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Implementing Community Based Health Insurance Schemes: A Mechanism for Health Care Service Delivery in Kano Metropolis

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Abstract

The lethargic nature of the Nigerian health system, ravaged by numerous operational and administrative crises, had necessitated the establishment of National Health Insurance Scheme (NHIS) as one of Nigerian government's health reform measure aimed at securing better health care for Nigerians. However, only the formal sector insurance scheme was fully operational while the informal sector scheme like Community Based Health Insurance Schemes (CBHIS) was not implemented particularly in Kano state and other Northern States where it is much needed. This study aimed at identifying how the implementation of CBHIS would ensure the actualization of NHIS major objectives, the challenges affecting its implementation and the politico-economic implications of both these challenges and the scheme itself. Mixed method approach where both qualitative and quantitative data were utilized. The qualitative data was obtained from in-depth interviews with relevant stakeholders such as traditional, religious, women and Youth leaders. The National Health Insurance Agency officials, Health Management Organizations and Civil Society Organizations were also interviewed. Quantitative data was obtained through the administration of questionnaires to healthcare enrollees of the NHIA and the Leaders of selected community based associations in the State. Quantitative data was analysed using frequency and percentage tables and qualitatively through selected themes relevant to the study. Findings revealed that the health situations of many in the communities are ravaged by many challenges ranging from inadequate finances (poverty), proximity issues, poor road networks, poor state of health facilities, inadequate drugs, adverse government policies, inadequate support from the government, lack of knowledge on the Islamic position of insurance among others. Additionally, findings revealed that the CBHIS is built on the premise of reducing existing gaps of inequality in access to quality healthcare and a financing strategy, yet its implementation is blurred by numerous challenges such as poor awareness about the scheme, low level of acceptance, poor government commitment, lack of trust on both government and board of trustees on the part of community members among others. The study concluded that, CBHIS would have served as the best health financing option that would strengthen community support for health care needs of members and help accepting health care financing as a collective responsibility of government and the community. Recommendation (s)

Keywords: Community-Based, Health Insurance Schemes, Health Care Service Delivery, Kano state

1.0 Introduction

The global convergence on the need for countries to achieve Universal Health Coverage (UHC); which compels health systems to provide both accesses to health services as well as financial protection against high cost of out-of-pocket expenditure has agitated (change this word) both low- and middle-income countries to device more sustainable revenue sources that would finance health care services (Wright & Schellekens, 2013). Like other governments, the Nigerian government adopted the National Health Insurance Scheme (NHIS) which was enacted in 1999; to ensure equitable access to quality health care and reduce health care cost through various programs in the formal and informal sectors. Since its inception in 2005, only the formal sector program has been fully implemented. While the informal sector schemes like the Community Based Health Insurance Scheme (CBHIS) was not implemented in many states in the northern part of Nigeria after more than 15 years of NHIS operations. Despite the importance of CBHIS to the poor and low-income earners within the informal sector, implementing the scheme in Kano is still a mirage. Thus, when compared with the southern part of the country where CBHIS is fully operational and successful, it is more than high time for implementing the scheme in Kano and other northern states. Thus, indicating that there is disparity in terms of the availability of health facilities and access to services across the regions and rural areas, with the North being most affected (Aregbeshola, 2017). It is against this back drop that this study was conducted to examine and advocate for the implementation of CBHIS in Kano metropolis so that the experience and benefits could later be extended to other parts of the state and could also serve as a tool for emulation by other states in the North-western part of Nigeria.

2.0 Problem Statement

The comatose nature of the Nigerian health system, ravaged by numerous operational and administrative crises, had necessitated the establishment of National Health Insurance Scheme (NHIS) as one of Nigerian government's health reform measure aimed at securing better health care for Nigerians. However, in Kano state and most of the northern part of Nigeria only the formal sector insurance scheme was fully operational while the informal sector scheme of NHIS like the Community Based Health Insurance Schemes (CBHIS) has not been implemented or rather neglected despite its benefits.

Although implementation of programs like the CBHIS under the NHIS for the informal sector especially in the Northern region has numerous advantages to people at the grass root, nevertheless, Kano state and specifically Kano metropolis been the most populous city with a population of 4,103, 000 (NBS, 2021) is yet to implement CBHIS. This is because Kano state lacks the advantage of group existence that could be used for the creation of CBHIS compared to other states in the southern regions where numerous associations either tribal, religious, trade and other exist. This also creates disparity in the operation of CBHIS between the North and other regions. A review of existing literature on CBHIS in Nigeria shows that studies are limited to other geo-political zones which explains the dearth or non-existence of CBHIS in Kano and other Northern states (Udeh et al, 2016). These gaps have necessitated a

study like this that will investigate the possible implementation of CBHIS so as to extend access to quality health care services to especially community members who cannot afford such services. Therefore, this study generated the following research questions in line with its objectives.

i. What are the major challenges faced by community members in obtaining quality health care services in Kano metropolis?
ii. Are community members in Kano metropolis aware of the operations of the NHIS and CBHIS?
iii. What are the major benefits of CBHIS to community members in Kano metropolis?
iv. Can CBHIS be implemented in Kano metropolis?

