

# Benue State Community Based Health Insurance Assessment



Benue State Community Based Health Insurance Assessment Report.  
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## Acronyms and Abbreviations

BOT – Board of Trustees

CBHIS – Community-Based Health Insurance Scheme

CHAIN - Closing the Gap to Sustainable Health Access in Nigeria

CSOs – Civil Society Organisations

LMIC – Low- and Middle-Income Countries

NHIS – National Health Insurance Scheme

OOP – Out of Pocket Payment

UHC – Universal Health Coverage

WHO – World Health Organisation

## EXECUTIVE SUMMARY

Community-based health insurance is a form of voluntary health insurance. Unlike many insurance schemes, CBHI schemes are typically based on the concepts of mutual aid and social solidarity. CBHI schemes are typically designed by and for people in the informal and rural sectors who are unable to get adequate public, private, or employer-sponsored health insurance. CBHI schemes are frequently initiated in settings where people have experienced the experience of substantial user fees payments for health care services. The option of CBHI schemes is rapidly gaining favour as these schemes are funded by annual or more frequent contributions, but do not require payments at the time of using health services, thus, lower the financial barriers to access.

Equity of healthcare access in Nigeria has been discussed extensively, and the present review focuses on ways in which participation in the CBHI elements of the Nigerian healthcare system might be improved. This report seeks to assess the state of the existing CBHI schemes in Benue state.

In Benue state, the NHIS State office has worked with CSOs to set up a number of CBHI schemes. The exact number of these, how many are operational and what groups of people they cover is not known. This proposed baseline assessment is designed to provide evidence for the next phase of CHAIN project's advocacy actions in the state. With a concise listing, ranking and inventory of existing CBHI Schemes in Benue State, schemes can be strengthened through training and other supports. Messaging to increase demand for health insurance in the state will now have directions for community members about how to get health insurance as the Benue State Health Insurance Scheme is set to start with the formal sector alone.

The overall objective of this research is to provide a well-documented identification, ranking and analysis of the all existing Community-Based Health Insurance Schemes in Benue State.

This baseline assessment was done using mixed methodologies: a desktop review of relevant documents, administration of questionnaires, and key informant interviews. From the survey, the key themes that emerged included; free healthcare for pregnant women and children under five; sources of funds for CBHIS; regular meetings by the board of trustees; routine supervision for CBHIS; provision of drugs; pool funding; awareness creation of health insurance; local government demands; free treatment and quality of care; success stories; lack of infrastructure; payment consistency of enrolees; out of pocket expenditure while enrolled in schemes; lack of

health professionals; NHIS delays in support; lack of amenities at facilities; and insecurities in the state.

From the quantitative data, 10% of CBHIS identified were fully registered, 75% of the CBHIS registered at the state government level, only 6% out of interviewed CBHIS have received any form of training from the state NHIS office, and only 1 CBHIS has between 1001 and 1500 enrolees.

Scaling CBHI Schemes is an investment worth pursuing. Empowering informal sector households, including the poor, to better manage their health risks, in a financially efficient and effective manner, can be an important part of the solution to the complex nexus of poverty and health problems. Over time, public support to include the development of CBHI Schemes into an evolving social protection system can make an important contribution to poverty reduction by providing poor communities with the financial tools, technical and management capacity needed to better manage critical health risks.

## **Impact of Out-of-Pocket Payments**

Providing affordable healthcare to the population of low-and-middle countries is a constant development challenge. The WHO estimated in 2010 that 100 million people are pushed into poverty and 150 million suffer financial catastrophe because of out-of-pocket expenditure on health services every year. (WHO, 2010)

In the majority of African countries, more than 40% of their total health expenditure was constituted by out-of-pocket payments (OPP) and this resulted in scarcity of funds for health (Adebayo et al., 2015) and in these countries, payment for healthcare is dominantly OOP (Ataguba., 2012). These payments are not adequate and are inefficient at helping people access healthcare without financial hardship (Knaul et al., 2006).

As a result, many households in LMICs lack adequate financial protection; households face financial catastrophe and impoverishing effects of paying for health services out-of-pocket. In fact, annual estimates show that about 44 million households, representing more than 150 million individuals, face catastrophic expenditure globally while about 25 million households, representing more than 100 million people, are impoverished because of direct healthcare payments. Over 90 % of these occur in LMICs (Xu et al, 2007).

The negative implications of OOP payments are well documented: they have been found to negatively impact the demand for healthcare, contribute towards poverty of households, promote inequities and generate little revenue (Meessen, 2006). This evidence has contributed to a shift in healthcare financing debates worldwide; away from out-of-pocket payments and towards systems and models that protect the population from catastrophic costs and impoverishment. Such mechanisms include health systems that are funded through general taxation revenues and/or health insurance contributions that pool risks and promote access to care for all irrespective of their socio-economic status (WHO, 2005).

