

Stakeholders' Values and Power Dynamics and Relations in Community Based Health Insurance: Evidence from Anambra State Nigeria.

Benjamin SC UZOCHUKWU^{*1,2,3}, Obinna E ONWUJEKWE OE^{2,3}, Ogochukwu P Ibe³, Nkoli N EZUMAH⁴

¹Department of community medicine, University of Nigeria, Enugu

²Department of Health Administration and Management, University of Nigeria, Enugu.

³Health Policy Research Group, College of Medicine, University of Nigeria, Enugu

⁴Department of Sociology, University of Nigeria, Nsukka

*Corresponding Author: bscuzochukwu@gmail.com

Abstract

Community based health insurance (CBHI) is a not-for-profit type of health insurance that has been used by poor people to protect themselves against the high costs of seeking medical care and treatment for illness. CBHI was piloted in Anambra State in Southeast Nigeria in 2003 as a way of increasing the provision and utilisation of health services. This study set out to identify the factors that influenced the development and implementation of the scheme.

The study was conducted in 2006-2007 and compared the experiences of two communities two communities judged to have different levels of success in implementing CBHI, in terms of community involvement and support for the scheme and levels of enrolment. It involved document reviews, In depth interviews with state and local level policymakers, managers, health workers, and members of Community Health Committees. In addition, 8 Focus group discussions with members and non-members of CBHI were conducted.

The result showed that the development and implementation of the CBHI followed a period of political transition with the introduction of a new State Governor who aspired to improve access to quality health care and who was personally responsible for driving the policy forward at rapid pace. Several factors affected the implementation of the scheme in the two case-study locations namely: relations between state and local government authorities; community support and participation; power dynamics between community actors; health workers attitudes towards the scheme and parallel drug acquisition and delivery systems.

In implementing new health policies, effort should be made to secure widespread backing among groups (both within and outside the Ministry of Health) with the power to sustain implementation; include local actors who can either sustain or block implementation in the development of new policies in particular health workers; take into consideration power dynamics between local community actors when designing policies that will be implemented at the local-level and ensure that policy guidelines are clearly communicated to those responsible for implementing the policy and to community members.

Keywords:CBHI; Community-based health insurance; Health Policy Analysis; Nigeria

Introduction

Over the years governments of many low income countries have been faced with the challenge of instituting and sustaining financing mechanisms that will reduce the high incidence and regressive burden of out-of-pocket payments. Such mechanism will need to mobilize enough resources for health care and provide financial protection against the cost of ill health across the population.²¹ In an effort to provide financial protection and improve the health status of citizens by improving coverage and affordability of health services, the Nigerian government launched its National Health Insurance Scheme.¹⁵ In practice the scheme covers only the employees of the formal sector. The concept of Community Based Health Insurance (CBHI) in Nigeria was thus spurred by the need to provide some form of risk protection to those in the informal sector.

CBHI is a not-for-profit type of health insurance that has been used by poor people to protect them against the financial risk of illness. In CBHI schemes, members regularly pay small premiums into a collective fund, which is then used to pay for health costs if they require services. Based on the concepts of mutual aid and social solidarity, many CBHI schemes are designed for people that live and work in the rural and informal sectors who are unable to get adequate public, private, or employer-sponsored health insurance.⁴

Empirical evidence suggests, however, that the scope of revenue generation and equitable redistribution of resources through CBHI schemes is limited.⁶ Some studies from countries in sub-Saharan Africa and Asia have shown that CBHI operations have only had limited successes in ensuring affordable, participatory, and sustainable access to health care.⁴ There is also the tendency that the poorest will be excluded from such schemes if flat rate premiums are charged.¹⁸

Past studies of CBHI have provided some indications of the way implementation processes influence experience. For example, a study of the Community Health Financing (CHF) scheme in Tanzania has shown that managerial practices and behaviour, in partial response to a top down imposition of policy, can undermine effective implementation.¹¹ Where such processes have been considered, they do not address the fact that these processes always involve contestation, bargaining and negotiation among a range of actors who, either deliberately or by chance, make decisions that shape policy, including how it is experienced by those it is intended to benefit.²⁰

