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Research Article

Perception of community-based health insurance scheme in Ogun State, Nigeria

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Abstract

This exploratory qualitative research is focused on perception of Community-Based Health Insurance Scheme (CBHIS) for the successful implementation, sustainability and effective operations of the scheme from the viewpoint of the target populations, preparatory to its rolling out in Abeokuta North and Ijebu Ode LGAs of Ogun State, Nigeria. The study was conducted through in-depth interviews and Focus Group Discussions (FGDs) with community members, community leaders, opinion leaders and Board of Trustees (BoT) members in the communities. Poor understanding of the concepts of CBHIS principles with little sense of community control and ownership of the scheme were largely demonstrated in the communities studied. Factors critical for their patronage of the scheme were identified as infrastructural improvement at the designated CBHIS health facilities, accountability and transparency in management of the scheme, availability of adequate number of the various cadres of health workers and availability of essential drugs. Other critical issues such as community acceptability and willingness to pay for CBHIS, and perceived ways of effectively operating the scheme were captured in the study. The study provides useful policy lessons with insights for improved planning and implementation of the scheme and also highlights the need to take cognizance of potential enrollees' expectations in its planning and execution to increase patronage and guarantee sustainability.

Introduction

Nigeria's health performance has been one of the poorest worldwide over the last 2 decades [1]. Studies have attributed this to severe limited access to health care [2] due to factors that include inability to pay and inequitable health care provision especially among the poor rural dwellers who account for 70% of Nigerian population and are prone to further impoverishment [3-7]. Out-of-pocket health expenditure in Nigeria is over 60%, making it one of the highest globally [8,9]. The predominance of out-of-pocket health financing makes it difficult for the poor to access quality health care services at the point of utilization [4,7].

Nigeria still has a high prevalence of communicable diseases and an increasing burden of non-communicable diseases with communicable diseases accounting for 66% of the total burden of morbidity in the country [10]. The top 10 health problems

causing death in Nigeria include lower respiratory infections, neonatal disorders, HIV/AIDS, malaria, diarrheal diseases, tuberculosis, meningitis, ischemic heart disease, stroke and cirrhosis [11]. In Nigeria, there are free established schedule of immunization in hospitals as part of pre-natal and post-natal care services for pregnant women and children against common vaccine-preventable diseases, namely tetanus, tuberculosis, diphtheria, whooping cough (pertussis), polio, and measles to reduce neonatal, infant and child mortality [12].

Public health financing in Nigeria has been through government subvention sourced from petroleum exports, and user-fees from patients. Decline in funding for healthcare commenced after the mid 1980's following a drastic reduction in revenue from oil exports, mounting external debts burden, structural adjustment programme and rapid population growth rate [13,14].

The mixed economy practised in the country enables public



private partnership policy that gives room for public and private sector participation in medical care provision [15,16].

While Nigeria accounts for 2.8% of the world's population, it bears, by contrast an alarming 10% of the global burden of under five year old children and maternal mortality [7]. Some of government's key responses to this are the Health Systems Reforms. Part of the reforms of government in the health sector aimed at improving efficiency in both public and private sectors and covering the marginalized poor is introduction of the National Health Insurance Scheme (NHIS) to help spread the risks and minimize costs of health care [5].

Evidence abounds on the impact of schemes to achieve universal health coverage [17]. A number of countries have successfully implemented National Health Insurance Scheme (NHIS) to provide effective and efficient health care for all or majority of their citizens in order to achieve universal access to medical care [18,19]. In Nigeria, having conceived the idea of the NHIS in 1962, it was promulgated 37 years later in 1999 (Decree 35 1999 now Act 35 1999) and launched 43 years later in 2005 [14,20]. The NHIS was designed to provide comprehensive health care delivery at affordable costs, covering employees of the formal sector, self-employed, rural communities and the vulnerable groups [21]. Presently, the NHIS covers less than 7% of the population that mostly constitute civil servants and those in the formal sector through community-based health insurance scheme (CBHIS) and other health insurance scheme(s). For the realization of the presidential directive of ensuring universal access to quality health care in Nigeria by 2015, all States of the Federation need to have a buy-in since the provision of healthcare is a concurrent responsibility of the three tiers of government in the country [9,22,23].

The NHIS Agency is presently intensifying efforts at reaching the informal sector which constitutes those in greatest need, focusing especially on community based and other health insurance schemes [22,24].

Although some studies on various aspects of health insurance schemes in Nigeria have been carried out [25-27], these have been limited in scope, focus, and study population groups. Furthermore, these studies have also not examined community perception on critical issues that could enhance or militate against the success of the health insurance schemes from the perspective of all key stakeholders of the schemes within one study, as designed in this present study which also focuses especially on targeted clients. This study is part of a major study that addressed the role of health insurance schemes in improving equity and access to quality healthcare in the country; the success and challenges to effective implementation, given the plan to roll out the schemes across the nation starting from 2014. The States' level of buy-in into the health insurance scheme and their challenges were also assessed as well as other issues relating to sustainability of the schemes such as enrollees' satisfaction, uptake, acceptability and, non-enrollees perception of the scheme, were also investigated. This paper reports on the sub-study that assessed

the community perception on critical issues for the success of the schemes, such as access, utilization, acceptability, willingness to pay, and issues on sustainability and effective operations of the scheme from the viewpoint of the target population, preparatory to the rolling out of the CBHIS in the study State. This is based on the premise that community participation is key to the success of the scheme. It also provides useful policy lessons with insights for improvement in the design of interventions aimed at improving the scheme for a guaranteed and affordable basic health care provision.

