Community Based Healthcare Financing: An Untapped Option to a more Effective Healthcare Funding in Nigeria

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SUMMARY

Context: The Nigerian health system is characterized by chronic under funding. This has resulted in poor performance of the health sector evident from Nigerian's poor reproductive health indices.

Objective: This review evaluates healthcare funding in Nigeria with respect to health budget and health expenditure, appraises the national health insurance scheme, and examines community health care financing as a plausible option to a more effective funding of healthcare in Nigeria.

Pattern of health funding in Nigeria: Federal Government budget on health ranged from N4,835 million-N17,581.9 million from 1996 to 2000. This amount represented only 2.7%-5.0% of the total Federal Government budget. Nigerian's Total Health Expenditure (THE) as a percentage of Gross Domestic Product (GDP) is low ranging between 4.3 %-5.5 % from 1996-2005. General Government Health Expenditure (GGHE) as percentage of THE is also low ranging from 21.8 %-33.5 %. Private sector expenditure on health as percentage of THE is high ranging between 66.5 %-78.2 % from 19962005, with private households' out of pocket accounting for 90.4 %-95.0 % over the period. Social security fund had no contribution to the general government expenditure over the 10-year period. The National Health Insurance Scheme (NHIS) currently covers only the formal sector of 4.5 million people (3.2 %) of the population.

Community-based healthcare financing (CBHF): Community-based healthcare financing has been recognized as a community-friendly and community-driven initiative that has a wider reach and coverage of the informal sector especially if well designed. Experience with the Anambra State CBHF scheme, and a few other similar schemes in Nigeria indicate high acceptability of the people to CBHF scheme.

Conclusion and Recommendations: Government and non-governmental organizations should collective develop various forms of CBHF to reach out widely to Nigerians.

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INTRODUCTION

Nigeria, with a population of 140 million, is the most populous country in Africa. Unfortunately, Nigerian health sector, a foremost social service sector has never really fared well, primarily due to its chronic underfunding, the sector having to compete with other equally important social service sectors education, housing, transportation, environment, and security. Over the years, until the recent Nigerian debt relief, fund that would have been used for the improvement of social services in Nigeria had been employed for the servicing of Nigeria's huge external debt, which had gulped as much as one third of the country's national budget. Little wonder then that Nigeria was ranked a dismal 187th position among the 191 United Nations member States in health system performance by the World Health organization (WHO) in 2000, being only ahead of Democratic Republic of Congo, the Central African Republic, Myanmar, and Sierra Leone.[1]

It is not surprising therefore that many Nigerians especially women and children and in particular the poorest of the poor, die from avoidable health problems such as preventable infectious diseases, malnutrition, as well as complications of pregnancy and child birth. This of course has translated to a perpetually tragically low life expectancy for Nigerians as low as 43 years for 2006.[2] It has been reported for example that Nigeria is one of the countries that has had no significant improvement in child survival over the past 40 years.[3] Compared to other African countries, Nigeria had a mere 10 % reduction in under-5 mortality rate (U5MR) whilst Ghana, Cameroon, and Kenya achieved 53 %, 40 %, and 42 % reductions respectively.[4] The poor standing of Nigeria in health is clearly evident from its un-salutary reproductive health indices, some of which are shown in Table 1.

The Nigerian health system in general is believed to be characterized by not only low public sector funding but also poor staff motivation and inequitable access to health.[6] Financing healthcare in Nigeria has continued to present formidable challenges to government, academics and policy experts.[7] The models of financing healthcare in many developed countries are rarely applicable in Nigeria because of limited institutional

capacity, paucity of data on health status and service utilization, corruption, unstable economic and political climates and consumers' low level of awareness of health development issues. There are two main approaches to healthcare financing the public and private approaches. The public approach includes general tax revenue (direct and indirect tax), loan-deficit financing, grants and insurance; while the private approaches include user fees i.e. fees-for-service, employer-financed scheme, insurance (employee or individual paid), and community financing options. Patients, currently, have increasingly shared in the financing of government health services through the payment of consultation charges and the purchase of drugs and other renewable items because the health institutions have inadequate government provision. Against this backdrop, several African government have proposed the introduction or expansion of insurance-based healthcare financing, to raise additional revenue to fund the cost of healthcare provision as well as diminish financial barriers to obtaining health care at the time of illness.[8]