3.0 Objectives of the Study

The aim of this study was to look at the possibilities of implementing CBHIS in some selected local governments of Kano metropolis considering its immense importance and benefits to the poor people. The objectives of the research were:

1. To identify the major challenges of obtaining quality health care among communities in the study areas.
2. To create more awareness about operations of the NHIS among community members in the study areas.
3. To identify the major benefits of CBHIS to community members in the study areas.
4. To find out possibilities or otherwise of implementing CBHIS in Kano metropolis.

4.0 Literature Review

4.1 Community Based Health Insurance (CBHI)

Community Based Health Insurance (CBHI) isperceived byAdinma and Adinma, (2010) as health insurance in which individuals, families, or community groups finance or co-finance costs of health services. Similarly, Donfouet&Mahieu, (2012) sees CBHI asa novel idea for offering both financial protection against the costs of disease and improving access to high-quality health care for low-income households coupled with the informal sector that are not protected by formal insurance. In Nigeria, Riman, (2012) considered CBHI as an effective means that protect the poor and vulnerable from the catastrophic burden of financing health services. When fully implemented, CBHI has the potential to address the problem of inadequate funding of the health system (Ijeoma, Adebayo, Babatunde&Angela, 2019).

On the other hand, CBHI scheme according to Carrin, Waelkens and Criel (2005) and Njoroge and Haron (2014)is a non-profit health insurance program for a cohesive group of households/individuals or occupation-based groups, formed based on ethics of mutual aid and the collective pooling of health risks in which members take part in its management. CBHIS being one of the Informal sector health insurance programs of the National Health Insurance Scheme was established by ***Act 35*** of the 1999 Nigerian constitution. Therefore, the scheme operates on the principal aim to reduce the high dependency on out-of-pocket (OOP) payments which accounts for more than 65% of all health expenditures in the form of user

charges and co-payments, which disproportionately affect the poorest in society and has been recognized as an important tool for making health care affordable among the poorest population.

The remaining part of this review provided lenses for understanding specific issues of health care situation and the rationale of implementing the Community Based Health care Insurance Scheme in Kano metropolis. To justify this position, the literature review was streamlined along the main objectives of the study.

4.2 The challenges of accessing quality health care

The Nigerian state in question is one of the largest and resourceful among many African states. Tracing its history from the forceful amalgamation of 1914, explains the nature of its diverse and irreconcilable differences among over four hundred ethnic groups of the state (Otite, 2000). The patterns of exploitation witnessed during the colonial history of the state escalated to the present post-colonial period with uncontrollable consequences. The spillover effects reshaped the state affecting its capacity to discharge its functions and responsibilities, especially of welfare issues to drive the country towards development. While it is characterized as a politically unstable and economically underdeveloped state as evidenced by over two thirds of its population living in poverty (United Nations (2005) and UNDP (2004)) the historical antecedents of colonialism, post colonialism and the wave of globalization, are the driving forces for its present condition. The internal (re)???structuring of the state is responsible for the reoccurrence of diverse ethnic and other identity- based conflicts, political instability, prolonged military rule alongside endemic socio-economic problems ranging from poverty, unemployment, corruption, crimes, insecurity, and the rise of different militia groups orchestrating all forms of crises on the state (Osaghae 2007, and Adejumobi, 2005).

However, considerable disaffection with the expanded role of the state globally occurred in the 1980's which led to its reassessment and a change in its role towards the supposed welfare function. The argument posed against the state was a bloated and inefficient public sector, mounting government indebtedness and spiraling public expenditure despite the state's control over important areas of the economy. As a way forward, series of reform agenda were introduced. The reforms were based on the liberalizing agenda of trade which involved the selling off publicly owned industries and corporations, deregulating utilities, curbing public expenditure, devaluation of currency among others. The reform measures were introduced to governments of developing countries especially in Africa through the global financial institutions; International Monetary Fund (IMF) and World Bank. The governments were accused through various claims of the state's failure in terms of administration which has rendered it unresponsive, unaccountable, undemocratic, and corrupt. These governments were forced to reduce their deficits and control public expenditure by implementing the Structural Adjustment Programmes (SAP) and utilizing the loans and grants accrued from the pacts. In return, the governments promised a reformation of their economies principally through privatization and by reducing the involvement and responsibility of the state particularly in service provision. In Nigeria, SAP has resulted to

monstrous deterioration in the living conditions of people, a continuous reversal of the economy in terms of development, increased pool of indebtedness, and a barrage of other inherent consequences, coupled with the tides of forces of globalization, the Nigerian state has become fragile and susceptible to all forms of encroachment in terms of its sovereignty. The imposition of SAP in Africa has had detrimental effects on most economies as they are faced with the worst forms of structural crises, increased debts, poor macro-economic performance, inability to satisfy the basic social needs of the people as well as collapse of the education and health systems. The changing role of the state shaped by the neo-liberal economic agenda has affected the health sector greatly, because the decade marked a global turn against the state in favor of the market. The anti-state, pro market philosophy argued for the poor performance of the public sector, claiming its characterization by costly and overstaffed bureaucracies, providing services in dilapidated facilities. These trends were reflected in the health sector and thus, led to the movement for health sector reforms (Olukoshi, 1993, Naiman and Watkin 1990).

