AWARENESS AND UTILIZATION OF THE NATIONAL HEALTH INSURANCE SCHEME IN EDO STATE, NIGERIA

BY

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JUNE, 2015

DECLARATION

I herby declare that the work in this thesis titled "Awareness and Utilization of The National Health Insurance Scheme in Edo State, Nigeria"was carried out by the researcher InegbedionUwayemeEdnaunder the supervision of Professor M. M. Mamman and Professor J. G. Laah. All information obtained from literature has been acknowledged in the text as well as the list of all references

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CERTIFICATION

This thesis titled "AWARENESS AND UTILIZATION OF THE NATIONAL HEALTH INSURANCE SCHEME IN EDO STATE, NIGERIA" by INEGBEDION UWAYEME EDNA meets the Regulations Governing the Award of Degree for Masters in Science, in Ahmadu Bello University, Zaria, it is also approved for its input to knowledge and literary presentation.

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DEDICATION

This thesis is dedicated to Almighty God for, guidance and protection over me. It is also dedicated to the memory of my late mother Mrs. VeronicaInegbedion and to my father and sibling for their relentless support in all ways during my study.

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I am indebted to God Almighty who has been faithful to me in all area of my endeavors.

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ABSTRACT

National Health Insurance Scheme (NHIS) is a strategy by the government for reducing maternal, morbidity and mortality rate because adequate utilization of the health care scheme is associated with improved health outcomes. This study investigated awareness and utilization of National Health Insurance scheme in Edo State, Nigeria. Systematic random sampling technique was used to select the 400 respondents from the study area. Data were collected using questionnaire and Focus Group Discussion. Questionnaires collected and analyzed using SPSS version 20.0. Both descriptive and inferential statistic was used to analyze the data generated and the significance level was set at 0.05. Most of the respondents 387 (99.9%) received all the services which includes physiotherapy services, immunization, family planning, eye Examination, preventive dental care, and mental health care.The findings also revealed that majority of the respondents (90%) are aware of NHIS and 65% utilized the scheme. The study found age variance, income, occupation, education, marital status, number of children and religion as a major factors controlling the awareness and utilization of NHIS. Findings revealed a high correlation between income occupation and education levels of respondents and frequency of NHIS usage. The correlation was significant at $p \leq 0.05$ levels ($\alpha = 0.05$). The study also revealed a high correlation between education and income levels of respondents with frequent of NHIS visit that was significant at alpha 0.05. The study recommends that adequate infrastructures, training and evaluation units that should be provided to the scheme that able to keep corruption under control and among others although awareness is high. However there should be intensive sensitization and mobilization by the health department in the following areas which include Akoko Edo,Esan-West and Uhunmwode.

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CHAPTER ONE: BACKGROUND TO THE STUDY

1.1 INTRODUCTION

The need for the National Health Insurance Scheme (NHIS) in Nigeria came up as a result of poor health indices, high mortality rate, and poor state of healthcare services, excessive dependence on government health facilities, pressure on public health facilities and poor integration of private health facilities into the nation's healthcare delivery system (NHIS, 2012). National Health Insurance Scheme (NHIS) was first introduced to parliament in the year 1962 when the need for health insurance in the provision of health care to Nigerians was first recognized. It was fully approved by the federal government in 1997 and signed into law in 1999. The scheme was officially launched on the 6th of June, 2005.

National Health Insurance Scheme (NHIS) is a cooperate body under act 35 of 1999 by the Federal Government of Nigeria to improve the health of all Nigerians at affordable cost. The NHIS is a social security system in which the health care of employees in the formal sector is paid from funds created by pooling of contribution of employers and employees. Beneficiaries to the scheme include students of tertiary institutions.

The objectives of the NHIS scheme are to among others; ensure that every Nigerian has access to good health care services while protecting families from the financial hardship of medical bills. Under the scheme, health care providers, referred to as Health Maintenance Organizations (HMOs) are responsible for providing and making payments for all persons who have registered and have paid the required premium. To provide this service, the HMOS liaise with the accredited medical establishment of a person's choice (ABU, 2013). The rising cost of health care services and the need to provide quality,

accessible and affordable health care services with the people's demand, necessitated the establishment of the national health insurance scheme (Omoruan, Bamidele and Philips, 2009).

