PERCEIVED EFFECTIVENESS OF COMMUNITY-BASED HEALTH INSURANCE SERVICES IN ABEOKUTA SOUTH LOCAL GOVERNMENT AREA OF OGUN STATE, NIGERIA

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ABSTRACT

Community-based health insurance (CBHI) has the capacity to promote access to basic primary health care, reduce unforeseeable or unaffordable healthcare costs and close the health financing gaps. Thus, the study determined the perceived effectiveness of CBHI scheme among beneficiaries in Abeokuta south local government area of Ogun state, Nigeria. A multi-stage sampling procedure was used to select 120 beneficiaries from the five randomly selected wards. Interview schedule was used to elicit information from the respondents. Data were analysed using descriptive (frequency counts, percentages) and inferential (Chi-square) statistics at p=0.05. Results indicate that more than half of the respondents were female (50.8%), married (69.2%), between the ages of 41-50 years (mean age = 47 years) and 51.7% had the family size of 2-4 members. Respondents were averagely educated with more than one third (36.7%) having at least secondary education. Respondents were averagely educated with more than one third (36.7%) having at least secondary education. Healthcare services mostly accessed under the CBHI scheme included education on health ($\bar{x}$ =0.83) and essential drugs ($\bar{x}$ =0.81) needed by patients during and after hospital admissions However, services like Expanded Programme for Immunization and Maternal and Child Health including responsible parenthood were found to be the least available services. Nonetheless, beneficiaries considered low level of education in decision making as a serious constraint to effectiveness of CBHI services. Respondents' level of education (χ^2= 11.575) and occupation (χ^2= 11.4321) were significantly related to the beneficiaries' perceived effectiveness of CBHI services. Community sensitisation and public education on CBHI scheme through the mass media will ensure healthy lives and promote the well-being for all at all ages.

Keywords: Health Insurance, Health services, Community health, Health care

INTRODUCTION

Community-based health insurance (CBHI) is an increasingly recognised tool to finance health care provision in the rural communities which constitutes about 70 per cent of the Nigerian population (NHIS, 2005). Given the latent demand from people for health care services of a good quality and the extreme underutilization of health services in almost all rural communities within the country, community-based health insurance programmes have been designed to apply the principles of insurance to the social context of communities, guided by their preferences based on their structures and arrangements.

The health sector in Nigeria in general is a concurrent responsibility of the three tiers of government (Federal, State and Local) (NHIS, 2008). Like every other sector in Nigeria, it has been faced with daunting challenges of accessibility and affordability. Hence, healthcare services delivery has been negatively impacted by the challenges with serious implications for accessibility of quality services rendered in health centres across the nation and by extension, the quality of health care service delivery (NHIS, 2004).

While it is an acknowledged fact that wide varieties of services are provided in health centres and more services are being integrated from time to time, lack of resources to access these services has made the optimum utilisation of services a mirage. The programme is created to ensure adequate and affordable healthcare for registered users (CPPA, 2013). This means directly paying for medical consultation, drugs and other health procedures. The huge personal commitment has severe implications on personal finance and may force people to reduce spending on food and other basic needs in order to meet basic and important healthcare needs.

This therefore, led the federal, state and local governments to implement the use of Community-based health insurance which is a system designed to provide for the health needs of people especially the rural communities and the informal sector. It is a programme created to ensure adequate and affordable healthcare for registered users (CPPA, 2013). The CBHI requires financial commitment from intending users, either monthly, quarterly, or annually, to the facilitators of the programmes.

The community-based health insurance scheme in the study area tagged '*Araya'* (which means 'good health') was established in 2013. It is expected to help attain the Sustainable Development Goal (SDG) 3 meant to ensure healthy lives and promote well-being for all at all ages. The health plan under the scheme covers primary healthcare, chronic disease treatments, maternity care including caesarean sections, child care, dental care, surgeries etc. Both public and private healthcare providers are partaking in the scheme. Improving the quality of the healthcare services at these facilities is a central aspect of the *Araya* CBHI scheme (Safe care, 2014).