Health insurance is a system where individuals prepay amounts to a company, which assumes responsibility for the costs of health care rendered. In other words, health insurance is a social security system that guarantees the provision of needed health services to persons on the payment of token contributions at regular intervals. The uncertainties about the timing and form of future health care consumption and consequently the cost of that consumption, have led to demand for health insurance. Health insurance increases welfare by spreading the risk of financial loss due to illness and therefore maintains income. It also relieves a consumer of concerns about health care prices and income constraint at the time of illness. Health insurance scheme has two prime functions. The first is a financial function - to provide a pool of funds to cover all or (in government subsidized schemes) part, of the cost of health care for those who contribute to the pool; and to encourage providers and consumers to use health services in a cost-effective manner. The second prime function is social, including social equity. It removes financial barriers to obtaining health care at the time of illness for the vulnerable groups in the society, i.e. the very young and elderly, and the chronically ill, most of who are in the low-income groups and/or require expensive health care.

Table 1: Some Nigerian's Reproductive Health statistic.[5]

Total fertility rate (2008)	5.7 %
Contraceptive prevalence rate (2008)	15 %
Unmet need for family planning (2008)	20.2 %
Teenage pregnancy rate (2008)	23 %
Girls married before 15 years	25 %
Maternal mortality rate (2008)	545 per 100,000
Life-time risk	1 in 16
New born mortality rate (2008)	40 per 1000 live births
Infant mortality rate (2008)	75 per 1000 live births
Under-5 mortality rate (2008)	157 per 1000 live births
Male adult literacy rate (2008)	74.4 %
Female adult literacy rate (2008)	54.0 %
Life expectancy (2006)	43 years

Some African countries like Nigeria[9], Ghana[10], and Zimbabwe8, have introduced various forms of National Health Insurance. However Community Healthcare Financing which is essentially household co-financing seems to be a more favoured health care financing option than National Health Insurance because of the inadequacy of the administrative network for collecting premiums on a national basis and the limited coverage attainable using pay-roll based contributions.[11]

UN agencies, donor organizations, and African Health Ministers have advocated policies that endorse community financing of the public health in Africa. Many financing schemes in Africa are based on fee-for-service. It is only recently that some African countries like Nigeria, Ghana, Zaire, Burundi, and Guinea Bissau have tried rural health insurance schemes, with benefits and administrative arrangement that vary from country to country.

This review evaluates health care funding in Nigeria with respect to health budget and health expenditure, appraises the National Health Insurance Scheme, and examines community health care financing as a plausible option towards rapid development of effective funding of health care in Nigeria.

Pattern of health budget and expenditure in Nigeria

Between 1996 and 2000 Federal budgetary allocation to health in Nigeria has ranged from N4,838 million in 1996 to N17,581.9 million in the year 2000. Health budget as a percentage of Total Federal Government budget had adopted a rather irregular pattern from as low as 3.4 % in 1996, increasing to just 5.0 % in 1997 and declining to a paltry 2.7% in the year 2000. This irregularity in pattern has also been reflected in the allocation to capital expenditure which had ranged from N1,659.6 million to N11,579.6 million over the period of 1996 to 2000 Table 2.[12] Irregularity in pattern of percentage health budget in relation to the total federal budget and also in the percentage budgetary allocations to capital expenditure does not necessarily reflect revenue yield to federal government which would have ordinarily influenced allocations in yearly proportions, but infact may connote the lack of plan in health systems and health services projections which had not taken cognizance of the increasingly declining health services to the people. The overall percentage of health budget to total federal budget which falls below 5% is a far cry from the WHO's recommendation of 15% health budget to total national budget. Federal government estimates has it that public funding on health is in the range of 1-2% of GDP.[13] The World Bank however gave a lower estimate of 0.3 % of GDP for the period of 1990-1996[14] and 0.2 % in 1990-1998.[15] These are very low figures when compared with the average for sub-Saharan Africa, which was 2.6 % for 1990-1996, from the same source and also the 5% recommended by WHO. This situation has not changed over the years. Even as recent as 2007, the Human Development Report of the UNDP classified Nigeria under the lowest percentage spending category in respect of public health expenditure as percentage of GDP which was still as low as 1.4 % ! A summary of the Nigeria-National expenditure on health from 1996-2005 is given in Table 3[16].