4.3 Rationale of the Community Based Health Insurance Scheme

The need for newer forms of healthcare financing in order to reduce the burden of high cost for health care services to attain the goal of Universal Health Coverage, the Community Based Health Insurance Scheme emerged as one of the informal sector program of the NHIS (Ogben and Illesanmi, 2018). The CBHI is a non-profit health insurance program for a cohesive group of individuals, households, or occupation-based groups, formed based on ethics of mutual aid and the collective pooling of health risks in which members take part in its management. Government and communities' world over have been implementing CBHIS because of the hope that it will end health inequality especially in the rural part of most regions while serving to enhance the welfare of citizens in the society. In Nigeria, it is one of the informal sector strategies of the NHIS to cater for the health needs of low-income people because every government is concerned with measures to maximize welfare, which is perceived to be a non- profit motivated services but aimed at satisfying basic needs of the less privileged provided by individuals, group or government (Dolgoff, 2012). It is social when the services are articulated for group and community interests for the purpose of improving the living conditions of the citizenry. This correlates with the opinion of Richard (2012), which saw social welfare to involve those non-profit functions of the society, public or voluntary organizations that are clearly aimed at alleviating distress and poverty or ameliorating the conditions of casualties of society. This corroborates with the concept of policy implementation which encompasses all actions by public and private individuals or groups aimed at achieving targeted objectives (Howlett and Ramesh, 2003). The interconnectivity of concepts in this study; makes the adoption of "Multi-actor" implementation framework suitable because of its focus on the need for decentralization of responsibilities, partnerships and restructuring of accountability relationships in service delivery. Multi-actor implementation framework is a strategic approach that involves the collaboration of multiple actors or stakeholders to implement a specific policy, project, or program. This framework emphasizes the involvement, communication, and coordination of various actors such as government agencies, non-profit organizations, private sector entities,

and community groups to achieve common goals (Ansell and Gash, 2007). Since quality is the watch word of the scheme, the framework is people centered; implying people, communities and other groups must be engaged in the design, delivery and ongoing assessment of the health services. This will go a long way in checkmating the activities and actions of other core actors who either have a political or commercial interest. This is possible through building collaborations with non-governmental organizations or other civil society groups as well as grassroots community groups. It is in line with this frame work the research engages many community groups who represent the various interests and perceptions of people in the community/LGAs under study.

4.4 Idealization of quality Health Care

Quality does not occur automatically but requires planning, determination, and commitment. The concept is clearly identified as a priority of universal health coverage, along with access, coverage, and financial protection. Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. This perception that quality of care can be measured, is ultimately aimed at health improvements rather than simply increasing service inputs or refining system processes, and should reflect the desires of key stakeholders, including service users and communities. More often, quality is perceived as a luxury that only rich countries can afford. This is a fallacy, building quality health services requires a multi-dimensional approach such as culture of transparency, community engagement, and openness about results.Technological innovation also plays a key role in offering new ways to expand high-quality health care services more rapidly, and at an affordable cost. These are possible in all societies – regardless of their income level. However, substandard care wastes significant resources and harms the health of populations, destroying human capital and reducing productivity. Quality health services not only prevent human suffering and ensure healthier societies, but they also ensure better human capital and healthier economies (Institute of Medicine, 2021). In a study conducted by Yakasai (2022), "quality" is perceived as a relative and multi-dimensional term. It involvesmanyvariables such as accessibility, functionality of the services, level of professionalism among the personnel and sustainability of the services. Invariably, quality encompasses fairly standard services that are in line with the best practices and services that one can be proud of as such services are effective in addressing one's medical problems.

5.0 Methodology

5 .1 Research Design

Considering the challenges affecting the implementation of CBHIS and the political economy implications of both these challenges and the scheme itself the main aim of this study is identifying how the implementation of CBHIS would ensure the actualization of the major objectives of NHIS. Therefore, the study used Exploratory Sequential Design in a mixed method approach in which both qualitative and quantitative approaches of data collection and analysis were utilized. In this design the qualitative will drive the quantitative data; thus, the quantitative data is used to complement the qualitative data.

5.2 Population and Target Population

The main population of the study comprises of all the people who live in the eight Local Government Areas of Kano Metropolis. In 2021, the National Population Commission (NPC) and National Bureau of Statistics (NBS) reported that the eight Local Government Areas of Kano Metropolis were estimated to have a population of 4,103, 000 people. But the target population of the study consisted of only the people who utilized health care services within Kano Metropolis. However, identifying the exact target population for the current research proved difficult as getting the accurate, up-to-date list of all the health care service utilizers within the metropolis was not feasible because of the significant in and out movement of the health care service seekers and delays in updating records from the side of health care providers (hospitals).

