time to be achieved if the provision of healthcare is not given the needed priority and ideational commitment. Thus, ability to pay should not be a determinant for accessing healthcare.

Further, beyond the conclusion of other studies (e.g. Ranson, 2003; Fonta *et al.,* 2010; Workneh *et al.,* 2017; Adhikari *et al.,* 2018) that also found affordability as a challenge in CBHI, discussions in Chapter 8 revealed an unethical practice which 'misleadingly' boosted the enrolment population in the programme. That is, some of the HCPs 'invested' their monies on the enrolment of community members to claim higher amounts in terms of capitation from the HMO. This is because the higher the enrolment in a facility the higher the capitation due to the provider. This finding calls attention to possible 'myth' that can surround CBHI enrolment data and it shows that apart from other factors (such as policy content, process and context), the roles of actors are vital to the success or failure of any policy (see Chapters 3 & 8).

10.2.3 Policy Transfer and Domination of the Policy Space

The international actors often explore the weakness of policy context and capitalise on technical know-how and financial resources to achieve policy transfer (see Delvaux & Schoenaers, 2012:105; Etiaba *et al.,* 2015:2; Walt & Gilson, 1994:362; Sanni *et al.,* 2017:376; Gilson & Agyepong, 2018:38). Other devices that are adopted include scary problem definition (to justify the need for a change), research and the need for 'best practices' (Tidjani, 2009; Stone *et al.,* 2020). However, as highlighted in Chapter 9, there are four (4) main reasons that influenced the acceptance of the policy offer in the case of Kwara CBHI. First, the healthcare situation in the communities was bad and there was no clear healthcare policy in the state; second, the state government saw the policy proposal as an opportunity to improve the people's access to healthcare; third, the proposed policy did not require spending from the fiscus initially; and lastly, the political gains of the programme.

The discussion in Chapter 5 reveals that there were problems in accessing healthcare services in rural Kwara. Often, the rural dwellers had to travel to Ilorin (the State capital) to access hospital care. This context provided an opportunity for the introduction of the CBHI

programme in the State. More so, there was no clear or substantive healthcare policy designed for the State apart from the global health policies adopted by the federal government such as Roll Back Malaria and Kick Out Polio which was merely designed at the global or regional levels to be incorporated into existing policies by various governments (see Chapter 5). In other words, the absence of healthcare policy provided an easy way of selling the idea of CBHI to the Kwara State Government. Further, findings in Chapter 9 show that the initial offer granted by the international partner to finance the programme prompted the leadership of the State to accept it. Also, the acceptance was motivated by the political gains (i.e. capacity of the programme to boost their political career) that could emanate from it.

Furthermore, actors in a given policy space tend to collaborate and support a policy which appears to serve their common interests (Liefeld & Schneider, 2012). Thus, discussion in Chapter 9 revealed that there were three (3) main levels of collaboration in the Kwara CBHI, namely: alliance between the Dutch government and the PharmAccess Foundation; alliance between the PAF and Hygeia Nigeria Limited; and alliance of these actors with the Kwara State Government. These alliances facilitated and eased the introduction of the programme because it served the interest of each of the parties in a way.

As noted by scholars (e.g. Fox & Reich, 2015; Maluka, 2018; Jacquin, 2019), the policy space of transferred programmes are often dominated by international actors. The discussions in Chapters 5 and 9 indicate that the Kwara CBHI in Nigeria was a ready-made model designed by the international actors and imposed on the Kwara State Government without space for modification. With the exertion of some relative force or influence, the introduction and implementation of the policy were also dominated by international actors (see Chapter 3, 5 & 9). The programme was rolled out as a partnership between the State Government and the international actors; however, the implementation, as done with the design, was dominated by the international actor. To conceal the level of domination of the policy space, some local actors were repurposed and allowed to act on the policy scene, especially with the role of the HMO and CHIS in the implementation of the programme (see Chapters 5 & 9). Also, as against the principle of partnership, the HMO that was engaged for the implementation was exclusively recruited by the foreign partner. This allowed it to dominate but directly stay-off the policy scene, to an extent; and remotely direct the process of policy implementation.

Evidences in Chapter 5, 7, 8 and 9 indicate that the transferred policy was not in line with the reality of the recipient's setting. Precisely, Chapter 9 shows that one of the main aims of the

international partner is to further commodify healthcare services – by making healthcare market work. This is however capable of disrupting any plan towards social provisioning of healthcare services. More so, the introduction of the programme was not in tune with the suggestion of scholars (e.g. Dolowitz & Marsh, 2000; Adésínà, 2008; Kalu, 2012; Andrianaivosoa, 2016) that before a policy is transferred, it must be carefully aligned with the circumstances of the recipient nations. In other words, the goal of the international partner was to enhance the performance of the private sector in providing healthcare services and was not in line with the economic realities of the people as well as the financial capacity of the state government.

Adésínà (2020:572) noted that "when those with voices in society are co-beneficiaries with the less well-off, there is a greater political commitment to the welfare instruments, and they tend to deliver better quality services to all concerned". Thus, beyond that ideational underpinnings that shaped the implementation of the programme (see Chapters 2 & 9), this study shows that weakness of socio-economic and political institutions can lead to policy failure because the transfer and domination of the policy space was partly due to the weakness of this institutional system of the state – which could not thoroughly sieve through the proposal and make decision based on common interest.

10.2.4 Financing Challenges and the Stoppage

Most CBHI programmes are faced with challenges (see Acharya *et al.,* 2012; Panda *et al.,* 2016; Mathauer *et al.,* 2017; Ranabhat *et al.,* 2019). Similarly, the study found that the Kwara CBHI also faced some challenges. However, differently, from most studies (e.g. Onwujekwe *et al.,* 2009; Aggarwal, 2011; Odeyemi, 2014; Akinyemi & Idowu, 2015; Adebayo *et al.,* 2015; Dror *et al.,* 2016; Kodom *et al.,* 2019; Ajuaye *et al.,* 2019) that discussed the problems of CBHI programmes without giving clear account of 'who did or caused what', this study analysed the challenges (in line with the conceptual framework adopted – see Chapter 3) of the programme based on the action(s) or inaction(s) of the main actors in the implementation of the programme. These include: the state government (distance and stock-out of drugs); the HMO (reduction in health benefits, inadequate enrolment coverage, low capitation and clash with HCPs); the HCPs (long waiting period, preference for non-enrollees and foray of HCPs into enrolment) as well as the abuse of care by former enrollees (see Chapter 8). This approach appears to be useful for better understanding of a policy (especially with the positionality of actors) and also serves as a 'route' towards problem-solving (based on the roles played by each actor).