Method

Study areas

The study was carried out in May 2014 in two selected urban local government areas (LGAs), Abeokuta North and Ijebu Ode in Ogun State, South West Nigeria where CBHIS was about to be rolled out for implementation. These are two of the twenty LGAs in the State for the state-wide phased roll-out of the scheme. Abeokuta North LGA has its headquarters in Akomoje and lies between latitude 7°12'N and longitude 3°12'E. It covers an area of 808 square kilometres with a 2014 projected population of 261,772 people based on the 2006 National Population Census at 3.5% growth rate [28]. Ijebu Ode LGA lies between latitude 6°49'15"N and longitude 3°55'15"E, it has its headquarters in Ijebu Ode. With a 2014 projected population of 206,951 people based on the 2006 National Population Census at 3.5% growth rate [28], it covers an area of 192 square kilometres. The two LGAs are located about 100km north of Lagos and the Atlantic Ocean (Figure 1).

Despite the dialectic difference, the people of the two LGAs have striking similarities in tradition, culture and economic activities primarily based on farming and trading. Basic social amenities like roads, water, health facilities and educational institutions are present in the two LGAs.

Study design

This is an exploratory qualitative study on community perception of CBHIS in Abeokuta North and Ijebu Ode local government areas (LGAs) of Ogun State, Nigeria. The study, carried out in May 2014, focused on community access, utilization, acceptability, and willingness to pay for CBHIS, perception on the sustainability of the scheme, and perceived ways of effectively operating the scheme from the viewpoint of the target population, preparatory to the rolling out of the CBHIS in the State.

Study population

Community members who are potential enrollees, community leaders, opinion leaders and Board of Trustees (BoT) members in communities where CBHIS is about to become operational constitute the target population for this study. The exclusion criteria included not being a permanent resident of the community or having lived there for at least 12 months at the time of the study, not being a community head and BoT member as the case may be aged below 18 years and unwillingness to participate in the interview.

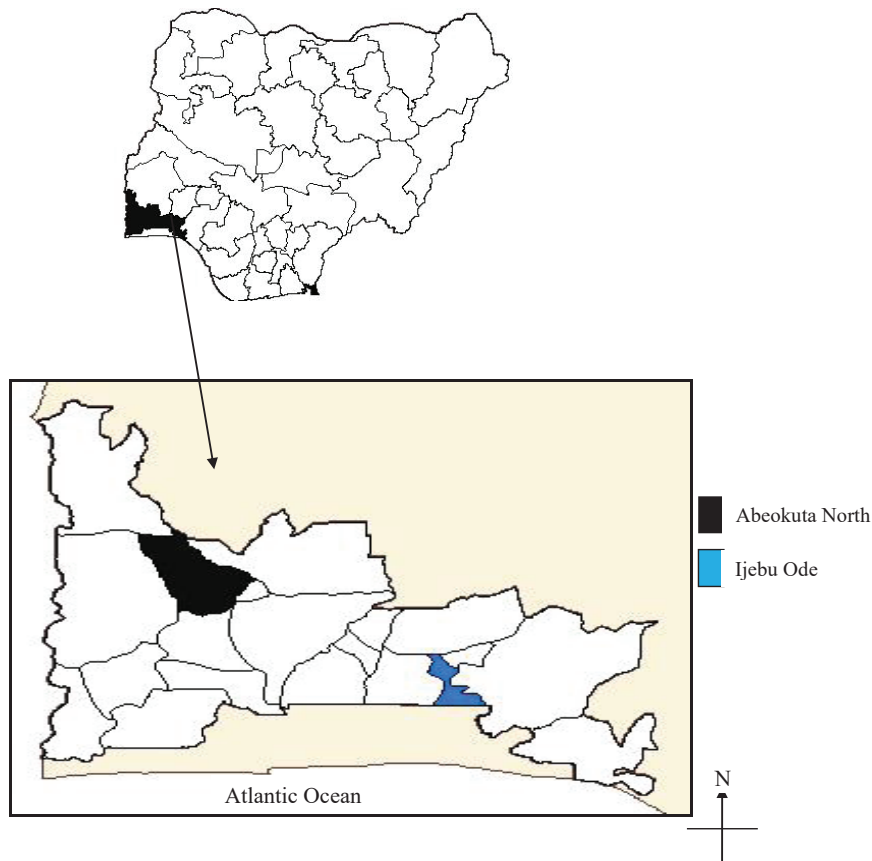


Figure 1: Map of Ogun State projected from Nigeria, highlighting Abeokuta North and Ijebu Ode LGAs.

Data collection procedures

The data collection exercise was carried out within a period of two weeks (a week per LGA). Multi-stage sampling technique was adopted in sample selection for the study. The sampling frame includes all the 6 LGAs namely: Abeokuta North; Abeokuta South (Ogun Central); Ado-Odo/Ota; Yewa North (Ogun West) Ijebu Ode; and Sagamu; (Ogun East) where CBHIS was planned to become operational as a pilot scheme in the State. Of these, two LGAs (Abeokuta North and Ijebu Ode) located in two (Ogun Central and Ogun East respectively) of the three senatorial districts of the State were selected by random sampling. First, two of the three senatorial districts (Ogun West, Ogun Central and Ogun East) in the State were selected by simple random sampling. Second, adopting the balloting approach, the names of the two LGAs in selected senatorial districts were written on pieces of paper, placed in separate containers, shuffled and one LGA was subsequently picked at random from each container without replacement. In each selected LGA, the only 5 wards comprising communities where CBHIS was planned to be flagged off as a pilot scheme were purposively [29] selected for the study. In the selected wards, communities served by the Primary Health Care (PHC) facilities designated as health care providers for the CBHIS were selected for the study.