## **Universal Health Coverage**

“Universal health coverage” (UHC) is the current global rallying call in an ongoing movement aimed at strengthening national health systems to extend their reach and promote equity. The conceptualization of access to health care as a human right has developed over the past half century, but it was only in 2005 that the World Health Assembly endorsed UHC in connection with sustainable health financing. As with all slogans, the details of what UHC encompasses

are complicated. UHC is defined as “access to key promotion, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access” (World Health Assembly Resolution 58.33)

Access to healthcare is essential to all the citizens of a country regardless of their socio-economic status. Therefore, provision of universal health coverage is a fundamental need for developing countries.

Nationwide, extension of primary health care coverage, health financing, and strong political support are the proven enabling factors for achieving UHC. However, maintaining the quality, equity, and efficiency of healthcare under different schemes/premiums of UHC could pose a challenge. (Zaman, 2017)

Consequently, UHC is a priority on the global development agenda, as demonstrated by its inclusion in the SDGs. Despite the global support for UHC, how to reach this objective in poor countries remains highly debated.

### **Universal Health Coverage and Out of Pocket Payment**

UHC has been difficult to achieve in many developing countries, with large populations remaining over-reliant on direct OOP expenses that include over-the-counter payments for medicines and fees for consultations and procedures.

Considerable arguments exist against OOP costs, as this system is not equitable and can hit the poorest community deterring them from going to the hospital. Even it can discourage people from seeking early treatment to use preventive medicine and healthy adaptation. (Zaman, 2017).

The World Health Organisation (WHO) views medical fees as a significant obstacle to healthcare coverage and utilisation and has stated that the only way to reduce reliance on direct payments is for governments to encourage the risk-pooling prepayment approach.

### **Community-based Health Insurance Schemes**

Community-based health insurance is a form of voluntary health insurance. Unlike many insurance schemes, CBHI schemes are typically based on the concepts of mutual aid and social solidarity and are typically designed by and for people in the informal and rural sectors who are unable to get adequate public, private, or employer-sponsored health insurance (Jütting, 2004). CBHI schemes are frequently initiated in settings where people have experienced an

unpredictable change in substantial user fees payments for health care services. The option of CBHI schemes is rapidly gaining favour as these schemes are funded by annual or more frequent contributions, but do not require payments at the time of using health services, thus, lowering the financial barriers to access.

A major benefit of CBHI schemes is the fact that the poor have increased access to basic health services. A systematic review of CBHI showed that there is evidence that CBHI provides some financial protection by reducing OOP spending, improves cost-recovery and could lead to an improvement in the quality of services. Such schemes help to improve financial access, utilisation, and quality of health care services through cooperative, community efforts. These benefits should in addition be equitable for the goals of setting up CBHI schemes to be attained.

CBHI has emerged as an alternative to user fees. CBHI schemes are designed to ensure that enough resources are made available for members to access effective health care. Contributions are accumulated and managed to spread the risk of payment for health care among all scheme members, although CBHI is known to be particularly vulnerable to adverse selection, where disproportionate enrolment by high-risk contributors accompanies non-participation by low-risk individuals.

Rwanda and Ghana have been successful countries in implementing the CBHI scheme in Africa (Makaka et al., 2012). However, the enrolment rate is reducing compared to the previous results. The perceived poor quality of care, challenge in the management of the scheme, high premium, and coinsurance are identified as factors of decrease in the enrolment rate (Jehu-Appiah et al., 2012). A study conducted in Ghana has identified barriers to the enrolment rate including lack of trust in the scheme, perceived poor quality of care, long waiting time for services among insured clients, and delay in card production (Jehu-Appiah et al., 2012).

Another study done in Rwanda also revealed that the poor quality of health care is a key factor that influences the low adherence to the CBHI scheme and also pointed out that the inconvenient model of premium payment (difficulties in raising premiums for all members before enrolment) was also a major factor of low adherence to the CBHI scheme. (Mukangendo et al., 2018)

All these factors are contributing to low enrolment in the developing world.

However, it's not all doom and gloom. The establishment of CBHIS in different developing countries around the world has shown an improvement in health outcomes and access for the population.

One study noted that CBHIs provided some financial protection by reducing OOP payments and improved cost recovery (Ekman, 2004).

Results from a household survey conducted among CBHI beneficiaries in 2013 showed that overall, the CBHI in Rwanda improves the access to health services for the population. About 78 percent of the households enrolled in CBHI indicate that CBHI covers most of their health care needs (including access to medicines). Also, most members do not have to delay seeking care when needed. (Ataguba et al., 2014)

The decentralised nature of health services in Nigeria is fraught with various challenges, hampering efforts towards universal health coverage. The lack of health insurance schemes at the community level leaves the people with no other choice than out-of-pocket payment for health services. When community members are not able to afford or access quality healthcare, they seek alternatives. These alternatives often are often substandard and raise even worse issues of quality and affordability of healthcare.

