EXPLORING A WORKABLEMODEL OF COMMUNITY BASED HEALTH INSURANCE PROGRAMME AMONG TRADERS ATGSM MARKET, FARM CENTER, KANO

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DECLARATION

I hereby declare that this work is the product of my own research effort; undertaken under the supervision of Professor Muhammad Lawan Umar. It has not been presented and will not be presented elsewhere for the award of degree or certificate. All sources have been duly acknowledged.

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CERTIFICATION

This is to certify that the research work from this dissertation by Muazu ShuaibuIshaqa (SPS /15/MPH/00012) was carried out under my supervision.

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APPROVAL

This dissertation has been examined and approved for the award of degree of Master of Science (M.Sc.) in Public Health.

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DEDICATION

I dedicate this work to the poor Nigerian citizens who are suffering from catastrophic health spending due to lack of reliable and sustainable health care financing

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ACRONYMS

CBHIS – Community-based Health Insurance Scheme

HCF - Health Care Financing

HH - Household

THE - Total Health Expenditure

HHH - Household Head

HHHE - Household health Expenditure

NHIS - National Health Insurance Scheme

OOP - Out-Of-Pocket

THE - Total Health Expenditure

ABSTRACT

Community based health insurance (CBHI) was recently launched by Kano State Government to reduce financial hardship in accessing health care for people in the informal sector. However, uptake has been very slow and discouraging. This study was carried out to provide an insight in to the design and implementation of this program among traders at GSM market, Farm Centre Kano.

The study was cross sectional in design, employed mixed method of data collection and assessed a random sample of 226 GSM market traders using semi-structured interviewer administered questionnaire. Focused group discussions and Key informants Interview guides were also used to explore views and perceptions of the respondents on the scheme.

The mean age of the respondents was 31.3±6.8 years. They were predominantly males (99.4%), married (51.6%) and had at least primary education (93.8%). The median annual out of pocket expenditure was N 21,950 with a wide range (N 2000 to N 805,000). The respondents' overall knowledge of CBHI was poor as 87.6% had poor knowledge. Overall knowledge predictors were tertiary level of education ([OR] 2.89 [95% CI] 1.23 - 6.81) and presence of family member with chronic illness ([OR] 0.387, [95% CI] 0.15 – 0.97). The commonest source of knowledge wasmass media (39.8%). Majority of the respondents (86.7%) showed willingness to enrol after being sensitized. Significant percentage(69.4%) said they can invest up to 5% of their annual income orpay N 200 monthly as premium. Preferred services to be covered include maternal and Child health,malaria, typhoid and hypertension.Government total controlin addition to monitoring role of traders' union leaders was advocated.Lack of awareness of the scheme and default in payment of premium were identified barriers to implementation of the scheme.This study pointed out that there is readiness to accept CBHIS by the traders at GSM market. However, awareness on its benefit need to be improved, premium should be uniform and government should be committed.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

A country's economic development is closely interrelated with the health status ofits populace.[1] An efficient and equitable health care system is an importantinstrument to break up the vicious circle of poverty and ill health.[2]However, in the world, particularly in the developing countries, a large number of people are suffering and dying due to lack of access to even the most basic medical care.[3] This is due to the unexpected health shock to pay for health care services by the poor people.[4]Although the right to social security and health is well established in international law, the situation is far from desired as an estimated 1.3 billion people worldwide still lack access to the most basic levels of health care.[5] This may not be unconnected to the variation in the socioeconomic determinants of health within nation and across the globe.[6]

The Nigeria's population (190,886,311 in 2017)[7] is largely informal with the rural dwellers and the urban/semi-urban self-employed like the traders, constituting over 70% of total population.[7,8] The poverty level among this segment of the population is high, (~58%);[9]their situation is worsened by low literacy, highly irregular income (subsistence economy) and high fertility. Characteristically, both financial and geographical access to health care services is grossly lacking.[8]Consequently, the poorer health indices recorded in Nigeria compared to other countries of the world is not surprising.[10].

Since the independence in Nigeria, successive governments have come up with the 2nd, 3rd and 4th National Development Plans, all of which have substantial portions dedicated to addressing issues related to national health care. [9]However, the results have not been

impressive because of low budgetary allocation to finance the plans. For instance, in 2017, government allocated only 4.17 % of its annual budget to health[11] which have been described as poor and grossly inadequate when compared to the 15% recommended by African union.[11]The implication is that patients have no financial risk protectionduring illness as they are charged according to a set of tariff for the services they used.This may constrain access to essential care or may lead to catastrophic health expenditure.[12]

The principle of commercial health insurance negate the interest of the larger poorer informal sector as premiums are not related to ability to pay but are risk-related (or "actuarial") – i.e. people pay premiums based on the expected average cost of providing services for them. This is determined by their health risks such as age, sex, family history and pre-existing chronic illnesses. Hence, people who are in high-risk groups pay more, and those with low risks pay less[13] These further make health access far from desired especially for the poorer household in the informal sector like the traders as they are more likely to harbour higher risk and less likely to have the ability to pay.

In Nigeria,the institutionalization of social health insurance in the country through the National Health Insurance Scheme (NHIS) was envisioned to provide financial risk protection by reducing out-of-pocket as well as the inequities in access to health services. [14]It has three carefully designed programmes to cover the whole population working under different spheres of life and the vulnerable groups. Thus,

TheFormal Sector Programme: This cover for public Sector (Federal, States and Local Governments), Organized Private Sector, Armed Forces, Police and Other Uniformed Services as well as students of tertiary institutions.

The Informal Sector Programme: This cover for communities (rural dwellers and the urban/semi-urban self-employed like the traders, constituting over 70% of total population) and voluntary contributors.

The Vulnerable Group Social Health Insurance Programme: This cover for physically challenged persons, prisons inmates, children under Five, refugees, victims of human trafficking, internally displaced persons, immigrants and pregnant women.[15]

Although, there is a noticeable increase in NHIS members over the years, effective coverage rate remains low. A study revealed that less than 2 % of the population mainly from the formal sector were covered leaving the larger poorer informal sector and the vulnerable group at the mercy of out of pocket expenditure. [16]

COMMUNITY BASED SOCIAL HEALTH INSURANCE: In many developing countries, particularly in Nigeria, the informal sector is covered by community based social health insurance (CBSHI) which is a scheme under NHIS. It is an innovative mechanism that provides low-cost health insuranceto low-income households. The method ensure health care provision and decrease out-of-pocket health expenditures by providing financial protection from the cost of seeking health care at the time of need.[4]It has three main features: prepayment for health care by the community members; community control; and voluntary membership.[17]Overall there is no "one size fits all" strategy or model for implementing CBSHIS. Experiences from different countries and states within the country show huge variation in the breadth, depth, and height of coverage achieved using different models.

InLagos State for instance, the State Ministry of Health (SMOH), one local government area (LGA), and three communities set up the Ikosi-Isheri Mutual Health Plan (MHP) in 2008.[18] Representatives of these bodies, plus a technical insurance specialist, form the Board of Trustees, which provides oversight to the MHP. Members pay a monthly fee of 400 Naira (US$2.49) for single people and 800 Naira (US$4.97) for a family of six. This fee covers consultation, antenatal care, and basic healthcare services. Enrolees pay directly for referrals and higher-level care. The MHP is heavily subsidised by the State MOH and the LGA. A review of this model in 2010 found that the quality of services was good in terms of

contributions to lower maternal and neonatal mortality rates, as well as drug availability and patient satisfaction. The community had an excellent relationship with the MHP. On the other hand, the researchers noted some high turnover among the health providers, who are civil servants, and recommended that the MHP hire private health providers. Member attrition was high, and members who used the services infrequently were asking for a discounted premium. Furthermore, the LGA was paying the premiums for more than half of the 1,000 active member families.

In Kwara state, Community Based Health insurance called the Hygeia Health Community Plan (HCP) focus on rural farmers. It uses a network of public and private health facilities to provide comprehensive health services.The plan had 55,807 enrollees (as of October 2011) who pay a premium of 300 Naira (US$1.90) per year. Nearly all (93%) of the costs are subsidized by the Dutch government and the State Ministry of Health. Enrolment was below target and many enrollees have dropped out due to migration. Some of the challenges the programme has experienced are enrollees' inability to pay premiums, inadequate number of providers, and uneven quality of services.Some of the lessons learned from the Hygeia CHP are that community involvement is important to ensure member retention; intensive marketing by community members or commissioned agents is required; pricing needs to reflect the ability and willingness of enrollees to pay and should reflect the disease prevalence in the community; continuous monitoring of service delivery is needed to ensure quality of care; and CBHIs that provide generous benefits cannot be funded solely by low-income communities.[16]Another key lesson is that private facilities can make important contributions to CBHIs, even in rural areas, despite skepticism regarding the role of the private sector. Also, charging a token premium fee, even to the poorest members, ensures that enrollees value their membership; it also discourages inflation of enrolment rosters with non-existent members.[19]

The launching of contributory health scheme in Kano State has opened a new chapter in the history of health care in the State. The scheme has programmes similar to the National Health Insurance. Participation for those in the formal sector is mandatory. However, the informal sector where the majority of the people in Kano State are recorded a very poor acceptance by the community members, perhaps due to lack of awareness of how the programme works, religious and cultural fallacies in addition to lack of trust on the community leadership.

Although, history has shown that membership of the 19th century mutual schemes (a form of community based health insurance in developed country) grew and eventually merged to form various types of national health insurance.[20] It is not safe to assume that CBSHI schemes in Nigeria and precisely in Kano will develop according to the historical precedent due to our differences in socioeconomic context. [21]The scheme has not gained popularity despite the availability of the policy and attempt at its implementation by the stakeholders. This necessitated the need to analyse our situation, considering our local context; values, religion and so on beyond economic and health theories. It is against this background that this study intends to explore and understand a feasible model of CBHIS that can be used to improve financial access to health among traders at GSM market, Tarauni, Kano.

1.2 STATEMENT OF THE PROBLEM

Nigeria is ranked as one of the fastest growing economies in the world with growth rate of 6.21 percent in 2014 from 5.65 in 2008.[20] Recently in 2014, the country's Gross Domestic Product (GDP) was rebased, making it the largest economy in Africa, with a GDP of US $510 billion. [20]However, the country's health system has long been blighted and reflected by negative health indices hardly coming to near international standards; with infant mortality rate of 101/1000 live births, Under 5 mortality of Rate 194/1000 live births, maternal mortality mate of 800/100,000 live births and Live expectancy at birth of 47years

(males).Healthy Life Expectancy of 41years for (males) and 42 years for (females). [15]Consequently, several deliberate strategies have been developed with the aimed of improving access to healthcare services and reversing the trend.[22] Reasons for these abysmal statistics are multifaceted but one key factor is the lack of access to quality health care by the majority of its citizens.[8] Majority of Nigerians particularly the informal sector who fund their health care out-of-pocket.[15] This means directly paying for medical consultation, drugs and other health related procedures at the time of need. This huge personal commitment has severe implications on who gets care at the time of need.

Trading in markets is one the most common source of informal employment in Nigeria, and market traders constitute a substantial portion of the country's working population.[23] With the economic downturn in Nigeria, market traders appear to be at the receiving end especially as their livelihood depends on the purchasing power of shoppers and buyers, in addition to their susceptibility to other adverse factors in the country's socio-economic environment. The market traders often undergo considerable amount of stress to make ends meet and constitute one of groups of individuals with the highest work hours.[23] The prevalence of undiagnosed hypertension was quoted as 25% among traders in Monday market in Maiduguri, Nigeria,[24]according to a study by Joannes et al. Their occupation also made them prone to sedentary lifestyle. Onuoha reported a prevalence of overweight and obesity to be as high as 36.5 % and 20.4 % respectively among traders in Nsuka market.[24] Additionally, traders in Nigeria, like many other workers in the country's informal sector, often do not have access to structured workplace preventive and curative health.[14]Studies have shown that community based social health insurance can potentially increase access to quality health care by eliminating or by significantly reducing out-of-pocket payment and thereby protecting those from the informal sector from catastrophic spending in health.[25] However, eligible communities are reluctant to key into this programme for different reasons. Some of these

reasons may include lack of awareness of what the scheme is and how it works, religious and cultural reasons as well as lack of trust on the leadership. Hence, the need to explore these reasons and establish appropriate institutional configuration and strategies that will motivate people to accept it which will go a long way to improve access to health among traders.

1.3 JUSTIFICATION FOR THE STUDY

According to WHO , 100 million people every year are driven into poverty due to catastrophic health expenditure.[26] It is imaginable that most of them reside in resource poor settings such as Sub Saharan Africa (SSA) with very weak modern health care systems and in most cases without any functioning health insurance schemes.[27] The result is high disease burden that has a risk of propagating a sickly, unproductive labor force. In Sub-Saharan Africa, formal and well-functioning health insurance schemes generally exist for the very few who are employed in the formal sector as seen.[28] In Nigeria for instance, the National Health Insurance Scheme (NHIS) was established under the law with the aim of improving access to quality health services by providing financial protection to individuals and families,[16]however, only less than five percent (5%) of the citizens are covered compared to more than 90% recommended by WHO.[29]For the majority, health care is accessed through out-of-pocket, which in many instances may lead to suboptimal use of health care services.[30]This had clearly demonstrated the inequities in access to health care.These inequities in access to use of health care services and expenditure on treatment provide impediments to achieving universal coverage. The negative impact of this impediments or systemic weakness in the access to health services impacts disproportionately on the informalsector of Nigerians and particularly traders who are largely poor, with low literacy, irregular income and high fertility.[31] This group characteristically, has the greatest burden of disease and the least access to health resources and services. A community based study found that both financial and geographical access to health care services are grossly lacking for this

group of Nigerians. [32]Some findings also showed that the disadvantaged informal rural dwellers, self-employed and poorer socioeconomicgroups like the traders experience the highest burden of health expenditure, and this is worsened by the near complete lack of financial risk protection.[33]The use of personal money was the commonest payment-coping mechanism reported by the study.[26]This make the much talked about Universal Health Coverage a mirage.

Community Based Health Insurance Scheme(CBHIS) is one of the plans under NHIS that has been recognized to be a powerful mechanism to achieve universal health coverage particularly for those in the informal sector[34]There is evidence to suggests that financial protection schemes that focus on price subsidies sometimes improve access to and utilization of health services through mechanisms that go beyond affordability. In Colombia, for instance, uptake of some services such as prenatal care and immunization increased after people enrolled in CBHI schemes, although these services were free for everyone irrespective of a person's insurance membership status.In an attempt to ensure an effective and sustainable healthcare system for the state workforce and their dependents, His Excellency, the executive Governor of Kano State signed into law the bill establishing the Kano State Contributory Healthcare Management Agency. The schemes under this agency provide health care coverage to public service employees, the organized private sector workers as well as those in the non-formal sector such as small scale businessmen and women through Community Based Health Insurance Scheme. This is a giant stride in the right direction as the formal sector enrolment had been concluded and implemented. The informal sector scheme (CBHIS) has been slow and disappointing, perhaps, due to some logistic reasons connected to its design and implementation which have not been addressed.Failure of CBHI is repeatedly linked elsewhere with failure to engage and account for the 'real world' needs of

beneficiaries, lack of clear legislative and regulatory frameworks, inadequate financial support, and unrealistic enrolment requirements.[25] I

This study is set to explore some of these areas with the aim of arriving at a workable model of community basedhealth insurance for traders atGSM market in Farm Centre, Tarauni Local Government Area of Kano State. Findings from this study can be utilized to develop institutional and environmental structure for implementation of CBHISP and also for advocacy with the ultimate aim of improving access to health care in the study area and Kano State in general.

1.4 RESEARCH QUESTIONS

1. What is the average annual out of pocket expenditure on health of traders at GSM market, Kano?
2. What do the traders in the GSM Market know about CBHI?
3. Are the traders in GSM market, Kanowilling to accept the community based health insurance scheme?
4. What are the traders' perception and views on a workable model of CBHI programmes involving them?
5. What are the barriers that can hinder the implementation of CBHI program at GSM market, Kano?

1.5 AIM AND OBJECTIVES

1.5.1 AIM

To explore a workable model of community based health insurance among GSM market traders in Farm centre, Tarauni Local Government Area, Kano State.

1.5.2 SPECIFIC OBJECTIVES

1. To determine the average annual out of pocket expenditure on health of traders at GSM market, Farm centre
2. To assess the awareness of traders at GSM market, Farm centre on CBHIS
3. To determine willingness to accept community based health insurance by the GSM market traders at Farm centre
4. To explore the trader's perception and views on a workable model of CBHI program involving them at GSM market Kano.
5. To investigate the barriers that hinder the implementation of CBHIS among traders atGSM market, farm centre, Kano.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter is set to review relevant literature on the difficulty faced by households in accessing basic health services.Large proportion of households in Nigeria is over reliant on out of pocket (direct payments) expenditures and this had posed a significant obstacle to achieving universal health coverage.[26] In order to reduce over reliant on direct payments for health, the World Health Assembly, WHO and various governments encouraged the risk pooling prepayments approach (Health insurance scheme, particularly community based health insurance (CBHI).[35] These themes were reviewed. This approach is faced with the challenge of low enrolment mainly due to lack of awareness, poor resource mobilization and poor sustainability.[36] These challengeswere also reviewed.Furthermore, selected examples of risk pooling prepayments approach to financing heath in Nigeria and other countries were also looked at.