Some studies highlight such influences over equity-promoting health policy implementation. They show, that weak management of critical interest groups during policy development may shape the design of new policies in ways that limit their equity-promoting potential.^{12,19} Also, limited efforts to engage with local level managers and providers about new policies may mean that they do not fully understand policy intentions and so implement guidelines and procedures incorrectly, or even avoid implementing new procedures.¹¹ In addition, the failure to take account of existing power structures within local settings, when designing and implementing new policies, may lead to unrealistic expectations about the role of community members, particularly marginalized community members, in local decision-making structures that intend to promote local influence over health care.^{8,13}

More effective implementation of policies that are intended to promote equity will therefore require more than improved design of policies or further monitoring and evaluation. It must also include active engagement with, and management of, the range of relevant actors, based on better understanding of the factors influencing their responses to new policies. For instance, in Nigeria, it is not known whether policy makers took the views of the health care providers and the communities into consideration when fixing the premium and deciding the benefit packages, and whether they have been properly sensitized and mobilized for the scheme.

This study explores the CBHI policy development and implementation process and the factors that have constrained or enhanced its implementations.

Background to CBHI in Anambra state

The CBHI policy in Anambra State was conceived and promoted by the Commissioner for Health and endorsed by the State Governor in 2003. Pilot schemes were established in one urban and nine rural communities. Membership of CBHI comprises individuals and households in a community, with a minimum of 500 persons required to form a user group.² The individuals pay a flat rate monthly, yearly or in convenient instalments; and a participant who defaults in payment of monthly contributions must pay all outstanding contributions before being allowed to re-access services. The households enrolled in the scheme pay premiums into the CBHI fund; the scheme pays the government for the use of the facilities, and the healthcare providers offer health care services to the scheme members. In addition, the government makes matching contributions to the premiums paid

by the households to the scheme, as well as providing subsidy to health care providers in form of salaries. Non members of the scheme also have access to the health facilities but pay some user fees directly to the health care providers to access care.

In the scheme, medical treatment is restricted to those obtainable at primary healthcare facilities, for example, antenatal care and delivery services, the treatment of ailments like malaria, diarrhea diseases and upper respiratory tract infections. Treatment is sealed at a cost of 5,000 Naira per month, above which the patient is expected to pay additional money.

The scheme is managed by a Community Health Management Organisation (CHMO) which is made up of 3 people employed by the Community Health Committee (CHC). The CHC is made up of the traditional ruler, the town union President, the town woman leader, a representative of the Ministry of Health, a representative of the LGA, and one male and one female from each village.

Methods

Study Area

The study was undertaken in Anambra state, southeast Nigeria. The total population according to the 2006 census was 4,453,964.¹⁴ The state comprises of 21 local government areas (LGAs), 235 districts, 177 communities and 328 political wards with the capital at Awka. The CBHI scheme has been established in 10 communities namely: Ifite Ogwari, Ugbene and Achala in Anambra north senatorial zone; Abagana, Alor, Neni and Awka in Anambra central senatorial zone; and Igbokwu, Okija and Mboji in Anambra south senatorial zone. Apart from Awka, the other communities are rural communities. Each community has a health centre which serves as the base focal health centre for the scheme, serving about 4-7 villages in each community.

Study Sites

The two study sites are of the same socio economic status but from two different rural LGAs and located in different senatorial zones of the state. The sites are called towns or communities, and each town is made up of several villages, administered by a town union made up of the town union chairman and his executive members who are elected by the community members. Each town also has a traditional/cultural leader called the "Igwe". The Igwe, assisted by members of his cabinet drawn

from the different villages in the community, is the custodian of the people's culture and heritage, and is either elected or ascends the throne by inheritance. For any meaningful development and peace to exist in the communities, the town union and the Igwe must have a cordial relationship. Overall, the Igwe is expected to be the father of the community and therefore accorded such respect; however, there are occasions when the Igwes and the town unions are at logger heads on matters of constitution and project implementation.¹⁶

Study Design

The study was a cross-sectional study that involved an initial set of data collection activities at the state level, followed by data collection in the two local level case study sites selected from the initial 10 pilot CBHI sites.