Purposive sampling technique was used to select all the interviewees and FGD participants for the study in the communities. Efforts were made to achieve geographical

dispersal of these groups throughout the communities of the selected LGAs. The FGD participants were recruited from places such as households, market associations, mosques and churches through the community, and market and opinion leaders in the study communities, and it was ensured that the FGD participants did not know of one another's selection prior to the start of the discussions.

The Focus Group Discussions (FGDs) were conducted among community members that included adult males and females aged 25 years and above and adolescent males and females aged 24 years and below who are potential enrollees in the scheme in the study LGAs.

The data collection tools and procedures were pretested to test the adequacy and consistency of the research design and tools prior to the main study. The main sections of the FGD and in-depth interview guides from which the focus of this paper was derived included those that probed the background characteristics of the participants/interviewees such as age, religion, level of education, marital status and occupation. Others probed into major health problems, people's health seeking behaviour, out-of-pocket expenditure on health, knowledge of insurance, household health insurance issues, acceptability, willingness to enroll and pay for health insurance, form of community engagement/involvement in the scheme, expectations of the scheme and perceived ways of sustaining the scheme.

A total of 6 FGD sessions were conducted in the study LGAs. The focus groups formed were homogenous with respect to sex, age and social class in order to minimize inhibitions in the flow of discussion. They had common characteristics relating to discussion topic. In each LGA, FGD sessions were held among adults aged 25 years and above and adolescents aged 18–24 years. Each FGD session was held in a comfortable neutral setting, and consisted of a moderator, a note taker and 7 to 10 participants of the same sex with similar social background. A total of 61 males and females participated in the discussions. Sample size for this study was decided based on saturation commonly used to determine sample sizes in qualitative research [30], The FGD sessions were recorded on tape and moderated in the local language. The 6 FGD sessions lasted a total duration of 281 minutes and an average of 47 minutes per FGD session. In each LGA, the FGD sessions were conducted within a time interval of 24 hours. The participants were assured of anonymity and confidentiality, and their permission was sought and obtained for use of the tape recorder during the discussion.

Complementary to the FGD sessions were a total of 13 in-depth interviews (IDIs) conducted with community leaders, and chosen chairmen and members of Boards of Trustees (BoTs) for the scheme.

Data analysis

The qualitative data from the FGDs and IDIs were analysed using the textual analysis programme, Textbase Beta, developed by Bo Summerlund and distributed by Qualitative Research Management of Desert Hot Springs, California, Textbase Beta software [31,32]. First, the tape recorded discussions in local language were transcribed and back-translated into English language. Second, the transcripts were subsequently typed, summarised, categorised, coded and sorted into text segments according to similarities and differences in individual opinions and views based on themes arising from the discussion guides.

Ethical issues

Ethical approval for the research protocol for the larger study with assigned number IRB/13/237 was obtained from the Institutional Review Board of the Nigerian Institute of Medical Research. The informed consent of the participants was sought and obtained in writing for those literate while the non-literates (to whom the contents of the document had been read out in local dialect) were requested to thumb print in the presence of a witness to signify their willingness to participate in the study. Privacy of each participant in the in-depth interviews was ensured through individual interview to avoid interference and influence by other persons. The participants were assured of the confidentiality of the information provided for the purpose of the study and no personal identifiers were used in the collection, analysis or reporting of the data.

Results

Socio-demographic characteristics of participants

The selected participants for the focus group discussion

(FGD) sessions were residents of the study communities. In general, the participants' ages ranged from 19 to 81 years with an average age of 46.8 years [43.9 years Abeokuta North vs. 52.4 years Ijebu Ode]. There was gender difference in the age distribution of the participants. The ages ranged from 20 to 40 years for men and 24 to 57 years for women and an average age of 49.8 and 42.5 years for men and women respectively. Most of them were married with a few who were widowed and never married. High literacy level was reported among the participants as most had a minimum of secondary education with a few having primary education while some had no formal education. Their occupations ranged from being artisans, drivers, clergymen, traders, farmers, and formally employed in both public and private sectors as civil servants and professionals to unemployed, pensioners, students. Some of the female FGD participants reported to be housewives.

Perceived common health problems of people in the study LGAs

The focus group discussions among the men and women in the communities showed the consensus that measles, dysentery (*jedi-jedi*), stomach pain, rheumatism, typhoid, diabetes, cough, pneumonia, anaemia, eye problem, convulsion, hernia, cholera, hypertension, with its consequence stroke, cancer and malaria are the common health problems that affect people of all ages and gender in communities of the study LGAs. It was disclosed that malaria affects a lot of children under five years and pregnant women in their localities while pneumonia, cough and measles were reported to be more among children only. Some health problems such as hernia that are gender-related were mentioned mostly by male participants who are more at risk of the health challenge than their female counterparts in both LGAs.