2.2 METHODOLOGY FOR THE LITERATURE REVIEW

PubMed and Google Scholar searches were undertaken using the terms (Community based health insurance OR Community health insurance) AND (Nigeria OR Developing country OR Africa). Papers that included reported analyses of Out of pocket expenditures, awareness on community based health insurance, willingness to enrolment and its challenges were included. Systematic review and meta-analysis on the subjects were also included. Websites of major stakeholders in the subject like the Nigeria National Health Insurance Scheme (NHIS), World Health Organization (WHO) and World Bank were also searched. Studies that used primary or secondary data were included. However, studies published languages other than English language were also excluded.

2.3 FINDINGS OF THE LITERATURE REVIEW

More than 60 articles were identified. Majority are cross sectional and or household surveys. Most of the papers dwelled on willingness to join CBHIS with few analysis of out of pocket expenditure. Analysis of some existing models in Nigeria from Kwara[25] and Lagos state[25] were also identified with emphasis on challenges of enrolment and sustainability of the scheme in Nigeria.

2.3.1 OUT OF POCKET (OOP) HEALTH EXPENDITURE

Out of pocket expenditure refers to payments made by the patients to both public and private providers at the point of receiving health services. When a system relies heavily on OOP, the payments required to access health care in relation to income can be high enough to result in financial catastrophe for individuals or households. Financing healthcare across the less developed and some developing countries is still characterized by the domination of out-of-pocket (OOP) expenses and the comparative lack of prepayment mechanisms like health insurance,[37] typical of this study area. This is because most households in such countries are without health insurance coverage thereby facing the risk of incurring large medical expenditures whenever a member of the household falls ill. Important insights on economic consequences of health shocks have been provided by several studies across countries to reshape public policies around healthcare issues and concerns.[37] Health policies are concerned not only with improving health status of population but also with protecting households from financial catastrophe of illness.[38]. Several other household level studies examining out-of-pocket (OOP) healthcare spending throw light on effect of poor health on economic wellbeing of household.[35,39] The growing consensus that OOP spending in the healthcare sector has become a significant factor contributing to impoverishment of several households in developing countries including Nigeria is receiving government's attention.[37.40,41] In view of this , Kano State government introduced the mandatory

Contributory Health Scheme to provide the needed financial protection to individuals and household to prevent them from catastrophic spending.

Catastrophic spending occurs when out-of-pocket (OOP) payments for health services consume such a large portion of a household's available income and the household may be pushed into poverty as a result. In other words, health spending is considered catastrophic when a household has to reduce other spending to compensate for health expenditure.[42]It can be calculated as the proportion of total income or effective income spent out-of-pocket on health care. Although WHO uses a 40% threshold for defining catastrophic health expenditures, the defined threshold for proportion of health expenditure qualifying as catastrophic health expenditures varies by study, typically ranging from 5% to 40% of income.[12]Any of such cut-off is necessarily fraught with problems and no firm consensus exists on the thresholds in literature.[43] Two approaches are frequently applied in the literature. The first approach sets the threshold in terms of proportionality of income. This approach considers the OOP payments as a proportion of income (X). That is (OOP/X). Thresholds used varied from 2.5% to 15%.[42] However, using the same threshold for both the poor and rich households is problematic for equity reasons as richer households are more likely to exceed the thresh- old level with less adverse effect than the poor ones especially at higher thresholds levels . The second approach is based on ability-to-pay. This approach considers OOP payments in terms of a measure of ability to pay (y), such that (OOP/y) where y =X-Sexp.The Sexp is subsistence deductions, while X is income as indicated in the first approach above (or consumption expenditures).

Moreover, the impact of these out-of-pocket payments for health care goes beyond catastrophic spending and many people, particularly the poor, may decide not to use services, simply because they cannot afford the direct costs.[44]Recent works have explored levels and determinants of out-of-pocket health expenditures in low and middle-income countries, with

a focus on catastrophic health spending. An analysis of World Health Survey data from 51 LMICs found health care expenditures accounted for 13% to 32% of total monthly household expenditure [45]. Other studies document a lower share of health care expenditures. One study found Kenyan households on average, spend 5% of their annual budget on outpatient services and 2% on inpatient services.[37]Bamidele in a cross sectional household survey reportedthat most respondents used OOPS as the commonest type of spending mechanism for health care consumption in Keffi, Nigeria. It alsoindicated that money for treatment is the major factor influencing treatment seekingfor household members followed by distance to treatment point and also treatment billhas influenced the choice of treatment point for household. They reported that the average monthly spending on food was N12,500 and the average money spends on healthcare was N3,516.[46]

Out-of-pocket expenditures by households in health accounts typically comprise direct spending by households, after deducting third-party payments, such as insurance. However, for estimation purposes, it is often necessary to estimate the gross level of direct spending, before taking into account reimbursements by third-party sources. In these guidelines, the measurement approaches described can be considered to apply generically to measurement of any household spending, whether it is later adjusted for third-party payment or not.[45]

According to Pal,[26] catastrophic OOP health expenditure is concerned with high levels of OOP health expenditure which might affect household's standard of living. From the literature, catastrophic expenditure has been defined as that level of OOP health spending which exceeds some fixed proportion of household income or household's ability to pay[26]

Nationally, half of low-income citizens devote at least 10% of their income to out-of-pocket health expenditure. The urban poor presenting at our clinic report an average expenditure of $3/episode of illness, lower than both the national and regional average by 20% and 27%, respectively.[47]Across health systems out-of-pocket payments range from less than 10% to

more than 80% of total national health spending. The level of OOP and their distribution have great impact on overall health system performance.[48] When a system relies heavily on OOP, the payments required to access health care in relation to income can be high enough to result in financial catastrophe for individuals or households. Moreover, the impact of these out-of-pocket payments for health care go beyond catastrophic spending and many people, particularly the poor, may decide not to use services, simply because they cannot afford the direct costs.[12]

This leads to a persistent interest in the impact of out-of-pocket spending on the affordability and equity of health systems. As a result, the level and distribution of out-of-pocket payments have been widely used as key indicators in the monitoring and evaluation of health system reforms.[44] National Health Accounts (NHA), which have been established in many countries, report out-of-pocket payments at the national level. In 55 countries these NHA estimates are routinely reported. At the same time, there are an increasing number of studies addressing the distribution of out-of-pocket payments and its impact on financial wellbeing and poverty across households.[49] These types of studies have triggered health system reform in many contexts.[50] However, researchers looked at results from two health expenditure surveys and found significant technical challenges to the use of these surveys, including a lack of standardization in the wording, framing, recall periods, and number of questions. In many countries, when fewer questions were asked, the average estimate for health spending was lower than for countries where additional items were included. Questions with a shorter recall period, for example four weeks, yielded a larger estimate of private health spending than questions with a longer recall period, such as 12 months.[51]

However, the instruments used to assess OOP vary across different types of surveys and, even within the same type of survey questions may vary from country to country. The value of any such survey depends crucially on the validity and comparability of the data. Measurement error in the context of expenditure data derived from surveys is a well-known

problem and could be introduced at any stage of the survey; design of the survey instrument, data collection, or data entry. [44]

2.3.2 DETERMINANTS OF OUT-OF-POCKET HEALTH EXPENDITURES

Out-of-pocket payments for health services are related to a number of institutional and provider-level factors, including inefficiencies in the delivery of health care that range from over-prescription of antibiotics and injections, use of expensive medicines in place of cheaper alternatives, medical errors, and incorrect diagnosis or treatment .[52] Individual and household characteristics also influence out-of-pocket health expenditure. The most commonly cited covariates include age, gender, education, household socioeconomic status, household location, type of illness or condition and its severity, type of health care provider (public versus private), and health insurance coverage.[52]

Age, gender, and education

In general, existing literature indicates that out-of-pocket health expenditures are higher for older individuals, women, and the more educated. A cohort study in Pelotas, Brazil found average medical expenditure for children decreased from age 12 to 48 months [53]An analysis of the determinants of out-of-pocket expenditures in China found that individuals age 65 and older were likely to have higher out-of-pocket expenditures compared to younger age groups.[53]A study in eight provinces in China found that, excluding maternal health expenditures, women age 20-34 had higher curative health expenditures than men in the same age range, and women's expenditures were more sensitive to family income than men's.[54]On the other hand, a study on the determinants of out-of-pocket and catastrophic health expenditures in a rural community in India found that men were more likely to incur out-of-pocket health expenses than women.[54]In Brazil, better-educated mothers are more likely to report higher out-of-pocket expenditures for medicines and private health insurance for their children.[53] In India, two studies found higher household educational attainment was

associated with increased spending on maternal health. A positive association between level of education and outof-pocket expenditure was found in a study of the determinations of out-of-pocket health payments for malaria among child under age 5 in Uganda.[54]

Socioeconomic status

Household socioeconomic status is the household characteristic most commonly associated with variation in out-of-pocket health expenditure. However, the relationship between income or household socioeconomic status and out-of-pocket expenditure can be mixed. Studies in Kenya, Namibia, Nigeria, Albania, Bangladesh, and India found that poorer individuals and households had lower absolute out-of pocket expenditures on health care than wealthier households, but the relative proportion of health care expenditure to total or non-food household expenditure was significantly higher in poorer households.[53]

Location

Location—whether the household is in an urban area or a remote rural area—can influence out-of-pocket health care expenditure, although the direction of the association can vary. In Kenya a national study found that mean spending among those with illness was significantly higher in urban than rural areas, although rural households spent a larger proportion of their annual budgets on health care compared with urban households.[37]In Nigeria mean out-of-pocket spending on health care was higher in urban than rural households.[55]In Albania rural clients attending Primary Health Centers paid less in consultation fees than those attending similar facilities in urban areas, but rural clients paid more in consultation fees at polyclinics. In India rural households paid more than urban households for delivery and neonatal care, regardless of socioeconomic level or state of residence.[54]

Type of provider

Health care expenditure also varies by type of provider. In general, seeking care from the private sector is associated with higher out-of-pocket health expenditures. A multi-country literature review found use of private facilities and hospitalization are both associated with

high out-of-pocket health expenditures.[56] An analysis of 39 World Health Surveys had similar findings.[57] One study in Bangladesh and two studies in India found that out-of-pocket expenditures for maternal health care were significantly greater in private facilities compared with public facilities [54]A study in Kasulu, Tanzania found that delivery at a government facility was cheaper than at a mission facility due to higher out-of-pocket expenditures on consultation, drugs, and diagnostics at mission facilities [28]. In Bangladesh out-of-pocket expenditures for antenatal care (ANC), normal delivery, and cesarean section were much higher in private compared with public facilities due higher consultation fees and costs for medicines [54] In India average out-of-pocket expenditures for antenatal care (ANC), delivery, and postnatal care were two to four times higher in private than public facilities [54]. In Uttar Pradesh, India, mean out-of-pocket expenditures for neonatal illness were statistically greater in non-government clinics and dispensaries compared with government clinics, and mean expenditures were greater for those who were hospitalized [54]. A study in Ethiopia on management of uncomplicated malaria found out-of-pocket expenditures were higher if more than one source of care was used, and average direct costs were higher for those using private versus public health facilities [54]. In Ulanga District, Uganda individuals seeking malaria treatment in the private sector had 19% higher direct medial costs than those in the public sector, although the difference was not statistically significant [58]

Type of illness and severity

More severe or complicated illnesses or conditions often result in higher out-of-pocket health expenditures. As mentioned above, hospitalization is associated with high out-of-pocket expenditure In South Delhi, India cesarean sections resulted in higher out-of-pocket expenditures than normal deliveries, in both public and private facilities [54]. In Matlab, Bangladesh, households spent almost 10 times more on complicated deliveries relative to normal deliveries [54]In Burkina Faso and Kenya, costs for complicated delivery were double

the costs for normal delivery. In Ecuador mean out-of-pocket expenditure for treatment of multidrug-resistant tuberculosis was over four times higher than treatment for non-resistant tuberculosis.[54]

User fees and health insurance coverage

Removal of user fees and introduction of insurance schemes, and other interventions have the potential to reduce out-of-pocket expenditure for health care in low- and middle-income countries. User fees refer to any point-of-service charges required and can include payment for registration, consultation, drugs and medical supplies, and outpatient and inpatient health care services. In Burkina Faso removal of user fees for children under age 5 reduced average out-of-pocket expenditure for care by more than 80%.[56] However, catastrophic health expenditures for tuberculosis remained high in Burkina Faso even after the removal of user fees.[54]Studies in Indonesia, Laos, India, and Vietnam found that health insurance schemes reduced out-of-pocket spending for health care.

2.3.3 COPING STRATEGIES WITH FINANCIAL COSTS OF ILLNESS

Income risk is part of daily life in developing countries. Risk has different sources and can be distinguished between common and idiosyncratic risks.[59]While common risks are covariate risks that affect all members of a community, idiosyncratic risks affect only particular individuals. Crop risks due to weather conditions are a typical example of a common risk. Health risks are in most cases idiosyncratic and health shocks are one of the most sizable and least predictable shocks.[60]

Households have developed several strategies to deal with risks since formal credit and insurance markets are usually missing or incomplete in low developing countries. The literature uses different terminologies on such strategies.[60]Alderman and Paxson,[61] call ex ante strategies risk management and ex post strategies risk coping, while other authors refer to any strategies applied during crises as coping strategies.[61]Coping strategies for illness costs

can be distinguish between ex ante and ex post strategies . Ex ante strategies deal with preventions. Examples include securing safe drinking water and sleeping under a mosquito net to reduce the likelihood to fall sick, and investing in insurance and in liquid assets, in order to be prepared for possible health costs.

Provide one of the studies that examine a household's ex post coping strategies with illness. The authors investigated strategies for managing financial illness costs in rural Bangladesh where households were not insured.Savings were found as the first employed strategy.[62] But, the ability to rely on savings depends on the economic situation of the region and the household. In addition to low income levels, rural household's incomes are often seasonally restricted. Consequently, it is unsurprising that several studies have shown that relying on savings is only feasible for a small proportion of the population[62]. In a country comparison Leive and Xu, point out that wealthier and urban household are more likely to use income and savings, indicating that rural areas are often less cash driven than urban ones.[62]

If savings are not enough to cover health costs, Sellable livestock were also identified as important second factor influencing the coping choice. In addition to livestock further assets might be sold to obtain cash, e.g. land or food. But, the evidence on selling assets is mixed and other studies have found it as an uncommon response.[62] Apart from selling food which is usually seen as last resort, an explanation why assets are often not sold is that these assets might be a productive and an integral resource for livelihood. In other words, selling assets can have serious adverse effects on future wellbeing.

Selling assets can be unsustainable and causes or sustains impoverishment In some areas there exists the ability to take loans if savings and sellable assets are not available. If the household does not own livestock or other possible collaterals, loans are generally not accessible. Hence, in particular poor households might have to rely on further strategies. One

possibility is to reduce leisure time by selling own labour or increasing the workload on the own farm to generate additional revenue.

Finally, and in many cases a very important coping strategy, is relying on community support. This includes borrowing money from friends or relatives or obtaining gifts. Since illness risks are idiosyncratic, such support is much more likely to occur than if it was a common risk. Community support depends crucially on the social networks a household has. If no savings and sellable assets are available, no access to credit exists, no possibilities to increase revenues through a higher workload, and no community support is present, households might remain without any healthcare even in cases of serious sickness. In view of this argument and many more reasons health insurance and particular community based health insurance have been identified as the strategy in coping with medical bill.

THE NATIONAL HEALTH INSURANCE SCHEME

In an attempt to combat the challenge of financial hardship imposed by out of pocket expenditure and improve health access, the National Health Insurance Scheme (NHIS) was established and kicked off in Nigeria in May, 2005. The scheme was established under Act 35 of 1999. It combines the principles of Socialism (being one's brother's keeper) with that of Insurance (pooling of Risks and resources). Its objectives among others are to ensure that every Nigerian has access to good health care services and families are protected from the financial hardship of huge medical bills at the time of need. In order to achieve its objectives, the NHIS developed various programmes to cover different segments of the society.[16] These programmes are stratified as:

FORMAL SECTOR: This cover for public Sector (Federal, States and Local Governments), Organized Private Sector, Armed Forces, Police and Other Uniformed Services as well as students of tertiary institutions.

INFORMAL SECTOR: This cover for communities ((rural dwellers and the urban/semi-urban self-employed like the traders, constituting over 70% of total population) and voluntary contributors.