As further discussed in Chapter 8, regardless of all other implementation challenges, the Kwara CBHI programme collapsed mainly because of funding. Specifically, the government could not meet up with the financial requirements, in terms of counterpart fund. The transfer of the policy was technically proposed in a way which did not give the government any reason for concern because it came with funding (see Chapter 9). Put differently, the introduction and implementation of the programme at inception required no direct financial commitment by the government but goodwill and logistic supports. However, after some years of implementation, the government was requested by the international partner to become contributory to the funding of the programme to achieve a successful transfer and ownership. Financing agreement during this phase was on a sliding scale for the government to increasingly take-up the financing responsibility of the programme (see Chapter 7). The government agreed to this and contributed to an extent, and then stopped. As a result, the international partner eventually withdrew its funding, and the programme came to a halt.

This is the trend through which international organisations try to impose policies on governments without considerations for the socio-economic realities on the ground in those settings (Uzochukwu *et al.*, 2015; Adésínà, 2020). Several ploys and powers are adopted to ensure the policies are accepted and promoted (see Chapter 9). This study demonstrates that financing conditionalities cannot compel governments to sustain a policy or programme, especially if they lack financial abilities. Short-term programmes are, however, capable of inciting violence and disunity among the people. More so, social assistance programmes (including healthcare) can only be beneficial if they are aligned with the long-term ideational plans and social realities of a people or nation.

10.2.5 Collapse of Policy: Return to the 'Old Ways'

Scholars have conducted studies (e.g. Uzochukwu *et al.* 2009) to trace the reasons behind stoppage of policy programmes. This study, however, goes further to examine the situation of the beneficiaries of the programme after the stoppage. As shown in Chapter 8, the study found that the primary goal of policy transfer was defeated in the case of the Kwara CBHI programme. Primarily, the purpose of policy intervention is to enhance the well-being of the people in a way. However, the collapse of the programme signified a reversal in the achievements recorded during the operational period. As claimed by the study participants, the healthcare service utilisation dropped drastically, and most people have returned to the use of traditional herbs because only a few can afford to pay for hospital care. Thus, the majority now

opt for self-medication, and hospitals are the last resorts when the situations are extremely bad (see Chapter 8).

Mkandawire (2015) attributed most policy failures in Africa to rent-seeking and neopatrimonialism. Precisely, Ranson (2003) linked the failure of public CBHI to government and external donors. However, McConnell (2014) argued that it may be unacceptable to declare that a policy failed especially, one with record of some positive achievements before stoppage. Andrews (2018) therefore clarified that success or failure of a policy intervention can best be assessed in terms of whether the programme solves the actual problem which motivated its design and implementation.

In the case of Kwara CBHI, the programme was introduced to tackle the problems of high OOP, disease burden, access to affordable and quality healthcare etc (HIF, 2012). It further aimed to cover at least 600,000 people by the end of 2017 (AIGHD, 2015). Meanwhile, as revealed in Chapters 5, 8 & 9, the programme did not to meet up with the set target of covering the rural population. Enrolment population was barely 140,000. Also, the programme has ceased to benefit those who were able to enrol during the operational period. In other words, the stoppage of the programme has returned the former beneficiaries to face the challenges of disease burden, poor access to healthcare and high OOP expenditure which it promised to tackle (see Chapter 8).

Apart from the launch of the new programme (KSHIS) by the former governor in 2018, more recently (i.e. September 2020), the incumbent governor of Kwara State, AbdulRahman AbdulRazaq launched the state-wide health insurance programme (see Shittu, 2020). However, this is a new scheme distinct from the CBHI programme operated between 2007 and 2016. As noted earlier, the stoppage leaves the enrollees of the old scheme adrift. Thus, if they want to join the new scheme, they have to start all over – with registration and enrolment. Also, the government seems to partly retain the dependence on donor funding for the new programme. Finally, there is no guarantee that a new governor will not renege on the current promises being made and as an earlier governor did?

10.3 Policy Recommendations

The following recommendations for both local and international actors are given the findings and discussions in this study.

At a broader level, the study recommends re-purposing the government's objectives regarding the attainment of meaningful development. This includes identifying the appropriate ways of fulfilling its obligations to the citizens through the design of long-term transformative social policies with ideational grounding. This is to be supported with unwavering commitment even in the face of possible challenges. The challenges of the healthcare system are akin to other social services provisioning, and all can be fundamentally addressed through spirited commitment.

For international actors, it is noted that policy transfer is not done in isolation without problem identification. Thus, the study suggests that international actors should adequately carry out their findings and identify that indeed, there is a need for policy transfer before proposing to transfer policies. More importantly, the transnational actors should ensure that the policies are relevant to the socio-economic realities of the recipient nations to achieve developmental outcomes and results. The art of experimenting for social policy learning should be agreed upon and recognized for that particular purpose and implemented within a stipulated period. The government should, therefore, be allowed to decide whether to continue with it or not, while foreign actors leave the policy scene.

Furthermore, international actors should be professional and ethical in the art of policy transfer. They should articulate from the onset, the extent of their financial abilities or commitments to avoid policy collapse. Policy failure or collapse of an intervention programme is capable of inciting violence against the government. Thus, if the transnational agencies are not interested in this, it is highly necessary to be cautious and prevent unintended consequences.

More so, international actors should revisit their approaches and long-term effects of the proposed policies. Instead of promoting discursive discourses, they should endeavour to equip the local actors, where necessary, with the needed skills and knowledge that can aid policy formulation and decisions from within, instead of being re-purposed or brainwashed to foster foreign interests. In other words, transnational actors should respect the interests of local actors and assist them in achieving their policy goals.

More precisely, transformative social policies can only yield meaningful results when leaders are committed and altruistic in their conduct; this includes the local policymakers and other stakeholders in the policy arena. In essence, leadership is crucial to the success of social policies. Thus, the study recommends that the government should design effective healthcare policies that are both ideationally-driven and comprehensive enough to provide access to all

without consideration for ability to pay or not, as advised by the WHO. With the alarming rates of poverty and unemployment in the developing countries and specifically in Nigeria, economic opportunities appear to be limited for most people to attend to their healthcare challenges. This can be resolved through the adoption of a single-payer system where healthcare is free at the point of use and publicly-financed. As briefly noted in chapter 9, with the current efforts against the COVID-19 pandemic, the state is responsible for all regardless of ability to pay, most importantly to curtail the spread; so also, should it be accountable for the citizenry during the time of no pandemic diseases.