State Level Data Collection Activities:

Initial state level activities included obtaining support for the study from Ministry of Health officials, and the collation of data on CBHI initiation and development.

Case Study Selection and Data Collection Activities:

Two communities from two rural LGAs were selected for inclusion in this study, reflecting the fact that most LGAs where the scheme has been initiated are rural areas. One more successful (Community A) and one less successful (Community B) CBHI site was chosen, with scheme success judged by State level CBHI task team members. These task team members were asked to indicate the communities where the scheme has been more successful and those that have been less successful. One community was consistently voted to be the most successful by all the members while three communities were voted to be less successful. When asked how they made their judgment, the task team members said that judgement was based on the level of community involvement in providing financial and material support in the early part of the scheme, and the level of enrolment in the scheme, as evidenced in their monitoring data. In each community, the Health Centre with which the CBHI is linked was then identified as the focal point for data collection activities.

The use of the case study approach allowed a detailed examination of the decision-making processes of the CBHI implementation, influences over these processes, and the potential success of CBHI in benefiting the poor. A case study design is particularly appropriate for a study of this type, which is seeking to understand why policy change

succeeded or failed. The inclusion of both potentially more and less successful experiences of policy impacts was to avoid the common criticism that implementation research focuses only on the negative,¹⁰ as well as facilitating the identification of practical policy and management recommendations.

Data Collection

In-Depth Interviews:

Using an in-depth interview guide, the policy makers and managers were interviewed. The sociologist conducted the interviews, assisted by a social science research assistants and a community physician, who took notes and tape-recorded the interviews. The policy makers interviewed included 1 senior politician, 8 state policy makers involved in the scheme, and 5 LGA officials. Information was collected on what motivated them to conceptualize the CBHI; how they managed the process of moving from policy development to implementation; which forms of engagement and communication with program managers, health workers and the community were used; what preparation were made; why the strategies they selected were used; and, what they think are the consequences in implementation of those strategies.

In-depth interviews were also conducted with 4 health workers per site in the focal health facilities to identify: their views of policy achievements and failures; their own roles in implementation, the factors influencing them, and the range of other influences over implementation experience; and, perceptions of possible influences over implementation. The interviews also sought to ask health workers whether CBHI threatened them or required them to work in new ways; who gained or lost as a result of the introduction of the scheme; and, what, if any, was the form of coordination between the health workers and the CBHI managers and Community Health Committee members.

Two members of the Community Health Management Organization were also interviewed in each site to ascertain: whether they received any information, communication, and/or engagement about policy from higher levels before, and during, implementation; and, whether there were any forms of coordination between managers and the policy makers, and between managers and the community committees. In addition, the interview sought to explore whether any parallel initiatives existed and, if so, how these multiple strands are managed; personal levels of 'motivation' in relation to work; whether the resources required for management

tasks linked to CBHI implementation were available, or how they could be obtained; and, whether any form of training was provided before the commencement of the scheme, and if so, which areas this covered.

Focus Group Discussions:

Focus Group Discussions (FGD) were held with both members and non-members of the CBHI scheme in all catchments villages within the communities. In total, 8 FGDs were conducted in each catchment area, lasting between 60 and 75 minutes, and with 9-10 members in each FGD. The participants were stratified by sex and membership of the scheme, and were purposively selected with the help of the village heads. A discussion guide was used to direct the discussions during the FGDs, which were moderated by a social scientist. Issues explored included participants' perceptions, acceptability and enrolment into the CBHI, as well as their own roles in implementation and the factors influencing them, knowledge, or otherwise, of the scheme; reasons for enrolling or not enrolling in the scheme; perceptions of the quality of services provided; the affordability of the scheme; attitudes towards insurance; and levels of trust in CBHI managers and health workers and the community health committee members. All the 16 members of the community health committees in the 2 sites.

Data Analysis

All interviews were taped, and notes were taken during the interview. Tapes and notes were transcribed/reviewed as soon as field workers returned from the field. State and case study data were analysed independently of each other as each set of data reflected different experiences. In addition, data from each case study was analysed separately, and then case study experiences compared and contrasted. Within each set of data, there was triangulation across interviews, and then, as relevant, between interview data and document reviews. This approach allowed identification of both similarities and differences in views and experiences, and supported investigation of explanations for key differences.