VULNERABLE GROUP SOCIAL HEALTH INSURANCE PROGRAMME: This cover for physically challenged persons, prisons inmates, children under Five, refugees, victims of human trafficking, internally displaced persons, immigrants and pregnant women. The achievement of NHIS was quite impressive. Currently, it has Accreditation for 9,584 of Health Care Providers HCPs (4,445 Primary, 5,139Secondary and 62HMOs), 22Banks; 19 Insurance companies and 98% of FGN employees and families are also covered.Extension of coverage to states like Bauchi (68,000), Cross/Rivers (40,000) and Kano among others was made. The TISHIP had also enrolled 121 Institutions (*865,142 students)* covered out of 498. However, he NHIS was bedevilled by the challenge of coverage as this coverage was considered relatively very low.[35] Only 1.5% of the Nigerian populace was covered mainly from the formal sector.

The largest informal sector remained barely untouched. It is recognised that the universal coverage desired by the Nigerian government is only achievable by strategically targeting the informal sector, mobilizing all stakeholders to operate in a synergistic manner to support as many rural and other informal sector groups like urban and semi urban self-employed people as possible, to establish sustainable and viable Community-Based Social Health Insurance Programmes (CBSHIP).[25] However, this required a lot of practical lessons from pilot studies, best practices from global literature and above all stakeholder's consultation. Current thinking in major international development agencies construes community-based health insurance (CBHI) as a transitional mechanism to achieving universal coverage for health care in low income countries.[63]

It appeared evident that community participation in health care in Nigeria and Kano in particular was low and the system lack a well - co-ordinated and broad-based health care financing strategy to overcome the challenged. Although limited governments' budgets for health care are a serious problem

2.3.4 COMMUNITY BASE SOCIAL HEALTH INSURANCE

The term "community-based health insurance" is a non-profit health financing scheme. It covers any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of an ethic of mutual aid and the collective pooling of health risks, and in which the members participate in its management. In addition, as noted below under "General Observations," the study expanded this definition of insurance to include prepayment schemes. In other words, the objective has been the exploration and analysis of health financing mechanisms for the community of traders focusing on health insurance[64].

PRINCIPLE OF COMMUNITY BASE HEALTH INSURANCE SCHEMES

Community-based health insurance schemes (CBHIs) apply the principles of insurance to the social context of communities, guided by their preferences and based on their structures and arrangements.[65] CBHIs can help communities manage healthcare costs and provide access to basic healthcare for the poor and other vulnerable groups. The schemes are especially useful in reaching rural residents and the informal sector—the part of the society that is not easily insured—including self-employed people (e.g., farmers, petty traders, and laborers). These people tend to be unable to pay out-of-pocket costs for basic healthcare at the point of service use, which if persistent, could possibly drive them into poverty.[66]

Health insurance encompasses risk-sharing. It is supposed to reduce unforeseeable or even unaffordable health care costs (in the case of illness) to calculable, regularly paid premiums.[67] But in Africa, public and private health insurance cover almost exclusively the formal sector, and therefore achieve a coverage rate of no more than 10 percent of the population. The

majority of African citizens – informal sector workers and the rural population – don't have access to this kind of social protection.[5]Typically, CBHIs are organised and managed by a local community organisation. The CBHI plan establishes agreements with various health providers, thereby forming a network of facilities.[16] Most schemes cover basic healthcare services (e.g., antenatal care, deliveries, and child healthcare) and family planning services, while some schemes may also cover costs of hospital treatment. The value of CBHIs is that they engage community members as enrollees and volunteers, ensure that health services meet community needs, and make primary healthcare accessible and affordable to members by pooling their resources and sometimes supplementing them with external funds.[66]

Whatever the role and place of CBSHIP in national health financing systems, it is clear that its development cannot do without a systemic approach. CBSHIP is about financing healthcare, but not only about that. It is also about organizing and empowering the demand side in the healthcare system.[63] In addition, development of CBSHIP must go hand in hand with gradually improving quality at the supply side, with the necessary institutional and regulatory environment to steer and control provider behaviour.[63] The implementation of CBSHIP therefore requires a system-wide approach. Similarly, monitoring and evaluation of CBSHIP development can only benefit from a multi-disciplinary perspective taking cognizance of local context. Evaluation and confirmation of CBSHIP's empowering potential would enable decision makers to consider CBSHIP not only as a financing device, but also as a social investment.

OBJECTIVES OF CBSHIP

Community-based Social Health Insurance Programme serves as a mechanism for mobilizing community resources to share in the financing of local health services for the informal sector. In addition, these schemes aim to improve access to health care services by eliminating or by

significantly reducing out-of-pocket payment for services. It also improves quality of care by increasing both the amount and reliability of resources available for providers; [5]

Management Model; Based on the lessons learned from the review of experiences in running CBSHIPs in Nigeria and the observations and recommendations from the Stakeholders' Consultative Summit, it was noted that given the heterogeneity of the country, no single CBSHIP management model will satisfy the needs of the different communities in the country. Based on this, three management Models are proposed:[15]

Board of Trustees as Programme Managers: This model recognises community elected Board of Trustees (BoTs) as the programme managers, carrying out the day – to – day management of the programme, including engagement with all other stakeholders. The model is obtainable where the community elected BoTs have sufficient technical capacity that they do not require external technical facilitation, (TF) or where they cannot afford to engage a TF. This model is most appropriate for communities that have developed long term practical experience in implementing successful CBSHIP.[15]

BOT as Programme Managers with External Technical Facilitation: This model recognizes the inherent weakness in the technical capacity of the BOT to effectively implement programme management and thus seeks to engage an NHIS accredited technical facilitator to provide programme support. The BOT in this model, while maintaining programme ownership and management, resort to use of technical facilitators because of gaps in their technical competence. They thus function in areas where technical competence is not needed. Technical facilitators (TF) will provide complementary technical support[15]

Technical Facilitators as Programme Managers: In this model, the BOT relinquishes technical management functions to TFs, performing only functions ascribed to BOT. Essentially the BOT gives policy guidelines and serve to recruit and monitor community members into the scheme. The TF implements policy guidelines. [5]

The challenge to streamline and coordinate these various financing options in the broader perspective of universal coverage remains a huge one. There is need for more thorough scrutiny and documentation of the set of strategies that have been followed in cases of successful scaling-up of local CBSHIP. Although awareness is low, it is essential if, eventually, the reason behind the lack of willingness to participate/ join the CBSHIP is explored and overcome. The precise configuration of the institutional and managerial environment that will encourage and motivate local initiatives and a solid embedding of CBSHIP is not exactly known especially in Kano where people's interpretation of insurance has increased their inertia to participate in the programme. These can be achieved through a well-designed community based research.[5]

The Nigerian NHIS is an agency under the Nigerian Federal Ministry of Health and consists of three main programmes: one formal and two informal.[18] The Formal Sector Social Health Insurance Programme (FSSHIP) covers public employees and the organized private sector, and is implemented via a managed care model funded through percentage contributions from employers and employees. It is mandatory for organizations with ten or more employees.[18] The two other schemes, the Urban Self-Employed Social Health Insurance Programme (USSHIP) and The Rural Community Social Health Insurance Programme (RCSHIP) are outside the formal sector and are non-profit voluntary schemes based on the CBHI model. Revenue is generated for the USSHIP by flat-rate monthly payments with contributions dependent on the health package chosen, whereas RCSHIP members acquire accreditation according to their health needs and then choose benefits, with cash contributions being made as flat-rate monthly payments or in instalments.[35]

2.3.4 CONCEPTUAL FRAMEWORK FOR COMMUNITY BASED HEALTH INSURANCE

Community Based Health Insurance (CBHI) is a risk-pooling approach that tries to spread health costs across households with different health profiles to prevent catastrophic expenditures that come with unexpected health events or chronic diseases, and enables cross-subsidies from rich to poor populations. In theory CBHI schemes have five characteristics: thus;

Dynamic risk pooling, where the schemes are organized by and for individuals who share common characteristics (geographical, occupational, ethnic, religious, gender, etc.), solidarity: where risk sharing is as inclusive as possible within a given community and membership premiums are independent of individual health risks, participatory decision making and management, nonprofit character and voluntary affiliation.[69]

There is no "one size fits all" strategy for implementing universal health coverage (UHC) in developing countries. Colombia, Mexico, and the Republic of Korea used top-down public (tax-based) financing and Social Health Insurance without CBHI; Rwanda used CBHI as the main model for reaching the informal sector,[69]argued that a bottom-up approach may better fit low-income counties and accelerate progress toward UHC. They provided a three-model framework for the development of CBHI schemes in low-income countries as a way to achieve UHC. These included the Generic, Enhanced and the Nationwide models. The characteristic of these models and their potential are discussedbelow;

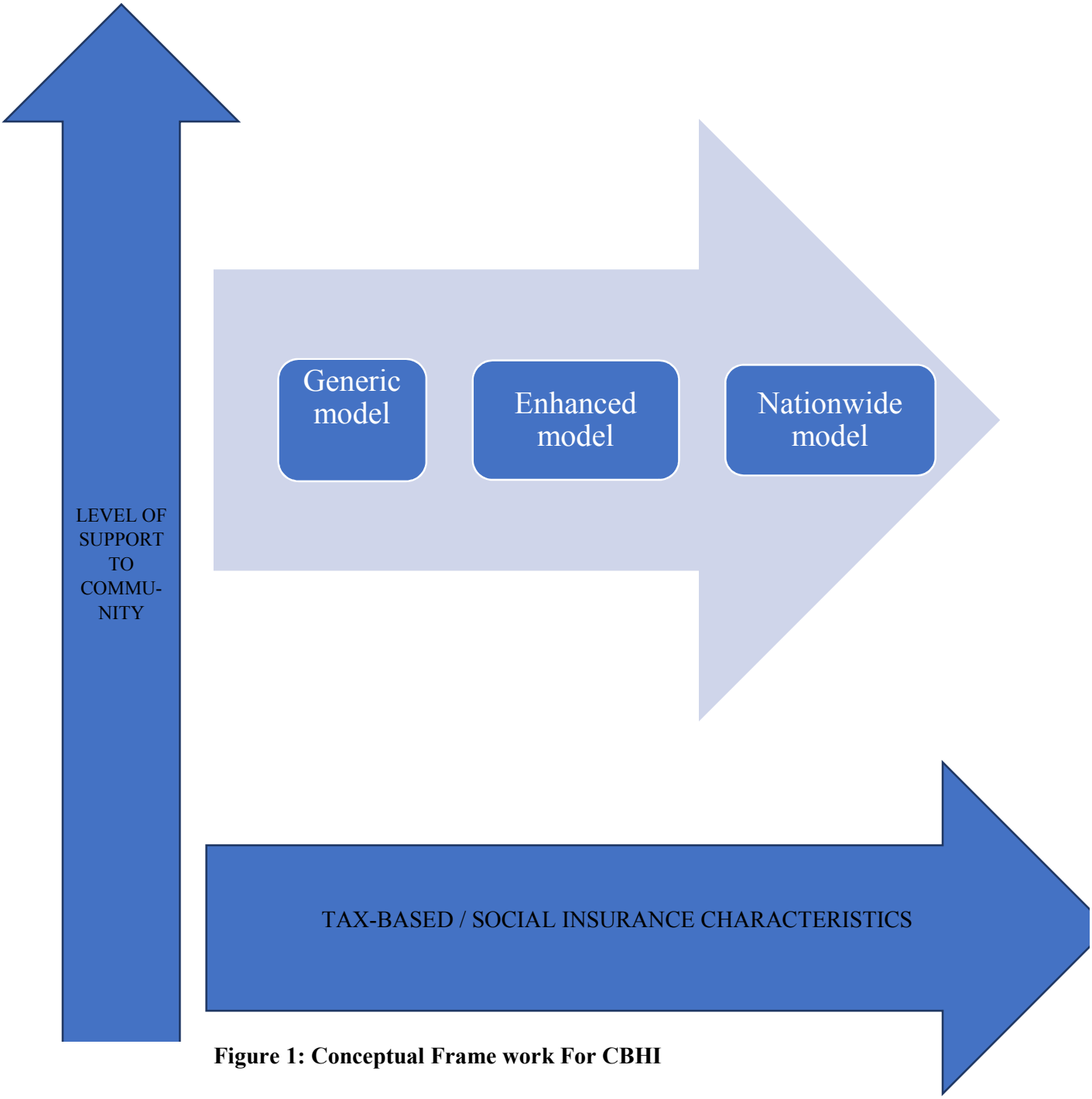

Figure 1: Conceptual Frame work For CBHI

GENERIC MODEL*:* In this model, the scheme is initiated and operated by the community. Participation is voluntary and the scheme is maintained by membership contribution. This is practiced in Gombe, Jigawa and Katsina states as a fee for service contract only between Nigerian Labour Congress and some selected facility managed by Venus Medicare Limited.

ENHANCE MODEL: In this model, there is government practical endorsement of the programme and government subsidy is provided to the poor and to catastrophic risk. Network for management and service delivery is the norm. This is practiced in few states in Nigeria like Lagos (The Ikosi- IsheriMutal Health Plan)

NATION WIDE MODEL: This is characterized by government political commitment, stewardship, legislation, and funding support. There is also regional level professional management, community level mobilization,abuse and fraud control.[69] The Kano State Contributory Health Scheme is based on this model. Thus, this study is also utilizing this framework.

2.3.5 BARRIES TO IMPLIMENTATION OF COMMUNITY BASED HEALTH INSURANCE SCHEME

Awareness: The informal sectors such as traders could be considered as having unstable income, poor and not organized in their mode of operation at work. This may serve as factor that may negatively affect operationalization of the scheme among this group of people.A descriptive cross sectional survey of 387 artisans in Osun state in South-western Nigeria reported that only 28.9% of the artisans were aware of health insurance and only 6.5% of them had heard of community health insurance before and only 0.5% was enrolled in a form of Community Based Health Insurance (CBHI). Most of the respondents in the survey 82.4% were willing to participate (WTP) in Health Insurance with the preferred organizer being government for 74.0% of them.[70]These have a lot of implication for implementation.

Funding: One of the weaknesses of CBHIs is that they are often highly dependent on external funding from the government and donor agencies. Such schemes tend to cover a relatively small, low-income group of enrollees and thus they do not have a sufficiently large risk pool to cover their operating costs. Premium payments and local subsidies are usually inadequate to cover the costs of healthcare, since most enrollees are poor and cannot afford high premium[66]. Also, while community involvement is beneficial to CBHIs, it is sometimes ineffective due to weak management and technical skills of serving members of the community within the CBHI structure. CBHIs should be part of a broader package of financing mechanisms—such as fee exemption schemes, equity funds, vouchers for beneficiaries, and results-based financing—that extend health coverage to under-served groups. CBHIs may not fit all situations, but they can make an important contribution to healthcare programmes

Planning and budgeting: An overall design strategy is insufficient, as it needs to be tailored to each area. An operational plan and a realistic budget targeted at the specific schemes should be developed prior to implementation. [67]

Balancing income and costs: Given the need to subsidizes healthcare for low-income groups, policymakers, planners, and implementers need to pay close attention to financing elements, including premium charges, fixed costs for service delivery, and ways to diversify income sources.

Obtaining high-level commitment: Leaders from the national level down to the LGAs must be strongly committed to providing healthcare to the poor and vulnerable groups such that they can commit to providing subsidies for CBHIs.

Engaging local communities: CBHIs rely on community members not only to keep up enrolment rates but also to participate in programme management, monitor implementation and educate community members on health issues.

Building a service network: The CBHIs with large memberships offer a range of health services through a network of public and private providers. Private providers can provide cost-effective services when involved and regulated to ensure provision of high-quality care. Payment mechanisms need to be carefully determined, with transparency and accountability ensured in order not to compromise the objective of the scheme.

Assessing progress: CBHI managers and funders need to conduct a baseline survey, regularly review service delivery and cost data, and undertake periodic assessments regarding the strengths and weaknesses of the programme. Impact evaluations are equally advised. This may present a technical difficulty to the managers of CBSHIP.