Also, local actors should be conscious that policy formulation attracts various interests and as such, protect the policy space from diversionary tendencies and domination by other benefits. In doing this, local actors must articulate their goals and ensure that policy decisions are in tune with the central goals proposed to be achieved. This also requires the acquisition of skills and knowledge to enable them to relate measurably with the transnational actors in the policy space and during policy negotiations.

Further, it is relatively impossible to prevent transnational actors and other groups with non-state interests from featuring on the policy scene due to the level of diffusion and cross-border exchange of ideas across the world. Thus, policy transfer and recommendation might continue to exist. However, this study recommends that since local actors have the prerogative to decide, notwithstanding possible sanctions, a critical review of proposed policies by international actors should be actively carried out to identify the suitability or otherwise based on the socio-economic and political realities of the state. And ultimately, how the proposed policy fits into the wider vision of the nation. Such policy offers should be politely rejected if they are discursive and cannot be aligned to the long-term interest of the country, regardless of the incentives and financial backing that are linked to them.

Also, other local but non-state actors (e.g. professionals and researchers) in the policy space should endeavour to imbibe the spirit of patriotism by acting in the interest of their nations. These actors are often re-purposed and recruited by the transnational actors into their coalitions in pursuing their goals through incentives and recognition.

Finally, governments of developing countries such as Nigeria, including Kwara State, should strive to be productive economically to attain financial independence to avert possibilities of accepting diversionary transfer policy offers. These policies are often accompanied with conditionalities that turn the local policy actors to ‘spectators’ on the policy landscape without

significant influence. Policies of this nature tend to fail with time because of the inability to meet up with the conditions and possible clash of interest among the recipients and the policy promoters.

10.4 Conclusion and Suggestions for Future Research

This study centrally focuses on the reasons behind the collapse of the Kwara CBHI. Generally, the study shows that the programme improved the health status of the people in the various communities but ability to pay enrolment premium was a challenge. It also indicates that the international partner dominated the policy space and gave no opportunity to the local actors to have input in the policy content. The policy context largely provided avenues for policy domination because there was no home-grown health policy in place. The study also demonstrates that the international partner initially funded the programme. At some point, the government was requested to make a financial commitment to the programme. The programme faced several challenges during implementation. However, the main reason for the collapse of the programme was funding.

It is given this that the study makes suggestions for further research that:

Though the Kwara programme was the most noticed and recognized, a similar programme was implemented in Lagos State but has also stopped. It is, therefore, necessary to also carry-out a holistic examination of the programme as implemented in Lagos. This will enrich our understanding regarding the promotion of CBHI policy in Nigeria as well as the dimensions of implementation and specific reasons for the stoppage of the programme in Lagos. Perhaps, the narratives and experience might vary in terms of the context, implementation process and roles of the actors. In the context of Kwara, there was no substantive health policy in place, easing the process of policy transfer. However, the experience in Lagos may differ, and the local actors might also have acted differently.

The CBHI programme in Kwara State was under-studied by some other states in Nigeria such as Ogun, Kaduna, Delta and Ondo etc. It is necessary also to examine other CBHI programmes in Nigeria to understand the level of success and otherwise, in that, they are not donor-funded like the Kwara programme. It would be interesting to learn about the funding mechanisms adopted in the programmes.

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APPENDICES

Appendix 1: Ethical Clearance (University of South Africa)

UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

10 May 2019

NHREC Registration # :
Rec-240816-052
CREC Reference # : 2019-CHS-Depart-. 64116271

Dear Afeez Folorunsho Lawal

Decision:
Ethics Approval from 10 May 2019 to 01 May 2024

Researcher(s): Afeez Folorunsho Lawal

Supervisor(s): Prof. J.O. Adesina

adesij@unisa.ac.za

Between Policy and Reality: A Study of a Community-Based Health Insurance Programme in Kwara State Nigeria

Qualifications Applied: PhD (Sociology)

Thank you for the application for research ethics clearance by the Unisa Department of Sociology College of Human Science Ethics Committee. Ethics approval is granted for three years.

The ***low risk application*** *was* ***reviewed and*** **expedited** by Department of Sociology College of Human Sciences Research Ethics Committee, on the 10 May 2019 in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the Department of

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

Psychology Ethics Review Committee.

3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date (**01 May 2024**). Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number **2019-CHS--Depart- 64116271** *should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Dr CG Thomas
Department Chair : Sociology
E-mail: thomacg@unisa.ac.za
Tel: (012) 429- 6560