Results

The following factors affected the development and implementation of the CBHI scheme:

Policy Development Affected by Political Uncertainty

The development and implementation of CBHI followed a period of political transition. The

government in power at the time of the study came into power under special circumstances: they were replacing the previous government which was said to have performed particularly poorly, but were of the same political party. The executive governor sets the overall policy thrust in the state. In this instance, the replacement Governor, concerned about the deplorable state of the health system in the state occasioned by the poor performance of the previous government, along with the need to score some political points, decided to throw his executive, political, financial and personality power behind the CBHI policy because he wanted to justify his election into office. Two months after the Governor was elected into office, he was abducted – allegedly with police co-operation – after he lost the support of his original sponsors during the election. Although the new governor regained freedom after few days, this incident showed the instability of his position and the political uncertainty within a state wanting to develop and implement a new policy. These difficulties were compounded as, 2 years after CBHI was conceptualized and rolled out, the executive governor was removed from office by a court action instituted by one of the aggrieved political parties, spending only 2 years of his 4 year term in office. His removal was said to have been facilitated and supported by his party as he lost the support of his original sponsors during the election and as a result, the little funding that the scheme had received was lost, along with the political support and sustained state support.

Relations Between State and Local Government Authorities

The CBHI policy was developed at the State level by a small number of key political figures. Members of the task force team were entirely drawn from the Ministry of Health with each member having another primary assignment in the ministry. Officials working for LGAs were not involved in the formulation of the scheme and they did not participate on the Task Force set up to supervise its development and implementation. This is despite the fact that they are responsible for overseeing health activities in local areas and function independently to the State. In some cases, poor communication and lack of mobilisation of the LGA officials resulted in resistance to the scheme and a lack of wide-spread support. As a consequence, the policy lacked local-level 'champions' to promote its uptake at community levels and committed officials to ensure that it was implemented appropriately by health workers. It is worthy of note that each administrative level (Federal, State and Local governments) is autonomous in Nigeria and because of this, it is difficult for state officials to monitor, supervise and

discipline LGA health workers, who are only responsible to the LGA effectively and without encroaching on the statutory functions of the LGA officials.

Community Support and Participation

Community support was an important factor in achieving high levels of uptake and continued enrolment of the scheme. In the area where the scheme was considered to be more successful, members were involved in a variety of activities including overall coordination, community sensitization, encouragement and advice, and providing infrastructure. Importantly, they perceived CBHI to offer benefits in the form of financial risk protection and access to good quality care. The level of community participation in the scheme was captured by the following quotes from the more successful site:

"At its inception, I was satisfied with the progress and response of people. Some philanthropists in our community paid for hundred persons to benefit from the scheme. The town also rendered all the necessary support." (IDI Community Health Committee member)

"We went to many places to inform people, to village meetings, to churches, so many of us like myself, I went to churches around my own quarter to inform people and enlighten them on the importance of going to the health center." (IDI, Community Health Committee member).

In the other community, managers and health workers did not mobilise the community, partly due to a lack of information, and this resulted in lower levels of uptake. The lack of participation and interest in site B was captured thus:

"We met many well- to- do people in our area. We talked to them about the program and they promised a lot of things to help in terms of vehicle, drugs and every other thing but they never did..... at a stage you know how government is this thing picked up and at the peak of it there was another change over of government. The whole thing collapsed. Now it is at standstill and nothing is working again." (IDI, Community Health Committee member)

Power Dynamics Between Community Actors

In the more successful case-study, the community leader who was respected and carried a lot of influence, controlled the CBHI drugs and ensured accountability. In doing so he secured trust in the scheme by community members, thus increasing enrolment. This trust was reflected by a respondent

thus:

“Yes we have trust in them. For example, her Royal Highness had managed a hospital before and knows everything about hospital. She is not a politician and puts in her own personal efforts. And those that are helping her are also reliable and trust worthy people that like the progress of their brothers. This is because we see the kind of suffering they undergo. At times, they use their car to go around and at times they cook begging people to come. So we have faith in them” (FGD participant, Men registered with CBHI)

