Achieving Universal Health Coverage in Nigeria:
Assessing the Community Based Health Insurance Scheme (CBHIS) in Lagos
Study Report

An Assessment project of
AndChristie Research Foundation/Centre for Public Policy Alternatives (ARF/CPPA)

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STUDY SUMMARY

Having started the National Health Insurance Scheme since 2005, with basically only about five percent of the government employees covered, excluding majority of Nigerians especially the informal sector, the Nigerian government decided to expand its public health insurance through a community-based social health insurance scheme (CBHIS). The program was piloted in Lagos in July 2008, with the aim of achieving universal healthcare coverage by 2015, with at least about 70 million people to be enrolled.

Six years later, available statistics have not shown a significant progress in the program. In the quest for in-depth information on the program implementation so far, its coverage, usage by potential beneficiaries and problems encountered, this brief assessment study was conducted with a view to recommending ways to ensure successful implementation and sustainability.

To realize these, secondary and primary data were explored through literature reviews and structured qualitative key informant interviews from stakeholders (board of trustees-BoT and mutual health officers) at the facilities (where the health services are being provided) in Lagos.

As at the completion of this study, only 3 (of the 20) local government areas in Lagos state currently implement the scheme. In total, only about 12,958 people are actively benefiting from the scheme, which is about 0.07% of the state population. Despite the fact that pockets of the scheme exist in some states across the country, if extrapolated, only a very small proportion of the country’s population have been reached, raising concerns as to whether the program can meet its target of enrolling at least 70 million people by 2015.

Although the observations from the interviews suggest that the government is doing well in ensuring the health service providers are duly compensated as at when due and routine monitoring of the scheme at the existing facilities, implementation has not been without challenges; such as reduction in the numbers of enrollees, inability of some beneficiaries to pay premium, unwillingness to continue, poor awareness and inadequate information, lack of trust because it is a new program, poor incentives for management (especially the BoT members).

To ensure its success, some measures must be taken. More needs to be done on awareness to inform and educate the community in order to build their confidence in the scheme. Program scale up to other communities, financial incentives for the BoT, and philanthropic assistance are also needed.
INTRODUCTION

Background

Nigeria, an oil rich nation, is the most populous country in Africa, a population of over 170 million people at a growth rate of approximately 3 percent; with urban-rural population almost at par (50.2%) and (49.8%) respectively. Nigeria is ranked as one of the fastest growing economies in the world with growth rate of 6.21 percent in 2014 from 5.65 in 2008. Recently in 2014, the country’s Gross Domestic Product (GDP) was rebased, making it the largest economy in Africa, with a GDP of US $510 billion.

Sadly, the country’s health system has for long been blighted reflected by negative health indices hardly coming near internationally acceptable standards. The World Health Organisation (WHO) have shown that Nigeria’s health system needs improvement. 2013 data from the World Bank showed that the life expectancy at birth of 52 years is below the Sub-Saharan Africa’s average (56 years). Infant mortality rate is 39 in every 1,000 live births, under-five mortality rate is 124 in every 1,000 live births, while maternal mortality rate was estimated at 630 (2010 figure) in every 100,000 births.

Reasons for these abysmal statistics are multifaceted. One key factor is the country’s poor budgetary allocation to health, which has in the past years hovered around 5-6 percent of total annual budget, and falls short of the 15% (US $14/N2, 268 per capita expenditure on health) expected of a developing country in order to achieve the World Health Organization’s recommendation for optimum health coverage by 2015. The total health expenditure as a percentage of GDP has not been consistent either.

Health expenditure and Health Insurance

To meet health needs, majority of Nigerians fund their healthcare out-of-pocket (OOP). This means directly paying for medical consultation, drugs and other health related procedures. The huge personal commitment has severe implication on personal finance and may force people to reduce spending on food and other basic needs in order to meet basic and important healthcare needs. The WHO explained that medical fees remains a significant obstacle to healthcare coverage and utilisation, and advocated governments to encourage risk-pooling prepayment approach as a major way to reduce reliance on direct payments.
The federal government of Nigeria started a national health insurance scheme (NHIS) in 2005 to provide health coverage for Nigerians. Only about 4 million of federal government employees have been fully enrolled in the scheme. In addition, over 1.6 million pregnant women and children under age five have been registered under the NHIS/MDG Maternal and Child Health (MCH) Project in twelve states.

However, this over five million coverage is only a fraction of the country’s population (less than 5%) and mostly from the formal sector; leaving the large informal population (majority of who are poor) unprotected.