Nigeria's total expenditure on health as percentage of GDP has been reported to fluctuate between 4.3% and 5.5 % over the

Table 2: Federal capital and recurrent expenditure on health 1996-2000 (N million)

(a) Year	(b) Health budget	(b) as % of total FGN budget	(c) Recurrent expenditure	(d) Capital expenditure	(e) Total expenditure	(e) as % of federal expenditure
1996	4,838	3.4%	3,175.3	1,659.6	4,834.9	1.98
1997	7,343	5.0%	4,702.3	2,623.8	7,326.1	2.06
1998	11,291.9	4.6%	5,333.6	8,307.2	13,640.8	3.08
1999	13,737.3	4.5%	8,793.2	7,386.8	16,180.0	1.71
2000	17581.9	2.7%	8,865.6	11,579.6	20,445.2	2.92

Table 3: Nigeria-National Expenditure on Health (Naira)

Selected ratio indicators for expenditure on health Expenditure ratios	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Total Expenditure on health (THE) as % of GDP	4.3	4.9	5.5	5.4	4.3	5.3	5.0	4.7	4.6	4.3
Financing agents measurement										
General government expenditure on health (GGHE) as % of THE	21.8	21.9	26.1	29.1	33.5	31.4	25.6	27.2	30.4	32.4
Private sector expenditure on health (PvtHE) as % of THE	78.2	78.1	73.9	70.9	66.5	68.6	74.4	72.8	69.6	67.6
Social security funds as % of GGHE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Private households' out-of-pocket as % PvtHE	94.5	94.9	95.0	94.8	92.7	91.4	90.4	90.4	90.4	90.4
Prepaid and risk-pooling plans as % of PvtHE	2.9	2.5	2.4	3.4	5.1	6.5	6.7	6.7	6.7	6.7

period between 1996 and 2005. General government expenditure on health as percentage of total health expenditure had been generally low over the same period ranging between 21.8 % and 33.5%. This is in contradistinction to private sector expenditure on health as percentage of total health expenditure which had ranged from 66.5%-78.2% over the same period. Private households' out of pocket expenses seems to constitute the major contributor to the overall private sector expenditure on health accounting for as high as 90.4% to 95.0% of private health expenditure over the period. Prepaid and risk pooling plan has been estimated to account for 2.4%-6.7% over the period. The table further shows that social security fund made no contribution whatsoever towards general government expenditure on health, accounting for 0.0% over the 10-year period under review. The implication of this statistics on health services delivery to the Nigerian people is very obvious. Government allocations to health are not only poor but general government expenditure which may infact represent funds-released is even poorer and infact leaves more to be desired. There is no doubt that most of the expenditure on health is borne from the people out of pocket expenses. This has grave implication to health care delivery for a country where majority of its people, infact 70 %, live below 1USD per day.[17] Health sector funding in Nigeria is likely to receive a tremendous boost if government develops social security fund and further encourages the improvement of prepaid and risk pooling amongst people in the private sector and rural areas.

The National Health Insurance Scheme (NHIS)

The Federal Ministry of Health (FMOH) set up a committee, which in 1985, recommended the adoption of a social insurance scheme for health care financing in the country.[18] The National Health Insurance Scheme is a body corporate established under Act 35 of 1999 by the Federal Government of Nigeria to improve the health of all Nigerians at an affordable cost. The NHIS programmes are classified under Formal Sector, Urban Self-employed, Rural Community, Children under Five, Permanently Disabled Persons, and Prison Inmates Social Health Insurance Programmes.