Equity of healthcare access in Nigeria has been discussed extensively, and the present review focuses on ways in which participation in the CBHI elements of the Nigerian healthcare system might be improved. This survey seeks to assess the state of the existing CBHI schemes in Benue state.

The overall objective of this research was to provide a well-documented identification, ranking and analysis of the all existing Community-Based Health Insurance Schemes in Benue State.

### **3.0 STUDY DESIGN AND METHODS**

This baseline assessment was done using mixed methodologies:

#### **Desktop Reviews**

There was a desktop review of relevant documents.

#### **Questionnaire Administration (Quantitative Method)**

Questionnaires were administered to CBHI Schemes in communities of Benue state. The questionnaires were completed by management, a member of the board of trustees or the technical facilitators of the CBHI schemes. One questionnaire per CBHIS was administered.

#### **Key Informants' Interviews (Qualitative Method)**

The qualitative part of the baseline assessment included conducting Key Informant Interviews (KIIs) with management representatives from the CBHI Schemes. Other respondents interviewed were community members (Enrolees), health workers, third party management organisations and the Benue state NHIS office.

#### **Study Location**

This study was done in Benue State which is one of the central area states in Nigeria with a population of about 4,253,641, from the 2006 census. It is inhabited predominantly by the Tiv, Idoma and Igede peoples, who speak Tiv, Idoma, and Igede languages respectively.

Benue State is named after the Benue River and was formed from the former Benue-Plateau State in 1976, along with Igala and some part of Kwara State. In 1991 some areas of Benue state, mostly the Igala areas, along with areas in Kwara State, were carved out to become part of the new Kogi State. Igbo people are found in the boundary areas like the Obi and Oju, to name a few.

Benue State consists of twenty-three (23) Local Government Areas. They are:

<b>Local Government Area</b>	<b>Headquarters</b>
Ado	Igumale
Agatu	Obagaji
Apa	Ugbokpo
Buruku	Buruku
Gboko	Gboko
Guma	Gbajimba

Gwer East	Aliade
Gwer West	Naka
Katsina-Ala	Katsina-Ala
Konshisha	Tse-Agberagba
Kwande	Adikpo
Logo	Ugba
Makurdi	Makurdi
Obi	Obarike-Ito
Ogbadibo	Otukpa
Ohimini	Idekpa
Oju	Oju
Okpokwu	Okpoga
Otukpo	Otukpo
Tarka	Wannune
Ukum	Sankera
Ushongo	Lessel
Vandeikya	Vandeikya

## Sampling Method

### Questionnaire Administration (Quantitative Method)

Questionnaires were administered to all identified CBHIS in Benue State and to least one CBHIS per Local government. The questionnaires were administered to CBHIS administrators and CBHIS Board members.

### Key Informants' Interviews (Qualitative Method)

A total of 18 key informant interviews were done amongst CBHIS administrators, CBHIS board members, CBHIS beneficiaries/enrolees, Heads of health facilities and NHIS staff

### Data Analysis and Management

The data from the questionnaires were carefully entered, cleaned and analysed using MAGPI Software.

The audio recordings from the interviews were transcribed and coded into appropriate themes and analysed thematically using MAXQDA software.

## 4.0 ETHICAL CONSIDERATIONS

### Confidentiality and privacy

The research team ensured privacy during the interviews by conducting the in-depth interviews of respondents in locations that ensured privacy and maintained anonymity. In reporting of data, coding was employed to anonymise the identity of respondents.

Consent was obtained from all participants by explaining the full extent of the survey and having them sign the consent form. The form described objectives of the survey, their rights to confidentiality and withdrawal at any point during the research.