Dr. S. Chetty
Ethics Chair : CREC
Email: chetts@unisa.ac.za
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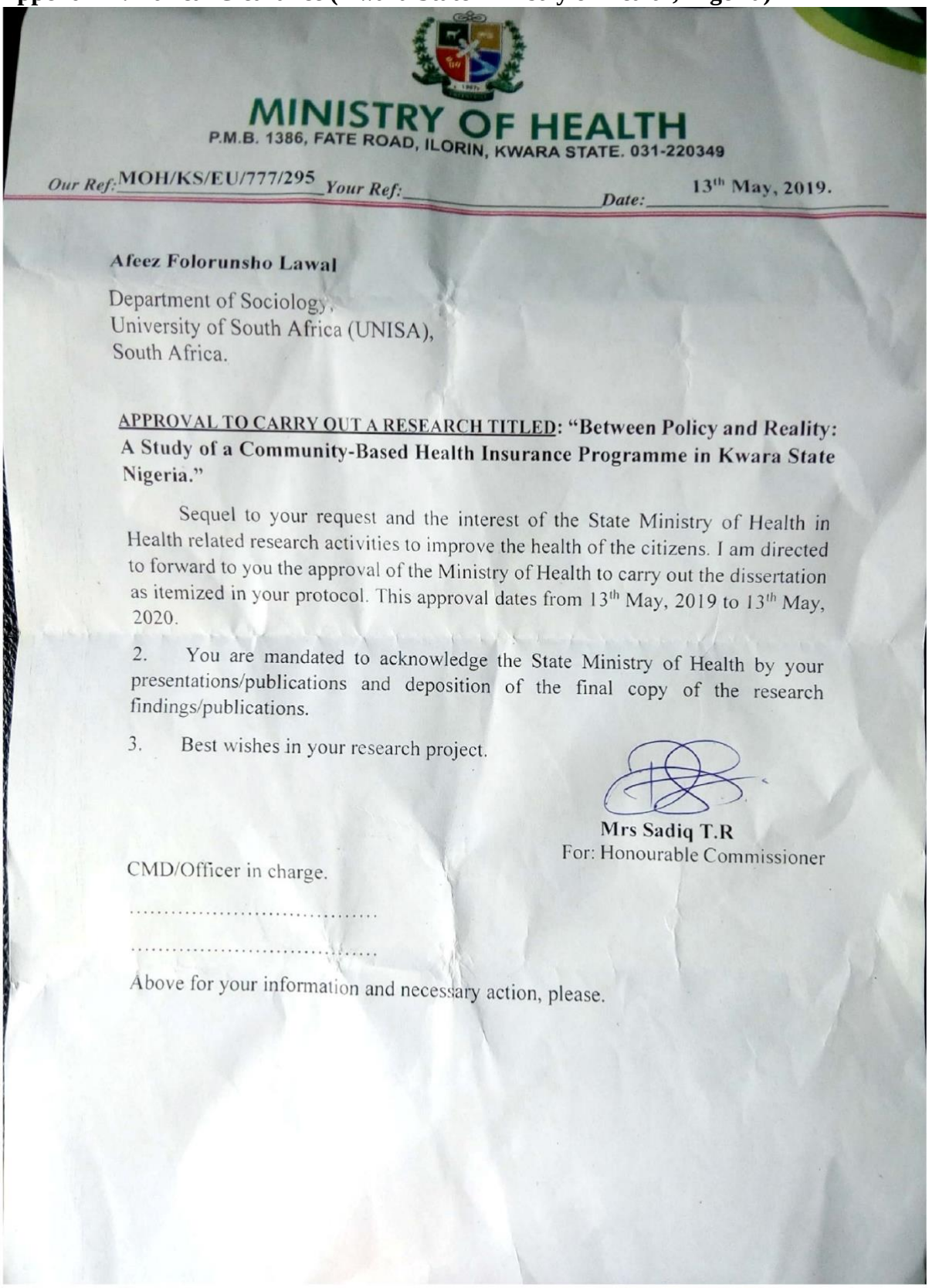
Appendix 2: Ethical Clearance (Kwara State Ministry of Health, Nigeria)



MINISTRY OF HEALTH
P.M.B. 1386, FATE ROAD, ILORIN, KWARA STATE. 031-220349

Our Ref: MOH/KS/EU/777/295 *Your Ref:* _____ *Date:* 13th May, 2019.

Afeez Folorunsho Lawal

Department of Sociology,
University of South Africa (UNISA),
South Africa.

APPROVAL TO CARRY OUT A RESEARCH TITLED: **"Between Policy and Reality: A Study of a Community-Based Health Insurance Programme in Kwara State Nigeria."**

Sequel to your request and the interest of the State Ministry of Health in Health related research activities to improve the health of the citizens. I am directed to forward to you the approval of the Ministry of Health to carry out the dissertation as itemized in your protocol. This approval dates from 13th May, 2019 to 13th May, 2020.

2. You are mandated to acknowledge the State Ministry of Health by your presentations/publications and deposition of the final copy of the research findings/publications.

3. Best wishes in your research project.

Mrs Sadiq T.R
For: Honourable Commissioner

CMD/Officer in charge.

.....

.....

Above for your information and necessary action, please.

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Appendix 3: Research Instruments

QUESTIONNAIRE FOR COMMUNITY MEMBERS (FORMER ENROLLEES)

INSTRUCTION: Tick the appropriate item from the available options and answer questions in the spaces provided

SECTION A: SOCIO-DEMOGRAPHIC DETAILS					
Gender	Male ☐		Female ☐		
Age (as at last birthday)					
Education	No formal Education ☐	Primary School Education ☐	Secondary School Education ☐	ND/NCE/Tech. School ☐	HND/University Graduate ☐
Religion	Islam ☐	Christianity ☐	African Traditional Religion ☐		Others ☐
Marital Status	Married ☐	Divorced ☐	Single Parent ☐		Single ☐
Household Size					
Occupation	Farmer ☐	Trader ☐	Technician ☐	Civil Servant ☐	Others ☐
Income per month					
Community					

SECTION B: PERCEPTION					
1. How did you know about the CBHI programme?	Mass media ☐	Family & Friends ☐	Community meeting ☐	Others ☐	
Please explain better	…….				
2. How did you feel when the CBHI programme commenced?	Very interested ☐	Somewhat interested ☐	Not very interest ☐	Indifferent ☐	
3. What prompted you to enrol in the programme?	Illness ☐	Affordability ☐	Benefit package ☐	Testimony of others ☐	Others ☐
If others, please specify					

	……..				
4. How many members of your household were enrolled?	…….				
5. When the programme was operational, how often did you use the hospital whenever you were ill?	Once or more a week ☐	Once or more a month ☐	Once over three months ☐	Once in six months ☐	Not used at all ☐
6. Looking back, how would you describe the conduct of the health care workers in the hospital towards enrolees?	Satisfactory ☐	Very satisfactory ☐	Not satisfactory ☐	Indifferent ☐	
7. How did you manage the illnesses of household members who were not enrolled?	Out-of-pocket payment ☐	Traditional Medicine ☐	Self-medication ☐	Others ☐	
If others, please explain	…….. ……..				

SECTION C: DESIGN AND IMPLEMENTATION OF THE CBHI PROGRAMME				
1. How will you describe the quality of service rendered under the programme?	Excellent ☐	Good ☐	Fair ☐	Poor ☐
2. Before the collapse of the CBHI programme, how will you describe enrolment into the programme?	Increasing ☐	Decreasing ☐	Stagnant ☐	I don't know ☐
3. Were you informed about the specific healthcare to be provided under the programme by the enrolment officials before you joined?	Yes ☐		No ☐	

4. Looking back, do you think the programme provided all the services it claimed to cover?	Yes ☐	No ☐
If no, please explain with example	…… …….. ……	
5. Did you undergo medical test before treatment at each episode of illness?	Yes ☐	No ☐
6. Did you always use alternative or traditional health care in addition to the hospital treatment?	Yes ☐	No ☐
If your answer is yes, please explain the reason.	……..	
7. Were there times you visited the hospital and you were not treated?	Yes ☐	No ☐
If your answer is yes, how did you feel and what was the reason given?	…… ……	
If your answer is yes, how did you eventually attend to that healthcare need?	…… ……	
8. Do you know of anyone who presented a medical condition that was not covered by the CBHI programme?	Yes ☐	No ☐
If yes, how did the person handle the cost of treatment?	…… ……	