Stakeholders in the NHIS include the Federal Government, the employees, the employers, the Health Maintenance Organizations (HMOs), Boards of Trustees (BOTs), and the Health Care Providers. The payment system is by capitation or fee-for-service. The former is the payment to a primary health care provider by the HMOs on behalf of a contributor for services rendered by the provider. This payment is made regularly in advance for services to be rendered. The later payment mechanism is made by HMO to non-capitation receiving health care providers who render services on referral from other approved providers.

The NHIS has inherent paradoxes and conjectures:

- The scheme is said to be about resource pooling and risk sharing in order to drastically reduce the pressures on the government for funding of health services. Ironically, with the current design of the scheme, it has been receiving substantial allocations from the Federal budgets, ranging from N0.4 to N4.5 billion annually.
- The NHIS approach has been proposed to be able to significantly improve access to health services by majority of Nigerians. Unfortunately this is unlikely to be so since the scheme presently targets mainly those in the formal sector of employment. This category of people constitutes

only about 4.5 million, a rather insignificant number compared to the nation's population of 140 million. Furthermore formal sector personnel are wage earners who may even be better placed to foot their health bills compared to the rural poor who are the majority of Nigerians.

- The NHIS has been proposed to mobilize resources from multi-nationals such Shell, Chevron, Nigerian National Petroleum Corporation, Central Bank of Nigeria, etc., along with contributions from employees from smaller companies to improve the quality of health services of the majority of Nigerians. The likelihood of this occurring is rather remote since these organizations are likely to develop their Health Management Organizations, health centres or other health care arrangements to cater specifically for their employees.
- Finally, the design of the NHIS is a typical "Top-Down" approach, rather than "Bottom-Up" approach which is unlikely to promote a sense of scheme ownership and sustainability.[19]

The design of the NHIS as proposed at its launching on 6th July 2005 is unlikely to promote relevance, equity, cost-effectiveness and quality delivery of health services making it imperative that alternative health care financing option needs to be explored. More recently following the presidential directive of a universal health insurance coverage for Nigerians by 2015, more money has been allocated for the NHIS especially from the Millennium Development Goals (MDGs) fund and yet more is being expected from the consolidated funds following the passage of the National Health Bills. Infact the Executive Secretary of the NHIS has recently proposed that the scheme will require a whooping N646.8 billion annually to provide health care coverage to the country's poor and vulnerable 70 %, representing about 98 million people and further announced the development of a blue print to roll out informal sector health insurance care in Nigeria.[20]

Community-Based Healthcare Financing (CBHF)

Community health care financing may be defined as voluntary contributions made by individuals, families, or community groups to support the cost of health care services, with particular emphasis on primary health care.[21,22] This support may cover partially or fully the cost of running such services. The contributions could be in cash, kind, or labour. Community financing alternatives include private donations; community contributions in kind; special fund-raising events; income-generating schemes; and individual fees for service in form of pre-payment, standard payment for all services, payment for cost of materials.[23] Unlike many insurance schemes, CBHF 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 sector who are unable to get adequate public, private, or employer-sponsored health insurance.[24]

Well organized and sustained small CBHF schemes can develop to strong and acceptable social health insurance system. This is true of the health insurance systems currently operating in Germany, Japan, and Korea. Today's CBHF schemes are operated in a manner similar to the friendly societies which existed in large numbers in the United Kingdom during the 19th century and also the traditional solidarity or welfare mechanisms in West Africa.