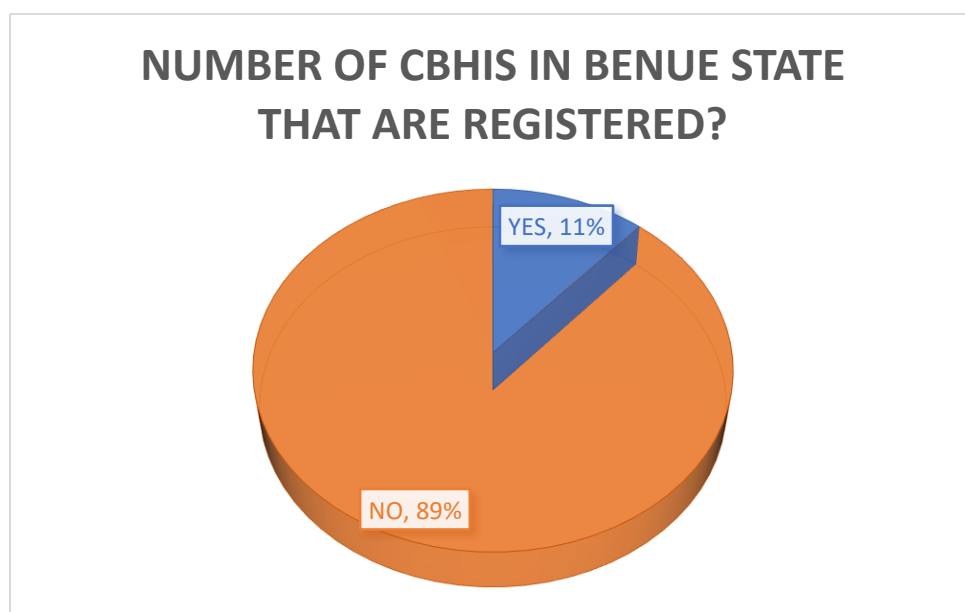
## 5.0 RESULTS

### Quantitative Analysis

A total of 35 questionnaires were administered for available CBHIS in Benue State.

Findings from the survey revealed that only 11% of CBHIS has had any form of registration at any level.

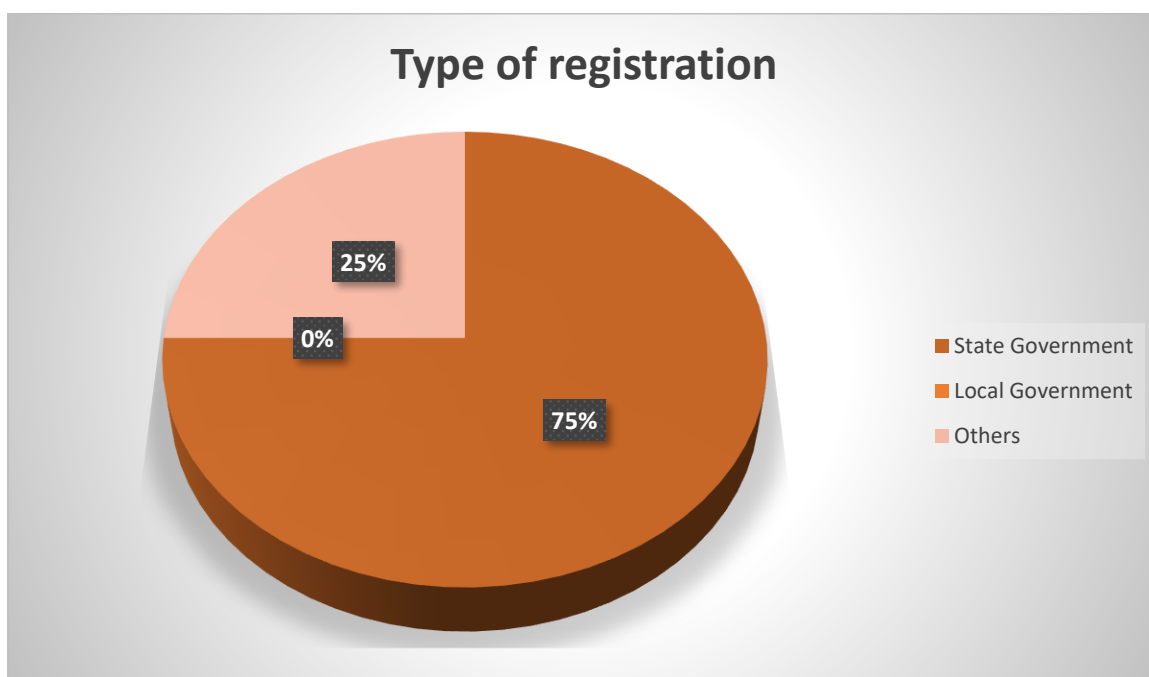
Number of CBHIS in Benue State that are registered?		
Code	Value	Percentage %
YES	4	11.43
NO	31	88.57
TOTAL	35	100



### Type of Registration

Findings from the survey also revealed that 75% of the registered CBHIS registered at the state level.

Type of registration		
Code	Value	Percentage %
State Government	3	75
Local Government	0	0
Others	1	25
Total	4	100