5.3 Sample and Sampling Techniques

Since the exact target population is not clearly known, this study used a multi-stage sampling technique in the selection process. The first stage is the identification of the local government areas in the metropolis which comprises 8 LGAs. Three (3) LGAs were selected purposively to represent 8 LGAs of Kano Metropolis, the selected local government areas are Fagge, Gwale, and Ungogo. Fagge local government was selected because of its highly cosmopolitan nature compared to other LGAs, Gwale was also selected for exhibiting the characteristics of a truly communal lifestyle while Ungogo was selected for having both rural and urban characteristics. The enrollees were selected using random sampling and they were issued with questionnaires in the facilities where they enrolled, the selection of health facilities was also randomly done. The community leaders were selected using purposive sampling for in –depth interviews (IDIs).The selection of Community Based Association (CBOs) and other Civil Society Organizations was randomly done using the list obtained from the Ministries of Youth Development, Commerce and Rural & Community Development. In addition, operational Agencies and HMOs were also purposively selected as they provided the relevant information to enrich the study.

5.4 Method of Data Collection

The mixed methods approach was utilized in the study for the collection of data and findings are very much relevant to the research. Therefore, both qualitative and quantitative data were collected. Firstly, the quantitative data from the health care service utilizers and members of CBOs using survey questionnaires were collected. The Questionnaires were administered to members of CBOs and enrollees. In this regard, 153 usable questionnaires were obtained from members of CBOs and 222 were obtained from NHIS enrollees. For the qualitative data, the study conducted IDIs with stakeholders at the operational level which comprises of key decision makers in those agencies responsible for implementation of the scheme as well as traditional and CBO leaders.

6.0 Analysis of Findings

Table 4.1 below provides responses from members of CBOs on **t**he major problems or challenges that prevented community people within Kano metropolis to strive to attainquality health care.

Table 4.1 Major problems preventing the attainment of quality health care

Options	**Frequency**	**Percent**
Lack of qualified personnel	25	16.3
Insufficient funds	70	45.7
Non availability of drugs and other services/equipment	14	9.2
Corruption	33	21.6
Favouratism	5	3.3
Others	6	3.9
Total	**153**	**100.0**

Source: Survey Research

Findings from Table 4.1 on the questionnaire administered to members of community based organizations with regards to the major problems that prevent community people in the attainment of quality health care indicated that 25 respondents representing 16.3 opined that lack of qualified personnel is one of the major problems that prevent community people from attaining quality health care, while 70 respondents representing 45.7 considered insufficient funds as the major problem. Also 14 respondents representing 9.2 believed that the main problem is non- availability of drugs and other services/equipment. Again, 33 respondents representing 21.6 believed that the main problem is corruption while 5 respondents representing 3.3 believed that the main problem is favoritism. Also, 6 respondents representing 3.9 opined other reasons apart from those mentioned.

Consequently, responses from the interviews withother stakeholders on identifying the major challenges community members face in accessing care, corroborated the quantitative findings as indicated by the following: *"Among the major problems is lack of proper consideration by the health personnel especially the doctors, as they hardly attend to patients on time even in an unconscious state"* (KN-FGE-WL-CM-IDI-2022). In a similar response, it was also attested that: *"Poverty is the major challenge in accessing healthcare need in our community, some people they do not go to hospital because they are traditionalists, they only accept native medicine and consult native doctors"* (KN-FGE-RL- CM-IDI-2022). However, another interviewee also said, *"the major problems are access to quality drugs, these drugs are not free, and most people can't afford. Also lack of access to quality health care and attention by the health personnel because of poverty among people"* (KN-GWL-RL-CM-IDI-2022). In a similar submission, otherrespondents opined that *"The most ravaging problem is financial difficulty. So many people are having health issues, but they don't have the means to get cured. Secondly, even if there is government intervention at the federal or state level, it does not reach the grass root. Thirdly, lack of community hospitals or health facilities except*

for one in KofarNaísa which is not even well functioning. The best treatment you can get for any ailment is Paracetamol which is being donated by concerned individuals not the government. (KN-GWL-WL-CM-IDI-2022). Furthermore, *"Lack of awareness and another most serious challenge is poverty, so they cannot afford any medical services because of poverty"* (KN-GWL-YL-CM-IDI-2022), were part of difficulties for community members to access care when needed. Finally, another interviewee said, *"To be honest, in this community majority of our people are poor. Therefore, paying for our healthcare need is very challenging. Again, proximity to specialist hospital in the main city is not always easy. Our small heath facility which is nearby cannot adequately address most of our healthcare needs properly"* (KN-UNG-RL-CM-IDI-2022). The above responses signified the numerous barriers/challenges such as poverty, inadequate hospital facilities, inadequate qualified personnel, proximity, insufficient drugs, and poor government interventions affecting community members to access health care when needed.

Table 4.2 Awareness on how Community Based Insurance Scheme operates and its requirements.

Options	Frequency	Percent
Yes	12	7.8
No	141	92.2
Total	**153**	**100.0**

Source: Survey Research

Table 4.2 above indicated that majority of respondents 141 representing 92.2 percent said they are not aware of how Community Based Insurance Scheme operates/or its requirements, while the 12 remaining respondents representing 7.8 percent said they are aware of how Community Based Insurance Scheme operates/or its requirements.