In recent times interest in the development of CBHF scheme in low income countries such as Nigeria has become inevitable for the following reasons: The wide spread introduction of user fees for public health services in many developing countries particularly of sub-Saharan Africa which occurred in the 1980s and 1990s a typical example is that following the Structural Adjustment Program (SAP) introduced in Nigeria in 1988; [25, 26] the virtual collapse of government health care services witnessed especially in poverty and war stricken countries of sub-Saharan Africa; the increasing role of private health care providers towards bridging health care gap consequent upon the collapse of public health services, even in rural communities and the obvious difficulty likely to be encountered in the expansion of formal health insurance to the informal sector.[24] CBHF enables an increase in financial access, utilization of health services, resource mobilization and quality of health care services through community effort. It reduces the out-of- pocket expenses payable by people seeking health care thereby leading to more frequent utilization of health care services and less delay in seeking care.[24]

The local communities play a great role in the determination of benefit packages in a CBHF based on needs, priorities and community member's ability to pay. Payments of premium to schemes can be adjusted to suit community members for example annual payment which may be carried out at a time following harvest and sale of farm produce as may occur in a predominantly farming community. Financial access can also be increased in a CBHF through the negotiation of lower rates for services by providers thereby enabling members to get more services for their money. CBHF schemes are usually organized in such a manner as to encourage community participation whereby community members have a stake in the election of scheme managers and also in the oversight of the scheme. Government and other higher level bodies can usually play an important role towards the successful outcome of a CBHF. This can be in the form of coordinating and facilitating technical assistance to scheme, training scheme managers and financial controllers, advocacy and dissemination of best practices as well as monitoring and evaluation of the scheme. It can also accredit and oversee CBHF schemes and develop legislation towards the schemes sustainability. Government can also co-finance CBHF through contributions in personnel, equipments, and infrastructure. In general the unlikelihood of a rural or informal sector health financing scheme to have enough funds to sustain itself in low income countries has been highlighted. Such CBHF schemes should therefore supplement government health care budget rather than standing alone.[24]

Sustainability has been a major concern regarding CBHF scheme. Sustainability refers to the ability of the scheme to continue operation over time. It has many dimensions to it which includes social, managerial, political and financial. Amongst major drawbacks to sustainability includes inexperience management, specific scheme design flaw, inadequate dues collection and the lack of institutional development. It is now thought that reinsurance (that is insuring the CBHF scheme by

larger insurance scheme) could be a way of obviating the problem of un-sustainability of the CBHF scheme.

Apart from sustainability, CBHF may have other drawbacks which may include not only poor premium collection, poor design and management inexperienced as mentioned earlier but also problems related to intra-communal leadership squabbles and resistance from health workers to the newly introduced scheme. Inspite of this there is no doubt the scheme holds potentials towards wider reach and greater acceptability by the low income population especially in the rural areas.

Brief on the Anambra State Community Healthcare Financing Scheme

Disturbed by the paucity of funds available for health services in the State and its deleterious impact on health care delivery, the Anambra State government through its Ministry of Health, in 2004 conceptualized and implemented the Anambra State Government/Community Healthcare co-financing scheme essentially to make additional funds available for the provision of quality health services to the people especially at primary health care level. The scheme has been defined as a community-based, community-driven, and community-friendly healthcare initiative that harnesses all available financial, human, and material resources in health to facilitate an accessible and affordable healthcare delivery to the community making use of an articulated government-community healthcare partnership.[27, 28] The scheme was initially piloted in 10 communities drawn from across the three senatorial districts of Anambra State. Structurally the scheme was constituted of:

1. The government which through its community health care financing committee carried out advocacy, sensitization, and relevant trainings for the communities and stakeholders; refurbished the health centres involved in the scheme while supplying them with basic equipments and seed drugs; deployed health personnel to these centres while retraining them where necessary; and monitored the implementation of the scheme. The government was also responsible for the development of legislative issues related to the scheme.
2. The Community Health Committee (CHC) constituting of members drawn from segments of the community to which are added representative of government. The CHC is the highest governing body of the scheme and the mouth piece of the community.
3. The Health Management Organization (HMO) a maintenance organization that sees to the smooth running of the scheme and constitutes a go-between for the health facility and the community.
4. The health facility harbors the health services under the scheme and is sufficiently equipped to render quality care at primary health care level.
5. The community this is the beneficiary to the scheme and contributes membership into the community health committee from the various villages of the community. The community also provided the unskilled work force in the health facility such as cleaners, care takers, and security men. Every member of the community is encouraged to join the scheme through payment of prescribed premium.