In the other community, the person responsible for coordinating the scheme was viewed as being dishonest and untrustworthy. As a consequence, community members lost interest in CBHI leading to low levels of uptake. This was captured thus:

“We had confidence that they will do that job but somebody that was entrusted with the work was not telling us the truth so that made most people to develop cold feet, but we thank God that he has answered God’s call. Even the health center they proposed to build around our area he obstructed it. He did not want anything to progress. Drugs brought by the health people to be given to people were also withheld... People actually did not understand what was happening. It was even after he died that people started to come out; he was not an honest person. We are somewhat grateful he has answered the call of God. So if they can get someone that will tell us the truth people will be interested to belong to the scheme.” (FGD participant, women not registered with CBHI).

Health Worker Attitudes Towards the Scheme

In both sites, health workers expressed reservation about the health insurance scheme. This was mainly because, as a consequence of altered payment mechanisms, they lost out on income that they would otherwise have been earned through user fees. Health workers’ ability to implement the scheme was also constrained by a lack of information about CBHI from the local government, limited training before and during its implementation and inadequate supervision from the doctor in charge of the facilities. This was stated by a health workers thus:

“I have not gained anything. Instead I am loosing. At the time we were practicing it, the organizers made promise to give us something because we suffer. But till now they have not given us anything, even pure water. The only thing they know is that you should keep your record properly, but there will not even be a pen for you. So there is nothing I gained from the scheme.” (IDI health worker community B)

“For me I have not received any training on this scheme except my professional course and workshops organized by the local government.” (IDI Health worker community B)

“if there is any training for it, I will appreciate it. At least to see that the scheme progresses.” (IDI Health worker community A)

It is likely that these factors resulted in health workers not following the guidelines for implementing CBHI. Instead they focused efforts on other duties. Further, health workers apparent reluctance about CBHI was observed by some community members and created distrust between the two groups. These opinion confirms the views expressed by many of the community members:

“We don’t have faith in the nurses. That is because; they are interested in their own only. They do not want this scheme to progress. They don’t even want the registered members to be coming to take drugs instead they want the unregistered member so that they do their business.” (FGD, men registered with CBHI)

“The nurses are not complying. They tell you they don’t know about it. That is one. Another thing is, these nurses actually were seeing the health centres as gold mine before now. They were using it sometimes to make money. We didn’t quite know it. And when the scheme started, they saw it as a threat. Now the community members are going to be seeing the things that they do. They were really pegged. So they see to it that it doesn’t work. You can imagine how that thing can go.” (IDI health committee member)

“The nurses initially were not happy, because it was a way of trying to slow them in their own income earning method. There are certain drugs they used to buy on their own and then sell it to the patients. So this made it difficult for them to engage in private practice. So that made the nurse not to be giving attention to people. Even at a time the nurses started having problem with the committee members. They said that they would no longer come to collect drugs unless they are brought to them... So all these where causing problem”. (FGD, men registered with CBHI)

Parallel CBHI and non-CBHI drugs

Parallel systems for purchasing and prescribing CBHI and non-CBHI drugs at the facility level created additional problems for health workers in implementing the policy. The design of the CBHI scheme meant that drugs purchased as part of the

scheme were stored alongside other drugs belonging to the LGA and health workers. This created an administrative burden for facility staff who had to manage two separate processes. It also resulted in health workers prescribing and selling their own drugs from which they could generate an income, rather than the CBHI drugs.

Discussion

In this study, the CBHI policy was developed at the State level by a small group of policy makers. In relation to this issue, research has noted that such personalized decision making by key political figures is not uncommon in African countries.¹⁷ Furthermore, it is also suggested that, under pressure to show results in short periods of time, as is characteristic of new governments, policies do not get designed properly.⁷ Whilst the political transition (the initial change of government) in the state opened a window of opportunity for the CBHI policy, it has been noted that, in such reforms, technical concerns are likely to be of secondary importance to political imperatives.²²

Also, the study offer insights into the particular challenges of implementing community based health insurance scheme in Nigeria. It also provides evidence of how community level politics can influence policy implementation. Experience in the more successful case study community shows how local political leaders can support effective implementation, for example, by mobilising community support and ensuring appropriate drug use. These actions, however, also conflicted with the routine health worker practice of selling drugs and, as there was no attempt to get the health workers to buy in and their lack of interest in the scheme challenged implementation. In Community B, poor CBHI scheme management was not addressed by local political leaders and this deterred community support for the scheme.