**Community Health Insurance Program**

To promote inclusive health insurance, the federal government through the National Health Insurance Scheme in 2008 started a rural community-based social health insurance program (CBSHIP). This also will help to achieve universal healthcare coverage (UHC) by 2015, with at least about 70 million people to be reached. Unlike individual health insurance which focuses on the coverage of the individual (with or without a dependant) community health insurance focuses on a group of individuals and provides health coverage is a uniform manner, with each member having equal access to the benefits. It often cost less as each member is expected to share the risk of payment.

It is pro-poor scheme to ensure that a greater number of Nigerians including the rural poor have access to quality health care. It will also reduce the high level of OOPs expenses and promote higher level of financial risk protection. Among others, the CBHI program is to act as a mechanism for mobilizing community resources to share in the financing of local health services for the informal population, and to improve the quality of healthcare by increasing both the amount and reliability of resources available for providers. It is expected that after reaching a large number of beneficiaries, the scheme will no longer rely on the government for sponsorship; rather it will be self-sustaining as members are expected to pay premiums duly so that funds are available to continuously provide services.

For sustainability, to provide and manage the infrastructure for the CBHI service delivery, two options have been designed; a public health facility will be built and equipped by the government, community or donated by a private individual to the community. The facility will then be contracted out to a private sector health provider who is to manage it in partnership with the government and the community. The other option is that a private health facility could be assessed and adopted for the scheme under the management of the Government, community and the owners of the private health facility.
Prototypes of this program have been implemented in varying designs across the globe. Some sub Saharan Africa nations that have practiced this model include: Ghana, Senegal, Mali, Uganda, Tanzania and Kenya. The general outlook has been disappointing; although a few of them - Ghana and Rwanda – are exceptions. Inadequate financial support, clear legislative and regulatory frameworks and unrealistic enrolment requirements, etc, have been noted as notable factors for the poor outcome. As at 2010 (six years after uptake), 66.4% of Ghana’s population had been enrolled in the scheme, with 29.6% in the informal adult sector. One key element for Ghana’s success is the strong public-private partnership: an adaptation of a network of CBHI-type entities, the central authority and sources of funding through the National Health Insurance Fund. These promoted a wide coverage and guaranteed financial sustainability.8

The CBHI program in Nigeria was expected to run as pilot in each state of the federation for three years. The premium to be paid depends on the community and the unit of enrolment is either the family or the household. Though still experiencing a paucity of data, existing information showed that uptake of this program has begun in some states, with each at different levels of implementation. For instance, the benefiting community members in Abuja pay N1, 500 per annum, while the FCT Administration pays N13, 500 for each member as subsidy9. The huge subsidy to be borne raises the concern of how sustainable this will be for the FCT administration. In Ayedun community in Ekiti state, each member pays N1, 200 per annum (or N100 monthly). In Gombe state, the CBHI document indicated that ‘Premium will be paid by a family unit of six members and the specific premium will be determined for any community after relevant research has been done to determine income status among other things. Any additional dependant would attract extra contributions from the principal beneficiary.

Assessment

It is about six years since the pilot of the CBHI program in Nigeria and it is expected that there should be some amount of data available to the public in order to assess the program to observe its coverage in terms of enrolment, awareness, usage and attitude among community members, and other indicators as set out in the program design. However, efforts to retrieve data have been unsuccessful. From desktop research, the finding is that each state designed the program as deemed suitable; as a result there is no central data bank on the status of the program across the country.

As we approach the 2015 deadline for meeting the CBHI deadline and ultimately the United Nations Millennium Development Goals (MDGs), it is necessary to evaluate the progress of the program thus far.
The aim of this exercise therefore is to assess the take off of the CBHI in Nigeria, with focus on Lagos state, in order to gauge the success and possible lessons (to be) learnt.

**Objectives of Study**

This study aims to:

1. Collect baseline and existing data on CBHI programs in Nigeria, with a focus on Lagos.
2. Assess enrolment data, as well as attitudes towards and usage of the program.
3. Assess the program’s overall value based on user experience to date.
4. Draw conclusions and make recommendations for future development and expansion of health insurance schemes in Nigeria.