The premium, as determined by members of the community was N100 and N50 respectively per adult per month and per child per month. The range of services given was that obtainable at primary health care level. An effective referral mechanism was also put in place. The scheme was well received by the pilot communities and was clamored for by communities that did not participate in the pilot scheme. The launching and flag-off of the scheme in each community was greeted by celebration and represented an opportunity to attract donations towards the improvement of the scheme. Amongst philanthropic donations given during such launching includes buses, refrigerators, ambulances, drugs, cash donation and even the payment of premium for indigent members of the communities over specified period of time.

In a study evaluating the impact of the Anambra community health care financing scheme on maternal health services in one of the pilot health communities, it was found that antenatal clinic attendance and delivery increased significantly over the three months following one year of the commencement of the scheme (late intervention period) compared to the first three months of the schemes implementation (early intervention period) Table 4. Similarly quality of care from the client perspective, together with the availability of drugs and equipments at the centre also showed significant improvement.[29] Clearly, the acceptability of the scheme by members of the community was indubitable.

Table 4: Distribution by utilization of maternal health services at the health facility

Services	Number of clients		z	p values
	Early intervention period March-May 2004	Late intervention period March-May 2005		
Antenatal Care	72	129	15.5	P<0.05
Delivery	33	74	12.4	p<0.05

CONCLUSION

In recent years the international community has displayed an unparalleled optimism as to the positive role CBHF will play in meeting the health funding needs of poor communities and increasing their access to quality health care. A review in 1997 identified only 81 documented CBHF schemes the world over, majority of which were in sub-Saharan Africa and Asia. The number of CBHF schemes today can be counted in thousands.[24,30] In Ghana for instance the number of CBHF schemes grew from four to 159 over a two year period.[24] In Nigeria CBHF has not developed to the extent expected of a country of its size and importance, and furthermore yearning for an accelerated effective development of its health care. The experience of the "Towards Unity for Health Initiative" of the WHO supported Odogbolu Health Project; the DFID supported Primary Health Care Systems/Bamako Initiative Project in selected Local Government Areas in Delta, Katsina, Kebbi, and Oyo States; the Oriade Initiative in Ekiti, Ogun, Osun, and Oyo States, as well as the Anambra State government community

health care co-financing scheme and reports from other community-based initiatives, suggests that Nigerian communities are willing and able to participate in local health management and development.[28, 31, 32, 33] Many stakeholders in Nigeria as in many other low income countries yearn for the expansion of CBHF on account of the obvious need for the provision of quality health services to alleviate the disease burden that is ravaging the population particularly its highly vulnerable segments children and pregnant women. It should be mindful however that the realization of the full potential of the CBHF scheme is contingent upon strong design and community ownership of such scheme. The development of CBHF should not be left for the NHIS. Every State government and even Non-Governmental Organizations in Nigeria including religious bodies should rise up to the development of one form of CBHF or the other to ensure a wider reach to, and indeed wider choice health insurance cover for the Nigerian people.