Despite all these, some financial mechanisms—such as performance-based financing (used in Rwanda) and requiring small user premiums (as in Kwara State)—can contribute to the effectiveness of CBHI schemes.[66]

2.3.6 WILLINGNESS TO ACCEPT CBSHIP: CONCEPTUAL FRAMEWORK

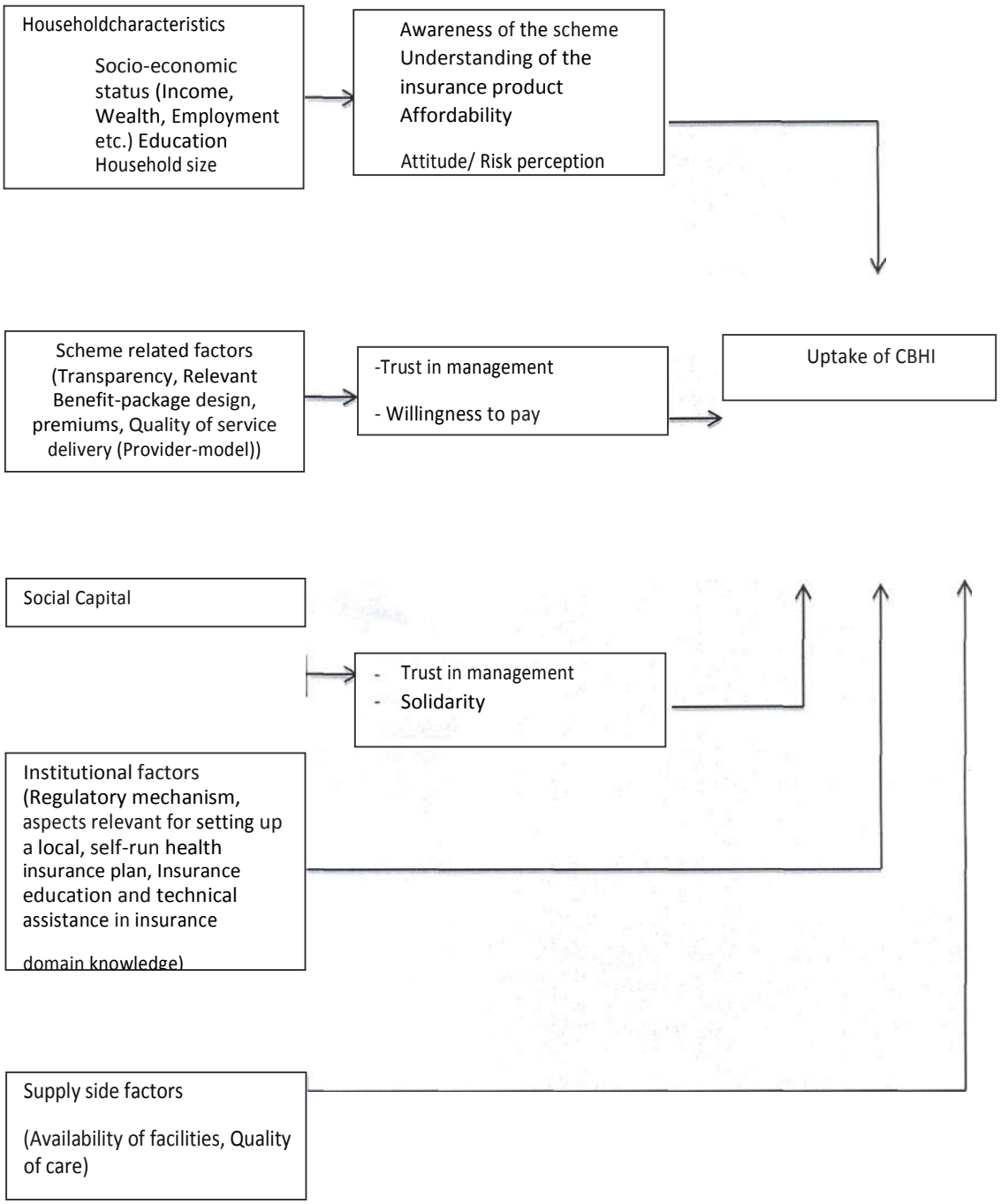

Figure 2: Process to the theory of change of factors affecting acceptance and enrolment of community-based health insurance scheme

Generally, insurance demand studies use expected utility theory to explain individuals' decision of whether or not to insure. This theory states that insurance demand is a choice between an uncertain loss that occurs with a probability when uninsured and a certain loss like paying a premium.[71,72] Expected utility theory assumes that people are risk averse implying that the more risk averse individuals are, the more insurance coverage they will buy. But this theory is silent about the association between households' socio-economic status and insurance enrolment. State-dependent utility theory suggests that consumers' utility level and tastes are influenced by their state, such as health or socio-economic status. [71]

Accordingly, people may have different degrees of risk aversion, which can influence their insurance decision. For example, Individuals who perceive their health status as very good may be less likely to enrol than individuals who perceive their health status as less than optimal. Households with higher socio-economic status are in a good position to afford (paying premium) or may have better understanding of the benefits of being insured. Poverty literature also suggests that poor have liquidity constraints that cause them to remain uninsured even when they may be better off with insurance. The New theory of consumer demand for health insurance (based on prospect theory: consumers prefer an uncertain loss to a certain loss of the same expected magnitude) suggests that consumers who voluntarily purchase unsubsidized health insurance are better off. As suggested by the endowment effect and status quo bias, the decision to insure may be complicated for individuals particularly in areas where insurance is a new concept and illiteracy rates are high. Poor individuals will insure if they perceive the benefits of insurance (for example, access to better quality care) as high than the cost related to giving up being uninsured. [71]

Social capital is also important in the CBHI context. Informal trust-building factors are equally or more important in explaining demand for insurance. Trust in insurance can relate to trust in the insurer or trust in the specific insurance product. If there is solidarity in the

community or trust in management, it will positively influence individuals' decision to enrol in CBHI. Institutional factors such as the technical arrangements made by the scheme management also influence people perception about the benefit of the scheme. Many CBHI operate within weakly defined legal and political systems, and are based on mutual, non-written agreements that are monitored and enforced by members. CBHI members often lack the technical capacities to manage an insurance scheme and negotiate with providers for better care.

Scheme related factors such as benefit package design, premium and transparency also affects people's decision to enrol. If the scheme is transparent regarding the schemes' rules and processes, requirements that claimants submit documents to prove validity of their claims, relevant to poor people's needs such as inclusion of out-patient care in the benefit package will create trust about the financial management of CBHI and positively affect the willingness to pay for insurance.

Providers' inferior quality of service delivery also does appear as a crucial factor for non-enrolment and an important reason for non-renewal of membership in a CBHI scheme. Supply-side factors such as availability and access to good quality primary and secondary health care facilities in the area may attract more members to enrol in the scheme.

Other theories like the social judgement theory recognized that the Brunswikian model was perfectly applicable to the field of judgment. Judgment could also be seen as a process where the judge perceives information about the environment from cues, which are integrated into a judgment. Social Judgment Theory, SJT, [73] adopts Brunswik's model to describe the process of judgment. The psychology of judgment must find the relations between the task system and the cognitive system

The key point of the Social Judgment Theory is that attitude change (persuasion) is mediated by judgmental processes and effects. Put differently, persuasion occurs at the end of the process where a person understands a message then compares the position it advocates to the person's position on that issue. A person's position on an issue is dependent on:the person's most preferred position (their anchor point),the person's judgment of the various alternatives (spread across their latitudes of acceptance, rejection, and non-commitment), the person's level of ego-involvement with the issue.

Social judgment theory says that at the instant of perception, people compare messages to their present point of view.

Individuals' opinions are not adequately represented as points along a continuum because degrees of tolerance around their positions must also be considered.

This research adoptsthe expected utility theory to explain individuals' decision of whether or not to accept CBSHIP. This theory states that insurance demand is a choice between an uncertain loss that occurs with a probability when uninsured and a certain loss like paying a premium.[71]this therefore present us with a clear understanding of why traders will be willing to accept or reject community base health insurance scheme, though in the context of other socio cultural and religious factors.

CHAPTER THREE

MATERIALS AND METHODS

3.1 STUDY AREA

The study was conducted at the GSM market in Farm centrelocated in Tarauni Local Government Area, Kano State. Kano stateis the most populous state in Nigeria with a population of 9.38 million people.[74]It is inhabited mainly by Hausa and Fulani people of Islamic faith. They are majorly traders, civil servants and farmers, though the city attracts population diverse in religion, ethnicity and occupation.[9]

The GSM market in Farm centre is the first GSM market in Northern Nigeria. The market was built under a public-private partnership (PPP) with the Urban Planning and Development Agency (KANUPDA), Kano. It has 72 standard shops, 60 modern sheds, two master sheds, two restaurants, a mosque and a parking lot. About 3000 traders had been resettled from various roadside shed to more appropriate locations in the market. Various spare parts of mobile phones,factory refurbished cell phones, tablets and Laptop are sold in the market in addition to repair. The market is populated by cell phone sellers and repairers.In addition, securities and union leaders who look after the affairs of the members of the GSM market association have their offices within the premises. There are various private and public health facilities around the market. Aminu Kano Teaching Hospital Kano is located about six km away from the market while Tarauni Primary Health Centre (PHC) is located within 3km away from the market.[75]

3.2 STUDY DESIGN

The study design was a cross sectional that used a mixed method of data collection (concurrent).

3.3 STUDY POPULALATION

This comprises of all GSM traders /repairers in the market and leaders of traders association.Key providers of the community based health insurance were also interviewed.Only two females owned standard shops in the market. Trading and cell phone repair are the main source of their income, though few of them also engaged in farming and civil service with Local, State or Federal government within Kano State.

INCLUSION CRITERIA

All adults (male and female members of the GSM market association) who consented and were present in the market during the study period

EXCLUSION CRITERIA

Those who are not members of GSM market traders' association

3.4 SAMPLE SIZE DETERMINATION

QUANTITATIVE

A minimum sample size (n = 226) was obtained using the formula $n = z^2pq/d^2$[276]

The study has more than one outcome but the prevalence of the outcome that will give the highest sample size was used. Using p = 82% (Proportion of public that were aware of health insurance in Kano metropolis) from previous study in Kano among.[77]

$n = z^2pq/d^2$

Where p = 82 %

z = standard normal deviate, set at 1.96 which corresponds to the 95% confidence level.

d= degree of accuracy (precision) desired=0.05

n = 1.962 x 0.82x 0.18/0.0025 = 226 (This was adopted being largest of the sample size)

QUALITATIVE

While estimating the sample size;the following points were taken into consideration. First, a small sample size was required for this component (qualitative research) because a certain point is reached in which the data reaches saturation, meaning that no new information is being provided in subsequent interviews.[78] Furthermore, the qualitative component of the study was meant to obtained information of high quality from the study participants.[79].

Other factors taken into consideration by the researcher while conducting the sample size estimation included the following; the heterogeneous nature (sellers and repairers of cell phones or those at demand and those at the supply site of the health insurance) of the study participants, which was a reason for having representation from each group[79].

3.5 SAMPLING TECHNIQUE

Two stage sampling technique was used to recruit 226 respondents out of the 3014 traders at the GSM market.

Stage one: respondents were grouped into two based on their major occupation and samples were recruited based on proportionate allocation. Thus, those involved in selling phones constituted 2140 (71.1 %) while those that mainly repair phones and computers constituted the remaining 874 (28.9%). Therefore, 71.1% of 226 (161) respondents were recruited from those that sold cell phone and 28.9% of 226 (65) respondents were recruited from those that mainly engaged in repair.

Stage two: Systematic random sampling technique was used to select the required number of respondents from each group. The GSM market trader's association register was used as the sampling frame. This list was obtained through the chairman of the traders association. The sampling interval was determined thus; sampling frame for group one (2140)/sample size (161) = 13.3, rounded down to 13. The first respondent (3^{rd}person) was selected from the first 13 people in the list of those that sold phones by balloting. Subsequently, every 13^{th} person was recruited until the desired sample size was completed. The same process was followed for group two; sampling interval was determined as 874/65 = 13. The first respondent was selected by balloting from the list of first 13 in group two and subsequently, every 13^{th} person was recruited. Six Focused group discussions were carried out with seven respondents each (n = 7) to explore the subject matter. Four Key Informant Interviews (KIIs) were also conducted with some key policy makers from government site and the leadership of the traders association.

3.6 INSTRUMENTS OF DATA COLLECTION

Three tools were used for data collection thus;

1. A semi-structured interviewer administered questionnaire(A1/A2) adapted from previous study[69] and modified to capture the specific objectives of this study was used to collect data from the respondents. The questionnaire has four sections and sought information on;

(A) Socio-demographic characteristics

(B) Out of pocket expenditure

(C) Respondents' awareness about CBHIS

(D) Willingness to enroll in to community based health insurance scheme. The questionnaire was pretested among 25 traders in Tarauni market (A market with similar socio-demographic characteristics with the study area.) to ensure appropriateness of the questions and response.

2. Focused Group Discussion Guide[69] (B1/B2): This was adapted from previous similar study and used to explore the views and perception of the traders on a feasible model that can work for them. Key topics explored in the FGDs include: respondent's awareness, willingness to join CBHIS and how to arrive at a workable model of CBSHIP for traders considering potential barriersand likely factors that can improve acceptance of the scheme.

3. Key Informant Interviews (KIIs)Guide[69] (C1/C2); was carried out using a guide adapted from previous similar study in Ethiopia. The KIIs were intended to gather information from the officials of Kano state contributory scheme (providers of CBHI) who have a better understanding of health care financing in general and CBHI implementation in particular on key issues such as management and governance, regulatory framework, sensitization and CBHI parameters (premium, benefit packages, general and targeted subsidies, etc.) with the purpose of drawing lessons.Leaders of the traders association were also engaged in Key informant interviews in order to have a goodview of the demand side.

3.7 STUDY PROTOCOL

The study used a variety of complementary (mixed) methods of data collection. It is based on one quantitative (interview with the traders) and two qualitative data collection techniques (key informant interviews (KII) and focus group discussions (FGD)). The combination of data collection methods provided a wealth of information in order to assess not only the process of CBHI design and implementation, but also their views and perception. Participation in the research was voluntary and a written informed consent was obtained before participation (Appendix B1/B2).

3.7.1 QUANTITATIVE COMPONENT

QUESTIONNAIRE; A pre-tested interviewer administered questionnaire was administered to the respondents by the researcher and two research assistants. The assistants were recruited and trained on questionnaire administration and interview technique for a period of two days before they were selected based on their performance on the post test. They were very conversant with the location, could speak Hausa and English language and had participated in research in the past.

Socio-demographic characteristics;The socio-demographic proforma consisted of items seeking information on background data like age, gender, religion, education, occupation, monthly income of family, type of family and house hold size. These were obtained using direct questions and responses were recorded as categorical nominal variables accordingly except for age which was recorded as quantitative discrete variable in years as at last birth day.

Out of pocket expenditure: Which refer to payments made by the patients to both public and private providers at the point of receiving health service. It was assessed usingeight- item World Health Survey questionnaire[80], which involved asking the households some questions on eight items directly. These questions elicit information on payments for outpatient services, hospitalization, traditional medicine services, dentists, medication, medical tests, health-care products and other expenditures within 12 months. The health spending estimates was then derived from the total cost obtained by summing the eight-item questions.A household's health expenditure is considered to be catastrophic if the ratio between the household's out-of-pocket health expenditure and its income reaches 10% or more.[80]

Awareness; Respondents' awareness on CBHIS was assessed, scored and graded using a a composite scale system adapted from similar past study.[81] It was a 25 points question under

different domains which included; general knowledge, objectives, benefits packages and requirements for enrolment into the scheme. Their responses were recorded as Yes, No or Don't Know.Each correct response to a question attracted one point, with no point given for a wrong or 'don't know' answer. Respondents scoring ≥17 points out of a total of 25 points were considered as having 'good' knowledge, those who scored 8-16 points were adjudged as having 'fair' knowledge, and those with score of ≤7 points were considered to have 'poor' knowledge.[82]Respondents were further categorised into those with ''GOOD'' knowledge (Good and fair) and ''POOR'' (poor) during analysis.

Willingness to enrol in to the scheme; Brief introductory explanation about CBHIS and its benefit package was provided to the respondents who are naive about CBHIS before determining their willingness to enroll.[32]The benefit package of the scheme was also explained to them: They were told that it will cover the prevailing morbidity in the community and includes family health services, preventive and curative care such as in-patient, out-patient services and antenatal care.Those that answered YES to the question on whether they are willing to enroll were considered to be willing to enroll. The respondents were also asked on the proportion of their income that can be willingly paid as premium and the preferred frequency of payments which were all documented. The various sections of the questionnaire were administered and their responses were documented appropriately.

3.7.2 QUALITATIVE COMPONENT

FOCUSED GROUP DISCUSSIONS(FGDS): Six FGDs were carried out with two categories of members of the GSM market traders association to gather information about CBHIS. The objective was to explore their perceptions and views on the most feasible model of CBHI that can be implemented.Efforts were also made to ensure that group participants belonged to a

similar category (Cell phone sellers and repairers) because their income varied.Thesediscussions (FGDs) were held with six different groups of seven members each. The FGDs focused on five main topics: Perceived burden of diseases, Health seeking behaviour, awareness of CBHI; willingness to enrol experiences and perceptions of the health care systemand recommendations on how best to implement the scheme for traders. Training and pilot testing were conducted over a four day period, and data collection took place thereafter and lasted for 6 days. Verbal consent was given by all participants and all discussions were audio recorded. Data were transcribed,translated and analysed using thematic analysis and were used to help interpret and validate the quantitative findings.

KEY INFORMANT INTERVIEWS(KIIS);Fourkey informants' interviews were conducted with two officials from Kano State Contributory Health Scheme (Supply side) and twoleaders of the traders association (Demand side).These were also translated, transcribed and analyzed.

3.8 DATA ANALYSIS

Data was stored in to an excel spreadsheet and analyzed using SPSS version 20 statistical software. Absolute numbers and simple percentages were used to describe categorical variable, such as sex and marital status etc. Similarly, quantitative variables, such as age, income and out of pocket expenditure were described using measures of central tendency (mean, median) and measures of dispersion (range, standard deviation) as appropriate. Relationships were assessed using bivariate and multivariate analyses. The chi-square test and Fisher's exact test were used in assessing the significance of associations between categorical variables. A P-value of < 0.05 was considered statistically significant..Qualitative data were collected, transcribed, translated and analysed using thematic analysis. They were then used to interpret and validate the quantitative findings.