**Research Question**

- What is the status of the CBHI in Lagos and Nigeria at large?
- Was any baseline survey conducted program commenced?
- What is the enrolment rate thus far?
- How is data managed and stored?
- What are the challenges faced and possible solutions (if any) adopted?
METHODOLOGY

Study Design and secondary data

To realize the research objectives, secondary and primary data were explored. An initial desktop research (online and literature search) was conducted to gather information on the program. Although various sources were consulted, the secondary data presented in this study was pulled from the report of an address delivered by the Lagos state commissioner for health, Dr. Jide Idris, during the ‘Lagos State Government Annual Ministerial Press Briefing (2013/2014)’, to mark the second year of the second term in office of the Governor of the state, Babatunde Fashola (SAN), at the Bagauda Kaltho press centre, Alausa, Ikeja, Lagos; on the 30 April 2014.

Interview

To obtain first hand information, visits were made (in July 2014) to the Ikosi-Isherri (the pioneer location of the scheme) and Ajeromi/Ifeолодun mutual health associations at the respective LGAs. At the Ikosi-Isherri; a quick interview was held with the representative of the ministry of health (MOH) at the LGA secretariat. Afterwards, a key informant interview was conducted with the chairman of the Board of Trustees, Mr. Kunle Sholesi, who has acted in that capacity since the program inception. The interview was held at his office in Olowora, the location of the health facility designed for the program. At the Ajeromi LGA CBHIS facility located at Olodi-Apapa, a meeting was held with the BoT chairman (Alhaji Lawal) and the board members before an in-depth interview with the mutual health administrator. After the interviews, the researcher toured the facility, interacted with some of the providers (a medical consultant and nurses) on duty as at the time of the visit and observed patients coming for consultations or exiting the facility. A quick interview was also held with the registrars and the registration process of the scheme was also observed in real time.

The interview was conducted using semi-structured approach, with interview guides designed in English language. Responses were documented using digital recording devices and simple note taking. After completion of interviews, the information collected was then transcribed by the researcher, using the note as a guide to ensure data quality.
Analysis

The information gathered from the desktop search and interviews were analysed, drawing case study where necessary.

Ethical Consideration

As part of ethical consideration for human subjects, participation in the study was voluntary. Telephone conversations were had with the BoT chairmen to inform them of the study, the purpose, procedure and end-benefit, as well as to seek consent, with assurance of confidentiality to all responses.

Challenges/Limitation

- Interviews were interrupted because the respondent had to attend to various issues. The interview lasted about 45 minutes.
- The research methodology may not be considered very rigorous in terms of number of interviews and stakeholder groups. Further interviews are needed for the state government representatives or ministry of health.
STUDY RESULTS

Summary

According to information from the ‘Lagos State Government Annual Ministerial Press Briefing’, and supported by information from interviews, the CBHI scheme is only being implemented in 3 (of the 20) local government areas in the state, viz: Ikosi-Isheri, Ibeju-Lekki and Ajeromi.

<table>
<thead>
<tr>
<th>LGA/LCDA</th>
<th>Year launched</th>
<th>Enrolees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ikosi-Isheri</td>
<td>23rd July, 2008</td>
<td>4,978</td>
</tr>
<tr>
<td>Ibeju-Lekki</td>
<td>1st February 2011</td>
<td>6,667</td>
</tr>
<tr>
<td>Aweroyen = 4,684</td>
<td>1st February 2011</td>
<td>6,667</td>
</tr>
<tr>
<td>Berekodo = 1,983</td>
<td>1st February 2011</td>
<td>1,983</td>
</tr>
</tbody>
</table>

History and Management Structure

The CBHI program in Lagos and Nigeria was piloted with the Ikosi-Isheri mutual health insurance scheme, which is currently in its 6th year of operation. It has experienced different challenges over these years, but has been able to remain functional as a result of sheer determination from the people and the government. According to the Ikosi-Isheri BoT chairman, the program ‘is not affected by strike nor is it a free health care system’.

The state government largely funds the scheme, while the communities designate representatives as board of trustees. The facility at the Ikosi-Isheri scheme was built by the state, while that at Ajeromi was initially managed by the local government as a primary health care centre (Tolu PHC), but later renovated by the Millennium Development Goals (MDGs) and eventually taken over by the state government for this purpose. The providers are responsible for providing all medical and consulting services; the administration is by the BoT, who are also members of the community. Community members are made to have a sense of ownership and can offer assistance in ways they deem fit. Administratively, preceded by the name of the LGA, the program is otherwise called ‘Mutual Health Association’; e.g. Ajeromi Ifelodun Mutual Health Association.