REFERENCES

1. World Health Organization. World Health Report 2000. Health Systems, Improving Health Performance. Geneva, WHO.
2. Wikipedia. Human Development Index. http://en.wikipedia.org/wiki/Human_Development_Index (Accessed 15/03/2010)
3. Federal Ministry of Health. Integrated maternal, newborn and child health strategy. Federal Ministry of Health, Abuja, Nigeria, 2007.
4. National Population Commission (NPC) {Nigeria}and ORC Macro. 2004. Nigeria Demographic and Health Survey 2003. Calverton, Maryland: National Population Commission and ORC Macro.
5. National Population Commission (NPC) {Nigeria}and ICF Macro. 2008. Nigeria Demographic and Health Survey 2009. Calverton, Maryland: National Population Commission and ICF Macro.
6. UNICEF/FGN. Children's and Women's right in Nigeria: A wake-up call. Situation assessment and analysis 2001, financing of health services, 94–98.
7. Ibukun-Oluwa O. Health insurance: A viable approach to financing health care in Nigeria? Private initiatives for primary healthcare project, 1996: 11.
8. Vogel RJ. An analysis of three national insurance proposals in sub-Saharan Africa. International Journal of Health Planning and Management, 1990; **5:** 271–285.
9. Nigeria Federal Ministry of Health. Report of the national committee on the establishment of health insurance scheme in Nigeria. September 1986.
10. Amenyah J. Prefeasibility study on national health insurance scheme, Accra mimeo manuscript, August 1985.
11. Carrin G. Community financing of drugs in sub-Saharan Africa. *International Journal of Health Planning and Management*, 1987; **2:** 125–145.
12. Central Bank of Nigeria. Annual report and statement of account 2000.
13. Federal Government of Nigeria. Nigeria, economic policy and strategy: The way forward, document prepared by the consultative group on Nigeria, Federal Government of Nigeria, Abuja, 2000.
14. World Bank, African development indicators 2000. The World Bank, Washington DC.
15. World Bank, World Development Report 2000, The World Bank, Washington DC.
16. Health Reform Foundation of Nigeria (HERFON). Primary Health Care in Nigeria the effect of socio-cultural, economic, and political factors. Nigeria Health Review 2007: 24.
17. Ladipo O. A. Reproductive health and Nigeria's sustainable development effort. Keynote address at the Health Summit, Abuja, 16th-19th February, 2004.
18. Federal Ministry of Health. Report of the special committee on national health care financing. Lagos: Federal Ministry of Health, 1985.
19. Osibogun A. The National Health Insurance Scheme: Some myths and realities. *Journal of Community Medicine and Primary Health Care* 2000; **12:** 1–3.
20. Onwuka N. Nigeria: Health Insurance Scheme to gulp N646.8bn. ThisDay Newspaper 14th June 2008.
21. Stinson W. Community financing, PHC Issues, APHA Washington DC., series 1, No. 4, 1982.
22. Stinson W. Potential and limitations of community financing. World Health Forum, 1984: 5.
23. Olumide A. Fundamental of health services management for doctors and senior health workers in Africa, 1st Edition, Kenta Publishers, Ibadan, Nigeria, 1997: 92.
24. Partners for Health ReformPlus, 21 questions on CBHF, An Overview of Community-Based Health Financing. March 2004.
25. Harrison K. A. Macro-economics and the African mother. (Editorial) *J. R. Soc. Med.* 1996; **89:** 361–362.
26. Ekwempu C. C., Maine D., Oluraba M. B., Essien E. S., Kisseka M. N. Structural Adjustment and Health in Africa. *Lancet*, 1990; **336:** 56–57.
27. Adinma J. I. B. Overview of the Community Health System and Healthcare Financing Scheme. Proceedings of advocacy workshop on Community Health System and Healthcare Financing Scheme. Anambra Health News, Special Edition, 2004: 6–10.
28. Ndibe O. J. Update on Anambra State Community Health System and Healthcare Financing Scheme. Proceedings of the 1st Anambra State Health Summit. Anambra Health News (Suppliment) 2005; **3 (2):** S14–S18.
29. Adinma ED, Nwakoby BAN, Adinma JIB. Effect on healthcare delivery, of integrating maternal health services into a health insurance scheme. Nigerian Quarterly Journal of Hospital Medicine. (In press).
30. Bennett, Sara, A. Creese and R. Monasch. Health Insurance Scheme for People outside Formal Sector Employment. Division of Analysis, Research and Assessment of the world health Organization, 1998: ARA paper No.16.
31. Osibogun A. Up-scaling the Leguru health society, community empowerment for health financing and co-management. Miral Printing Press, Surulere, Lagos, August 2003: 21.
32. The DFID primary health care systems/Bamako initiative in Nigeria: Report of the Institute of Development Studies evaluation study, Institute of Development Studies, Brighton, for Department for International Development (UK) and National Primary Health Care Development Agency, Abuja, 1998.
33. Dare O. O., Ibidapo O. O. and Coker D. A. O. Results of baseline surveys in the Oriade initiative, submitted to the expert panel for better health in Africa, The World Bank, Washington DC, 1998.