Accordingly, regarding knowledge and awareness about the scheme, findings from the qualitative research provides in-depth explanations.One interviewee acknowledged that: *"Lack of awareness and the knowledge of the benefits of the scheme. Government can go to religious places like mosque, in wedding gathering or naming ceremony for awareness this will facilitate accepting the scheme and engage in mobilizing other community members to participate in the scheme"* (KN-FGE-RL-CM-IDI-2022). Re-emphasizing the low-level of awareness about the scheme another interviewee affirmed that: *"Honestly, I'm not aware about this CBHIS. It is from you nowthat I heard about it"*(KN-FGE-TL-CM-IDI-2022).

In another submission echoing the lack of publicity of the scheme it was stated that, *"Ours as HMOs is to market it but actually it needs government intervention to create awareness among the populace and enlightenment"* (KN-HMO2-SA-IDI-2022).

Table 4.3 Reasons for enrolling with the NHIS

Reasons For Enrolling	Frequency	Percent
Reduce out of pocket expenditure	13	5.8
Access to quality health care	137	60.9
Flexibility to choose health care facility	45	20.0
Increase willingness to access care from health facilities	27	12.0
Total	**222**	**100**

Source: Survey Research

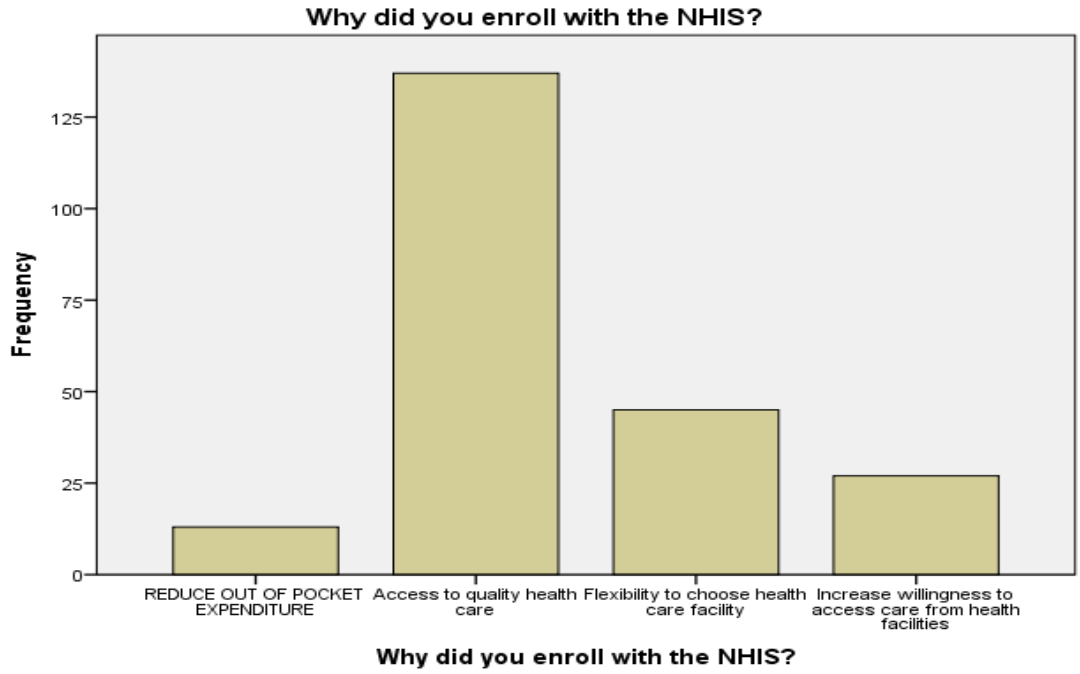

Figure 4.1: *Reasons for enrolling with NHIS*

Table 4.3 and figure 4.1 above, revealed that 13 respondents representing 5.8% enrolled into NHIS because the program reduced out of pocket expenditure. But 137 respondents representing about 62% enrolled because the program provides access to quality health care services. Also, 45 enrollees representing 20% joined the NHIS because the program offered flexibility of choosing health care facility. Additionally, 27 respondents representing 12% enrolled because ofincreased willingness to access care from health facilities.

On the other hand, findings from interviews with NHIS officials, HMOs and CSOs revealed that the rationale for the introduction /implementation of CBHIS was highlighted by a state agency as was emphasized, *"CBHIS is a program introduced long ago by NHIS as an authority to take insurance coverage to the grass-root with the view that most of the population in Nigeria constitutes about 85% of the informal sector. That is why the issue of CBHIS was introduced by the management of NHIS",* (KN-NHIA-DMP-IDI-2022). In