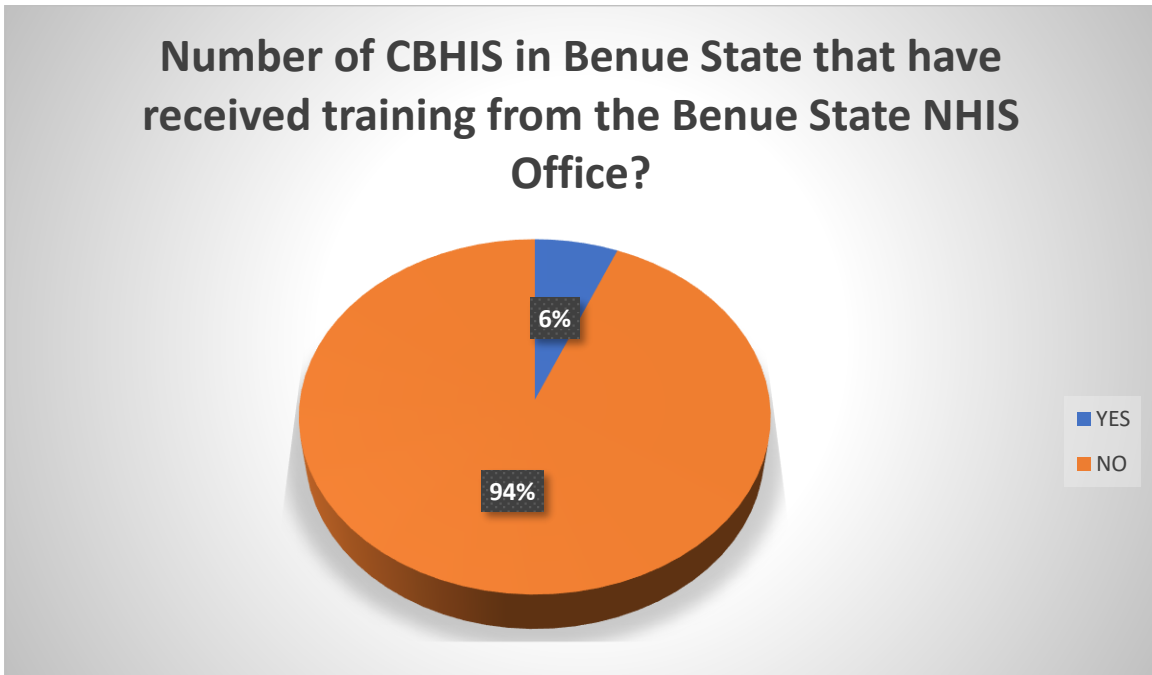


### Number of CBHIS in Benue State that have received training from the Benue State NHIS

At the time of the study, only 6% of CBHIS had received any form of training from the State NHIS.

Number of CBHIS in Benue State that have received training from the Benue State NHIS Office?		
Code	Value	Percentage %
YES	2	6.25
NO	30	93.75

TOTAL	32	100
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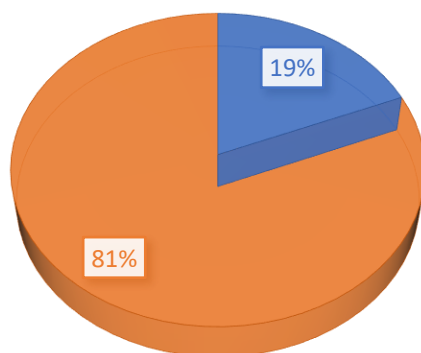
**Number of CBHIS in Benue State with a Board of Trustees**

The survey showed that only 19% of CBHIS interviewed had inaugurated a board of trustees.

<b>Number of CBHIS in Benue State with a Board of Trustees?</b>		
Code	Value	Percentage%
YES	6	18.75
NO	26	81.25
TOTAL	32	100