NHIS was officially introduced in Edo State in September 2009 along with 24 states of the Nigeria although the programme was said to have made progress, it goal of 90 percent converge was excessively ambitious, especially in view of the economic strains in the Nigeria economy (NHIS, 2009). Edo state is faced with high population growth, ignorance, poor health facilities, poor nutrition, high rate of environmental pollution, superstitious belief and norms (Yohersor, 2004).

Prior to the establishment of NHIS several systems, ranging from free health care, out–of–pocket purchase, retainer ship, inbuilt health facilities within corporate organization to private health indemnity insurance have been in use. Many have lost their lives due to their inability to meet their health needs. Statistics have shown that about 70 percent of Nigerians pay out of pocket for their health-care needs (Agba, 2010). A situation, many countries have eliminated through health care financing.

This and many more are justification for health watchers the NHIS to function effectively. It is not surprising that agitation for an efficient and sustainable health insurance scheme in Nigeria has engaged government at all levels. Since the promulgation of National Health Insurance Scheme acts. No doubt, establishment of a health insurance scheme became imminent and the need to enlighten the general public on the importance of the scheme to ensure utilization and consequently achieving the Millennium Development goal as it pertains to health (Chikwe, 2013).

1.2 STATEMENT OF THE RESEARCH PROBLEM

Health care financing has become important in the developing world, it has been implemented as part of health reform programmes and strategies aimed at providing effective and efficient health care for citizens, Health insurance schemes in many low and middle income countries, most especially in the African continent are still in their early stage of implementation with the goal of universal coverage of the population. In Nigeria, evidence shows that the knowledge and utilization of NHIS is still very low (NHIS, 2012).

Funding remains a major problem to the scheme, the percentage of government allocation to UN or WHO have always been about 2 percent to 3.5 percent of the national budget (James Robert and Jerome, 2008). In 1996 2.52 percent of the total national budget was spent on health, 2.99 percent was spent in 1998, 1.95 percent in 1999, 2.5 percent in 2000 and a marginal increase to 3.5 in 2004 (WHO, 2007). Also, in addition to the foreign issue facing NHIS (NISER, 2012) pointed out that some of its aspects still need improvement. The scheme covers only one percent of the nation's population, (the federal government workers) and its implementation were largely urban based and, the health benefits package are considered inadequate, as it excludes some life-threatening health challenges such as those related to kidney, heart and liver. NHIS drug list which enrollees stated excluded some essential prescription drugs due to cost considerations. Health facilities at some lower levels hospitals were reported inadequate in spite of the capitation funds paid to them for improvements.The dearth of facilities at a lower-level hospital was mentioned as a cause of high timed referrals, whose protocol under the scheme was considered as cumbersome by enrollees

In the year 2005, the Federal Government of Nigeria launched the National Health Insurance scheme as a policy for healthwith the optimism that the system will reduce the morbidity rate in our population and frequent outbreaks of preventable diseases. Since the introduction of the NHIS the impact of this strategy has not be known in Nigeria as a whole as well as in Edo State (Kannegisser, 2009).The general health condition in Edo State is poor as a result of social/environmental, malnutrition, morbidity, infectious and parasitic diseases, infant mortality, and lack of health care facilities (NHIS, 2009). Commencement of services to enrollees started in September 2005 and up to this time 4 million identity cards have been issued so far, 62 Health Maintenance Organization (HMO) have been accredited and registered and more applications are being processed (NHIS 2009). The establishment of NHIS Presently with 5,494 health care providers, 24 banks, 5 insurance companies and 3 insurance brokers have been accredited and registered. States that have so far shown their interest in NHIS as at 2006 are Rivers, Edo, Benue, Ekiti, AkwaIbom and Federal capital territory, while Cross River State has fully enrolled (NHIS 2006). NHIS in 2009 reported that the scheme is one of the fastest growing social health insurance schemes in the world. NHIS is a form of managed care that pool regular financial contribution of members and pay a net work of providers of health care for defined specific set of health care services, which are accountable for cost containment and improving health outcomes. A contribution entitles the insured person, the spouse and four children under the age of 18 years have access to health care after registering with an approve health maintenance organization (Akande and Bello, 2002). NHIS also captures those in tertiary institutions.

The programme for higher institution students have been approved by the Federal government, through this programme an estimated 48 million Nigerians will come on the

scheme, which is the first scheme in the world that has a specific programme for students (Kannegisser, 2009).