Registration and Premium

The scheme was basically designed for a family of six viz: father, mother and four children (less than 18 years), though it offers other plans too (see table 2). Although the facilities collect similar premium, N1,
200, the fee at registration differs. At the Ikosi-Isherī plan, an interested participant in the scheme registers with N1, 300 for a family of six (premium of N1, 200 and actual registration fee of N100), Ajeromi scheme charges just the premium. The premium was N800 when the scheme was launched at the Ikosi-Isherī scheme but later scaled up to the current price, with inflation cited as the main reason for this.

Registering an additional family member attracts a fee of N200 or N300, depending on the facility. Premium must be paid between 1st and 7th of every month (the ‘due date’), while payment made afterwards is considered late. Although late payment may not attract any penalty, the Ajeromi facility keeps record of payment behaviour of participants, with the intention to reward such at some point in time; although observations from records showed that only a fragment of the participants pay early. Renewal of premium is often done at the administrative office of the facility, though there is an option of using the banks.

A default in payment of premium in a month attracts a fine. At the Ikosi-Isherī facility, it is 20% (of the premium, N240) and accumulates as long as the beneficiary defaults. Members that default consistently for six months are eventually dropped from participating in the scheme. This is however not the story at the Ajeromi facility, as no fine is imposed for default. One reason for this is to encourage participation in the scheme, giving that the program is still at its inception phase. Overall, a lot of members still default in payment of premiums.

Table 2: Examples of plans in the CBHI scheme

<table>
<thead>
<tr>
<th>Plan</th>
<th>Premium (N)</th>
<th>Criteria at registration</th>
<th>Additional criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>600</td>
<td>&gt; 18 years; only 1 person</td>
<td></td>
</tr>
<tr>
<td>Family of six</td>
<td>1,200</td>
<td>1 father, 1 mother and 4 children (&lt;18 years)</td>
<td>Every addition of another child attracts N200* or N300&quot;</td>
</tr>
<tr>
<td>Family of 7</td>
<td>1,500</td>
<td>1 father, 1 mother and 5 children (&lt;18 years)</td>
<td></td>
</tr>
</tbody>
</table>

*The Ikosi-Isherī scheme, *the Ajeromi Ifelodun scheme

According to the Ajeromi mutual health administrator, registration closes the 15th of each month, this is to enable them make necessary preparations for the new month. Registration can still be made on that day (15th), only that it will be accompanied with an out of payment for any medical service(s) rendered and/or drugs prescribed to the person. This however applies to that day only, with normal registration resuming afterwards.
Recruiting service provider and types of services provided

Medical service providers (a medical professional, hospital, etc) are selected from the private sector, following a transparent selection process, which is characterize by public advertisement and bidding process. After receiving bids from various would be providers, the BoT submits these bids to the Ministry of Health. The MoH carries out independent checks on the providers and invite the eligible ones for interviews. The selected provider is given a set of conditions such as the number of staff to be employed, the types of services to be provided, etc. The choice of inclusion of auxiliary nurses differs for the facilities. While the Ikosi-Isheri facility did not agree to recruitment of auxiliary nurses, Ajeromi allowed.

A salary structure (capitation) is then agreed with the provider and is always paid on the 7th of every month. The provider is allowed to determine the salary of its staff. Afterwards, a memorandum of understanding (MoU) is signed with the provider.

The medical staff at the Ikosi-Isheri facility includes 5 medical doctors/consultants, 3 matrons, and 9 nurses. Those at Ajeromi include 2 medical doctors, 2 professional nurses, 4 auxiliary nurses, 2 midwives, 1 community health worker (CHEW) and 1 laboratory scientist. The facilities are operated 24 hours daily, with at least a nurse and a medical consultant on duty. The consultants operate a shift system every 8 hours, with at least one person on duty during weekends.

Only primary health care services and basic maternal and childcare services including malaria, typhoid, sexually transmitted infections (STIs), blood pressure checks, antenatal care, routine immunizations, counseling and basic laboratory tests, are provided at the facility; while other cases are referred to secondary and tertiary health institutions. Recipients pay a token of N50 for every consultation visit to the facility for any medical purpose.

Subsidy

For every participant in the scheme, the government pays a subsidy for each person to support and sustain the scheme. According to the BoT chairman in Ikosi-Isheri, it is about ‘N1, 200 extra for each participant’.
The scheme was designed to be self-sustaining in the long run, though this is not the case at the moment. In the Ikosi-Isheri scheme, the salary of the provider is jointly paid between the state government and the scheme. This is because the scheme has ‘never’ been able to register an adequate number of people monthly in order to aggregate premium that is adequate to pay the provider. The government also makes allocation for administrative expenses. In the Ajeromi scheme, capitation and drug purchases are borne solely by the state government, while funds obtained from premiums are used for other administrative and logistical purposes. This will continue until the facility registers at least five thousand active members.