## NUMBER OF CBHIS IN BENUE STATE WITH A BOARD OF TRUSTEES?

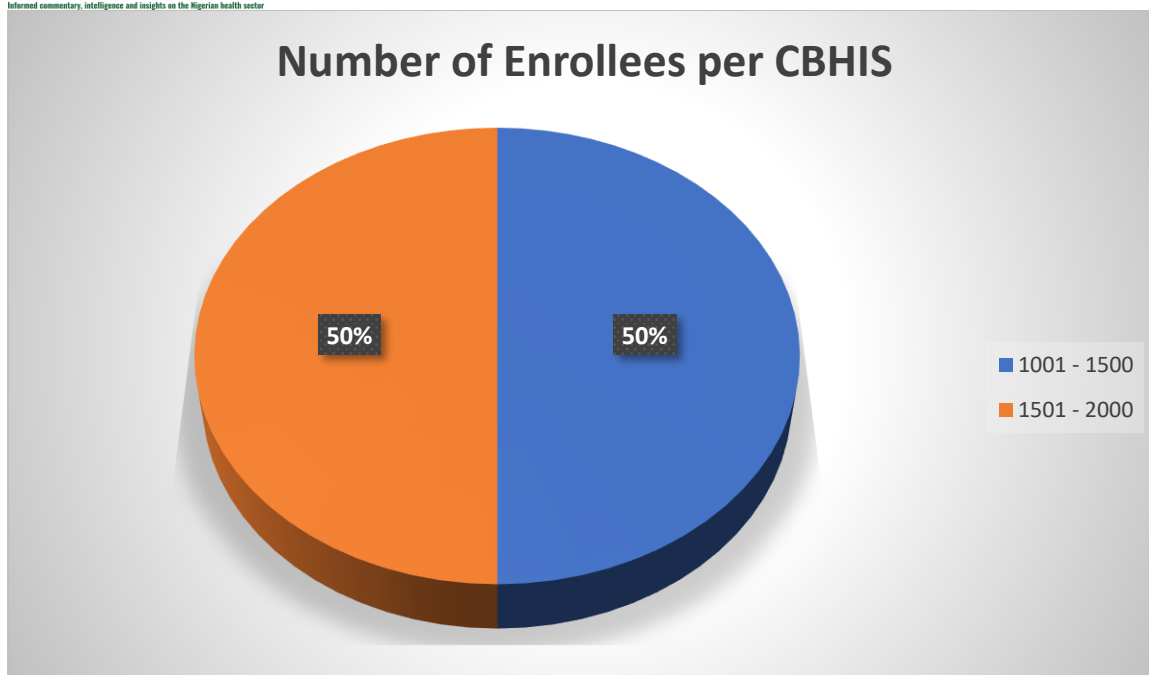
■ YES ■ NO



### Number of Enrolees per CBHIS:

As at the time of the survey, only 1 CBHIS had between 1001 and 1500 enrolees and also only 1 CBHIS had between 1500 and 2000 enrolees.

Number of Enrolees per CBHIS		
Code	Value	Percentage %
Less than 500	0	0.0
500 – 1000	0	0.0
1001- 1500	1	20
1501 – 2000	1	20
Above 2000	0	0.0
Total	2	50



### Qualitative Analysis

The following is the thematic framework of the Baseline assessment CBHIS in Benue state, following interviews and focus group discussions carried out with the following individuals and groups.

- NHIS Benue State Office
- State Health Officials
- CBHIS administrators and Board members
- Representatives from Communities (Enrollees)
- Health workers
- Community leaders (political, religious, cultural, women, youths, artisans, Okada riders, Keke NAPEP riders, farmers)

Following the qualitative data collecting, audio files were transcribed and coded by recording or identifying passages of text that are linked by a common theme or idea. This allowed the index of text into categories and the establishment of a framework of thematic ideas. All the relevant ideas in the text were identified and highlighted.

The following major themes emerged:

### **The Concept of Insurance**

The data revealed the lack of basic understanding of the concept of “insuring life.” Rather the more popular idea leaned towards the concept of free health care and charity. From advocacy messaging to the generation of pooled funding, the resounding theme seems to be the alleged promise of free health as opposed to the concept of insuring health.

*“The major problem we are facing is that of inadequate funding. We had requested assistance from our prominent sons and daughters but very many of them have not responded very well. The amount of money we thought we will generate through them in order to keep the program vibrant is not coming. Most of the major sources of income we were expecting, we are not able to get money through those sources” - Administrator CBHIS Benue.*

*“They told them that it was free treatment. When they paid that 150 naira, they will be doing free treatment. When they get money, they go somewhere else but when they don’t get money that is when they come here.” - Health Facility Head of a CBHIS*

### **Community-Based Health Insurance Scheme (CBHIS)**

The data showed that the intention for the establishment of CBHIS was based on the need to help those who can’t afford healthcare to have access to the healthcare that they need.

#### **1. NHIS support for CBHIS**

NHIS has provided a spectrum of support of CBHIS in Benue, from the establishment through to management support to help in the effective management of the scheme by community members.

NHIS and HMOs have been involved with training for the CBHIS but some of the CBHIS haven’t been able to access training.

*“For communities that are well educated, the BOT members, since they are members of the community, they can do the day to day running of the programme. So, we train them, first of all, to know the operations of a CBHIS, because that is the foundation. If they don’t know what they are doing, they won’t be able to manage it effectively.” - NHIS staff*

#### **2. NHIS regulation of CBHIS**

NHIS helps to regulate and guide the practices of the CBHIS through an extensive pre-registration process. NHIS has also put in monitoring systems to detect fraud and prevent mismanagement.

*We also train them on record keeping, finance mobilisation, because, apart from their own contribution and the intervention that is coming from the NHIS, they have other ways they can also source for funds. So, we train them on how to go about it, we also guide them through the registration process because they are supposed to register with CAC before they can register with us. They are supposed to have a functional bank account, so we make sure that we guide them through that process.” - NHIS Staff*

## **Existing CBHIS in Benue State**

### **1. CBHIS Models**

The CBHIS in Benue State is based on different models. One includes an enrollee paying a fixed amount and this guarantees access to healthcare for the enrollee for a fixed period. Another is where a certain percentage of the cost of healthcare is paid by the enrollee.