3.9 ETHICAL CONSIDERATION

Ethical approval was obtained from Kano State Health Research Ethical Committee of the ministry of Health: MOH/Off/797/T.I/952(Appendix D). Permission was obtained from the chairman, GSM market traders association. Informed consent of the participants was also sought for and obtained. Participants were informed that participation in the research was voluntary and is not associated with any health risk. They were also educated on the benefit ofcommunity based health insurance. Provision of Helsinki declaration was respected.

3.11 LIMITATION OF THE STUDY

Data was self-reported (over 12 months) and therefore subject to recall bias especially on out of pocket expenditure and monthly income. However, the interviewers were well trained on questionnaire administration. The interviewees were given sufficient time for adequate recall of long term memory. Additionally questionnaires were translated to Hausa language to ensure uniformity in administering it.

CHAPTER FOUR

RESULTS

All the 226 traders recruited responded to the research questionnaire, given a response rate of 100 %.

4.1 SOCIODEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

The age of the respondents ranged from 17 to 52 with a median of 31 mean of 31.3 ±6.8 years. Majority of them were males224(99.1%) and had formal education 212(93.8%). Almost half of the respondents were married but only 6(2.7%)were employed underthe formal sector in addition to trading. Majority of them 151(66.8%) earned N500, 000 or less per annum. The median monthly income of the respondents was N30,310 with a range of N2,000 to N 250,000. Other characteristics are as shown in table 1.

Table 1:Sociodemographic characteristics of the respondents

Characteristics	Frequency (n=226)	Percentages(%)
Age(31.3 ± 6.8)		
<20	5	2.2
20-29	90	39.8
30-39	103	45.6
40-49	25	11.1
≥50	3	1.3
Sex		
Male	224	99.1
Female	2	0.9
Marital Status		
Single	111	49.1
Married	113	50
Divorce	2	0.9
Religion		
Islam	222	98.2
Christianity	4	1.8
Tribe		
Hausa	188	83.2
Fulani	25	11.1
Yoruba	2	0.9
Igbo	4	1.8
Others	7	3.1
Education		
None	1	0.4
Quranic only	13	5.8
Primary	16	7.1
Secondary	121	53.5
Tertiary	75	33.2
Occupation		
Civil servant	6	2.7
Trading only	215	95.1
Artisan	5	2.2
Household with chronic illness		
Yes	40	17.7
No	186	82.3
Monthly income		
≤ N18000	47	20.8
>N18000	179	79.2
Total	226	100.0

4.2 COMPONENTS OF ANNUAL OUT-OF POCKET EXPENDITUREOF THE RESPONDENTS

Table 2 showssources ofout-of pocket expenditure of the respondents within 12 months before the study. The most frequent source of spending was on transportation to the health centres 210 (92.9%), followed by spending on drugs for treatment 205(90.7%). More than three-quarters, in addition spent money in seeking for health services in the chemist197(87.2%) and traditional medicine 179(79.2%).

Table 2: Components of out-of pocket expenditure on Health among the respondents (Multiple responses)

Components of Out-of pocket expenditure	Frequency (n=226)	Percentage (%)
Traditional medicine	179	79.2
Consultation	193	85.4
Investigation	193	85.4
Patent medicine store	197	87.2
Prescribed drugs	205	90.7
Transportation	210	92.9

4.2.1 SUMMARY OF ANNUAL OUT-OF POCKET EXPENDITUR (NAIRA) AMONG RESPONDENTS

The annual out of pocket expenditure ranged from N 2000 – N 805,000 with a median of N21950.The median amount spent ontreatment in the hospital (N 8000) was the highest while consultation had the least (N 1000). Significant amount (N 2000) was also spent in the chemist

Table 3: Summary of Annual Out-of Pocket Expenditure (N) Among the respondents

Items	Median (N)	Minimum (N)	Maximum (N)
Transportation	1900	100	55,000
Consultation	1000	60	70,000
Investigation	3000	200	200,000
Hospital treatment	8000	1000	350,000
Traditional medicine	1000	100	30,000
Chemist	2000	100	40,000
Annual out-of pocket expenditure	2,195	2000	805,000

4.2.2 PROPORTION OF ANNUAL INCOME SPENT AS OUT OF POCKET EXPENDITURE

The median proportion of annual income spent on health was 5.1% with a very wide range of 0.4 % to 124.2 %. The median annual income of the respondents was N360000 with a range of N 24000- N3000000. (Table 5)

Table 4: Summary of respondents annual income and Out of pocket Expenditure

Statistics	Annual Income (N)	Annual Out of Pocket Expenditure (N)	Proportion of Income Spent on Health (%)
Median	360000	21950	5.06
Minimum	24000	2000	0.42
Maximum	3000000	805000	124.23

4.2.3 CATASTROPIC HEALTH EXPENDTURE AMONG THE RESPONDENTS

Of the 226 respondents, 69(30.5%) incurred catastrophic health expenditure within 12 months prior to this study (Table 6)

Table 5: Prevalence of Catastrophic Health Expenditure among the respondents

Proportion of respondents' Annual Income Spent on Health	Frequency (n=226)	Percent(%)
Not catastrophic (<10%)	157	69.5
Catastrophic (≥10 %)	69	30.5
Total	226	100.0

4.3 AWARENESS OF COMMUNITY BASED HEALTH INSURANCE SCHEME AMONG THE RESPONDENTS.

More than one third (43.4%) of the respondents had heard of NHIS but only 29 (12.8%) ever heard of CBHIS and much fewer13 (5.8%) were ableto describe what the scheme was correctly. Similarly, very negligible percentage knew the objectives of the scheme. More than ten per cent (11.9%) know that the scheme increase access to care and ensure people get access to care irrespective of who they are, while 23 (9.7%) felt it improve quality of care. Twenty-six (11.5%) felt the scheme mobilized resources to health facility. More than 10 % of the respondents knew that the services covered by CBHIS included ANC and maternity care for up to 4 live birth, post natal care, family planning education, hospital care with private facility. However,only 21(9.3%)knew that out- patient consultation and drugs were covered by the scheme and only 10 (4.4%) knew that prosthesis is in the exclusion list of CBHI.Only 5.8% knew that head of family and all his dependents can be registered.(Table 7).

Table 6: Respondents Awareness on CBHI

Parameter	Number giving a Correct Response (n=226)	Percentages (%)
Ever Heard of NHIS	98	43.4
Gave correct description of NHIS	34	15
Ever Heard of CBHIS	29	12.8
Gave correct description of CBHIS	13	5.8
Know objectives of CBHIS include:		
Increase access to care	27	11.9
Improve quality of care	23	9.7
Improve utilization of service	21	9.3
Ensure people have access to care irrespective of who you are	26	11.5
Mobilization of resources to health facility	26	11.5
Know that the services covered by the CBHIS under the Kano state contributory scheme include		
Outpatient consultation	21	9.3
Prescribed drugs and diagnostic test	21	9.3
ANC and maternity care for up to 4 live birth	27	11.9
Post natal care	28	12.4
Family planning	28	12.4
Hospital care with private or public facility	26	11.5
Eye examination and care	26	11.5
Dental care	21	9.3
Prosthesis	10	4.4
Know the requirement for enrollment in to the scheme include:		
Must be a civil servant	28	12.4
Must be above 18 years	15	6.6
Only head of the family can be registered	34	15
Head of family and children only	9	4
Head of the family and all his dependents	13	5.8
Payment of monthly premium	19	8.4
Premium is decided by government	25	11.1

4.3.1 KNOWLEDGE OF COMMUNITY BASED HEALTH INSURANCE

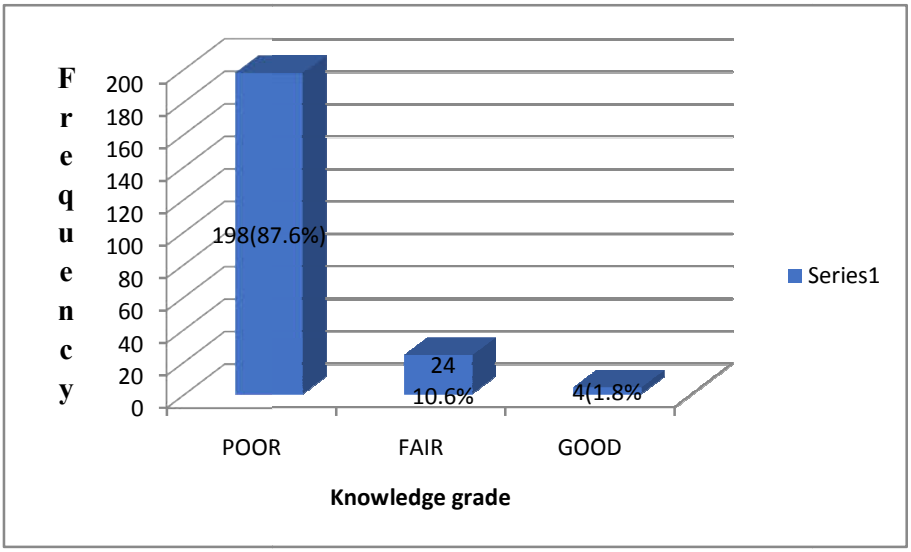

Figure 3:Knowledge grades among respondent

Figure 3

The respondents' knowledge grade based on their composite scoreshowed that more than eighty per cent 198 (87.6%) of the respondents had poor knowledge of CBHIS and only few 4 (1.8%) had good knowledge of the scheme.

4.3.2 SOURCES OF INFORMATION ON COMMUNITY BASED HEALTH INSURANCE

The most common90 (91%) source of information about the scheme was the mass media. Other sources include the mosque, school, internet and the research team.

Table 7: Respondent's Sources of information about CBHIS

Source	Frequency (n=98)	Percentages (%)
Mass media	90	91
Others*	8	9

*Mosque, Internet, School, Interviewer

4.4 WILLINGNESS TO ENROLL IN COMMUNITY BASED HEALTH INSURANCE SCHEME AMONG THE RESPONDENTS.

4.4.1 ENROLMENT STATUS

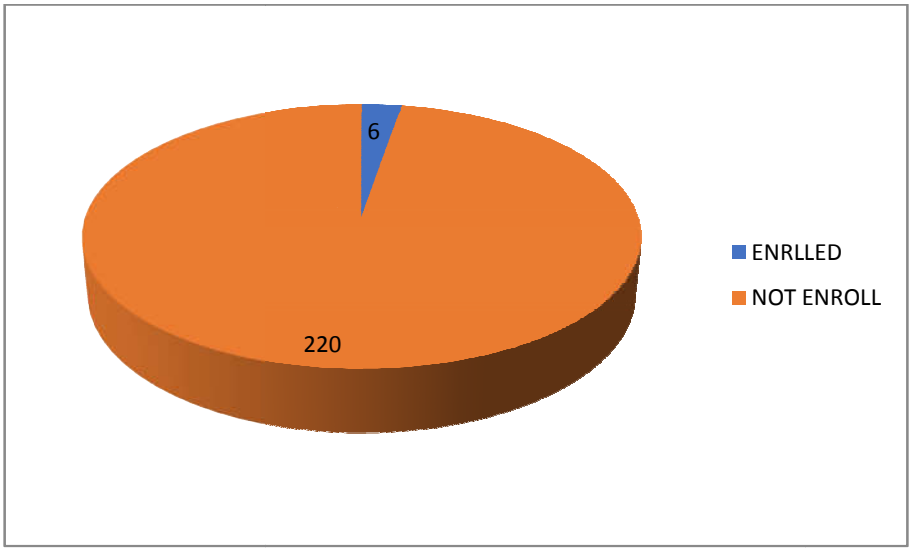

Figure 4: Enrolment in to health Insurance

Only 6 (2.7%) of the respondents were enrolees in the formal sector health insurance of the state (Figure 4) because they are employees of Kano state government.

4.4.2 WILLINGNESS TO ENROL

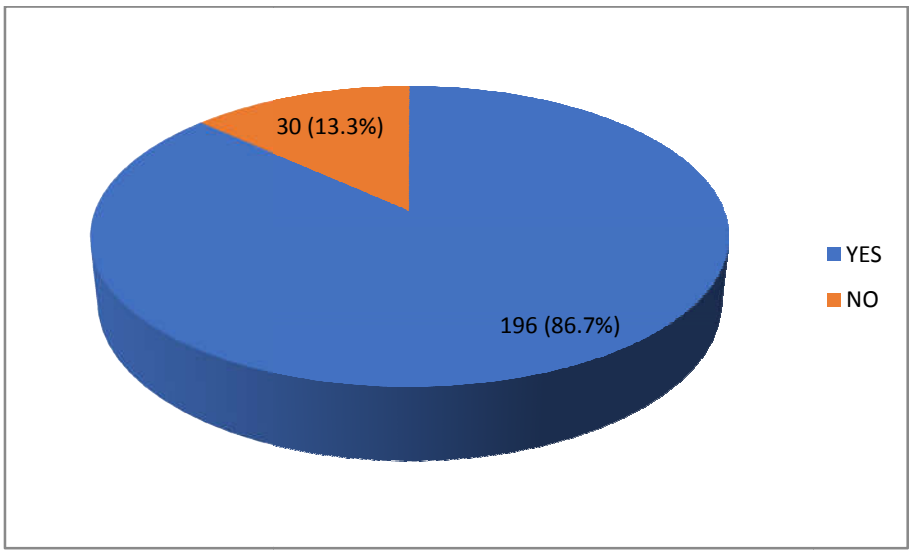

Figure 5: Willingness to enrol in Health Insurance

More than 80% of the respondents are willing to enrol in to CBHIS (Figure 5)

4.4.3 PROPORTION OF INCOME WILLING TO INVEST AS PREMIUM

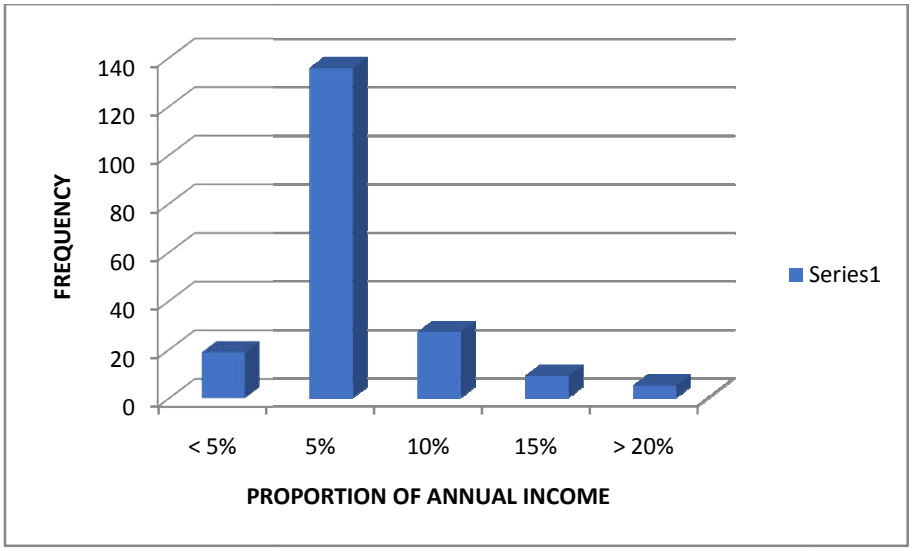

Figure 4: Proportion of income willing to be invested as premium by the respondents

Among those who are willing to enrol, 136 (69.4%) are willing to invest up to 5% of their annual income as premium. Only 5 (2.6%) of those willing to enrol felt they could pay 20% or more of their income as premium (Figure 6)

4.4.4 PREFERRED FORM OF PREMIUM

The most preferred form of premium 180 (91.8%) was cash payment. Very few 16 (8.2%) preferred to pay premium in kind.