In terms of enrolment since premiums are flat rates, it is possible that the poorest members of the community may not be able to afford to pay, a fact that has been noted by some authors.³ In order to reach the poorest members of the community, the cost of participation would have to be reduced for the poor by the scheme itself or government would have to subsidize their premiums. And it has been suggested that this could be achieved by linking community financing schemes to social funds.²³

Community participation also affected the success of implementation of the scheme. Where there are high levels of community involvement in organising and running such programmes together with issues

and decisions concerning the rate of premium and time of collection, it could create a feeling of ownership in them which will invariably increase their support for the scheme. Trust in the integrity of the managers of the CBHI schemes may also have an effect on enrolment and sustainability of the scheme, as noted by Carrin et al⁵, members may be unwilling to renew their membership and non members unwilling to join if they perceive that managers cannot judiciously manage funds.

It is also quite obvious that the implementation of CBHI policy was constrained by policy makers' seemingly weak understanding of how policy objectives and design could provoke opposition at the local level and, hence, derail implementation. This has been noted by Grindle and Thomas,⁹ in whose study the policy makers did not take into cognizance how the LGA and health workers will react to the policy, especially when they were not properly consulted. In the present CBHI, Policy makers were also naïve to the politics that go on in the communities and as noted by Nwosu,¹⁶ the nature and magnitude of community disputes in the state had devastating consequences, not only on government projects, but also on community development.

Policy Recommendations

In planning and implementing new policies such as CBHI, efforts should be made to have sufficiently widespread backing among groups (both within and outside the Ministry of Health) with the power to sustain implementation. An important reason why the CBHI scheme was not successful is that the policy was designed by a small group of influential actors who did not seek to gain widespread backing from others within the Ministry of Health, local government officials, or State legislators. Not only did this create resentment and distrust, but also when the State Governor was removed from power, there was no one left who was committed to sustaining the implementation of the policy.

Efforts should be made to manage the interests and values of those local actors whose direct roles in implementation mean that they can either sustain or block implementation. It is evident that the implementation of the CBHI policy was constrained by policy-makers' limited understanding of how policy objectives and design can provoke local-level opposition and derail implementation. In the case of CBHI, health workers and LGA officials were not involved in the formulation of the policy, and as a result there was no consideration for how it would affect their incomes. This in turn meant that policy guidelines were not followed, few health workers

actively promoted the scheme to community members, and CBHI drugs were wasted.

In designing policies that will be implemented at the local level, the power dynamics between local community actors should be taken into consideration including the relationships between different community members. The CBHI scheme was developed at the State level and did not succeed in getting enough local-level political support. Managerial roles for local actors and clear mechanisms for accountability of local implementers are important in maintaining the trust and support of communities.

Sustainability can be complicated if there is inadequate range of political engagement, and there should be enough political engagement locally, as well as managerial roles for the local actors. Moreover, in order to ensure sustainability, a larger group is required for policy making, and appropriate legislative back up is crucial.

Government should also ensure that policy guidelines are clearly communicated to those responsible for implementing the policy and to community members. Poor communication about the policy from State to Local level, from policy-makers to implementers, and from health workers to community members was a major barrier to implementation and uptake. In the case of CBHI, policy guidelines were not communicated to nurses and health workers received inadequate training in the scheme. Health workers limited understanding of the policy meant that they did not follow the guidelines and that they did not effectively communicate the benefits of CBHI to community members. Poor communication about the policy from State to Local level, was a major barrier to implementation and uptake.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

UBSC, GL and OOE conceived and designed the study, UBSC, OOE and ENN collected the data and UBSC, ENN and EOP analysed the data. UBSC wrote up the initial manuscript with input from all the authors.

Acknowledgement

This study received financial support from the UK Department for International Development (DFID) for the benefit of developing countries through the

Consortium for Research on Equitable Health Systems (CREHS).