Malaria was described by many of the participants as a very common public health challenge of people in communities of the two LGAs. A female participant explained that, "...malaria is a general problem, there's no one not affected...it is very common here because there are many mosquitoes around us...it affects everyone regardless of age, it even affects pregnant women." A male FGD participant in Totoro further emphasized that, "malaria is the most prominent illness in our community and it has serious health complications in children." A female FGD participant from Oke Ago Owu community in Abeokuta North LGA revealed that, "Malaria affects both the young and old people. Also, everybody coughs...it affects children as well as adults...I observed recently that cough is so rampant now among people in the community." A male participant in Ijebu ode expressed his concern thus: "Malaria is the commonest sickness in our community despite efforts to control it through measures that include protection of oneself from mosquitoes and clearing of our environment...malaria is still rampant." Another male participant in Totoro was fatalistic in his resort to fate on the persistence of malaria in the community saying: "...even with these measures, malaria is still rampant because of our environment...we pray that God would help us."

Different health care options available and health seeking behaviour of the people

Most FGD participants in both LGAs reported to live in close proximity to health facilities located within their communities.



When asked what they do when they or their children are ill, a large number of the FGD participants reported going to the hospital for treatment. Other actions mentioned were: self-treatment at home, which varied from using left over drugs; going to the chemist or pharmacy; cooking and drinking herbal remedies prepared from leaves, roots and barks of some specified trees (*agbo*) freely obtained from the home environment or bought from herbalists in the market; visiting a traditional healer to praying. A female FGD participant in Abeokuta North LGA stated that, “Our main means of taking care of the sick around us is by going to the hospital for treatment.” Also, a male FGD participant in Ijebu Ode LGA pointed out that, “I rarely go to the hospital when feeling sick. Once I drink *agbo*, I usually get well but in case the sickness persists I’d just visit any nearby chemist shop to buy some drugs particularly paracetamol...that’s all. It is only if I don’t get well after visiting these two places that I can then resort to going to the hospital.”

Regardless of their gender and location in the two LGAs, it was a consensus among those participants who preferred taking herbal remedies to going to the hospital because the herbal preparations are affordable, more accessible and perceived to be more efficacious against all kind of illnesses than the orthodox medicines given in the hospital. On the other hand, the reason for high preference for hospitals by most participants particularly the women is because of the experienced and trained medical personnel and diagnostic equipment available for provision of quality health care. This is contrary to the perceived trial and error style of health management by traditional medical practitioners and patent medicine sellers.

It is worthy of note that most FGD participants demonstrated good health seeking behaviour with good knowledge of what do and how to take action as first aid for example when a child is convulsing to alleviate the illness at home before seeking more appropriate treatment outside at the hospital. There was gender difference in the health seeking behaviour of the participants, as more women knew the action to take in providing health care within the home than the men. Similarly, more women than men prefer going to the hospital when they or their children are ill.

Knowledge and perception of CBHIS

There were mixed reactions on awareness of CBHIS from FGD participants in the two LGAs. Those in Abeokuta North LGA particularly the males had more awareness than those in Ijebu ode LGA. Among the few who knew about the scheme in Abeokuta North LGA, radio jingles and informal means such as family, friends, neighbours and the Community Development Associations (CDAs) were the main sources of information about the scheme.

Virtually all the female FGD participants in Abeokuta North LGA knew about health insurance from their past experience either as students of higher institutions where they were mandated to enroll as students or as mothers paying a health insurance plan premium of ₦500.00 (\$3.13) to ₦600.00 (\$3.75) per term for their children in public primary and secondary

schools. All the women however had negative stories to tell about poor implementation of the school health insurance plan. A woman in a focus group in Abeokuta North LGA recalled that, “There are selected hospitals that accept to offer any health care for our children we enrolled in school health insurance plan despite the money we paid. The schools usually send our children home when sick or injured in school with a teacher guiding them home to their parents or guardians for treatment. We then have to spend money from our pockets again to treat these children...Of what use is the school health insurance plan then? For me, I’ve stopped paying the school health insurance premium for my children...I’d rather take responsibility for caring for my children myself than wasting my money in a plan that is of no benefit to one.”

Among those who had no knowledge of CBHIS, a female participant in a focus group in Abeokuta LGA for example pointed out that, “We’ve not heard of the community health insurance scheme here...For someone like me, I don’t listen to radio because most times I watch movies on TV. Nobody, not even the health workers or the King’s (Oba) town criers have some around to announce anything of such to us just as they usually do for immunisation and availability of long lasting-insecticide for malaria.”

None of the FGD participants and those interviewed had registered and had access to health care services under the CBHIS in both LGAs because enrolment into the scheme was on-going as at the time of the study.

The FGD participants expressed strong impression and positive perception of the scheme as well as the benefits of enrolling in CBHIS and accessing affordable quality health care services under it. Though the participants had divergent views in their description of perceived benefits of CBHIS, the pattern of discussion in most of the focus groups is similar regardless of gender as men as much as women had same positive perception particularly as it relates to the exemptions of vulnerable groups including pregnant women, children under five years and the aged (70 years and above) from paying to access health care services in the scheme and with the cost of health care for the general populace subsidized by the State government in collaboration with the beneficial local government authority. Only a very few of the participants saw the scheme as a desirable product worth paying any price for, in anticipation of unforeseen health risk. A male participant in a focus group in Ijebu Ode for example said, “I’d pay the ₦4,000.00 (\$25.00) premium or even more in the scheme seeing what I stand to gain in enrolling.”