9. After enrolling, did you drop out of the programme before it collapsed? If your answer is yes, what was your reason?	Yes ☐	No ☐
	…… ……	
10. Since the collapse of the CBHI programme, have you visited a hospital for medical consultation?	Yes ☐	No ☐
If your answer is no, explain how you have been attending to your health care needs.	…… …… …… …… ……	
11. In your view, was there effective evaluation and monitoring of the programme?	Yes ☐	No ☐

SECTION D: FUNDING					
1. Who was responsible for your premium?	Self ☐	Spouse ☐	Relatives ☐	Politician ☐	Others ☐
2. Were you responsible for anyone's premium?	Yes ☐		No ☐		
If yes, how many people?	……				
3. How will you describe the affordability of the premium?	Very affordable ☐	Somewhat affordable ☐	Not very affordable ☐	Not affordable ☐	Indifferent ☐

4. How much do you think will be affordable as premium by majority of the members of your community if health insurance programme is re-introduced?	……	
5. Did you pay the same amount as premium throughout your enrolment in the programme?	Yes ☐	No ☐
If no, what do you think about the increment?	…… …… ……	
6. Do you think the government has the financial capacity to provide free healthcare services to the citizens?	Yes ☐	No ☐

SECTION E: STOPPAGE		
1. What were the challenges you observed in the programme when it was operational?	…….. ……..	
2. Were you formally informed that the programme would be winding down?	Yes ☐	No ☐
If yes, what were the reasons given?	…….. ……...	
3. What other things do you think led to the stoppage of the programme?	…….. ……...	

QUESTIONNAIRE FOR COMMUNITY MEMBERS (NON-ENROLLEES)

INSTRUCTION: Tick the appropriate item from the available options and answer questions in the spaces provided

SECTION A: SOCIO-DEMOGRAPHIC DETAILS					
Gender	Male ☐		Female ☐		
Age					
Education	No formal Education ☐	Primary School Education ☐	Secondary School Education ☐	ND/NCE/Tech. School ☐	HND/University Graduate ☐
Religion	Islam ☐	Christianity ☐	African Traditional Religion ☐		Others ☐
Marital Status	Married ☐	Divorced ☐	Single Parent ☐	Single ☐	
Household Size					
Occupation	Farmer ☐	Trader ☐	Technician ☐	Civil Servant ☐	Others ☐
Income per month					
Community					

SECTION B: PERCEPTION				
1. How did you know about the CBHI programme?	Mass media ☐	Family & Friends ☐	Community meeting ☐	Others ☐
Please explain better	…….			
2. How did you feel when the CBHI programme commenced?	Very interested ☐	Somewhat interested ☐	Not very interest ☐	Indifferent ☐
3. How many members of your household were enrolled?	…….			
4. Were you responsible for anyone's premium?	Yes ☐	No ☐		

If yes, how many people?	…….			
5. How did you manage the illnesses of household members who were not enrolled?	Out-of-pocket payment ☐	Traditional Medicine ☐	Self-medication ☐	Others ☐
If others, please specify	…….. ……..			

6. Why did you not enrol in the CBHI programme?	Financial constraint ☐	Enrolled in another health insurance scheme ☐	Lack of trust ☐	Lack of interest ☐	Not around in the community at that time ☐	Others ☐
If others, please specify	…… ……					

7. If your reason was financial constraint, would you have enrolled if someone was ready to pay your premium?	Yes ☐	No ☐
If your answer is No, please explain	…… ……	

SECTION C: DESIGN AND IMPLEMENTATION OF THE CBHI PROGRAMME			
1. Did you ever visit the hospital for medical attention when the CBHI programme was operational?	Yes ☐	No ☐	
If your answer is yes, who was responsible for the bill?	Self ☐	Family & friends ☐	Others ☐

If others, please specify	…… ……	
2. Do you think non-enrolees who visited the hospital for medical attention were given similar quality of care enjoyed by the enrolees?	Yes ☐	No ☐
If your answer is no, please explain	…… ……	

SECTION D: FUNDING		
1. Do you think the government does not have the financial capacity to provide free healthcare services to the citizens?	Yes ☐	No ☐
SECTION E: STOPPAGE		
1. What do you think led to the stoppage of the programme?	…….. ……...	

INTERVIEW GUIDE FOR COMMUNITY MEMBERS (Former Enrollees)

SECTION A: Socio-Demographic Details

1. Age:……..

2. Gender:……

3. Educational Qualification:……..

4. Religion:…….

5. Marital Status:…….

6. Occupation:…….

7. Location/Community:……

SECTION B: Perception about the CBHI Programme

1. How will you describe the CBHI programme that was operational in your community?

2. How did you feel when it was introduced? Please explain.

Probe: How did you hear about the programme? Please explain.

Probe: Did anyone visit your community to provide the information? How were the sessions organized?

Probe: If any, how useful was the information in guiding you in the enrolment and benefit utilisation process?

3. What prompted you to enrol in the programme?

4. What do you think about the quality of service rendered under the programme? Please explain.

6. When the programme was operational, how often do you think people used the hospital whenever they were ill?

Probe: Do you think they used it regularly?

7. Before the collapse, do you think the enrolment rate into the programme was increasing or decreasing? Please expatiate.

8. Looking back, how would you describe the conduct of the healthcare workers in the hospital towards enrolees?

Probe: Do you think they attended to patients very well or not? Please explain

SECTION C: Design and Implementation of the CBHI Programme

1. How did most people feel about the quality of service rendered under the programme? Is that the way you feel too?

Probe: What will you say about the benefit package?

Probe: Do you think the programme covered most of the diseases common in this community?

Probe: Were you informed about the specific medical conditions covered by the programme?

2. How did you manage the illnesses of family members who were not enrolled in the programme?

Probe: Did community members often use alternative or traditional health care in addition to the hospital treatment? Please explain.

3. In your experience, were there times enrolees went to the hospital and were not treated? If yes, what were the reasons given?

4. Since the programme stopped as a former enrolee, have you visited a hospital for medical consultation? If no, how have you been attending to your healthcare needs, or you have been using alternative medicine or self-medication?