Table 8: Preferred form of premium by respondents

Most preferred form of Premium among those willing to enroll	Frequency (n=196)	(%)
Cash	180	91.8
Kind	16	8.2

4.4.5 PREFERRED FREQUENCY OF PREMIUM PAYMENT PER ANNUM

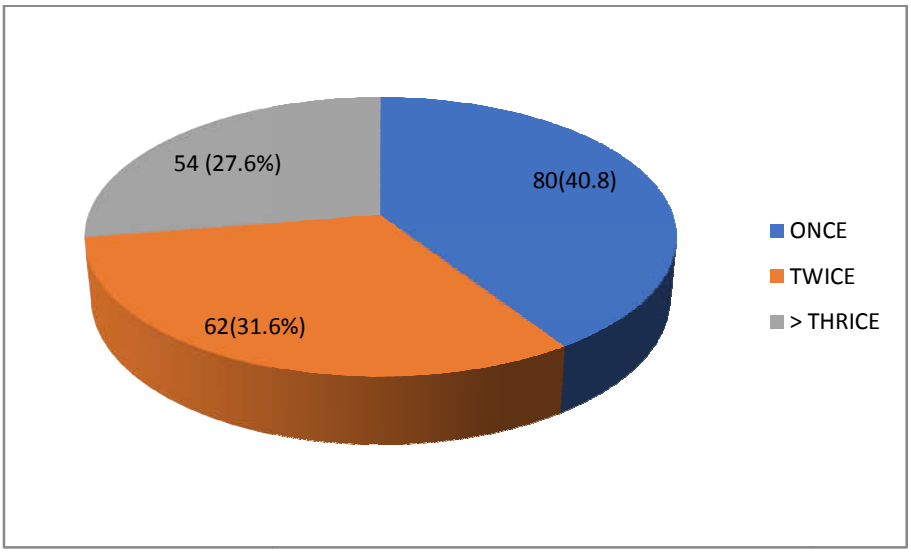

Figure 5: Preferred frequency of premium payment per annum

Up to 80 (40.8%) preferred to pay the premium once in a year, while 62 (31.6%) felt twice per annum was better. Only 50 (27.6%) chose thrice per annum. Figure 7

4.4.6 REASONS FOR NOT WILLING TO ENROLLE

Those who were not willing to enrol stated that lack of confidence in the scheme 23 (76.7%) and inadequate knowledge 18 (60%) about the scheme were their major reasons. More than 50% of those not willing to enrol also stated that illness does not occur frequently in their household and almost one-quarter 7 (23.3%) felt that their reasons were limited availability and low quality of health services. Few others 5 (16.7%)felt that lack of designated office for registration proximal to the market is a reason for not willing to enrol in the scheme (Table7).

Table 9: Reasons for not willing to enrol in CBHIS

Reasons for not willing to enrol in CBHIS (n=30)	**Frequency (%)**
Illness does not occur frequently in our household	17(56.7)
The registration fee and premium are not affordable	9(30)
Want to wait in order to confirm benefit from others	11(36.7)
I do not know enough about the CBHI scheme	18(60)
There is limited availability of health services	7(23.3)
The quality of health care services is low	7(23.3)
The benefit package does not meet our need	11(36.7)
Lack of confidence in the scheme	23(76.7)
Others*	5(16.7)

*Others: There is no designated place for registration near the market, too young to join the scheme

4.5 FACTORS ASSOCIATED WITH OUT-OF POCKET EXPENDITURE, AWARENESS ON CBHIS AND WILLINGNESS TO ENROLL IN THE SCHEME AMONG RESPONDENTS.

4.5.1 Factors associated with Out-of pocket expenditure on Health.

Table 10: Respondents do not differ in their health spending based on age, sex, marital status, tribe, educational status or presence of persons with chronic illnessor monthly income. Those that earn above the minimum wage 60(87%) incurred higher catastrophic health expenditure compared to those earned N18000 or less though the difference is not statistically significant.

Table 10: Factors associated with Catastrophic Health spending among respondents

	Non Catastrophic n=157(%)	Catastrophic n= 69(%)	Total	χ^2	P value
Age(31.3 ± 6.8)				0.39	0.843
<40	138(87.9)	60(87)	198 (87.6)		
≥40	19 (12.1)	9(13)	28(12.4)		
Total	157(100)	69(100)	226(100)		
Sex					0.518**
Male	156(99.4)	68(98.6)	224(99.1)		
Female	1(0.6)	1(1.4)	2(0.9)		
Total	157(100)	69(100)	226(100)		
Marital Status				1.18	.810
Single	75(47.8)	36(52.2)	111(49.1)		
Married	81(51.6)	32(46.4)	113(50)		
Divorce	1(0.6)	1(1.4)	2(0.9)		
Total	157(100)	69(100)	226(100)		
Tribe				0.54	0.817
Hausa	130(82.8)	58(84.1)	188(83.2)		
Non-Hausa	27(17.2)	11(15.9)	38(16.8)		
Total	157(100)	69(100)	226(100)		
Education					0.069**
Informal	13(8.3)	1(1.4)	14(6.2)		
Formal	144(91.7)	68(98.6)	212(93.8)		
Total	157(100)	69(100)	226(100)		
Occupation					0.511**
Trading only	148(94.3)	67(97.1)	215(96.1)		
Trading plus any other	9(5.7)	2(2.9)	11(4.9)		
Total	157(100)	69(100)	226(100)		
Household with chronic illness				0.089	0.766
Yes	27(17.2)	13(18.8)	40(17.7)		
No	130(82.8)	56(81.2)	186(82.3)		
Total	157(100)	69(100)	226(100)		
Monthly income				3.625	0.057
≤ N 18000	38(24.2)	9(13)	47(20.8)		
>N 18000	119(75.8)	60(87)	179(79.2)		
Total	157(100)	69(100)	226(100)		

****Fisher's**

Factors associated with Knowledge of Community-based Health Insurance Among Traders

There was association between respondents' knowledge of community based health insurance scheme and presence of chronic illness in the family and educational status of the respondents. However, there is no difference in knowledge of community based health insurance among different age group, sex, marital status or tribe.

Table 11: Factors associated with Knowledge of CBHI among the traders

Characteristics	Knowledge of CBHIS		Total	χ^2	p-value
	Good (n=28)	Poor (n=198)			
Age				0.840	0.359
<40	23(82.1)	174(87.9)	197(87.2)		
≥40	5(17.9)	24(12.1)	29(12.8)		
Total	28(100)	198(100)	226(100)		
Sex					0.999**
Male	28(100)	196(99)	224(99.1)		
Female	0(0)	2(1)	2(0.9)		
Total	28(100)	198(100)	226(100)		
Marital Status				1.468	0.226
Not married	11(39.3)	102(51.5)	113(50)		
Married	17(60.7)	96(48.5)	113(50)		
Total	28(100)	198(100)	226(100)		
Tribe					0.702**
Hausa	24(85.7)	164(82.8)	188(83.2)		
Non Hausa	4(14.3)	34(17.2)	38(16.8)		
Total	28(100)	198(100)	226(100)		
Education				5.990	0.014*
Secondary and below	13(46.4)	138(69.7)	151(66.8)		
Tertiary	15(53.6)	60(30.3)	75(33.2)		
Total	28(100)	198(100)	226(100)		
Chronic illness in household					0.008*
Yes	10(35.7)	30(15.2)	40(17.7)		

No	18(64.3)	168(84.8)	186(82.3)		
Total	28(100)	198(100)	226(100)		
Monthly Income				1.68	0.682
≤N 18000	5(17.9)	42(21.2)	47(20.8)		
>N 18000	23(82.1)	156(78.8)	179(79.2)		
Total	28(100)	198(100)	226(100)		

Statistically significant** * Fisher**

Table 12: Showed output of logistic regression for variables that are statistically significant on bivariate level. Those Households with persons having chronic illness are almost 40% likely to have knowledge of CBHIS ($p < 0.03$) than those without. Also those with tertiary level of education are almost three times more likely to have knowledge of CBHIS than those with no education ($p< 0.08$, OR= 2.893, 95 CI 1.230- 6.806).

Table 12: Output of logistic regression from variables that were found to have statistically significant association with Poor knowledge of CBHI from bivariate analysis

Variables	**P - Value**	**Crude odds ratio**	**Odds ratio**	**95% Confidence Interval**
Presence of chronic illness in family				
Yes	0.002	0.32	0.31	0.145--0.969
No	-	-	-	- - -
Secondary & below level of education	0.015	0.38	0.36	1.230—6.806
Tertiary level of education	-	-	-	- - -

There is statistically significant association between willingness to enrol in CBHIS and marital status of the respondents (< 0008) Table 13.

Table 13: Factors associated with Willingness to Enrol in CBHIS

Characteristics	Willingness to enrol in CBHIS		Total	χ^2	p-value
	YES (n=196)	NO (n=30)			
Age				1.039	0.388
<40	170(86.7)	28(93.3)	198(87.6)		
>_40	26(13.3)	2(6.7)	28(12.4)		
Total	196(100)	30(100)	226(100)		
Sex				0.309	0.578
Male	194(99)	30(100)	224(99.1)		
Female	2(1)	0(0)	2(0.9)		
Total	196(100)	30(100)	226(100)		
Marital Status				9.300*	0.008
Single	94(48)	19(63.3)	113(50)		
Married	102(52)	11(36.7)	113(50)		
Total	196(100)	30(100)	226(100)		
Tribe				1.148	0.284
Hausa	161(82.1)	27(90)	188(83.2)		
Non-Hausa	35(17.9)	3(10)	38(16.8)		
Total	196(100)	30(100)	226(100)		
Education				0.862	0.407
No formal	11(5.6)	3(10)	14(6.2)		
Formal	185(94.4)	27(90)	212(93.8)		
Total	196(100)	30(100)	226(100)		
Chronic illness in household				0.250	0.874
Yes	35(17.9)	5(16.7)	40(17.7)		
No	161(82.1)	25(83.3)	186(82.3)		

Characteristics	Willingness to enrol in CBHIS		Total	χ^2	p-value
Monthly income	Yes	No		0.013	0.90
<N18000	41(20.9)	6(20)	47(20.8)		
>N18000	155(79.1)	24(80)	179(79.2)		
Total	196(100)	30(100)	226(100)		

4.5 QUALITATIVE FINDINGS

This section explored the perceived burden of disease among traders, their health seeking behaviour, sources of financing health, awareness of and willingness to join CBHIS.It also investigates the barriers that hinder the implementation of the scheme among traders at the GSM market.

4.5.1 PERCEIVED BURDEN OF BURDEN OF DISEASE AMONG THE TRADERS

Most traders felt that malaria, typhoid fever, hypertension and peptic ulcer disease are the main disease burden in the community. Few others described pregnancy complications and neonatal illness and death as the main disease burden causing a lot of suffering, disability and death. One of the traders stated that

'' *Some of the common diseases that affect people in this community are malaria, typhoid, high blood pressure and ulcer*''

Another trader stated that''*... among the common sicknessthat disturb this community are complication during pregnancy and child birth due to lack of antenatal services''*

4.5.2 HEALTH SEEKING BEHAVIOUR OF THE TRADERS

Predominantly, the traders patronized the herbal medicine vendor to seek medical care first, because they consider it cheaper and close to their homes. Then the nearby chemist especially

those manned by hospital staff. The hospital is the last resort especially if the illness persists. This is associated with a lot of delays and complications. One of the traders stated that ‘’*…like what my colleague said, it depends on ones earnings and financial capability because we prefer to use the herbal medicine because is cheaper while those that can afford are treated in the hospital’’*

4.5.3 SOURCES OF FINANCING HEALTH CARE AMONG TRADERS AT GSM MARKET

The traders use out of pocket to finance their medical bill and if there is no money, the patient cannot access care in some instances. The disease will progress in severity and complications will set in. Sometimes, there may be assistance from relatives and well to do in the society. One of the trader who repair phones in the market stated that

’’ If we don’t have money to go to hospital or chemist, we seek for assistance from well to do in the society’’

One of the leaders from the traders association commented on the difficulties faced by the traders when they or any family member fall ill.

He stated that thus, ‘*’...sometimes we had to go cap in hand to seek for financial assistance to pay hospital bills for our member but this would have been prevented if we have a scheme like this’’*

4.5.4 AWARENESS ON CBHIS AMONG TRADERS AT GSM MARKET, FARM CENTRE

Although CBHIS is an alternative means of financing health care in the informal sector, majority of the traders were not aware of the scheme but few that have heard about it felt it will improve health by increasing access to health care. A 34 year old trader stated that

‘*’I have been hearing about health insurance scheme but I do not fully understood or have knowledge of it from anybody.’’ One of the leaders in the traders association stated that ‘’CBHIS is a welcome development and we will support its implementation fully’’*

The Kano state contributory health scheme admitted that the traders at GSM market have not been approach yet

‘’….. We have not approach the GSM market yet, but the National Health Insurance Scheme may have done that though I am not sure’’

4.5.5 WILLINGNES TO JOIN CBHIS AMONG TRADERS AT GSM MARKET, FARM CENTRE

Most of the traders were willing to join the scheme because it will increase access to care and make life much easier by providing financial protection to families in times of illness. A top management team of the GSM market association stated that ‘’We are many in this market and we are totally in support of this program and ready to enroll in the scheme because it’s a good development

’’ One of the directors in the agency expressed his confidence stating that ‘’I am very sure that the traders will embraced the scheme because it has addressed many aspect of controversies’’

4.6 VIEWS AND PERCEPTION ON WORKABLE MODEL HOW TO MOBLIZE THE TRADERS

Most traders felt that their union should be sensitized, equipped and empowered with all the necessary information needed to address all myths and misconceptions the traders may have about the scheme. One of the phone sellers said that

‘’ *The union leaders are the decision making body of the association and are therefore, in good position to liaised with the agency and create committee that will mobilized and register traders in to the scheme.’’*

They opined that the agency should come closer to the traders by having a liaison office in the market that will make the process of registration trader friendly. One of the officials of the agency suggested that

‘’smaller groups should merge to form to form a larger one because the scheme is a game of number’’ This will ensure sustainability, according to her.

4.6.1 PREMIUM

Most respondents felt that a flat rate of N100-200 naira per head per month will be adequate as premium. Although, few others felt that weekly payment was more appropriate.

‘’ A union leader suggested that ‘’…. The premium should be uniform at N 200 monthly for everybody’’

A phone repairer said ‘

However, one of the senior official of the agency highlighted that ‘’the operational guideline stipulated N300 per head per month for a community of at least 1000 people.’’

4.6.2 SUBSIDY FOR INDIGENT PATIENT

The government should pay for those who cannot afford to ensure sustainability according to some respondents. However, official of the agency referred to the operational guidelines and stated that

‘*’The National Health Insurance Scheme (NHIS) is mandated to pay for the vulnerable in the society which included the pregnant women and children under five. She also added that philanthropists are encouraged to make donations in order to increase the financial pool’’*

4.6 3 SERVICES COVERED BY THE SCHEME

Most respondents felt that inclusion of child and maternal health care in the package would certainly encourage participation in the scheme according to most respondents.

‘’Among the common diseases or sicknesses that mostly disturb this community are maternal cases which include complication during pregnancy, and neonatal deaths due to inability of a pregnant mother to attend antenatal services when she became pregnant. Malaria, Typhoid, Peptic ulcer and some chronic diseases should also be included.’’

4.6.4 MANAGEMENT AND GENERAL ADMINISTRATION OF THE SCHEME

Majority of the respondents opined that the general administration and financial management should be handled by those employed by the government, so as to improve confidence of the traders while their union leaders should be involved to monitor the process. One of the union leaders stated that

‘*’ Management of funds should remain with the government but the community leaders should monitor it carefully making sure it is spent for that purpose’’*

4.7 BARRIERS THAT HINDER THE IMPLIMENTATION OF CBHIS AMONG TRADERS AT GSM MARKET

4.7.1 LACK OF AWARENESS OF THE SCHEME AMONG POTENTIAL BENEFICIARIES:

Majority of the traders and their leadership were not aware of the scheme. This made them skeptical about joining the scheme. One of the traders stated that

‘’ *I don’t have knowledge about this Community Based Health Insurance Scheme (CBHIS) but need to be enlighten before I will consider joining.’’*

In a similar way, a leader of the GSM market traders association also responded that*‘’One of the challenges is to create more awareness to the GSM market traders before implementation so that people will be convinced before registration’’* An official of the agency also felt that ‘’*....there is need to step up sensitization and awareness creation activities using social media and film stars to sensitize the public.’’*

4.7.2 INABILITY TO PAY PREMIUM BY MEMBERS

Officials of the Kano State Contributory Scheme expressed concern over sustainability in the informal sector because according to them the informal sector is unstable and highly unpredictable because of irregular nature of their earnings and therefore, premium cannot be deducted from source. A senior official of the agency stated that ‘*’...larger groups should swallow smaller groups, so as to have a large pool’’* Philanthropists should also be encouraged to donate into the scheme, so as to have a robust pool. ‘*’She also added that those who have issues with pay should join the vulnerable group to avoid ruining the CBHIS due to* non-payment of premium.’’

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 DISCUSSION

5.1.1 OUT-OF POCKET EXPENDITURE:

In this study, up to 97.3% of the respondent's utilised out-of pocket expenditure to settle medical bill while only 2.7% who are also civil servants pay through the Kano State Contributory Health Scheme. However, this could be due to absence of wide-scale paymentalternatives to OOPS. It is possible that if NHIS and CBHIS were widely available, payment by Out of pocket spending wouldnot be so high.This finding agrees with the WHO report which placed the rate as 95.4% in Nigeria.[43]. Onoka et al also foundOut-of pocket expenditure usage ranged between 68.4 and 96.9 per cent and health insurance coverage of less than 1% in different communities of Ebonyi states.[83]Banwat et al reported 91.5% among rural community in north central Nigeria.[84]Conversely, as low as 15% usage of OOP had been documented in Rwanda.[85]These differences could explained by the differences in uptake of health insurance across the different communities.