Nonetheless, so far, the effectiveness of the CBHI scheme has not been totally ascertained. This is due to the fact that the majority of the population in Nigeria at large (especially in the rural areas and the informal sector) still cannot use the healthcare services they need. This is partly because the services are not available or the direct out-of-pocket payments that are needed at the point of care prevent them from having access (Tarry, 2012). It is against this background that this study attempted to determine the perceived effectiveness of community-based health insurance in Abeokuta south local government area of Ogun State, Nigeria by providing answers to the following research questions:-

1. What are the personal characteristics of beneficiaries of CBHI?
2. How accessible are CBHI services in the study area?
3. What is the frequency of access to CBHI services in the study area?
4. How affordable are CBHI services in the study area?
5. What are the challenges faced in the course of using the CBHI services?

METHODOLOGY

Study area - The study area is Abeokuta south local government area of the state. It is located at the coordinates 7°09′00″N 3°21′00″E (NPC, 2006). It has a population of 250,278 people and land area of 71 sq km². It is bounded in the south by Lagos state and in the north by Oyo and Osun states, in the east by Ondo state and in the west by the Republic of Benin. Agriculture is the main occupation of the rural people with cultivation of crops like cassava, millet, cocoa, maize, yam, rice, plantain, palm produce, cashew and so on. A reasonable segment of the populace comprises traders and artisans. Other occupations of the people include hand-weaving, mat-making, tie and dye (*Adire*), soap making, wood carving, among others.

Population of the study – This comprise of all beneficiaries of the community-based health insurance scheme in Abeoukuta south local government area, Ogun state.

Sampling procedure and sample size - Multistage sampling procedure was employed to draw sample. In the first stage, purposive sampling method was used in selecting ten (10) wards out of the fifteen (15) wards in Abeoukuta south local government area due to the concentration of the scheme in the area. In the second stage, Simple random sampling technique was used in selecting 50% (5) wards (Ake 1, Ake 2, Ijemo, Oke- Ijeun, Oke-Ejigbo) out of the ten (10) wards. Finally, in the third stage, simple random sampling was used in selecting 40% of the total number (300 beneficiaries across the wards) of beneficiaries in the selected wards to arrive at 120 individuals interviewed.

Method of data collection: Interview schedule was used to elicit primary data from the respondents.

Measurement of dependent variable

Respondents' Perception of Healthcare Services accessed under CBHI - This was measured with 15 perception statements, which the respondents rated with 5-point scale of Strongly Agree, Agree, Undecided, Disagree and strongly disagree which were used to assign scores. For all positive statements; Strongly agree was assigned (5) points, Agreed (4) points, Undecided (3) points, Disagreed (2) points and Strongly Disagreed (1) point, while all negative statements was scored in the reverse order. Maximum and minimum scores were 75 and 15 respectively. Respondents with perception scores of 35 or less than 35 marks were categorised into unfavourable perception of the effectiveness of CBHI, while those with 36 and above were categorised into favourable perception of effectiveness of CBHI.

RESULTS AND DISCUSSION

Respondents' personal characteristics

Results on Table 1 reveals that 26.7 % of CBHI beneficiaries' age were between the age of 41 and 50 years with the mean age of 47 years. This may be due to the fact that the majority are middle-aged according to the definition of the national health policy document and are approaching the challenging health phase of their lives. According to CPPA (2013), this invariably gives this particular age group cause to be a lot more meticulous about their health. Slightly above half (50.8%) were female, while 49.2% were male. This is an indication that women are likely to seek health care needs particularly on reproductive health services covered by the CBHI (Iyayi, 2007). This can also be attributed to their roles as care givers for child health at the household level (NHIS, 2005).

Table 1 further shows that majority (69.2%) of the respondents were married, while 19.2% were single and 11.7% were either divorced or widowed. This may be due to the fact that single-parent families have a lower financial capacity to accessing health care than couples who co-habit and are likely to share healthcare needs responsibilities. This therefore implies that such families can conveniently afford the premium of the CBHI scheme (Adenusi, 2011). On religion, Christians formed the majority (55.8%), while the Muslims were 44.2%. The indication from the findings implies that understanding the social and religious factors related to the use of healthcare services can influence the choice of CBHI services (Musah and Hudak, 2016).

The information on the level of education in Table 1 reveals that individuals with tertiary education formed majority of the respondents (42.5%). Illiteracy has been reported to negatively impact on the health care service delivery system as it fuels incidence of ill-health and lowers their financial capacity to access the existing health facilities. Invariably, evidence indicates that increasing literacy among people is a viable strategy for improving all major health indices for members of the population. (Iyayi, 2011). On occupation, more (36.7%) of the beneficiaries were civil servants, while very few (0.80%) were farmers. This could be attributed to the fact that the farmers especially in the rural communities of the study area can hardly afford the cost of healthcare services and the often resort to traditional medicine (Yvonne, 2013).