5. In your view, was there effective evaluation and monitoring of the programme?

6. Do you think the programme achieved the purpose for which it was established?

SECTION D: Funding

1. As a former enrolee, who was responsible for your premium?

2. Were you responsible for anyone's premium?

3. How much was the premium per year?

4. Do you think the premium was affordable to most members of this community? Please explain.

5. Was the premium increased at some point?

Probe: What do you think about the increase or non-increase? Please explain.

6. Do you think the government has the financial capacity to provide free healthcare services to the citizens? Please explain.

SECTION E: Factors leading to stoppage of the Programme

1. What were the challenges you observed in the programme when it was operational?

Probe: Those things you believed could affect the growth of the programme? Please explain.

2. Are there other things that you heard people complain about the programme when it was operational?

3. Which ones among these problems were resolved before the programme stopped?

4. Were you formally informed that the programme would be winding up? If yes, what were the reasons given?

5. What reasons did you hear led to the stoppage of the programme? And you, what do you think led to the stoppage of the programme? Probe: what do you think went wrong?

Is there any other thing you will like to discuss with me on this issue?

Thank you very much for participating in this research.

INTERVIEW GUIDE FOR COMMUNITY LEADERS

SECTION A: Socio-Demographic Details

1. Gender:……

2. Educational Qualification:……

3. Religious Affiliation:……

4. Community:……

SECTION B: Perception about the CBHI Programme

1. When was the CBHI programme introduced in your community?

2. How did you feel when you heard about the programme?

Probe: How did you hear about the programme? Please explain.

Probe: Did anyone visit your community to provide the information? How were the sessions organized?

Probe: If any, how useful was the information in guiding community members in the enrolment and benefit utilisation process?

3. Were you also in the enrolment of the programme?

Probe: How many members of your household are covered?

4. What prompted most community members to enrol in the programme?

5. What do you think about the quality of service rendered under the programme? Please explain.

6. In your assessment, how often did the community members use the hospital when the programme was operational?

Probe: Did they use it regularly or not? Please explain.

7. Looking back, how did the health care providers relate with the enrolees whenever they visited the hospital?

Probe: Did they attended to the enrolees well or not? Please explain

SECTION C: Design and Implementation of the CBHI Programme

1. How did most people feel about the quality of service rendered under the programme? Is that the way you feel too?

Probe: What will you say about the benefit package?

Probe: Do you think the programme covered most of the diseases common in this community?

Probe: Were you informed about the specific medical conditions covered by the programme?

2. Were there times when enrolees went to the hospital and were not treated?

Probe: Did you receive any such report? Please explain.

3. Is there any community effort towards the running of the programme?

Probe: Was there any collaboration with you as community leader in the implementation process of the programme? Please explain.

4. Is there any channel of communication for you to reach the people in charge of the programme?

Probe: How did you always discuss your ideas and lodge complaints with the authorities in the programme?

5. Do you think most people in the community were covered by the programme?

Probe: what will you say about the medical conditions covered by the programme?

6. How have the community members been catering for their healthcare needs since the stoppage of the programme?

Probe: And you too, have you been paying out-of-pocket, using alternative medicine or self-medication? Please explain.

7. In your view, was there effective evaluation and monitoring of the programme?

8. Do you think the programme achieved the purpose for which it was established?

SECTION D: Funding

1. How much was the premium for enrolment per year?

2. Was there any increment at some point? If Yes, tell me what you think about that.

3. Was the premium affordable to most members of this community?

4. Do you think the government has the financial capacity to provide free healthcare services to the citizens? Please explain.

SECTION E: Factors leading to stoppage of the Programme

1. What were the challenges you observed in the programme when it was operational?

Probe: Those things you believed could affect the growth of the programme? Please explain.

2. Are there other things you heard people complain about the programme when it was operational? Please tell me.

3. Which ones among these problems were resolved before the programme stopped?

4. Were you formally informed that the programme would be winding up? If yes, what were the reasons given?

5. What are other reasons did you hear led to the stoppage of the programme? And you, what do you think led to the stoppage of the programme? Probe: what do you think went wrong?

Is there any other thing you will like to discuss with me on this issue?

Thank you very much for participating in this research.

INTERVIEW GUIDE FOR KEY INFORMANTS (Health Care Providers – Rural Facilities)

SECTION A: Socio-Demographic Details

1. Gender:…….

2. Profession:……

3. Location/Community:…….

SECTION B: Design and Implementation of the CBHI Programme

1. What are your distinct responsibilities in the implementation of the programme?

Probe: Were you involved in the policy design? What do you think about that?

2. In your own assessment, do you think the enrolees were satisfied with the quality of service rendered by your hospital?

3. What complaints did they lodge with you?

Probe: What problems do you have relating with the enrolees?

4. How well did the programme meet the health care needs of the enrolees?

Probe: Maybe some treatments required were not covered by the health plan? Explain please.

Probe: Do you think the programme covered most of the diseases common in this community?

Probe: Looking back, were there times when enrolees came for medical care and you did not attend to them? Please explain.

5. Was it a requirement of the CBHI programme to conduct medical test on patients before treatment at each episode of illness? Please explain.

6. Do you think CBHI is the best policy option in rural areas considering the economic realities of the people?

7. What would you say about how people have been taking care of their health care needs since the stoppage of the programme?

Probe: Have they been making out-of-pocket payments or turned to alternative medicine or self-medication? Please explain.

8. How will you describe your relationship with community members and programme managers when the scheme was still functional? Probe: Were there personality clashes?

9. In your view, was there effective evaluation and monitoring of the programme?

10. Do you think the programme achieved the purpose for which it was established?

SECTION C: Funding

1. Was the premium affordable to most members of this community?

Probe: Did they find the amount affordable?

2. What do you know about the funding of the programme?

Probe: Do you know if the premium was subsidized by the government, an organization or individual? Please elaborate.

3. How viable is CBHI as a health care financing strategy? Please expatiate.

4. How do you think universal health coverage can be achieved?

5. Do you think the government does not have the financial capacity to provide free healthcare services to the citizens? Please explain.

SECTION D: Factors leading to stoppage of the Programme

1. What were the challenges that faced the programme when it was operational? Probe: Those things you believed could affect the growth of the programme? Please explain.

2. Are there other things that you heard people complain about the programme when it was operational?

3. What challenges did you face in delivering healthcare services under the programme?

Probe: Do you have a conflicting interest or clash with the implementing partners? Please explain.

4. Do you think the programme was characterized by bad management?

5. Were you formally informed that the programme would be winding up? If yes, what were the reasons given?

6. What reasons did you hear led to the stoppage of the programme? And you, what do you think led to the stoppage of the programme?