**Coverage/enrolees**

According to the Ikosi-Isheri BoT chairman, the scheme has recorded as much as 23,000 people at one time or the other, but only about 5000 are actively participating by regularly renewing their premium and receiving the service. There are about 1,700 registered participants in the Ajeromi scheme. The mutual registrars also confirmed that an average of 30 people register monthly, similar to what obtains at Ajeromi. There was no indication on the minimum number of enrolees; it does appear the scheme has been designed to remain for a long time, irrespective of the current number of enrolees.

Although the scheme was designed for members of a community, some members of other communities also use the services. The Ikosi-Isheri scheme was specifically designed for three major areas (Olowora, Isheri and Magodo), but it registered some non-community participants, with some from as far as Ibafo and environs. The BoT chairman stated that one of the reasons for this is that the scheme is not yet available in other locations. This poses a challenge to the ‘community ownership’ of the scheme. So far, the Ajeromi scheme has not registered any non-community members and noted that this may include out of payment option.

**Data management system and monitoring**

Monthly stakeholders meetings are held and reports are disseminated to the state for record and monitoring purposes. The administrative side of the facility is equipped with basic information and communication technology (ICT) infrastructure, to aid the creation and management of data and relevant information. The Ikosi-Isheri facility has also received visits from other state’s health ministries, such as Ekiti and Akwa-Ibom. In the Ajeromi facility, data management has been contracted to an independent database company.
OBSERVATION

Following the analysis of the available information and data gathered during this assessment study, some inferences have been drawn from the implementation of the community based health insurance scheme in Lagos.

- Coverage is still very poor. Table 3 shows a breakdown of the estimated population of the locations where the programs are being implemented and the percentages covered so far. For instance, in six years the Ikosi-Isheri scheme has only covered less than 1 percent of its population.

- As at the completion of this study, only 3 (of the 20) local government areas in Lagos state currently implement the scheme. In total, only about 12,958 people are actively benefiting from the scheme. Conservatively, this is about 0.07% of the state population. Despite the fact that pockets of the scheme exist in some states across the country, if extrapolated, only a very small proportion of the country’s population have been reached at this time. The concern as a result is if the program can meet its target at least 70 million people by 2015.

<table>
<thead>
<tr>
<th>LGA/LCDA</th>
<th>Duration of operation (months)</th>
<th>Enrolees</th>
<th>Estimated Population</th>
<th>% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ikosi-Isheri</td>
<td>72</td>
<td>4,978</td>
<td>934,614</td>
<td>0.53</td>
</tr>
<tr>
<td>Ibeju-Lekki</td>
<td>26</td>
<td>6,667</td>
<td>99,540</td>
<td>6.7</td>
</tr>
<tr>
<td>Ajeromi/Ifeiodun</td>
<td>16</td>
<td>1,313</td>
<td>1,435,295</td>
<td>0.1</td>
</tr>
</tbody>
</table>

- Absence of in-depth research. There were no indication that any sort of research or perception study was conducted among the community members before implementation in order to determine key factors such as prices individuals will be willing to pay as premium, and their expectations; it will help to know what they want and what they are willing to pay to get them. Neither has there been any research to assess recipients’ satisfaction of the scheme. This also will avoid making of assumptions as well as provide information on areas needing improvement.

The scheme has been faced with lots of challenges. The major problems include: attrition (withdrawal or loss of members) and default in the payment of premium among participants, poor awareness and patronage, illiteracy among some, poverty, and lack of support from the local government. Others are lack of philanthropic support, poor services, and poor incentives for the management.
 Loss of members, either voluntarily or due to other reasons, has been a key deterrent to the coverage and success of the scheme. It has been difficult to retain them, and this has been attributed to poverty and inadequate information on the scheme. Participants, especially the poor, may sometimes find it challenging to consistently pay premium monthly and even harder to pay the accompanying fines (as in the Ikosi-Isherri scheme); as a result there are too many inactive members in the scheme.

There is still poor awareness and paucity of information. These are key factors responsible for the current state of the scheme, though there have been some effort to create awareness. For instance, there was a weeklong awareness campaigns before the commencement of the scheme in Ajeromi. Sadly, these campaigns have not been consistent, though little is still being done during antenatal and immunizations visits.

That the scheme is new to many is also another concern, as majority still do not trust that it can truly serve its purpose nor consistently meet their health needs. The Ikosi-Isherri BoT chairman supported this view, maintaining that the problem with the scheme is not that people are not aware, but that people are still sceptical about it. He also maintained that scheme is being trivialised by some, especially those who prefer private health care and can afford to pay out pocket.