Planned CBHIS health package and expected benefits from the scheme

Benefits derivable from the health package of the Ogun State CBHIS tagged ‘ARAYA’ include: improved access to healthcare delivery by setting high standard; reduction of poverty in the state by reducing out of pocket expenses for health care delivery; augmentation of government expenditure on health; increased efficiency in the healthcare delivery system and provision of free health care for pregnant women and children under five years of age and those over 70 years. Beneficiaries of



the scheme are expected to pay ₦7000.00 (\$43.75) as premium per year of which a subsidy sum of ₦2,000.00 (\$12.50) and ₦1,000.00 (\$6.25), is to be contributed by the State and Local Government thereby enabling enrollees to pay ₦4,000.00 (\$25.00) per annum while vulnerable group, who are the pregnant women, children under five years of age and those over 70 years of age, have free access to the scheme.

When the FGD participants and those interviewed were probed on their expectations of the scheme, majority of them had very high expectations from the implementation of the scheme with their anticipation of affordable quality and comprehensive health care delivery by managers of the scheme. The expectations from the scheme, based on the consensus of the focus groups, in the two LGAs included: affordable premium; availability of trained health personnel to provide prompt and appropriate consultations; access to out-patient and in-patient services with emphasis on medical emergencies, management of common ailments such as malaria and some chronic non-communicable diseases such as hypertension and diabetes; maternal and child health care services; access to diagnostic tests and genuine drugs; surgeries; effective means of transportation for referral and positive attitude of health workers to patients, short waiting time accountability and transparency. The offered CBHIS (ARAYA) health package is summarised in Table 1.

There was neither gender difference in the expected benefits of the focus groups in the two LGAs and nor did these expectations vary from one LGA to the other. Despite these expectations, many still expressed their concerns and scepticisms of government sincerity and the scheme's sustainability with the common slogan of "promise and fail in previous programmes" in reference to previous government programmes. This depicts the wrong belief that success or

failure of the scheme lies with the government rather than, largely, with the community being a community driven programme.

The trend of the discussions showed little or no sense of community ownership of CBHIS among majority of people in communities of the two LGAs. Most FGD participants and those interviewed believed the scheme is owned by the government rather than the community. Moreover, there was an element of fatalism in the responses of some FGD participants who believed only God can help in the management of the scheme. A few would like the government (represented by the LGA Chairman) to control the scheme.

Participants' willingness to enroll and pay health insurance premium

With the high positive perception about the scheme among the participants, virtually all the focus groups were willing to enrol members of their households and pay their health insurance premiums following education on the CBHIS package and its benefits.

Evidence from the group discussions showed that a large number of the FGD participants expressed their feelings on the need for managers of the scheme to pay more attention to providing quality health care for the people rather than the emphasis on premium. Most focus groups and some of those interviewed were much more concerned about the sustainability of the scheme and the quality of health care services including genuine drugs, and prompt and good diagnosis and treatment to be provided than the premium to be paid. They wondered if the prepaid premium would be refunded to them at the end of the year if they do not use health services equivalent to the premium amount, a point that portrays their poor knowledge/understanding of the concept of the scheme.

In view of their low income due to the poor economic situation in the country and lack of poverty alleviation programmes in most communities of the LGAs, the annual premium of ₦4,000.00 (\$25.00) per enrollee per annum was adjudged too high and unaffordable by many of the FGD participants and those interviewed. Expressing disinterest to pay the premium, some FGD participants, particularly the adult female focus group in Ijebu ode LGA, were worried about getting value for their money particularly when they believed they could access cheaper and affordable health care services at some private missionary hospitals through out-of-pocket payment. This category of participants preferred out-of-pocket payment for health services as and when utilised. Their argument for this stance was their lack of perceived need for insuring themselves and or dependants against health risks. They claimed to be healthy, rarely fall sick and visit the hospital, hence no merit for pre-payment.

In a bidding process, the minimum amount the participants were willing to pay as annual premium ranged from ₦1,000.00 (\$6.25) to ₦2,000.00 (\$12.50) while the maximum amount ranged from ₦1,000.00 (\$6.25) to ₦4,000.00 (\$25.00) per individual. At the minimum and maximum bidding amount,

Table 1: ARAYA scheme (CBHIS) benefit package.

-	Consultation
-	Management of common ailments e.g. malaria, upper & lower respiratory tract infections, sexually transmitted infections, typhoid fever, tuberculosis and diarrhoeal diseases etc.
-	Management of non-communicable diseases including uncomplicated hypertension and diabetes.
-	Maternal and child health including antenatal booking, antenatal care, normal delivery, postnatal care a, family planning, emergency obstetric care, ectopic pregnancy, routine immunization, growth monitoring, nutrition services, treatment of diarrhoeal diseases in children, integrated management of childhood illnesses and prevention of mother-to-child transmission (PMTCT).
-	Diagnostic tests that include malaria parasite, widals, PCV, pregnancy test, urinalysis, blood sugar, ultrasound scan for pregnant women, full blood count and AFB for tuberculosis diagnosis.
-	Health education and promotion
-	Disease surveillance
-	Referral and coverage for caesarean sections
-	Medical emergencies
-	Preventive oral care
-	Surgeries (appendectomy and herniorrhaphy)
-	Accident and emergency



virtually all the participants were willing to pay for all dependants in their respective households. There was no gender and geographical difference in the expressed willingness to pay the health insurance premium among the participants whenever the scheme becomes operational in their respective communities.