corroboration, another interviewee representing a perspective of the HMOs opined that, *"In the business of health care financing we call it the informal sector health insurance in which we engage people from market associations, transport associations, union workers as well as other organizations and associations within the community…we develop a plan as well as funding and financing scheme suitable for their low income so we can engage every organization relative to their own income, the structure of that organization and also the family structure…*"(KN-HMO1-DA-IDI-2022). The later view however provided another dimension of the scheme's rationale as it represents a health financing insurance that takes into cognizance suitability for the people it is meant for, especially in terms of cost (contribution), thus a means to reduce the gap of inequality in accessing health care between the high- and low-income members of the community. In addition, introduction of such program or scheme will promote the spirit of self-help and mutual support among community members as was indicated, *"…so the people at the community base cannot afford the health care, so the foundation of it all is to see how one member of the community can help the other, they can be dependent even though they are independent as individuals"*(KN-HMO1-DA-IDI-2022). Complementing this assertion is another response:*"CBHIS is a programme developed by federal government to provide health insurance coverage to communities, to provide universal coverage of health insurance in the country. It provides for the health needsof people that are living in the rural areas, people that are not working in the formal sector and people that are less privileged in the society. Thus, it is meant for all the people living in the communities like retirees, KekeNAPEP riders, market associations and the people in non-formal sector"* (KN-HMO2-SA-IDI-2022). Another perceived its rationale as*follows: "is to ensure the health needs of the citizens for them to easily access health services in the country without any hitches. It serves as the only mechanism bridging gaps between haves and haves not, where the salary earner of 30,000 naira will enjoy the services of the salary earner of 80,000 naira or even more"* (KN-CSO1-DGSI-SA-IDI-2022). The submission made here signifies that the scheme is a measure to bridge inequality especially in terms of income distribution as equal treatment or services would be provided to everyone in the society irrespective of economic or social status. In terms of coverage, the scheme was designed to cater for the health needs of people at the community level as was contained in the statements made by staff of the NHIA, *"initially it was designed to cover only community people…*" (KN- NHIA-DMP-IDI-2022).

Table 4.4: Experience of the NHIS Programme

Experience of the scheme	Frequency	Percent
Not very satisfactory	43	19.4
Not satisfactory	31	14.0
Neutral	18	8.1
Satisfactory	70	31.5
Very satisfactory	60	27.0
Total	**222**	**100.0**

Source: Survey Research

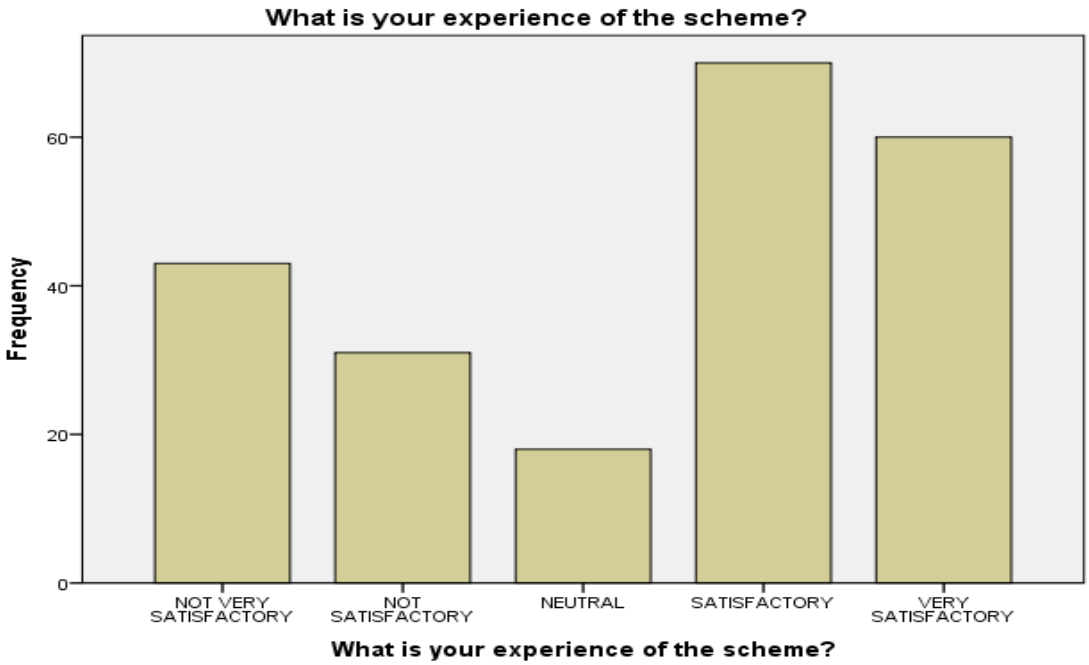

Figure 4.2: Experience of the NHIS programme

On the respondent's experience with NHIS scheme, Table 4.4 above revealed that 43 NHIS enrollees representing 19.4% were not very satisfied and 31 NHIS enrollees representing 14.0% were also not satisfied. But 18 NHIS enrollees representing 8.1% chooses to be neutral. On the other hand, 70 respondents representing 31.5% were satisfied and similarly 60 NHIS enrollees representing 27.0% were also satisfied with their experience with NHIS scheme.

Table 4.5: Major benefits of enrolling with the NHIS

Major benefits	Frequency	Percent
Reduce out of pocket expenditure	30	13.5
Access to quality health care	81	36.5
Flexibility to choose health care facility	45	20.3
Increase willingness to access care from health facilities	55	24.8
Others (specify)	11	5.0
Total	**222**	**100**

Source: Survey Research

Table 4.5 above, revealed that 30 respondents representing 13.5% enrolled into NHIS because the program reduced out of pocket expenditure. But, majority 81 of respondents representing about 36.5% enrolled because the program provides access to quality health care services. Also, 45 enrollees representing 20.3% joined the NHIS because of the program offered flexibility to choose health care facility. Additionally, 55 respondents representing 24.8 % enrolled as a result of increased willingness to access care from health facilities. Lastly, 11 respondents representing 5.0% enrolled into the program in order to enjoy other benefits different from those listed.