CBHI beneficiaries with family size of 2-4 formed majority (51.7%). This implies that most family heads can effectively maintain a family size of 2-4 individuals. Therefore, it encourages collective enrolments of several families under the CBHI scheme thereby making healthcare services available for every family member (Safecare, 2014). Estimated monthly income in Table 1 shows that 36.7% of the CBHI beneficiaries earned ₦50,000 - ₦100,000 and 60.8% earned ₦10,000 - ₦50,000. The level of income to a large extent could influence affordability of the CBHI services premium.

Table 1: Distribution of respondents by their personal characteristics (N= 120)

Variables	Frequency	Percentage
Age		
Less or equal 20	4	3.3
21-30	16	13.3
31-40	21	17.5
41-50	32	26.7
51-60	26	21.7
Above 60	21	17.5
Sex		
Male	59	49.2
Female	61	50.8
Marital Status		
Single	23	19.2
Married	83	69.2
Divorced	5	4.2
Widowed	9	7.5
Religion		
Christianity	67	55.8
Islam	53	44.2
Level of education		
Non-formal	8	6.7
Primary	17	14.2
Secondary	44	36.7
Tertiary	51	42.5
Occupation		
Farmer	1	0.8
Artisan	29	24.2
Transport worker	8	6.7
Trader	38	31.7
Civil servant	44	36.7
Household size		
2-4	62	51.7
5-7	49	40.8
8-10	9	7.5
Estimated monthly income ₦		
500-10000	3	2.5
10000-50000	73	60.8
50000-100000	44	36.7

Respondents' access to health care services

Response to accessibility of health care services under the CBHI scheme in Table 2 was based on the nine primary health care services (ELEMENTS-P). The results indicate that majority (74.2%) accessed services on locally endemic

disease control such as; diphtheria, malaria and tuberculosis. Furthermore, substantial proportion (67.5%) accessed services on essential drugs needed by patients during and after hospital admissions and education on health (66.7 %). CBHIs is an instrument of social protection targeted towards the informal sector who are often poorest category of the communities. It implies that access to CBHI services would allow the poor to be more risk-taking and thus provide them an opportunity to gradually move out of poverty, while attending to their health issues (Holzman and Jorgensen 2001).

Table 2a: Distribution of respondents by accessibility to healthcare services

Items	Frequency	Percentage
Education on health	80	66.7
Locally Endemic Disease Control such as Dipthera, Malaria Tuberculosis, etc.	89	74.2
Expanded Programme for Immunization (E.P.I)	20	16.7
Maternal and Child health including responsible parenthood	20	16.7
Essential drugs needed by patients during and after hospital admissions	81	67.5
Nutrition Sensitization	30	25.0
Treatment of Communicable Diseases like Schistosomiasis, leprosy and non-communicable diseases like hypertension and diabetes mellitus	40	33.3
Safe water and Sanitation	31	25.8
Provision of emergency treatments	29	24.2

Respondents' distribution on the frequency of access to CBHI Services

Respondents' distribution on the frequency of access to CBHI services in Table 2b revealed that education on health, essential drugs needed by patients during and locally endemic disease control such as diphtheria, malaria after hospital admissions were ranked respectively most frequently accessed services. The Primary Health Care unarguably is the main focus of health delivery in Nigeria. However, the overall performance of the health system in Nigeria can be seen as a direct consequence of the dismal situation at the level of Primary Health Care. Gupta, et al (2004:75) reported in a survey of the situation in some primary health care facilities in Nigeria that simple treatments for conditions such as childhood diarrhoea, which are Oral Rehydration Solution (ORS) sachets, were not available in 70% of the facilities surveyed. Consequently, CBHI services turn out to be the available health services that can be easily accessed for basic health challenges.