For the scheme to run efficiently, it usually requires a large number of enrollees and in situations where funding is not enough, the CBHIS seeks for outside funding.

*“When they pay their premium, the money is paid into the Organization’s account. Each month we update our list of enrollees, and we send that updated list to the hospital every month with a check attached to it. The check covers for the number of enrollees we are sending to the hospital for that month.” - BOT Chairman, Gwer East*

### **2. Importance of CBHIS**

Beneficiaries all spoke about the fact that they are assured of receiving healthcare whether they have money at that point or not. Beneficiaries also spoke about times when they have had emergencies and being enrolled allowed them to access healthcare easily. Beneficiaries also mentioned that they have been able to have easier access to healthcare and also improved quality of care received through the CBHIS.

*“We realized that a good number of people in this Local Government, had difficulties accessing healthcare because of the economic situation in the country. Very many of us are poor and we cannot use our personal money to cater for our needs. So, we decided to setup this organization to assist indigent members of the Local Government to be able to access healthcare.” BOT Member, Gwer East.*

## Challenges with CBHIS in Benue State

### 1. Lack of Infrastructure/ Lack of adequate health professionals

Even though CBHIS helps create access to healthcare, unfortunately the health system still has its problems such as insufficient health workers and the unavailability of drugs, which means enrollees now have to pay out-of-pocket to buy them.

*“Yes, we get very many complaints from the enrollees. Most of them complain that when they go to the hospital and drugs are prescribed for them, they don’t get the drugs”*

**BOT Member, Gwer East**

### 2. NHIS delays in support

Pregnant women and under-5 children are not able to access healthcare that should be free for them due to issues of disbursement from the NHIS.

*“The problem I’m having especially with the pregnant women is because, initially, they told us it was a completely free services and care for the pregnant women but as we visit the clinic, especially on delivery, they are items they will need for the delivery and they will be asked to go and buy those items so most of them it became an emergency for them because at such times they may not have money and it becomes a difficult situation.” - Enrollee VINACO CBHIS*

### 3. Insecurities in the state

Due to insecurity in parts for the state, some of the enrollees are forced to leave their communities in search of refuge.

*“It affects us, it was here the 2 reverend fathers were killed if you heard of it. So, we were scared. Some of my family were not here, they moved into an interior village.” -*

**Enrollee VINACO CBHIS -**

### 4. Default in payments by enrollees

Default in payment from enrollees is also another impediment to the efficiency and effectiveness of the CBHIS.

*“And other complaints like the Government hospitals, the doctors are always on strike and when the doctors are not on strike, either the nurses are on strike or the doctors are not on seat sometimes.”* **BOT member Gwer East**

## **Recommendations for CBHIS in Benue State**

### 1. Awareness creation of health insurance

Since CBHIS is community based, more awareness about the benefits must be created in the community to enable for there to be better utilisation and sustainability.

*“What made me enrol is because they mentioned some things that are very easy for us in the community and we can afford to do it. Maybe my child falls sick in my absence, before my wife will take them to the hospital, it will be a long process. But now that we are registered, if that happens, she will bring the child to VINACO hospital and the child will be taken care of.”* -

**Beneficiary Vinaco**

### 2. Routine Supervision

Increased Supervision of CBHIS and also transparency about finance is important to maintain integrity of the scheme and also prevent fraud.

*“It is good that you keep up the good work and keep coming to supervise the scheme to ensure that they are doing the proper thing in the health facilities.”* **Beneficiary CBHIS**

### 3. Pool Funding

CBHIS should be open to external funding to combat the issue of non-compliance with payments from enrollees

*“The major problem we are facing is that of inadequate funding. We had requested assistance from our prominent sons and daughters but very many of them have not responded very well. The amount of money we thought we will generate through them in other to keep the program vibrant is not coming. Most of the major sources of income we were expecting, we are not able to get money through those sources”* - **BOT member Gwer East**

### 4. Provision of drugs

Hospitals should be equipped enough to serve the needs of the community.

*“I want them to tell the Federal Government to give them enough medicine so that when the doctor prescribes, they will give us.” -Beneficiary CBHIS*

## **6.0 Discussion**

The aim of the study is to provide an analysis of all existing Community-Based Health Insurance Schemes in Benue State.

As at the time of the study, only 10% of CBHIS were registered. This could be due to challenges with registration of CBHIS schemes and poor enrolment by community members.

Survey result showed that only 25% of CBHIS registered are at the local government level. The registration process at the local government is not known and the State NHIS office did not mention any LGA registration process. If the LGA registration is known and standardised, this could ease the registration process for intending CBHIS given their close proximity to the community.