Several researches have been conducted on National Health Insurance Schemes. Tabor (2005) carried out a study on public health insurance in Northern Nigeria, the study reported that publicly insured children were more likely to have emergency department visit than un-insured children. Tabor examine insured public children were more likely to have access to NHIS facilities than the uninsured children. Agba (2010) using surveying design examined employee's access to health care services in Cross River State, and noted the existence of discrepancies among employees in their access to the NHIS. Federal civil servants have more access to the scheme in Cross River State than those of the State government and Local Government staff. The study emphasize on the impact of NHIS on each categories of urban and rural workers access to health care.

In addition, Osuchukwu and Ushie (2011) carried out a study on factors effecting the utilization of NHIS in Asaba in Delta state, Nigeria. Their study revealed that NHIS utilization is still low in Nigeria. The underutilization of NHIS service varies from region to region and from state to state. A cross-sectional study indentified (72.2%) of respondent utilize NHIS clinic, people in the urban area utilize the service than those in rural areas, the focus of this study was directed on factors affecting the utilization of NHIS services in Delta state.

Oriakhi and Onemolease (2012), using multiple stage sample procedure, examined knowledge and willingness to participate in community based health insurance scheme in Edo State, Nigeria. Their findings show that about 60 percent of the respondents indicated willingness to participate in the community based health insurance scheme, 21.7% were not

willing to participate, while 18.9 percent were unsure. The fact that majority indicated willingness to participate in community based health, suggest that the scheme has prospects.

Studies such as Tanimole (2011), Adekunle and Oluwole (2012) among others, examined the effects of NHIS utilization at university of Ilorin (UNILORIN) Teaching Hospital Staff Clinic. The result shows that NHIS led to 144 percent increase in the utilization of health services in Kwara State and a total of 29,422 patients were seen in the period under preview. Mean attendance per month before and after the commencement of NHIS was 357 and 870 respectively.

Mensah (2010) examined the impact of NHIS on pregnant women in Oporoma, Bayelsa State. The study found out that pregnant women who participated in the scheme enjoyed reduced incidents of birth complications as they are more likely to receive pre-natal care, deliver at a hospital and are attended to by a trained health professional during birth. In Edo state the NHIS has been in use for some years now but the evaluation of the level of awareness is rarely documented. This is the basic for this studies.

The research will attempt answers to the following questions

i. What is the awareness level of NHIS in the study area?
ii. What is the level of utilization of NHIS in the study area?
iii. What are the nature and conditions of NHIS facilities in the area?
iv. What are the factors that influence the awareness and utilization of NHIS in Edo State?

1.3 AIM AND OBJECTIVES

The aim of this study is to assess the awareness and utilization of NHIS in the study area. In order to achieve this aim, the following specific objectives will be pursued, to

i. examine the awareness level of NHIS in the study area
ii. determine the utilization level of NHIS in the study area
iii. identify and characterized the type of existing health care facilities in the study area.
iv. examine the factors that determine access and utilization of NHIS in the study area

1.4. RESEARCH HYPOTHESIS

Based on the question and objectives of the study the following hypothesis is put forward:-

1. There is no significant difference in the access and utilization of NHIS by socio-economic sub-groups.
2. There is significant difference in awareness and utilization of NHIS by socio-economic sub-group.

1.5 SCOPE OF THE STUDY

Edo is made up of 18 Local Government Areas, but for the purpose of this study 3 LGAs were systematically selected for detailed study. These LGAs are Akoko Edo, Esan West and Uhunmwode. Where one LGA was sampled from each senatorial district, the selection is based on the LGAs with the highest number of health care facilities and also represents the attributes of the state, the survey includes public/civil servant, farmers, fulltime house wives and traders within the selected Local Governments Areas of Edo State. The study covers the period of 2005 to 2013.

1.6 Significance of the Study

The major reasons for undertaking this study is that it will provide insight into health care system and provide basic information about National Health Insurance Scheme for policy planning to the people of Edo state, the finding of this research work are expected to constitute valuable source of data for future references and planning and provision of health care facilities where they are lacking.

The awareness and utilization of NHIS is an important health indicator, awareness and utilization of these services has taken decline trend over the years. NHIS is a fundamental pillar for sustainable development in many developing countries including Nigeria, there is high mortality rate as a result of inadequate awareness and utilization of NHIS.