Table 4.6 Acceptance of the scheme by members of the community or Associations

Options	Frequency	Percent
Yes	89	58.2
No	64	41.8
Total	153	100.0

Source: Survey Research

On whether other members of the community or Association would accept the scheme or not, 89 respondents representing 58.2 percent said yes, while the remaining 64 respondent representing 41.8 said no they will not.

Table 4.7 Factors preventing people from accepting the Scheme.

Options	Frequency	Percent
Lack of awareness about the scheme	80	52.3
Misperception of the scheme	30	19.6
Social norms	25	16.3
Mistrust of funds trustees	13	8.5
Others	5	3.3
Total	**153**	**100.0**

Source: Survey Research

On what factors the respondents think may prevent people from accepting the CBHI scheme, 80 respondents representing 52.3 percent said lack of awareness about the scheme, while 30 respondents representing 19.6 percent said misperception of the scheme. also, 25 respondents representing 16.3 percent said social norms is the main factor and 13 respondents representing 8.5 percent considered mistrust of funds trustees as the major factor. lastly, 9 respondents representing 5.9 percent said other factors not mentioned here may prevent people from accepting CBHIS.

Findings from interviews discovered that although people are willing to accept the scheme yet there exist some problems. First, *"The program is yet to be implemented for so many reasons talk less of identifying its major benefits or otherwise. The issues of CBHIS came with a lot of requirements. This is what poses problems to the communities. The problem is that issue of CBHIS lack of proper awareness, lack of willingness, willingness from part of the people to pay and lack of much commitment from the government to fully sensitize people from the grass root to understand the concept of what health insurance is all about and viz a viz the problem of non-challant attitude of our people alongside other factors like culture, religion and other peculiarities…"*(KN-NHIS-DMP-IDI-2022).The assertion above explains the complexities enshrined in implementing the scheme. Considering the rationale for its establishment it is not wrong to conclude that the objective has been lost despite the immense benefits it will bring to people at the grass root. The submission also attested to the need for more commitment/political will of government and collaborative effort of community engagement to leverage the hitches preventing successful implementation. While buttressing some of the factors that may affect implementation of the scheme, a response was that *"Poverty, lack of trust, how to form board of trustee as they may think that their contributions might be squandered by the community association officials"* (KN-FGE-TL-CM-IDI-2022). Another added, *"Resistance, Ignorance, Religious factors and Financial constraints"* (KN-CSO2-PM-SA-IDI-2022). Similarly, *"Lack of awareness, abject poverty and lack of sincerity from the government"* (KN-CSO1-DGSI-SA-IDI-2022), were other factors considered to affect acceptance or implementation of the scheme. Closely related to the challenges are, *"Lack of cooperation among the community members, lack of enlightenment from the side of government and endemic poverty among the community members"* (KN-HMO2-SA-IDI-2022). In essence, this is also responsible for low or non-acceptance of the scheme by community members. In corroboration, one respondent opined that, "*local believe, lack of adequate knowledge, and financial constrains are contributory reasons for non- implementation of the scheme in many communities such ours"* (KN-UNG-RL-CM-IDI-2022)

Table 4.8 Role of the community members in ensuring smooth operation of the scheme

Options	Frequency	Percent
Acceptance	61	39.9
Enlightenment	44	28.8
Support	32	20.9
Others	16	10.5
Total	**153**	**100.0**

Source: Survey Research

With regards to the role of the community members to ensure smooth operation of the scheme, 61 respondents representing 39.9 percent considered accepting the scheme while 42 respondents representing 28.8 percent said enlightenment. Additionally, 32 respondents representing 20.9 percent said support and 20 respondents representing 12.9 percent said other options not provided here "…will ensure smooth operation of the scheme".

Qualitative data also provided what community members will do to ensure smooth operation of CBHIS. The basic criteria for implementation as asserted was that *"First criteria are that you have to be a member of an organization, secondly you must have a source of income weather it is daily, weekly or monthly and lastly you must be willing to pay for this"* (KN-HMO 1-DA-IDI-2022). A more detailed submission on the requirements for establishment was provided by the regulatory agency where it was acknowledged that"…*It takes into considerations other issues, other factors like (1) for a community to key into CBSHIP it must come in group of 10 to 1000… 2) they must also elect what is known as a board of trustees. 3) They must have a bank account. They must register with all relevant registration bodies at local, state, and federal government levels. They must also have an office. They must also have access to ICT. These are some of the challenges that delay in the implementation of the program. Coupled with this we have other peculiarities like poverty…as they are required to make a monthly contribution of 300 Naira per head of those 1000 people. Under this program also the minimum package is primary care only"* (KN-NHIA-DMP-IDI-2022). The above assertions clearly pointed out the necessity of community-based associations as important corner stones in the establishment of community based health insurance scheme.