However, there was gender difference in the amount participants were willing to pay as more males were willing to pay higher amount than the females. Similarly, the trend of discussions showed more older FGD participants particularly those with more stable source of income expressed willingness to pay higher amount as premium than the younger ones and those with irregular source of income. The aspiration of some elderly ones aged over seventy years and above in some focus groups on provision of free health care services for them by government was very high. On the mode of payment, a very few expressed readiness to pay the premium once/ annum while most preferred instalmental payment, ranging from 2 to 4 times a year.

Despite their willingness to pay the premium, many FGD participants were still of the opinion that the scheme should be fully subsidised by government. Some participants particularly the female focus groups in Ijebu Ode LGA suggested *“starting the scheme fully subsidised by government and thereafter introduce the premium which can later be increased gradually after gaining the people’s confidence on the scheme.”* Another male participant in a focus group in Abeokuta North stressed same view that, *“They (Government) should start the scheme free of charge. It is after the people have started enjoying it or benefitting from it (the scheme) that the people can then asked to pay the premium.”*

It is important to state that participants paid less emphasis on the premium and greater emphasis on sincerity, accountability and transparency of government and managers of the scheme which they believed could jeopardize the sustainability of continuous provision of quality health care services. This category of participants exhibited a “wait and watch” attitude with the common reference slogan of “promise and fail in previous programmes” by past government regimes. A male participant in a focus group in Ijebu Ode LGA for example stated that, *“It is only easier said here as we’re discussing it (CBHIS). If one gets to the health centre now, one would get frustrated by the poor attitude of the health workers to work...the doctors will not even look at your side not to mention the nurses will be shifting responsibility. Presently as we speak, there’re people groaning in pains in the hospitals because they’re told there’s no doctor on call to attend to them. We’re not talking about the money here. We’re less concerned about the money; our concern is the quality of service one will access on getting to the health centre after paying the premium in terms of prompt attention from health workers.”* A BoT member in Abeokuta North LGA also said, *“From past experience, the commencement of government programmes is usually good, well-packaged and appealing to people, but as time goes on for example if they start supplying drugs to them at the local government headquarters for distribution to the wards or communities, then you’d stop hearing anything about such supplies.”*

Perceived community structures needed for effective CBHIS

The fact that communities potentially have valuable contributions to make in the design, organization and implementation of effective health services and programmes such as the CBHIS, the people’s perception on who, within their socio-cultural structures, should be involved in the scheme, is of great importance.

The opinions of the focus groups on the community members/structures participants would like to see involved in the management of the scheme in the localities are as presented in Table 2. There was an element of fatalism in the responses of some FGD participants as they believed it is only God who can help in the effective implementation of the scheme. Though most mentioned community leaders, opinion leaders, CDA chairman and respected, trusted and popular community volunteers as those within the community structures they would like to see involved in the management of the scheme. There was little or no sense of community ownership of the scheme among the FGD participants and those interviewed as a few of them also opined that “government represented by the LGA Chairman should be in control of the scheme.”

Table 2: Perceived community structures needed for effective CBHIS implementation.

-	Community leaders
-	Opinion leaders
-	Respected, trusted and popular community volunteers
-	CDA Chairman
-	Only God can help

The membership composition of BoTs in Abeokuta and Ijebu Ode LGAs showed that the BoTs varied from 7 to 20 people and were not gender-balanced. Majority of the BoTs were men, reflecting local cultural practice of men being the decision maker. The BoTs are composed of community volunteers rendering selfless service for their communities. The BoT members in Abeokuta North LGA had been inaugurated by the local government authorities to signify their formal existence as recognized entities. This is unlike those in Ijebu Ode LGA where they are yet to be inaugurated as at the time of the study. Some BoT members were selected by the community leaders while most were nominated for selection by the Community Development Associations (CDAs) of the different communities of the wards in the study LGAs. None of the BoTs in Abeokuta North LGA had a chairman as at the time of the study.

Other members of the BoTs in wards of the two LGAs comprised of community representatives, drawn from different neighbourhoods, men and women who were opinion and religious leaders, business men and women, representatives of market traders’ associations and others who are engaged in different vocations that include farming and teaching in either primary or secondary schools. A few others were retired civil servants.



Members of BoTs interviewed, in the Abeokuta LGA, were actively involved in community mobilization and sensitization particularly in facilitating the registration of potential enrollees preparatory to the rolling-out of the scheme in the State. They also claimed to have had series of formal meetings with both the LGA Medical Officer for Health and the staff of the Health Maintenance Organisation (HMO) together with whom the mode of operations of the BoTs including mobilization and sensitization as well as enrolment of community members were planned for implementation.

In Ijebu Ode LGA, the BoT Chairmen were mostly the community heads (*Baales* and *Olori Ituns*). The BoTs in this LGA, unlike most of the BoTs in Abeokuta North LGA, composed of more experienced persons in health-related community activities with many of them being existing members of Community Health Committees (CHCs) performing day to day oversight functions over the Primary Health Care (PHC) facilities prior to their being designated as health providers for the scheme.

Strategies of mobilizing and sensitizing the communities for involvement

On the best means of mobilizing and sensitising the community, the common responses were the use of microphones and loudspeakers for public announcements using mobile town criers, directed by community leaders, distribution of handbills, and airing of radio jingles.