Only 6% of CBHIS had received any form of training from the State NHIS and at the time of the study. The State NHIS was the only organisation with oversight over the CBHIS in the state. This means that capacity building for these schemes is low. This could be a reason for the high failure rate of the schemes. Access to training for running and potential CBHIS will directly influence the level of sustainability

As at the time of the survey, only 19% of CBHIS had constituted a Board of Trustees. The presence of community members constituting a Board of Trustees in the running of a CBHIS is simply to help manage the schemes operations and to give a sense of ownership to the community itself. The absence of a BOT in most of these schemes will directly influence the effectiveness and efficiency of the CBHIS.

A study done in 2013 showed that those CBHIS that have encouraged effective communications and client education are rewarded by a high level of member participation and low dropout rates (Habiyouzeye, 2013). This shows that the success or failure of any CBHIS scheme lies in the ability to communicate to the community members and this thus seems to be a gap in existing schemes and according to the survey, has led to only 1 CBHIS having between 1001 and 1500 enrollees.

The main contribution of CBHI to extending social protection to disadvantaged sections of the population is by targeting people in the informal and rural sectors. By reaching those who would otherwise have no financial protection against the cost of illness, they also contribute to

equity in the health sector. Thanks to the way they are organised and managed, they also contribute to fostering democratic governance in the villages and of the healthcare sector, and social solidarity.

CBHIS in developing countries is formed with a variety of goals and objectives, other than to improve access and quality of health care. Sometimes schemes are started as a way of mobilising or stabilising revenues for hospitals and other health care providers. In other cases, a CBHIS is established to replace the free provision of health care services with fee-based services. (Del Conte 2000).

CBHIS provides coverage for a defined set of primary health care expenditures, such as clinic and drug expenses. Most also cover part of the costs of hospital treatment. Accordingly, they perform two distinct health access functions. They act to pool high-cost health risks, a pure insurance function, and they facilitate entry of low-income households to a public health care system that has its arrangements for financing, pooling risks and providing services (Baeza et al, 2002).

The level to which community members understand the concept of insurance is directly related to how they will embrace the idea. This shows the importance of communication and increasing awareness on the benefits of CBHIS amongst community members.

The main strength of such a community financing scheme is the degree of outreach penetration achieved through community participation, their contribution to financial protection against illness and the increase in access to health care by low-income rural and informal sector workers. (Tabor, 2005)

CBHIS can play a useful risk protection role and in so doing, complement a sound public health care effort. CBHIs provide poor households with the financial means to access publicly-provided healthcare services. They also provide households with the financial wherewithal to tap preventative and primary health care services, to reach private providers, and to improve health education and awareness.

Findings from the survey revealed that the State NHIS has provided a spectrum of support of CBHIS in Benue, from establishment through to management support, to help in the effective management of the scheme by the community members. They seem to be committed in helping intending CBHIS in terms of training support and regulatory oversight. It was revealed from

the survey that the State NHIS tried to provide training for CBHIS on finance and resource mobilisation. It was also revealed that even with these, some CBHIS have not been able to have access to these trainings due to different reasons. The survey revealed the extent to which delays in financial support for the pregnant women and Under 5 children have resulted in them having to pay out of pocket for healthcare.

Another challenge faced by CBHIS as revealed by the respondents is the poor condition of the health system. Even though the CBHIS is created to provide access to healthcare, unfortunately the health system still has its problems such as unavailability of drugs, insufficient doctors and unavailability of proper medical equipment.

A board member of a CBHIS spoke about the insecurity in the state and how it has disrupted the operation of CBHIS. As a result, a large part of the community is forced to migrate to other areas thereby rendering the CBHIS defunct. Another respondent spoke about how the killing of two prominent members of the community sparked a massive exodus of community members away from the community. For any CBHIS to run successfully, there has to be a sense of security so that the community is fully invested.

With all these issues, the CBHIS in Benue State has made an impact on the communities despite all the challenges. A lot of beneficiaries spoke about being able to access healthcare due to their enrolment in CBHIS. Beneficiaries have enjoyed a variety of benefits from the reduction in the cost of health care, to health security, to even improved quality of care received at the facilities.

## **7.0 Conclusion**

CBHI has been proposed as a transitional mechanism to achieving universal coverage for health care in low-income countries (World Health Organization., 2005).

There is evidence that CBHI provides financial protection by reducing OOP spending and by increasing access to health care, as seen by increased rates of utilisation of care. The very low and diminishing population coverage rates, however, put the implications of this finding in doubt. There are also strong indications that they still exclude the poorest and perhaps those most in need, with little effect on access to care for these target groups. On the other hand, the review has also shown that there are examples of successful schemes that have operated for several years, suggesting that CBHI can be a feasible option in certain contexts and situations.

Little systematic information has been compiled, however, on the particulars of the scheme contexts.

Despite the challenges, scaling-up CBHIs is a worthy investment. Empowering informal sector households, including the poor, to better manage their health risks, in a financially efficient and effective manner, can be an important part of the solution to the complex connection of poverty and health problems..

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