Table 2b: Respondents' frequency of access to CBHI services

Service components	NA		OA		AA		Mean	Rank
	F	%	F	%	F	%		
Education on health	34	28.3	73	60.8	13	10.8	0.83	1
Locally Endemic Disease Control such as Diphtheria, Malaria Tuberculosis, etc.	36	30.0	77	64.2	7	5.8	0.76	3
Expanded Programme for Immunization (E.P.I)	99	82.5	13	10.8	8	6.7	0.24	9
Maternal and Child health including responsible parenthood	97	80.8	12	10.0	11	9.2	0.28	8
Essential drugs needed by patients during and after hospital admissions	38	31.7	66	55.0	16	13.3	0.81	2
Nutrition Sensitization	84	70.0	25	20.8	11	9.2	0.39	5
Treatment of Communicable Diseases like Schistosomiasis, leprosy and non-communicable diseases like hypertension and diabetes mellitus	79	65.8	38	31.7	3	2.5	0.37	6

Service components	NA		OA		AA		Mean	Rank
Safe water and Sanitation	83	69.2	23	19.2	14	11.7	0.43	4
Provision of emergency treatments	91	75.8	19	15.8	10	8.3	0.33	7

NA=never accessed, OA=occasionally accessed, AA=always accessed

Affordability of CBHI services by respondents

Table 3 reveals that essential drugs needed by patients before and after hospital admissions was rated the most affordable (mean =1.79), while locally endemic disease control such as Diphtheria, Malaria, Tuberculosis (mean =1.72) was rated second and the least affordable service was nutrition sensitisation (mean =1.40). On the whole, all the services under the CBHI scheme had high affordability level as the mean score was greater than or equal to one in all the services examined. This is consistent with Adenusi (2011) who posited that CBHI facilitates promotes access to healthcare. This can be stimulated through government commitment to stewardship by enabling low income group members to benefit partial or full subsidy from the scheme.

Table 3: Distribution of respondents' by level of affordability of CBHI services

Affordability	NA		SA		VA		Mean	Rank
	F	%	F	%	F	%		
Education on health	3	2.5	43	35.8	74	61.7	1.59	4
Locally Endemic Disease Control such as Diphtheria, Malaria Tuberculosis, etc.	3	2.5	28	23.3	89	74.2	1.72	2
Expanded Programme for Immunization (E.P.I)	2	1.7	45	37.5	73	60.8	1.59	4
Maternal and Child health including responsible parenthood	1	8	48	40.0	71	59.2	1.58	4
Essential drugs needed by patients during and after hospital admissions	1	8	23	19.2	96	80.0	1.79	1
Nutrition Sensitization	5	4.2	62	51.7	53	44.2	1.40	7
Treatment of Communicable Diseases like Schistosomiasis, leprosy and non-communicable diseases like hypertension and diabetes mellitus	4	3.3	38	31.7	78	65.0	1.62	3
Safe water and Sanitation	4	3.3	56	46.7	60	50.0	1.47	6
Provision of emergency treatments	4	3.3	50	41.7	66	55.0	1.52	5

NA=not affordable, SA= slightly affordable, VA=very affordable

Constraints to accessing CBHI services

Results presented on Table 4 indicate that inadequate siting of healthcare centres, long distance to healthcare centres and low level of education in decision making were the major constraints to accessing the services under the CBHI scheme. These are critical variables to utilisation of CBHI services. This in tandem with the study of Ekman (2004) who found that education levels are related with uptake of health insurance programs in the developing world. In addition, Ager and Pepper (2005) found that CBHI users might be deterred from accessing the services if the distance to be covered is too long.

Table 4: Distribution of respondents by constraints to accessing CBHI services

Constraints	Not Severe		Severe		Very Severe		Mean	Rank
	F	%	F	%	F	%		
Lack of awareness of services provided	92	76.7	21	17.5	7	5.8	0.29	5
Poor Promptness in service delivery	109	90.8	8	6.7	3	2.5	0.12	10
Low Level of education in decision-making as regards seeking healthcare	33	27.5	69	57.5	18	15.0	0.88	3
Lack of empathy from service providers	108	90.0	7	5.8	5	4.2	0.14	9
Unaffordability (fees paid) of service	102	85.0	12	10.0	6	5.0	0.20	6
Long Distance to healthcare	34	28.3	53	44.2	33	27.5	0.99	2

Constraints	Not Severe		Severe		Very Severe		Mean	Rank
centre								
Inadequate siting of healthcare centres	29	24.2	62	51.7	29	24.2	1.00	1
Poor patients-doctor relations	106	88.3	9	7.5	5	4.2	0.16	8
Excessively long patient waiting time	105	87.5	6	5.0	9	7.5	0.20	6
Low health worker to patient ratio	101	84.2	14	11.7	5	4.2	0.20	6
Poor sanitary measures	105	87.5	10	8.3	5	4.2	0.17	7
Lack of means of transport and bad roads	53	44.2	38	31.7	29	24.2	0.80	4