Lack of support from the local government. The scheme has not benefitted tangibly from the local government. One reason attributed to this was that the local government or its representatives were not involved in the planning, design and implementation of the scheme, a suggestion that the scheme is being politicised.

Poor services have also been noted to be a deterrent to patronage, especially among members who truly understand the scheme, but apparently were not satisfied with the services rendered by the provider. This was observed at the Ajeromi facility, but was resolved by recruiting another provider.

Poor incentives. The scheme still suffers poor incentives for the managers (board of trustees). The chairman noted that neither he nor other members of the board receive any salary package; the management however tries to compensate members with little incentives as sitting allowance.

Lack of philanthropic support. Although it is supposed to be a community owned and supported program as well as receiving support from the rich in the community, the respondents to the interviews sadly noted that this has never been the case.
Rural-Urban Mix

It is important to note that there is a sharp contrast between the urban and rural settings. The classic rural communities are the hard to reach. Typically, the rural environment is characterized by the absence of adequate resources such as good roads, pipe-borne water, and the existence of very few ill-equipped (staff, drugs, etc) primary healthcare facilities. These facilities may even be located far from their homes so that accessing timely healthcare may be difficult. Some of these rural communities are so poor to be able to afford healthcare services. Despite all these, it remains a home for a large proportion of Nigeria’s population.

Although, the difference between urban and rural health care is usually expressed in terms of access to and utilisation of healthcare, cost (if affordable or not), and geographic distribution of providers; the CBHIS is concerned about the providing accessible and affordable healthcare services for the informal sector, irrespective of the location. The scheme is termed ‘rural’ as it mainly targets citizens in the informal sector and who do not participate in any formal insurance program nor can afford to continuously maintain OOP in order to access basic health care services. Also, in terms of cost of receiving healthcare, the scheme is cheaper for beneficiaries, be it from the urban, semi-urban or core rural area.

**CONCLUSION AND POLICY RECOMMENDATIONS**

A quick review of the community based health insurance scheme in Lagos through desktop research and collection of primary information has shown the status of the program in the few years of implementation. Although, there was no contact with the beneficiaries, overall observation is that it has been very beneficial in terms of access to affordable services and at affordable prices (premium).

However, coverage is very low and may take many years, beyond the 2015 goal to achieve universal health coverage in Nigeria. There is still a lot to be done as majority of the members either drop out or remain inactive due to couple of reasons, either because they could not afford continuity of renewing premium or not benefitting from the services as thought they would. A further research would be beneficial in this respect.

The findings from this study therefore necessitate the following recommendations that may need to be addressed in order to improve the success rate of the program and achieve the goal in the State:
- Increased awareness among community members in all Local Government Areas. This is necessary and may take the form of community awareness campaigns or other means such as use of print and electronic media.

- Program design should be community specific. By this, each community must be seen as unique with its own characteristics, though may share similarities with other. Socio-demographic factors such as income status and socio-economic status of the people must be taken into consideration. As a result, the implementation of the scheme in that community must share the observed characteristics.

- To encourage participation, promote ownership among community members and mobilise resources, there should community engagement and advocacy visits to stakeholders in the community.

- The services provided must be of quality and deliver in a manner that meets the needs of the users. This is necessary to build trust and confidence in the system. This will encourage users to pay premium in timely manner, knowing that they will get the benefits in the future of a payment today. It will also encourage them to invite others to use the scheme.

- This scheme should be devoid of politics such as party partisanship, nepotism etc. Local government must be engaged appropriately, irrespective of political differences or affiliations.

- Overall, for the program to be successful, all noted challenges must be addressed. There should be incentives for the BoT, either as salary or other benefits. Also, it must be free of politics or engaging politicians in the management of the scheme.

- The success of the CBHIS and its ability to achieve its goals including achieving UHC in Nigeria depend greatly on the sustainability of the program and the ability to scale it up. Ownership, political will, local leadership, as well as motivation and building trust in the people have been identified as key factors for the success of the program.\(^9\)

- This study is not exhaustive; more still needs to be done in terms of research in order to develop a robust study report. First, perception and satisfaction surveys are necessary to understand people’s opinion, knowledge, and use of the program. Also, there must be well planned and well implemented monitoring and evaluation programs. The findings from these processes will not only help churn out vital statistics, they also will help promote the sustainability of the scheme.
REFERENCES