On the specific roles communities and Community Based Associations would play to facilitate the scheme's implementation in selected communities, responses from interviews were that "*If associations like ours collaborate with government in creating awareness people will accept it and ensureimplementation of the scheme"* (KN-GWL-YL-CM-IDI-2022). Another said, *"We will enlighten the community members about the scheme" (KN-GWL-WL-CM-IDI-2022). Finally, another response assured of "Accepting the scheme and also engage in mobilizing other community members to participate in the scheme"* (KN-FGE-RL-CM-IDI-2022). All the responses signify positive perceptions and readiness to support the scheme's implementation in various capacities, thus serving as cardinal structures

that would facilitate acceptance, implementation, ownership, and sustainability of the scheme.

Additionally, the stance of Islamic position oninsurance was also inquired and responses were as follows:*"yes, it is, because it helps you cut down the cost of your health care and Islam supports anything that will help. I once went for a medical consultation in Dubai and they inquired if I've insured for health and I affirmed that I haven't, they exclaimed that if I had, the cost will be less. It being an Islamic country is evident of its permissibility in the religion"* (KN-GWL-WL-CM-IDI-2022). Another response added, "From religious view, it is an ambiguous matter because it's like refusing fate" (KN-GWL-TL-CM-IDI-2022). In addition, another supported "*religion encourages assistance to one another, if that comes in, then it could be said to be permitted otherwise not"* (KN-GWL-RL-CM-IDI-2022). However, many respondents do not know the stance of Islam on insurance as one pointed *"I'm not an Islamic scholar, this question is better to be answered by Islamic scholar,*" (KN-FGE-TR-CM-IDI-2022). This suggested that there is need for more enlightenment from an Islamic perspective by Islamic scholars to provide an acceptable position on the concept of insurance. This will facilitate acceptance and willingness to key into the scheme by community members. Even though, in Islam, the permissibility of health insurance is a topic of debate among scholars. Some Islamic scholars consider health insurance permissible if certain conditions are met, such as ensuring that the insurance is free from elements of uncertainty (gharar) and exploitation (ghasb). They argue that health insurance can be seen as a form of pooling resources to help cover the costs of medical treatment, which aligns with the principle of cooperation (ta'awun) in Islam. Therefore, fatwas (rulings) on insurance from renowned sources in Islam varies depending on the school of Islamic thought. Some Muslim scholars believe that certain forms of insurance may be permissible in cases of necessity, while others consider any type of insurance involving elements of riba (interest) or gharar (uncertainty) to be impermissible according to Islamic law (sharia). For example, the Islamic Fiqh Council of the Muslim World League has issued a fatwa stating that conventional insurance involving elements of uncertainty (gharar) is not permissible. However, they have also recognized the need for certain types of insurance, such as health insurance and car insurance, in specific circumstances (Ainul, 2021).

7.0 Conclusion

Based on the findings of this study, it is concluded that Community Based Health Insurance scheme represent a buyable option of financing health care at community level with minimal cost. It would also serve as a medium for collective ownership of health care responsibility among community members, while complementing the effort of government to ensure delivery of quality health care to the populace. Thus, CBHIS if implemented in Kano metropolis would serve as the best health financing option at community level that would strengthen community support for health care needs and help in accepting health care financing as a collective responsibility of government and the community. However, the degrees of challenges surrounding its knowledge and awareness constitute setbacks to its implementation. Even though community members demonstrate preparedness in accepting

the scheme, poor knowledge about the scheme especially on the religious position makes members skeptical about accepting and mobilizing for the schemes' establishment in their communities. Thus, employing a multi-faceted strategy of involving other stake holders and more government commitment would go a long way in smoothing the path for successful implementation of the scheme in the study areas and beyond.

8.0 Recommendations

Government

- There is need for the government to be more committed in implementing the informal sector programs such as the CBHIS.
- Establish partnerships with Civil Society organizations and media to create more awareness campaigns at community levels about the scheme.
- Organization of town hall meetings with stakeholders at community levels to educate them on the need for collaboration.
- Politicians and other government officials can also champion the course of investing in the scheme as a form of support for their communities.

Community Based Associations

- CBAs need to revive functionality of the associations through making members more responsive to the attainment of collective needs like health care.
- Organize mass sensitization for members on the benefits of the scheme to the members and community at large with the aid of relevant authorities.
- Engage Islamic scholars to position the scheme within the confines of Islamic doctrine to mobilize support and acceptance for the scheme constantly.

Community Leaders

- Traditional, religious, women and youth leaders should utilize their positions to canvass for support to accept and establish the scheme in their various communities.
- Leaders should educate members on the need to partner with government to finance health care to obtain quality health care for themselves.
- Identify and encourage philanthropists willing to invest for humanity purpose.

Civil Society Organizations/Media.

- Collaborate with government to adequately sensitize community members on the benefits of establishing the scheme.
- Community engagements should take into cognizance feedback from the communities to enable review of the implementation process.
- Organizations dealing with health care delivery should venture into supporting communities to implement the scheme.
- Networking should be encouraged between members of associations and between communities to develop ideas and strategies to implement the scheme.

- The strengths of communities should be identified and leveraged upon to support the establishment of the scheme smoothly.

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