Beneficiaries' perception of the healthcare services under the CBHI scheme

Table 5 shows that slightly above half (55.0%) strongly agreed to the statement that information on issues like HIV, family planning and sexual health appears to be easily accessible under the scheme. About 47.5% agreed to the fact that control measures against locally endemic diseases such as diphtheria, malaria, and tuberculosis etc. seems not to be adequately tackled. Respondents with these conditions are more likely to patronize CBHI services before forming this opinion. This is consistent with Weisman and Jutting (2000). They affirm that long-term illness, such as HIV/AIDS and tuberculosis can predispose the vulnerable to risk and shock while attending to their health needs.

Majority (54.2%) agreed that expanded programme for immunization (EPI) is routinely carried for children. About 50.8% strongly agreed to the statement that adequate treatment of non-communicable diseases such as hypertension and diabetes mellitus were covered by the scheme. Generally, beneficiaries were favourably disposed to the CBHI services' effectiveness. This implies that the services could have reduced the burden of out-of-pocket expenditure required to access health services. In line with view, Berman (2000) opined that household expenditure might account for up to 80% of total health expenditures due to high user charges in both public and private hospitals.

Table 5: Percentage distribution of beneficiaries' perceptions on the healthcare services under the CBHI scheme

Perception statements	SA	A	U	D	SD	WM
Information on health issues like HIV, Family planning and sexual health appears to be easily accessible under the scheme.	55.0	40.8	1.7	0.8	1.7	4.47
Control measures against locally endemic diseases such as; Diphtheria, Malaria, Tuberculosis etc seems not to be adequately tackled under the scheme	34.2	47.5	9.2	5.0	4.2	4.03
Expanded Programme for Immunization (EPI) is routinely carried out especially for children under the scheme	34.2	54.2	6.7	5.0	0.0	4.18
The ante-natal care and services provided under the scheme could compete favourably with what is obtainable in the absence of any health insurance	5.0	32.5	58.3	1.7	2.5	3.36
Follow up services after ante-natal looks deficient under the scheme	6.7	11.7	60.0	20.0	1.7	2.98
Post natal appointments are well administered under the scheme	4.2	26.7	64.2	5.0	0.0	3.30
Essential drugs are always available on prescription by doctors	48.3	44.2	2.5	0.8	4.2	4.32
Clients are always compelled to purchase these essential drugs from the health centres' pharmacies	3.3	9.2	5.8	43.3	38.3	4.04
I have neither sighted nor consulted a nutritionist under the scheme	6.7	20.8	63.3	7.5	1.7	2.77
Clients are regularly educated about nutrition issues	5.8	9.2	71.7	10.8	2.5	3.05
Adequate treatment of non-communicable diseases such as hypertension and diabetes mellitus are being offered under the scheme	50.8	40.0	5.0	0.8	3.3	4.34

Perception statements	SA	A	U	D	SD	WM
Adequate healthcare services for communicable diseases such as; leprosy and schistosomiasis are not offered under the scheme	5.8	14.2	66.7	10.8	2.5	2.90
Safe water and sanitation are not guaranteed under the scheme	7.5	42.5	40.8	7.5	1.7	2.53
In spite of the poor water sources, health centres using the scheme strive to provide safe water and sanitation.	12.5	27.5	49.2	8.3	2.5	3.39
The healthcare staff are not often prompt in attending to patients that are covered by the scheme with emergency cases	9.2	11.7	5.0	41.7	32.5	3.77

SA-Strongly Agreed, A-Agreed, U- Undecided, SD-Strongly Disagreed, D-Disagreed, WM- Weighted Mean

Hypotheses Testing

Result of the inferential statistics presented in Table 6 shows that level of education (χ^2= 11.575) and occupation (χ^2=11.4321) were significantly related to the beneficiaries' perceived effectiveness of CBHI services. This consistent with Ekman (2004) who found that education levels are related with take up of health insurance programs in the developing world. To some extent, the formal sector has been covered by health insurance, the reason for which many low-income clients are not familiar with the concept of insurance program. This situation according to Tarry (2012) has the tendency to elicit better perception of the scheme among the middle and high income earners.