The median annual income of the respondents was ₦360000 per household which was much higher than the current Nigeria Federal Government minimum wage of two hundred and sixteen thousand naira (₦216,000) per annum. However, the predominantly lower income earners in this study population would most likely earn far below this median income as signified by a very wide range (₦ 2400- ₦ 3 000000). On the other hand, the median annual out of pocket expenditure in this study stood at₦ 21950 but with a very wide range too (₦ 2000 - ₦ 805000). This translates to ₦ 1829 per month per household. This is considered high if compared to their monthly income but inadequate to even treat an episode of acute malaria for one member let alone the whole household members.

In this study, 30.5 % of the respondents spent more than 10% of their annual income to settle medical bill (Catastrophic) and the proportion of respondents with catastrophic spending reduce as one move from lower to higher income. This association is statistically significant. Per harps, this could be attributed to their low capacity to pay their medical bill..This is close to 24% found by Uzochukwu in Awka Ibom, Nigeria.[26] Although, they found that the prevalence of catastrophic spending was higher among the higher income class. This may reflect the availability of quality health services available in the study area. As high as 40 % was reported among households in Enugu.[83] This may be the reflection of service availability and higher purchasing power of the households compared to this environment.

5.1.2 AWARENESS ON COMMUNITY BASED HEALTH INSURANCE AMONG TRADERS IN GSM MARKET.

In this study, awareness on Community based health insurance scheme was very low as less than 15% of the respondents ever heard about community based health insurance of which only 5.8% knew its correct description. Very few of the of the respondents knew about the objectives and benefit package of the scheme.About one-tenth knew that the scheme ensure that people have access to care irrespective of who they are. Knowledge on the requirements for enrollment was particularly defective as only 12.4% knew that prospective beneficiary must not be a civil servant and only 8.4% knew that premium is paid monthly.This is surprising, considering the educational status of the respondents (more than 80 % have secondary school level of education and above) and the fact that Kano is the state capital city where the headquarters of the state Mandatory Contributory Health Scheme is located. These findings may be a reflection of theweak media advocacy on the subject matter by the stakeholders. A similar finding was reported byLawan and his colleagues in a cross sectional survey assessing the challenges to scale up of the Nigeria National Health Insurance Scheme among adults residents of Kano metropolis. They found that less than 50% of the respondents

knew the objectives of the NHIS and the ways of enrolling in the scheme.[82]Another cross sectional survey among traders in Ebonyi reported that only 30.3 % of its respondents were aware of NHIS.[52] Surprisingly a much lower figure (8.5%) was reported from Osun[70] where the level of education is comparatively higher than the North western region where Kano State located. This may reflect a very weak system of information dissemination.There is significant association between respondents' knowledge of CBHIS and educational status, \annual income and presence of person with chronic illness in a household. These findings are consistent with other similar studies.[52,82]

5.1.3 WILLINGNESS TO ENROLL IN TO COMMUNITY BASED HEALTH INSURANCE BY TRADERS AT GSM MARKET, FARM CENTRE KANO

After thorough explanation of CBHIS and its concept by the interviewers, most of the respondents (86.7%) were willing to be covered by the health insurance program and majority are willing to pay up to 5% of their monthly income as premium in cash. Marital status was found to be statistically significant. This high level of willingness may be explained by the new knowledge gained by the respondents during the interview. This finding is consistent withthose reported by Banwat and colleagues in North central part of Nigeria who found that 93.6% of the study population were willing to join CBHIS[84], though more educated and singles were more willing to join according to their report. The different with regards to the marital status may just be a reflection of differences in sociodemographic characteristics.Melaku reported from South west Ethiopia reported that 78% were willing to join CBHIS.[36] They also found strong association between willingness to join and most socioeconomic factors, indicating that once CBHIS was introduced, it will be patronized by all the different segments of the society. Rosé line, reported as low as 60% among rural Ethiopian.[33] This may highlight the influence of place of residence whom may be of lower educational status.

5.1.4 VIEWS AND PERCEPTION OF THE TRADERS ON A WORKABLE MODEL OF CBHIS.

Majority of the respondents felt that CBHIS was a good initiative by the government and is highly welcome by the traders. However, most of them felt that government should show strong commitment in terms of leadership and financial support to ensure sustainability while the traders should be empowered with appropriate information to enable them take an informed decision. They opined that benefit package should cover common health problems faced by the traders and members of their family like maternal and child health, Malaria, Typhoid, diabetes, hypertensionand stroke among others.

Registration should be traders friendly and be placed proximal to the market where beneficiaries can move in and out easily from the market. The suggested premium was N 200 flat rate monthly per household member which would be subject to review based on prevailing circumstances.

5.1.5 BARRIERS THAT HINDER THE IMPLIMENTATION OF CBHIS AMONG TRADERS

Low level of awareness and understanding of the concept of CBHIS negatively influence willingness to join the scheme and by extension affect enrollment. This study found that more than 80% of the respondents have poor knowledge of the scheme and when sensitized, significant per cent were willing to enroll in to the scheme. This is consistent with findings from systematic review by Fadhallahwho found that respondents lack of awareness affects enrolments.[86] One study reportedhigh amount of premium and timing of premium collection to negatively influence enrollment.Some studies conducted in Nigeria, Thailand and Uganda reported that stringent membership criteria (e.g. only allowing families of 5 to enroll or requiring 60% of a community to enroll before providing services or insuring the whole household) limited some communities from participating in the scheme.

5.2 CONCLUSION

Almost one-third (30.5%) of the traders suffered catastrophic health spending from out-of pocket expenditure. More than two-third (87.6%) of the respondents had poorknowledge of CBHIS and those with tertiary level of education are three times more likely to have the knowledge.Up to 86.7% of the respondents showedwillingness to enrol in the scheme. Nationwide model was the most acceptable because of its strong government support and involvement.Respondents also felt that the service package should cover maternal and child health with affordable uniform monthly premium and devoid of difficulties in the process of registration. Lack of awareness on the scheme and default from payment of premiumare the barriers to the implementation of the scheme among traders of GSM market.

5.3 RECOMMENDATION

Kano State Contributory Health Agency should mobilized all the necessary resources and launch an awareness campaign on the benefits of health insurance using local artist‘’Jarumai from Kanny wood’’ in the television, radio programmes and social media etc. This will create awareness and promote its uptake among the traders. The representatives of the traders association should be engaged on sensitization training by the agency, particularly on how the scheme works and how to play their role efficiently in the scheme’s management. This will enhance trust, accountability and enrolment in the scheme. The felt need of the prospective beneficiary should be adequately addressed with all enthusiasm by the scheme implementation team through continues client satisfaction survey to ensure sustainability.

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APPENDICES

APPENDIX A1 :

QUESTIONAIRE

A STUDY ON EXPLORING A WORKABLE MODEL OF COMMUNITY-BASED HEALTH INSURANCE AMONG TRADERS AT GSM MARKET FARM CENTRE, TARAUNI, LGA , KANO.

Date ---------- Study number ----------

-My name is MUAZU, SHUAIBU ISHAQA, a student from Bayero University Kano. I am conducting a study on ‘’EXPLORING A WORKABLE MODEL OF COMMUNITY BASED HEALTH INSURANCE SCHEME AMONG TRADERS AT GSM MARKET FARM CENTRE, TARAUNI, LGA, KANO’’ as part of requirement for the award of Msc Public Health in the department of Community Medicine. You are being requested to voluntarily participate in this study because of its importance in increasing access to quality health care delivery and reducing financial hardship for families in need of health care. If you agree to participate, you will be asked some questions about yourself, your family and health. There is no risk in participating in this study and the result will be made known to you. All information shall be treated with utmost confidentiality. Your refusal to participate will not affect you or any other member of your family.Do you have any questions?

I agree to participate in this study.

---------- ----------

Signature/thumbprint of participant

SECTION A: **SOCIODEMOGRAPHIC DATA**

1. Iinitials) ----------

2. What is your Age (in in completed years): ……

3. Sex 1. Male □ 2. Female □

4. Residence ----------

5. Marital Status 1. Single □ 2. Married □ 3. Divorced □ 4. Widowed □

6. Marital Setting. 1. Monogamous 2. Polygamous (no of wives)…….

Total number of persons in Household…….

7. Religion 1. Islam □ 2. Christianity □ 3. Traditional □ 4. Any other □…..

8. Tribe 1.Hausa□ 2 Fulani □ 3. Yoruba □ 4. Igbo □ 5. (Others specify) □ ……

9. Highest Educational Level : 1. None □ 2. Quaranic only □ 3. Primary □ 4. Secondary □ 5.Tertiary □

10. Occupation:

1. Civil Service □ 2. Trading only □ 3. Artisan □ 4. Farmers 5. Others……

11. Household Income per month : ……..

12. Person / s with chronic illness and/or disability in the household

1. YES ……

2. NO

if yes specify age in years ……and relationship…….

SECTION B: AVERAGE OUT OF POCKET EXPENDITURE ON HEALTH (IN THE LAST ONE YEAR)

14.1	14.2	14.3
Types of expenditure	Did you purchase	Expense
	1 = Yes 2 = No	Naira
Expenditure on health		
Transportation		
Consultation		
Investigation		
Treatment		
Hospitalization		
Traditional medicine		
Others		

SECTION C: AWARENESS OF CBHI

15. Have you ever heard about National Health Insurance NHIS ? 1. YES 2. NO

Community based health insurance program (CBHI)?

1=Yes

2=No ***If No skip 16***

16. From whom did you hear about CBHI?

1= neighbors/friends

2= CBHI officials in public meeting

3= CBHI house to house awareness creation campaigns

4= mass media: TV, radio

5= health professionals in health facilities

6=others, specify_____

17. The OBJECTIVES of creating CBHIS is/are (multiple response)

17.1. Increase access to care 1.Yes 2. No 3. Don't know

17.2. Improve quality of care 1. Yes 2. No 3. Don't know

17.3. Improve utilization of service 1.Yes 2.No 3. Don't know

17.4 Ensure equity 1. Yes 2. No 3. Don't know

17.5 Moblization of resources to health facility 1.Yes 2.No 3. Don't know

18. Which of these services is/ are covered by the CBHIS under the Kano state contributory scheme? Multiple (response)

18.1 Outpatient consultation 1. Yes 2. No 3. Don't know

18.2 Prescribed drugs and diagnostic test 1. Yes 2. No 3. Don't know

18.3 ANC and maternity care for up to 4 live birth 1. Yes 2. No 3. Don't know

18.4 Post natal care 1. Yes 2. No 3. Don't know

18.5 Family planning 1. Yes 2. No 3. Don't know

18.6 Hospital care with private or public facility 1. Yes 2. No 3. Don't know

18.7 Eye examination and care 1. Yes 2. No 3. Don't know

18.8 Dental care 1. Yes 2. No 3. Don't know

18.9 Prosthesis 1. Yes 2. No 3. Don't know

19. Pre requisite for enrollment

19.1 Must be a civil servant 1. Yes 2. No 3. Don't know

19.2 Must be above 18 years 1. Yes 2. No 3. Don't know

19.3 Only head of the family can be registered 1. Yes 2. No 3. Don't know

19.4 Head of family and children only 1. Yes 2. No 3. Don't know

19.5 Head of the family and all his dependents 1. Yes 2. No 3. Don't know

19.6 Payment of monthly premium 1. Yes 2. No 3. Don't know

19.7 Premium is decided by government 1. Yes 2. No 3. Don't know

SECTION D: WILLINGNESS TO ENROLL

20. Have you enrolled your household in any form of health insurance?

1 = Yes

2 = No

21. If no, why has your household not enrolled in any insurance programme? (multiple responses allowed-list in order of importance)?

(code) ____, _____, _____

1=Illness and injury does not occur frequently in our HH

2=the registration fee and premiums are not affordable

3 = want to wait in order to confirm the benefits of the scheme from others

4 = we do not know enough about the CBHI scheme

5 = there is limited availability of health services

6= the quality of health care services is low

7 = the benefit package does not meet our needs

8= Lack of confidence in scheme management

9 = other reasons, please specify……..

22. Are you willing to enroll in the CBHIP?

1 = Yes

2 = No

23. If yes, what proportion of your income are you willing to invest as premium for the CBHIP?

1. 5% 2. 10% 3. 15% 4. 20% 5. > 20%

24. In what form would you be willing to make contribution on the premium

1. Cash 2. Kind

24. How often would you be willing to make contribution on the premium per year?

1. Once 2. Twice Three times 3. > Three times…….

25. Would you recommend CBHI coverage? 1. Yes 2.No

26. If yes how likely are you to recommend CBHI to your friends?

1. Never 2. Rarely 3.Sometimes 4. Always

27. How likely are you to recommend CBHIP coverage to your family member?

1. Never 2. Rarely 3.Sometimes 4. Always

APPENDIX A2

TAMBAYOYI

BINCIKE AKAN YADDA DA ZA'A AIWATAR DA TASWIYAR INSHORAR LAFIYA GA KANANAN YAN'KASUWA A KASUWAR WAYA DAKE GIDAN GONA A KARAMAR HUKUMAR TARAUNI CIKIN JIHAR KANO.

Rana ---------- Lamba ----------

Sunana is MUAZU, SHUAIBU ISHAQA, dalibi a Jami'arBayreo Kano. Ina yin bincike ne akan ''AKAN YADDA DA ZA'A AIWATAR DA TASWIYAR INSHORAR LAFIYA GA KANANAN YAN'KASUWA A KASUWAR WAYA DAKE GIDAN GONA A KARAMAR HUKUMAR TARAUNI CIKIN JIHAR KANO.'' Yana da yadagacikinrukunankarmarbabbarshaidardigiri a bangarenlafiyaral'ummadnbangarenbincikencututukaal'ummanababbarJami'ar Bayero Kano. Munanemanizininamincewar ka da mu tattauna da kai sabodakarakula da ingancinlafiya da samohanoyin rage radadintalauchi da talakawarsukefama dashi wajennemanlafiya. Idan ka amince ka shigawannantattaunawa, zamuyimakawadansuyan' tambayoyi da yashafe ka, iyalinka da kumalafiyar ka. Babuwanihadariwurinamincewar ka a cikinwannanbincikekumazamusanar da kai sakamakonwannanbincike. Dukabin da mukatattauna da kai zaizamacikinsirriba tare da waniyasaniba.

Rashinamincewarkabawatamatsalabacegakanka ko wani mamba ko kumaiyalinka.

Kana da watatambaya?

Na amince da a tattauna da niakanwannanbincke.

---------- ----------

Sa hannun ko dangwalenamaiamincewa

SASHE A: **ABUBUWAN DA SUKA SHAFI RAYUWA**

1. Mukami) ----------

2. Shekaru: ……

3. Jinsi 1. Maza □ 2. Mata □

4. Mazauni ----------

5.Matakin Aure 1. Bani da Aure □ 2. Ina da aure □ 3. Mun rabu □ 4. Bazawara □

6. Marital Setting. 1. Mace daya□ 2. Mata da yawa

Jimlar mutanen gida…….

7. Addini 1. Musulunci □ 2.Kiristanci □ 3. AddininGargajiya □ 4. Wanidaban □…..

8. Kabila 1.Bahaushe□ 2 Fulani □ 3. Bayarabe □ 4. Inyamiri □ 5. (Wanidabanbayyana) □ ……

9. MatakinIlimi : 1. Babu □ 2. Kur'ani □ 3. Firamare □ 4. Sakandare □ 5.Yai da Jahilci □

10. Sana'a:

1. Ma'aikacinGwamnati □ 2. Dan Kasuwa □ 3. Dan buge-buge □ 4. Manomi 5. Wanidabanbayyaba……

11.Kudin shigowa a wata : ……..

12.Mutanen da sukedauke da cutamaiyaduwa ko masushanyewarjiki a gida

1. E ……

2. A’a

Idanhakane ka fadishekarunsu ……dadangantaka…….

SASHE B: MATSAKAICIN KUDIN KULA DA LAFIYA (A SHEKARAR DA TA GABATA)

14.1	14.2	14.3
Abubuwan da aka kashe	Ka saya	Kudin
	1 = E 2 = A'a	Naira
Kudin da ka kasha a kula da lafiya		
KudinMota		
KudinganinLikita		
Kudingwaje-gwaje		
Kudinmagani		
Kudinkwanciya		
Maganingargajiya		
Saura		

SASHE C: FADAKARWA AKAN CBHI

15. Ka tabasaninwaniabuakan InshorarLafiya ta KasaNHIS ? 1. E 2. A'a

InshorarLafiya ta Al'umma (CBHI)?