References

1. Atim, C. (1999). Social movements and health insurance: a critical evaluation of voluntary, non-profit insurance schemes with case studies from Ghana and Cameroon. *Social Science and Medicine* 48, 881–886.
2. Anambra State Ministry of Health. (2004). Anambra State Healthcare Financing and Community healthcare System. Proceedings of Advocacy workshop, Awka, Nigeria.
3. Bennett, S., Creese, A., & Monasch, R. (1998). Health Insurance scheme for people outside formal sector employment. ARA paper No. 16. Geneva: World Health Organization (WHO), Division of Analysis, Research and Assessment.
4. Bennett, S., Kelley A., Silvers B., Gadhia R., & Salamata, L. (2004). 21 Questions on CBHF: An Overview of Community-Based Health Financing". Bethesda, MD: Abt Associates. Partners for Health Reformplus (PHRplus).
5. Carrin, G., Waelkens, M., and Criel B. (2005). Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems. *Tropical Medicine and International Health* volume 10 no 8 pp 799–811.
6. Ekman, B. (2004). Community-based health insurance in low-income countries: a systematic review of the evidence. *Health Policy and Planning* 19(5).
7. Gilson, L., Doherty, J., Lake, S., McIntyre, D., Mwikisa, C., and Thomas S. (2003). The SAZA study: implementing health financing reform in South Africa and Zambia. *Health Policy and Planning*; 18(1): 31–46.
8. Gilson, L., Kalyalya, D., Kuchler, F., Lake, S., Oranga, H., and Ouendo M. (2001). Strategies for promoting equity: experience with community financing in three African countries. *Health Policy* 58: 37-67.
9. Grindle, M., and Thomas J. (1991). *Public Choices and Policy Change: The political economy of reform in developing countries*. Baltimore: The Johns Hopkins Press.
10. Hill, M., and Hupe, P. (2002). *Implementing Public Policy*. London: Sage publication
11. Kamuzora, P. (2005). Factors influencing implementation of the Community Health Fund in Tanzania. Study Report to EQUINET.
12. McIntyre, D., Doherty J., and Gilson L. (2003). A tale of two visions: The changing fortunes of Social Health Insurance in South Africa. *Health Policy and Planning* 18(1): 47-58

13. Ngulube, T.J. (2005). A policy analysis of the budget process for primary health care in Zambia. Study Report to EQUINET.
14. Nigeria Population Commission. (NPC). 2006. National census figures, Nigeria Population Commission, Abuja.
15. Nigerian National Health Insurance Scheme. (1999). www.nhis.gov.ng assessed online on June 1st 2010.
16. Nwosu, H. (2008). Laying the Foundation for Nigeria's Democracy: My account of June 12, 1993 Presidential Election and its Annulment. Macmillan Nigeria Publishers Limited. P 18
17. Porter, RW. (1995). Knowledge utilization and the process of policy formulation: towards a framework for Africa. Washington DC. Academy for Educational Development.
18. Ranson, M., Sinha, T., Chatterjee, M., Gandhi, F., Jayswal, R., Patel, F., Morris, S., and Mills, A .(2007). Equitable utilisation of Indian community based health insurance scheme among its rural membership: cluster randomised controlled trial *BMJ*. 334:1309 doi:10.1136/bmj.39192.719583.
19. Thomas, S., and Gilson, L. (2004). Actor dynamics in financing reform: the contested process of health insurance policy development in South Africa, 1994-1999. *Health Policy and Planning* 19(5): 279-291.
20. Walt, G., and Gilson, L. (1994). Reforming the health sector: the central role of policy analysis *Health Policy and Planning* 9(4): 353-370.
21. World Health Organization. (2000). *The World Health Report —Health Systems: Improving Performance*. WHO, Geneva.
22. Zaharadis, N. (1999). Ambiguity, time and multiple streams. In: Sabatier PA (ed). *Theories of the policy process*. Boulder; Westview press.
23. Jütting, J. (2001). "The impact of health insurance on the access to health care and financial protection in rural areas of developing countries: The example of Senegal" *Center for Development Research*, December, <http://www.zef.de>.