Table 6: Statistical analysis of respondent's socio-economic characteristics

Variables	N	χ^2-value	Df	r-value	p-value
Sex	120	0.067	1		0.796
Education	120	11.598	3		0.008*
Occupation	120	11.432	4		0.002*
Marital status	120	4.917	3		0.178
Age	120			0.230	0.011*

Furthermore, inferential statistics result on Table 7 shows that constraints (r = -0.403, $p \leq 0.05$) faced by the beneficiaries in accessing the services was significantly correlated to the perception of the CBHI effectiveness. In a related study, Onwujekwe *et al* (2010) opined problems with quality of service, lack of trust in the integrity of the schemes, beneficiaries preferences not receiving sufficient attention and variation in community needs were identified as the bottleneck to effectiveness of the scheme in Nigeria. Invariably, it connotes therefore that beneficiaries' disposition to CBHI effectiveness is a function of the constraints faced in accessing the services.

Table 7: correlation between constraints faced by the beneficiaries and their perception of the effectiveness of the CBHI scheme

Variable	r-value	p-value
Constraints	-0.403	0.000

CONCLUSION AND RECOMMENDATIONS

Consequent on the findings of this study, it can be concluded that most of the services of essential primary health care were provided under the Community based health insurance scheme. Services indicated as available, accessible and affordable were essential drugs needed by patients during and after hospital admissions and education on health. Low level of education in decision-making as regards seeking health care, inadequate siting of healthcare centres and long distance to healthcare centre were the most prominent constraints in accessing the services under the CBHI scheme.

The following recommendations are proposed based on the study conclusion:

1. Government and non-governmental agencies should make efforts to sensitize communities more through awareness campaigns particularly on the healthcare services available under the CBHI scheme.
2. Community mapping should be conducted by relevant stakeholder to foster equitable resource allocation to mitigate the challenges of distance and improper siting of healthcare centres.

3. Promotion of community engagement through active community participation, ownership and resources mobilisation in order to achieve sustainability of the scheme.

REFERENCES

Ekman, B. (2004). Community-based health insurance in low-income countries: a systematic review of the evidence. *Health Policy Planning.* 19(5): 249–70.

Ager, A. and Pepper, K. (2005). Patterns of health service utilization and perceptions of needs and services in rural Orissa. *Health Policy and Planning.* **20:**176-184.

Berman, P. (2000). Organization of ambulatory care provision: a critical determinant of health system performance in developing countries. Bull World Health Organ. 78(6): 791–802.

Onwujekwe, O., Onoka .,, Uguru, N., Nnenna, T., Uzochukwu, B., Eze, S., Kirigia, J., Petu, A. (2010). Preferences for benefit packages for community-based health insurance: an exploratory study in Nigeria. BMC Health Serv Res.;10:162. doi: 10.1186/1472-6963-10-162

Adenusi, O. (2011). *"Community health insurance scheme-Kwara/Hygeia"* Conference presentation *http://www.healthfinancenigeria.org* .Accessed April 2015 Centre for Public Policy Alternatives (CPPA) 2013.*Health insurance perception survey (Anassessment of knowledge and attitude of individuals to health insurance).* Accessed May 2015

Holzmann, R., and Jorgensen, S. (2001). Social Risk Management: A New Conceptual Framework for Social Protection, and Beyond. In *International Tax and PublicFinance*, Vol. 8, No.4, 2001, 529-556.

Iyayi. F. (2011). Socio-cultural factors influencing primary health care (PHC) service in Nigeria.(unpublished Monograph)

Musah, A.A. and Hudak, R.P**.** (2016). Religious Barriers to Health for Members of the Bronx Ghanaian Immigrant Muslim Community in New York City**.** *Journal of Religion and Health* Volume 55, Issue 2, pp 671–679

NHIS (2004). National Health Insurance Scheme*:* - Operational guidelines, National Health insurance Scheme, Abuja. Accessed May 2015

NHIS (2005)*.* National Health Insurance Scheme*:* - Operational guidelines, National Health Insurance Scheme, Abuja. Accessed May 2015

NHIS (2008). National Health Insurance Scheme*:* - *Operational guidelines, National Health Insurance Scheme, Abuja.* Accessed May 2015

Safe care (2014). Basic health care standards news article. *African health markets for equity (AHME) supports ogun state to achieve universal health coverage.* Available at http://www.safecare.org/newsarticles

Tarry, A. (2012). *Making the transition to universal health coverage in Africa health journal 1(1):2.* Accessed March 2015

Yvonne, H. (2013). *Implementing community based health insurance;* Lessons from the case of Rwanda *pp 25,26*