For the purpose of the scheme, communities were mobilized and sensitized using town criers who were sent round the communities to beat the gong 1 to 2 days before any meeting date to inform and remind people about the upcoming event. A BoT Chairman pointed out that, *“The community people have been massively mobilized and sensitized about the scheme by our town crier and they are waiting for the scheme’s commencement date.”* Aside from beating the gong by town criers, the Community Development Association (CDAs) and health workers of primary health centre were also used to reach out to people. Many of those who had heard about the scheme on radio mentioned the Ogun State Broadcasting Corporation (OGBC) popularly called ‘Ogun Radio’ as their source of information on the scheme.

Suggestions on sustaining the scheme

The perception of most focus groups and those interviewed on how the scheme could be sustained and implemented to encourage use of the facilities and ensure continuous patronage from enrollees and potential enrollees more or less reflect their expectations of the scheme. The key suggestions from the focus groups included the need to ensure accountability and transparency in the management of the scheme by the managers, continuous community mobilisation and sensitisation, reduced insurance premium, improved attitude of health workers to patients, short waiting time, frequent availability of genuine and essential drugs and there should be intense security around the PHCs to prevent drug pilferage and other vices. Enrollees’ prompt payment of premiums was also viewed as important for sustainability of the scheme. Also, a

community leader in Ijebu Ode LGA was of the opinion that the sustainability of the scheme can be guaranteed if the staff of the CBHIS-designated PHCs are empowered to regularly conduct research into the health needs of priority of their immediate population of coverage. This is expected to help the health workers know the health services of high priority to package for the populations they would be serving under the scheme. The consensus of the focus groups is reflected in the response of a male FGD participant in Ijebu Ode LGA who pointed out that, *“People will only be encouraged to patronise the scheme at the different designated health centres if they get quality health care services from the health staff. Otherwise, people will be discouraged to continue paying for what they cannot benefit from.”* A community leader also stressed that, *“Once it (the scheme) starts and people see that those who enrolled don’t complain of incompetency of health staff, frequent unavailability of essential drugs and long waiting time at the health centres, you’d see more people coming to join the scheme”.*

Only a few in the focus groups expressed the need for community control and ownership of the scheme as a measure for the scheme’s sustainability. A male adolescent focus group participant in Abeokuta North LGA suggested, for example that, *“The community rather than the government should be in control of the scheme...this is because regimes of government change every now and then.”* On the contrary, the lack of communal sense of ownership and control of the scheme among many participants in the focus groups and those interviewed further manifested when some participants in an adult focus group in Ijebu Ode LGA suggested that *“government should establish a taskforce or committee to which enrollees can submit their complaints or suggestions for necessary actions.”*

The suggested ways of sustaining the scheme and ensuring continuous patronage are summarized in Table 3.

Table 3: Suggestions on ways of sustaining the scheme and encouraging continuous patronage.

-	Fulfillment of promised health package.
-	Provision of prompt and good treatment of all health challenges by the health workers.
-	Availability of skilled health personnel.
-	Regular access to genuine and essential drugs.
-	Provision of communication channels for complaints and/or suggestions by enrollees.
-	Good attitude of health workers to patients.
-	Commitment and dedication to work among health workers.
-	Continuous community mobilization and sensitization.
-	Accountability and transparency of the scheme managers in implementation of the scheme.
-	Design and introduction of family health package.
-	Need for community control and ownership to ensure continuity.
-	Establishment of monitoring taskforce/committee.
-	Prompt payment of premium by enrollees.
-	Intense security of the health facilities to prevent drug pilferage and other vices.
-	Empowerment of CBHIS-designated PHCs to regularly conduct research into the health needs of priority of their immediate coverage populations.



Discussion

This study assessed the community perception of CBHIS preparatory to its rolling out in Abeokuta North and Ijebu Ode LGAs of Ogun State, Nigeria. This is in a view to understand critical issues the community perceived are essential for the development, maintenance, institutionalization and sustainability of the scheme, and perceived way of effectively operating the scheme for the success of the scheme. The manifestation of high knowledge of health insurance and the impressive perceptions about the scheme is encouraging. This encouraging scenario was more evident in Abeokuta North LGA than in Ijebu Ode LGA and could be used as a platform to launch more community education programmes on the scheme. Hence, for the success of ensuring that more people in the two LGAs become aware of the scheme, community mobilisation and sensitisation about the scheme and its benefits as well as challenges need to be intensified in the LGAs targeting the men who are mostly the household heads with financial responsibilities for all household members. This can be achieved using the best applicable local channels of mobilisation and sensitisation identified in the study. The level of awareness can also be increased through the production and distribution of handbills with simple illustrated messages and, by intensifying airing of information on the scheme, through both radio jingles and television, in different local languages particularly at prime time. Given that radio or television can bring household members information and new ideas [33], the use of radio and television will have more far-reaching impact on the population of LGAs where the scheme is presently being piloted and other LGAs of the State where the scheme would be expanded to after the pilot phase.

Even though the premium for the scheme was determined by the State government through actuarial studies, a large number of the study participants who are potential enrollees of the scheme were artisans, traders and farmers who have been reported to earn low income [34]. Given that the generally accepted core of universal health coverage is that the health system should be financed in accordance with the ability to pay as a desire to enhancing protection against health care costs and improve equity of access to health care [35], the ability to pay the insurance premium among the potential enrollees should be of concern to the planners of the scheme in the State.