Probe: what do you think went wrong?

7. How has the stoppage affected your turnover? (FOR PRIVATE HOSPITALS ONLY)

Is there any other thing you will like to discuss with me on this issue?

Thank you very much for participating in this research.

INTERVIEW GUIDE FOR KEY INFORMANTS (Health Care Providers - Referral Hospitals)

SECTION A: Socio-Demographic Details

1. Gender:…….

2. Profession:……

3. Location/:…….…….

SECTION B: Design and Implementation of the CBHI Programme

1. What are your distinct responsibilities in the implementation of the programme?

Probe: Were you involved in the policy design? What do you think about that?

2. In your own assessment, do you think the enrolees were satisfied with the quality of service rendered by your hospital?

3. How well did this the programme meet the health care needs of the enrolees?

Probe: Maybe some treatments required were not covered by the health plan? Explain please

Probe: Do you think the programme covered most of the diseases common in this community?

Probe: Looking back, were there times when enrolees came for medical care and you did not attend to them? Please explain.

4. What would you say about how people have been taking care of their health care needs since the stoppage of the programme?

Probe: Have they been making out-of-pocket payments or turned to alternative medicine or self-medication?

5. Was it a requirement of the CBHI programme to conduct medical test on patients before treatment at each episode of illness? Please explain.

6. How will you describe your relationship with community members and programme managers when the scheme was still functional? Probe: Were there personality clashes?

7. In your view, was there effective evaluation and monitoring of the programme?

8. Do you think the programme achieved the purpose for which it was established?

SECTION C: Funding

1. Do you think the premium was affordable to most members of the enrolees?

Probe: Did they find the amount affordable?

2. What do you know about the funding of the programme?

Probe: Do you know if the premium was subsidized by the government, an organization or individual? Please elaborate.

3. How viable is CBHI as a health care financing strategy? Please expatiate.

4. How do you think universal health coverage can be achieved?

5. Do you think the government does not have the financial capacity to provide free healthcare services to the citizens? Please explain.

SECTION D: Factors leading to stoppage of the Programme

1. What challenges did you observe faced the programme when it was operational? Probe: Those things you believed could affect the growth of the programme? Please explain.

2. Are there other things that you heard people complain about the programme when it was operational?

3. What challenges did you face in delivering healthcare services under the programme? Probe: Do you have a conflicting interest or clash with the implementing partners? Please explain.

4. Do you think the programme was characterized by bad management?

5. Which year did the programme stop in your hospital?

6. Were you formally informed that the programme will be winding up? If yes, what were the reasons given?

7. What reasons did you hear led to the stoppage of the programme? And you, what do you think led to the stoppage of the programme? Probe: what do you think went wrong?

8. How has the stoppage affected your turnover? (FOR PRIVATE HOSPITALS ONLY)

Is there any other thing you will like to discuss with me on this issue?

Thank you very much for participating in this research.

INTERVIEW GUIDE FOR KEY INFORMANTS (POLICY MAKERS - State Government Officials)

SECTION A: Socio-Demographic Details

1. Gender:…….

2. Profession:……

SECTION B: Design and Implementation of the CBHI Programme

1. What was the motive behind the introduction of the CBHI programme?

Probe: How did it come about, the policy option, planning, design and implementation? Please explain in detail.

Probe: Who was responsible for the design policy content of the CBHI model implemented in the State?

2. How will you describe the health policy in the State before the introduction of the CBHI programme?

Probe: Was there any variation in the goal of the existing policy when the programme was introduced? Please elaborate.

3. What was the remark of the federal government and international agencies (such as WHO, UNICEF etc) about the programme?

Probe: Were they pessimistic or optimistic? Please explain.

4. What was the nature of the agreement signed between the State Government and the various partners?

5. How will you describe the success of the CBHI programme in the State?

Probe: Do you think it achieved the purpose for which it was established. Please list the major achievements.

Probe: What were the specific achievements of the programme in the state?

6. Was the State Government satisfied with the enrolment population as at the end of the programme in 2016?

7. What were the specific evaluation and monitoring strategies put in place when the programme was operational? Please tell me.

8. What was the provision put in place to get feedback on the programme?

Probe: Which medium was available to them lodge complaints about the health service?

9. Was there anytime that some healthcare services were removed from the coverage of the programme? Please explain.

10. What assistance or plans were put in place by the Government to attend to health care needs of enrolees with ailments that were not covered by the health plan? Please explain.

11. How do you think the people have been catering for their health care needs since the stoppage of the programme?

Probe: through out-of-pocket payments, alternative medicine or self-medication? Please tell me.

12. How many years do you think it could take the State to achieve universal health coverage through CBHI?

13. Majority of the CBHI schemes in the rural communities were established in 2015. Is there any reason for that? Please explain.

14. What was the role of the National Health Insurance Scheme (NHIS) in the programme?

Probe: Did it play any role from planning to the implementation as well as regulation of the programme?

SECTION D: Funding

1. How would you describe the funding system of the CBHI programme by the State Government and the Dutch Health Insurance Fund (HIF)?

Probe: Did the HIF abide by the funding agreement? Please expatiate.

2. What was the percentage of contribution provided by each party for the programme? Please explain.

3. Was funding ever a challenge during the lifespan of the programme?

4. What would you say regarding decision-making on the programme?

Probe: Were decisions jointly made by the partners or not. Please explain.

5. Do you think CBHI could be effective in a community with people who do not have stable income? Please explain.

6. Was the premium increased at some point?

Probe: What do you think about the increase or non-increase? Please explain.

7. How much do you think will be affordable as premium by majority of the community members if health insurance programme is re-introduced?

8. How viable is CBHI as a health care financing strategy? Please expatiate.

9. What informed the policy option adopted by the State Government? Please explain.

10. Is the State Government servicing a debt on the health sector? If yes, when and what was the loan taken for?

Probe: Apart from the partnership, was there any contribution from government or international agencies?

11. Do you think the government does not have the financial capacity to provide free healthcare services to the citizens? Please explain.

SECTION E: Factors leading to stoppage of the Programme

1. What were the challenges of the programme when it was operational?

Probe: Those things you believed could affect the growth of the programme? Please explain.

2. How were the challenges tackled?

Probe: Which other challenges do you think were not well not fully resolved?