1=E

2=a'a***Idanba haka bane katsallake 16***

16. Ainakajilabarin CBHI?

1= makwabta/abokai

2= CBHI ma'aikatansu a wajen taro

3= CBHI gida-gidasunawayar da kai

4= ta hanyoyinsadarwa: talabijin, rediyo

5= kwararrunma'aikatanlafiyaaasibiti

6=wanidaban,bayyana_____

17. HUJJOJIN kirkiro CBHIS shine/sune (cikakkunbayanai)

17.1. karaingantaharkarlafiya 1.E 2. No 3. Ban saniba

17.2.Inganta lafiaya1. E 2. A'a 3. Ban saniba

17.3. Ingantaamfani da asibit 1.E 2.A'a 3.Ban saniba

17.4 Tabbatar da kulawa 1. E 2. A'a 3. Ban saniba

17.5 Amfani da asibiti1.E 2.A'a 3. Ban saniba

18. Wadanne da gacikinkulawa/ yakunsa a CBHIS a karkashinkulawarinshorarlafiya ta jiha? jimlar (bayanai)

18.1 GaninLikita 1. E 2. A'a 3. Ban saniba

18.2 Magani da kumaGwaji 1. E 2. A’a 3. Ban saniba

18.3 Awo da kula da maiciki har zuwahaihuwa ta hudu 1. E 2. A’a 3. Ban saniba

18.4 Mula da maihaihuwa 1. E 2. No 3. A’a

18.5 TsarinHaihuwa 1. E 2. A’a 3. Ban saniba

18.6 Kula da maraslafiyaaasibutgwamnati ko nakudi 1. E 2. A’a 3. Ban saniba

18.7 Gwajin da idanu da kulawa 1. E 2. A’a 3. Ban saniba

18.8 Kula da hakori 1. E 2. A’a 3. Ban saniba

18.9 Prosthesis 1. E 2. A’a 3. Ban Sani ba

19. Hanyoyi Shiga

19.1 Ka tabbatar kai ma’aikacingwamnati ne 1. E2.A’a 3. Ban saniba

19.2 Shekarunkasama da shatakwas 1. E 2. A’a 3. Ban saniba

19.3 Maigidakadai za a yiwarigista 1. E 2. A’a 3. Ban saniba

19.4 Maigida da yarakawai 1. E 2. A’a 3. Ban saniba

19.5 Maigida da iyalansagabadaya 1. E 2. A’a 3. Ban saniba

19.6 Biyankudininshora ko wane wata 1. E 2. A’a 3. Ban saniba

19.7 Gwamanatiita za ta tantane yadda za’abiya 1. E 2. A’a 3. Ban saniba

SASHE D: AMINCEWA DA IN SHIGA

20. Ka tabashiga da kai da iyalinkawani da gacikinkamfanininshorarlafiya?

1 = E

2 = A'a

21. Idan b aka tabashigaba, menenedalilinkana kin shigadayadagacikinharkarinshora?(Bayanaisukasance a tsaredaki-dakiakanmuhimmancinsu)?

(Namba) ____, _____, _____

1=rashinlafiya da dahadaribasafaruwa a ko da yaushe a gida

2=kudinrigistasuna da yawabazamuiyabiyaba.

3 = inaso in tabbatarmuhimmancinsa da kumakaruwadagawannantsari da gawajenmutane

4 = bamu da cikakkenbayaniakanCBHI tsarin

5 = akwaikarancinkayanaiki

6= basu da ingancinkula da marasalafiya

7 = abubuwan da sukedaukedasubasu da inganci

8= rashinkawarewarshugabanninkwamitin

9 = wanidabanbayyana

……..

22.Kana da niyyarshiga CBHIP?

1 = E

2 = A'a

23. Idanhakane, nawadagacikinkudin ka, kakeganinzakarikabayarwa?

1. 5% 2. 10% 3. 15% 4. 20% 5. > 20%

24.Ta wacehanyazakaiyabadanakakaro-karonnalafiyar?

1. Kudi 2. Taimako

24. Ta yayayazakaiyabadanakakaro-karonnalafiya a shekara?

1.Sau daya 2. Sau biyu 3. >Sau uku

25. Za ka iyayabawaCBHI ? 1. E2.A'a

26. idanhakanewaceirinyabawazakaiyiakan CBHI gaabokanka?

1. bazantabayiba 2. Ba lallaibane 3.wani lokaci 4. kullum

27. ta wacehanyazakayabawaayyukan CBHIP gaiyalanka?

1. bazantabayiba 2. Ba lallaibane 3.wani lokaci 4. kullum

APPENDIX B1

FOCUSED GROUP DISCUSSION

Focus Group Discussion: Moderator's Guide ''Exploring a workable model of Community Based Health Insurance CBHIS'' for Traders at GSM Market, Kano.

Focus group number……..

Number of participants……

"Good morning /afternoon, my name is Dr. Muazu Shuaibu, a Master student from department of Community Medicine, Bayero University Kano. I am conducting a research on ''Exploring a workable model of Community Based Health Insurance Scheme among Traders at GSM market, Farm Centre Kano.'' I will guide this discussion and with me is (name of the assistant) to assist in taking notes of all your responses but without your names. A tape recorder will also be used in case we miss out anything in writing. I will like to mention at this point that all what we discuss here will be treated as confidential and only be used for the purpose of this study. This session will last about 45minutes to one hour. You will be required to sign a consent form or thumb print to indicate your agreement to participate in this discussion".

ICE-BREAKER THROWN TO RELAX THE DISCUSSANTS:

1. Let familiarize ourselves. Tell us your name, age and how many wife/wives and children do you have?
2. Have you attended any formal school? Which income-generating activity/activities are you engaged in other than trading?

1.0 PERCEIVED BURDEN OF DISEASE

1.1 What is/are the common diseases/s encountered in your household / community?

1.2 How does this disease/s affect your family/ community?

1.3 (Probe-

Children- *absent from school, decrease leaning, poor growth and chronic disability*),

Women-*Affect parenting, lead to chronic disability and death*)

Men- *absent from work, disability, Cost of illness and death.*

2.0 HEALTH SEEKING BEHAVIOUR

2.1 Where do people commonly seek care from/ Reasons for their choice?

2.2 Considering the most recent illness in your household, where do you obtained care from? Was there any delay in seeking care? PROBE: *Within 24hrs, > 24hrs? Reasons for any delay*

3.0 SOURCES OF HEALTH CARE FINANCING

1.1 How do you source money to pay for medical bill? (Probe – *OOP, others*)

1.2 Any difficulty?

1.3 What are the difficulties?

1.4 Are you happy about it? Why not?

1.5 (Probe- *How do you cope???*)

4.0 AWARENESS OF NHIS/CBHIS

4.1 Are you aware of the existence of Contributory Health Scheme/CBHIS newly introduced in Kano?

4.2 What is it all about?

4.3 What are its benefits/ usefulness?

Probe- *does it increase access/provide financial protection*?

4.4 What about its acceptability among GSM traders?

4.5 What are the payment forms- kind/cash? /Payment schedule? What are the services available?

5.0 WILLINGNESS TO JOIN CBHIS

5.1 Do you think that GSM market traders can benefit from the CBHI scheme? Please describe what you think as their benefit? Do you think the benefits make joining/ paying worth in your opinion?

5.2 Who should take the decision of joining the scheme? Association ? Or individual?

6.0 VIEWS AND PERCEPTION ABOUT A WORKABLE MODEL.

6.1 What do you think should be done in the CBHI scheme set up to make you and other traders at the GSM market a member?

(Probe: Payment levels, Subsidy, Payment scheduling, Benefit package, Service availability etc.), Management team; their roles and responsibilities

6.2 How can sustainability of the scheme be sustained?

6.3 What are the likely challenges in implementing this programme for GSM market traders? Probe - *Any concern/fear, perception, or unmet expectations /Reasons???*

6.4 How can these challenges be overcome? THANK YOU

APPENDIX B2:
JADAWALIN TATTAUNAWA

JadawalinTattaunawa: Mai Kula da Lokaci ‘’akan yadda za’aaiwatar da taswiyarinshorarlafiyagakanananyan’kasuwa a KasuwarWayadakeGidanGona a KaramarHukumarTarauni a cikinJihar Kano.

JadawaliNamba……..

Mutanen da sukahalarta……

SunanaDr.Mu’azuShuaibudalibimaikarantarBabbarDigiri a Sashenkula daLafiyarAl’ummanaJami’ar Bayero, Kano, inabincikeakann yadda za’aaiwatar da taswiyarinshorarlafiyagakanananyan’kasuwa a KasuwarWayadakeGidanGona a KaramarHukumarTarauni a cikinJihar KanodagacikinrukunankarbarBabbarShaidarDigiridagaJami’ar Bayero Kano take Bayarwa.Wanantattaunawazatazamacikinsirriba tare da wanidagawajeyasaniba.Munakumanemanizinin ka da muyiamfani da rediyowajendaukarbayanan ka saboda ta taimaka mana wajenrubutacikakkenbayanan a dunkule. Wannantattaunawa za ta dauke mu natsawonminti 45 (arba’in da biyar). Rankayadadeakwaitakardar da muke so ka sahannuwandazamununawashugabanin mu tabbacinmunyiwannantataunawa da kai. Dagakarshemunanemanizinin ka da mu farawannantataunawa?

3. Yanzuzamufahimcijunanmu.musansunayen mu, shekarudayawanmatan muda kumayawanya’yanmu?
4. Kana da iliminboko? Banda kayantireda da kakesayarwa kana watasana’ar ta daban?

7.0 CUTUTUKA DA AKE KAMUWA DASU

7.1 Wane irincututukasukeaddabarmutanenwannangari?

7.2 Wane irinillawannancutar take haifarwa?

7.3 (ka badamisali-

Yara – *rashinzuwamakaranta,rashinfahimta, rashingirma da shanyewarjiki*),

Mata –*rashinhaihuwa,tanakawoshanyewarjiki da mutuwa*)

Maza- *rashinzuwaaiki, shanyewarjiki, tana haifar da rashinlafiya da mutuwa.*

8.0 HALAYEN MARASA LAFIYA

8.1 Ainamutanesukekarbarmagani/ wane dalilisukedasunazabarwuri?

8.2 Wannancuta da take addabarmutanengari, inasukezuwakarbarmagani? Sunabatalokacikafinsugama'aikatanasibiti? MISALI: *Awa ashirin da hudu, ?Menenedalilinbatalokacin?*

9.0 HANYOYIN TALLAFAWA HARKAR LAFIYA

1.6 Ta yayakakesamokudinbiyanmagani? (Misali)

1.7 Akwaiwahala?

1.8 Wane irinwahalolikakefuskanta?

1.9 Kana farincikin haka? Me yasa?

1.10 (Misali-*Ta yayakakesamunnatsuwa???*)

10.0 FADAKARWA AKAN NHIS/CBHIS

10.1 Kana d masaniyaakankungiyarinshorarlafiya ta matakinjihawaddagwammantinjihakafa?

4.2 Me ta kumsa

4.3 Meneneamfanin ta/ ayyukanta?

Misali-*tana kara/ko tana kawosaukin kasha kudi*?

4.4 Yayakarbuwarwannan ta kasance a wurin Yan' kasuwarWaya?

4.5 Yaya tsarinbiyanyake- kyauta/kudi? /tsarinbiyan? Wace irinkulawasukebayarwa?

11.0 AMINCEWA DA IN SHIGA CBHIS

5.1 Kana jinyan' kasuwarwayazasukaru da wannantsarinna CBHI? Kayi mana bayanin ta yadda sukekaruwa? Kana jinkaruwar tana da amfani/ wajenbiyaanakara'ayin?

5.2 Who should take the decision of joining the scheme? Association ? Or individual?

12.0 RA'AYI DA HANGE TA YADDA ZA'A TSARA AIKIN.

6.1 Wane tsariyakamataayi a CBHI ta yadda sauranyan'kasuwarWayazasuzama mamba a cikinwannantsarin?

(Misali: BiyanKudi, takaitacce, Jadawalinbiyankudi, abindayakunsa, gamsuwaraikinda sauransu.), ShugabaninKwamitin; dokoki da kumaayyukansu

6.2 Ta waccehanyawannantsarinzaisamukarbuwa?

6.3 Wane matsalolikakeganinza'afuskantawajenaiwatar da wannantsaringa Yan' KasuwarWaya?Misali – *kasancewa/tsoro, ra'ayi, koabin da zaibiyobaya /Dalilai???*

Ta yayaza'akaucewawannanmatsaloli? MUNGODE

APPENDIX C1:
KEY INFORMANT INTERVIEW:

Moderator's Guide ''Exploring a workable model of Community Based Health Insurance CBHIS'' for Traders at GSM Market, Kano.

The purpose of this assessment is to gather data to evaluate the impact of pilot CBHI schemes from different perspectives including improving financial access, quality of health services, increasing resource mobilization and community participation. This assessment will also provide recommendations for the scale-up of the pilot schemes at national level. If there are questions for which someone else is the most appropriate person to provide that Information, I would appreciate if you introduce me to that person. Any information you will provide as part of this interview will be held strictly confidential. Any reference to the information you provide in our analysis will be made without mentioning or implicating your name in any way.

Interviewee

Title):……

……

……..

Phone no: ……

Date:……

Generally, can you talk about your organization and your responsibilities in relation to the NHIS/CBHI implementation?

1. What are the primary policy purposes of Contributory Health Insurance in Kano?

Can you describe for us the processes under which the Contributory health Scheme and specifically the CBHI scheme was developed?

(Directives and Byelaws developed?) What was the role played by the stakeholders in the establishing them:

a. Federal FMOH and NHIS?

b. State MOH?

c. Local Government/ Councils?

d. Traditional rulers?

e. Community members? Traders, farmers

f. Any role for health providers?

2. Can you tell us about the informal sector component of the Kano state contributory health scheme?

3. Are GSM traders covered ??

4. Any reason/s? For not covering the GSM traders especially looking at their strong base in Kano?

5. What are the major issues/ possibility around kick starting the CBHI for them?

7. How can the GSM traders 'community be mobilized to prepay and enroll in the Kano Contributory Health Scheme

8. What are your plans (State government) on the management of the scheme's funds for successful service delivery?

9. What are the roles of members in the management and oversight of the scheme ?

10. Given the design parameters currently in place: mode of enrollment, package, premium, subsidy and management

i. what do you think will be the challenges/barriers in its implementation for traders in GSM market?

ii. Which of the design parameters needs a re-look to facilitate enrolment by the traders?

11. What will you do to ensure sustainability of the scheme?

Any need on enhancing pooling beyond GSM MARKET?

THANK YOU

APPENDIX C 2

MUHMMIN TATTAUNAWA

Mai Kula da Lokaci ‘’akan yadda za’aaiwatar da taswiyarinshorarlafiyagakanananyan’kasuwa a KasuwarWayadakeGidanGona a KaramarHukumarTarauni a cikinJiharKano..

Dalilinwannantattaunawa don a samohanyoyi da za’aawaitar da tsarinCBHI dagabangaroridabam-dabam da kumaingantahanyoyinsamokudi, ingantalafiya, hanyoyinkarawayar da kanjama’ada sushigawannantsarin. Wannansakamakonzaikawoshawarwari ta yadda za’a ta yadda zaikarbikarbuwa a matakinkasa.Idanakwaiwadansuyan’tambayoyi da waniwaddashiyacancantayakawobayanai, zanyifarincikiidanzakagabartadanigawannanmutum.Wananbayanai da ka bamuzaikasancecikinsirri. .

Mai Amsatambaya

Title):……

……

……..

NambarWaya:

……

Rana:……

A dunkule,za ka iyayi mana bayaniakanwannankungiya da kumairinayyukanta da yadanganciishorarlafiya.

1.Menene dalilainakafawannankungiya ta ishorarlafiiya a matakinJiha?

Zakaiyagaya mana hanyoyinkafawannankungiyarinshorarlafiya?

(Directives and Byelaws developed?)Wane gudunmawamanyanma’aikatansukabayarnaganinkafuwarwannankungiya:

a. Ma’aikatarLafiya ta MatakinKasa da HukumarInshorarLafiya ta Kasa?

b. Ma’aikatarLafiya ta Jiha?

c. KaramarHukuma?

d. Masurike da sarautargargajiya?

e. Yan'Kwamiti? Yan'kasuwa, fManom

f.Ggudunmawama'aikatanlafiya?

2. zakaiyagaya mana wasudagacikinkungiyoyinwadandasukayihadaka da kungiyar inshore a matakinjiha?

3. Yan' KasuwarWayasunaciki ??

4. Akwaiwanidalili? Na rashinshigar da Yan'kasuwarwayanaganin yadda suke da karfinkungiya a Kano

5. Wane irinmatsaloli /kakeganinyiwuwarsunakaddamar da CBHI a Kano?

7. Ta yayaKungiyar Yan' KasuwarWayazasujawohankalunmutaneakanshigainshorarlafiya.

8. Menenetsarin ka (gwamnatinJiha) ta yadda za a kaddamar da wannaninshorarlafiyacikinnasara?

9. Menenegudummawarmambobi da tabbatardoyewarwannantsari?

10. Ta yadda tsarinyakasancenaaiwatar da tsarinshigainshorarlafiya;

i. wane irinmatsalolinkakeganinza'afuskantawajenaiwatar da wannantsaringaYan'kasuwarWaya?

ii. Wane tsarinya dace da Yan' KasuwarWaya?

11. wane hanyoyiza'abi don dorewarwannantsarin?

MUNGODE