It is important to highlight the fact that while the expressed willingness to pay the insurance premium in the study LGAs found similar to findings on willingness to pay for Community Based Health Insurance Scheme in Lagos South-Western Nigeria [36] and Katsina, North-Western Nigeria [37] seems encouraging, there is need for caution because the focus groups and those interviewed could possibly have responded to a service not currently available, their actual willingness to pay could wane by time the reality of the amount of premium to be paid for themselves and dependants actually dawns on them taking cognisance of their earnings, household size, and ability to pay.

Entirely free programmes are unsustainable due to lack of government funds and limited time of donor support in

sustaining programmes. Hence, avenues of mobilizing the communities to financially embrace the scheme as a self-help programme as emphasized by Onwujekwe, et al. [38] and Adeneye, et al. [39,40] need to be pursued.

The managers of the scheme need to be mindful of some hospitals outside the scheme providing similar services at lower cost as found in the study which could jeopardize the patronage of the scheme, particularly in communities where such hospitals operate in the same vicinity with the PHCs designated for the scheme. This is important in order to avoid a situation similar to complaints about the implementation of social health insurance programme that include denial of healthcare services, enrollees having to access care at designated facilities are made to purchase drugs and non-drug supplies outside the facilities from out-of-pocket or demand for payment of additional fees by the healthcare providers on the pretext that the services requested by the enrollees are not included in the benefit packages as reported in past studies from parts of Nigeria [41-45].

Understanding the socio-economic and cultural settings of a community fosters the knowledge of what works in the community and provide good leverage of successful implementation of programmes. This important given the argument of De Allegri, et al. [46] that socio-cultural practices are important in shaping the decision to enroll in CBHIS. For a successful implementation of the CBHIS, a critical issue to consider is the socio-cultural structure of the community, part of which is the solidarity expressed from the community in their involvement and participation. According to Lawn, et al. [47], community engagement with emphasis on involvement and participation is an essential element of health programmes. Positive change is reported to more likely occur when communities become integral part of a programme's development and implementation [33]. This is demonstrated in successfully implemented health programmes on Chagas disease, leishmaniasis, leprosy, onchocerciasis, African trypanosomiasis [48], schistosomiasis [39,49,50] and malaria [40].

The goal of the concept of community involvement and participation is to transform communities from passive recipients into active participants of health care programmes [34]. Local communities are to be actively involved in both programmes and decisions that affect their health, using their own supportive and developmental capacities to address their needs [47,51]. This result finds connection with the findings of Shittu, et al. [52] that emphasised that community participation is essential to the continuity or collapse of the scheme given that the propensity of membership participation and the volume of peoples' contribution in CBHIS are crucial to determining the financial freedom people enjoy under the scheme when seeking healthcare service.

Consequent to the little or no sense of community control and ownership of the scheme demonstrated largely in the study, there is the need to intensify efforts on avenues of mobilizing communities particularly those in the study LGAs during the pilot phase of the scheme and eventual coverage of the entire



State for active participation in the scheme as emphasised in the CBHIS blueprint [22]. The State and local government authorities need to help mobilise and organise communities to implement the scheme successfully by providing technical assistance to build local management and technical skills to operate the scheme. Most importantly for the people to be actively involved and appreciate the significance of taking control and ownership of the scheme, education programmes on the goal of the scheme which is to allow communities organise a pooling arrangement to finance their health care needs as a strategy of expanding affordable and quality health care to more people, are suggested to be designed and implemented targeting the communities. Futuristic plans also have to be designed targeting adolescents in this respect. This is because adolescence marks a period of developmental transition from childhood to full-fledged adulthood; the experiences and behavioural patterns formed on CBHIS in these adolescent years can have lasting effects on their adulthood which will eventually impact on the sustainability of the scheme.

It is believed that involvement of the existing community structures identified in the study in the implementation of the scheme particularly in the planning process of the scheme as a practical step in the blueprint for the implementation of CBHIS in the country [22] will provide a platform for easy take-off of the scheme particularly in other LGAs in the State where the scheme is planned to become operational after the pilot scheme.

Taking cognisance of the expectations of potential enrollees of the scheme as expressed in the study, and the need to guarantee consumer satisfaction and encourage patronage of the scheme, it becomes imperative that the minimum standards for primary health care in the country are met in the PHC facilities designated for the scheme in the LGAs with focus on systematic infrastructure upgrade, management, adequate number and proportion of the various cadres of health workers and support staff, service provision and essential drugs as emphasised by the National Primary Health Care Development Agency [53].

The suggestion on empowerment of the PHC health staff on how to regularly conduct research into the health needs of priority of their immediate population of coverage attests to the concern and expectations of the people about the scheme being responsive to their health needs. It is recommended that the scheme managers therefore address this concern as evident in the study because it is in conformity with the role of managers of CBHIS as stated in the blueprint for the implementation of CBHIS [22].

Limitations of the study

As a result of insufficient funding, the study was limited to only 2 of the 6 LGAs where CBHIS was planned to become operational as a pilot scheme in the State. This exploratory qualitative study was on a small size of community members who participated in the FGDs and IDIs. The data therefore may not be regarded as fully representative of and generalisable for all categories of people in the State. This, however, does not

discount the validity of the findings. Rather, further studies are needed to be carried out using a larger and more inclusive sample.

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