3. Which year did the programme stop?

4. What factors led to the stoppage of the programme? Probe: what do you think went wrong?

5. Were there disagreements or conflicting interests between the partners implementing the programme?

6. How has the stoppage affected the health care situation of the rural communities?

7. Were the enrolees formally informed that the programme would be winding up? If yes, what were the reasons given?

Is there any other thing you will like to discuss with me on this issue?

Thank you very much for participating in this research.

INTERVIEW GUIDE FOR KEY INFORMANTS (POLICY MAKERS – National Health Insurance [NHIS] Official)

SECTION A: Socio-Demographic Details

1. Gender:…….

2. Profession:……

3. Location/Community:…….

SECTION B: Design and Implementation of the CBHI Programme

1. In your view, was the Kwara CBHI designed based according to the Community-Based Social Health Insurance Programme (CBSHIP) model of the NHIS? If no, what were the basic differences?

2. Is the CBHSHIP better than the Kwara CBHI model. Please explain.

3. What was the role of the NHIS in the design and implementation of the CBHI programme?

Probe: Was the NHIS formally informed or carried along in the process? If no, what was supposed to be the role of the NHIS if you were involved?

4. How will you describe the success of the CBHI programme in the State?

Probe: Do you think it achieved the purpose for which it was established. Please list the major achievements you observed in the programme.

5. How many years do you think it could take the State to achieve universal health coverage through CBHI or CBSHIP? Please explain your views.

6. How will you describe the reaction of the federal government and international agencies (such as WHO, UNICEF etc) to the programme?

Probe: Were they pessimistic or optimistic? Please explain.

7. In your view, was there effective evaluation and monitoring of the programme?

SECTION D: Funding

1. Do you think the premium paid by the enrolees was affordable?

Probe: Do you think they found the amount affordable?

2. What do you know about the funding of the programme?

Probe: Do you know if the premium was subsidized by the government, an organization or individual? Please elaborate.

3. How viable is CBHI as a health care financing strategy? Please expatiate.

4. How do you think universal health coverage can best be achieved? Please explain.

5. What do you know about the funding system for the CBHI programme in the State? Please tell me.

6. Did the NHIS commit any fund to the programme?

7. Do you think CBHI or CBSHIP can be effective in a community with people who do not have stable income? Please explain.

8. How viable is CBHI as a health care financing strategy? Please expatiate.

9. What do you think informed the policy option adopted by the State Government? Please explain.

10. Do you think the government does not have the financial capacity to provide free healthcare services to the citizens? Please explain.

SECTION E: Factors leading to stoppage of the Programme

1. What were the challenges you observed in the programme when it was operational? Probe: Those things you believed could affect the growth of the programme? Please explain.

2. Do you think the programme was characterized by bad management?

3. Do you think there were disagreements or conflicting interests between the partners implementing the programme?

4. What factors do you think led to the stoppage of the programme? Probe: what do you think went wrong?

5. Are there other things that you heard people complain about the programme when it was operational?

Is there any other thing you will like to discuss with me on this issue?

Thank you very much for participating in this research.

INTERVIEW GUIDE FOR KEY INFORMANTS (LOCAL and INTERNATIONAL PARTNERS – Dutch Health Insurance Fund, PharmAccess and Hygeia HMO)

SECTION A: Socio-Demographic Details

1. Gender:…….

2. Profession:……

3. Location/Community:…….

SECTION B: Design and Implementation of the CBHI Programme

1. What was the motive behind the introduction of the CBHI programme?

Probe: How did it come about, the policy option, planning and implementation? Please expatiate.

2. Was it an idea of the State Government or your organization? Please explain.

3. What was the nature of the agreement between the State Government and your organization?

4. How will you describe the success of the CBHI programme in the State?

Probe: Do you think it achieved the purpose for which it was established. Please list the major achievements.

5. Was your Organization satisfied with the enrolment population as at the end of 2016 when the programme ended?

6. What were the specific evaluation and monitoring strategies put in place when the programme was operational? Please tell me.

7. What was the provision put in place to get feedback on the programme?

Probe: Which medium was available to them lodge complaints about the health service?

8. Was there any time that some healthcare services were removed from the coverage of the programme? Please explain.

9. What is your understanding of the health policy in the State before the introduction of the CBHI programme?

Probe: Was there any variation in the goal of the policy when the programme was introduced? Please elaborate.

10. How well did the programme meet the health care needs of the enrolees?

Probe: What assistance or plans were put in place to attend to health care needs of enrolees with ailments that were not covered by the health plan? Please explain.

11. How do you think the people have been catering for their health care needs since the stoppage of the programme?

Probe: through out-of-pocket payments, alternative medicine or self-medication? Please tell me.

12. How many years do you think it could take the State to achieve universal health coverage through CBHI?

13. Majority of the CBHI schemes in the rural communities were established in 2015. Is there any reason for that? Please explain.

14. What was the role of the National Health Insurance Scheme (NHIS) in the programme?

Probe: Did it play any role from planning to the implementation as well as regulation of the programme? Please expatiate.

SECTION D: Funding

1. How would you describe the funding system of the CBHI programme by the State Government and the Dutch Health Insurance Fund (HIF)?

Probe: Did the State Government abide by the funding agreement?

2. What was the percentage of contribution provided by each party for the programme? Please explain.

3. Was funding ever a challenge during the lifespan of the programme?

4. What would you say regarding decision-making on the programme?

Probe: Were decisions jointly made by the partners or not. Please explain.

5. Do you think CBHI could be effective in a community with people who do not have stable income? Please explain.

6. Was the premium increased at some point?

Probe: What do you think about the increase or non-increase? Please explain.

7. How much do you think will be affordable as premium by majority of the community members if health insurance programme is re-introduced?

8. How viable is CBHI as a health care financing strategy? Please expatiate.

9. What informed the CBHI policy option implemented in Kwara State? Please explain.

10. Do you think the government does not have the financial capacity to provide free healthcare services to the citizens? Please explain.

SECTION E: Factors leading to stoppage of the Programme

1. What were the challenges of the programme when it was operational? Probe: What were those things you believed could affect the growth of the programme? Please explain.

2. How were the challenges tackled?

Probe: Which other challenges do you think were not well not fully resolved?

3. Do you think the programme was characterized by bad management?

4. What factors led to the stoppage of the programme? Probe: what do you think went wrong?

5. Were there disagreements or clash of interest between the partners implementing the programme?

6. How has the stoppage affected the health care situation of the rural communities?

7. Were the enrolees formally informed that the programme would be winding up? If yes, what were the reasons given?

Is there any other thing you will like to discuss with me on this issue?

Thank you very much for participating in this research.