Studies of this type have the potential to reveal the problems confronting health care, benefit and pave ways for policy makers, the local government, the state government, the federal government as well as research institutions and nongovernmental organization NGOs. It will serve as a framework for assessing the development and level of awareness and utilization of national health insurance scheme in these areas by the government. It will help to known area that are affected by lack of NHIS facilities, utilization of the facilities it will help to draw attention for what is needed during budgets and other developmental projects.

1.7 OPERATIONAL TERMS

NHIS – is a mechanism, which enables the burden of the direct cost of health care to an individual to be spread among a group of people who share the risk and over a period of time rather than being met at the point of delivery by a single individual.

Utilization is a integral part of managed care, health plans designed to control and limit medical expenses.

Awareness – is a state or ability to perceive, to feel or to be conscious of events, objects, or sensory patterns. In this level of consciousness, an observer can confirm sense data without necessary implying understand more broadly.

Health Insurance – Is a system of advance financing of medical expenses through contribution, or premium paid into a common fund, to pay for all or part of health services specified in an insurance policy or plan.

Health Care – Refers to the work done in providing primary care, secondary care, and tertiary care as well as in public health

Nick sharing in health care – is about humans taking care of other humans recognizing need for enhanced information around clinical and operational best processes, created and implemented

HMO - Health Maintenance Organization

WHO - World Health Organization

UN - United Nations

NHS - National Health Service

NISER - Nigeria Institute of Social and Economic Research

1.8 ORGANIZATION OF THE THESIS

This thesis is made up of six chapters and the chapters are arranged to enable each chapter properly ties to the next.

Chapter one is the background of the problem and high lights the need for the study. The discussion in this chapter includes the listing of the aim and objective, statement of

research problem, research questions, scope and the study, justification of the study and explanatory notes on some terms.

Chapter two reviews some of the relevant literature. The literature is reviewed in such a way that only the findings of the studies and method used are mentioned.

Chapter three focuses on the study area and properly discussed the location, relief and drainage, climate, soil and vegetation, historical growth, population, settlement, transportation system, traditional craft and modern industries, agriculture and health care facilities. The chapter also deals with the methodology that is used in this study, high lighting the types and sources of data analysis.

Chapter 4 focuses on the results, discussions, and analysis of respondents

Chapter five focuses on cross-tabulation and discussion of the factors that determine awareness and utilization of NHIS services

Chapter 6 includes summary, recommendation, and conclusion.

CHAPTER TWO:CONCEPTUAL FRAME WORK AND LITERATURE REVIEW

2.1 CONCEPTUAL FRAMEWORK

2.1.1 CONCEPT OF HEALTH

Some definition of good health emphasized self-actualization the fulfillment of the individual with normal body function and concept of well-being (Mahler, 1996). Datong (1988) emphasized that health does not only means the fitness of the body but also the soundness of mind and emotion which makes life worth living. WHO (1978) has given a comprehensive definition of health as a state physical, mental health and social well being and not merely the absence of disease or infirmity. Physically, the body functions to laid down standard within the range of normal development and functions of all the system. Mentally, the individual realizes his own ability could cope with normal stresses of life, work productive and fruitfully and able to make contribution to his own community. Social well being implies the individual ability to adjust with this social life at home, with people around him and at work place.

Ademola(1998) defines health within the context of peace, security, shelter, education, food, stable ecosystem, sustainable resource and social justice and equity.

Health is a fundamental human right of the individual, family, and community for this study.

2.1.2 EVOLUTION OF HEALTH INSURANCE

Andersen, (2005) the practice of pooling resources to ensure protection against the risks of ill-health grew mainly out of labour developments, in Mediaeval Europe, craftsmen formed societies. ("guilds") which in turn created funds to help members in times of distress, due to sickness. Each member contributed to the fund on a regular basis.

The threat to the individual worker's earnings because of illness was seen as a risk to be shared, and from the late eighteenth and early nineteenth century's groups of workers and small farmers in the same industry or location formed sickness funds as mutual benefit societies to serve this purpose. First cash benefits were provided, and then the guilds asked doctors to certify sickness.

To ensure services for their members, some guilds then began to contract with providers on a regular basis, and later to develop their own medical services, particularly in countries with a low supply of doctors and hospital beds. New initiative came from employers: the schemes often becoming compulsory as employers in specific high-riskindustries, such as mining made employmentconditional upon regularcontributionsto a fund to cover health care. With these developments**,** the concept of contributions related to earnings rather than to individual risk became firmly established in some countries (ILO and Pan-American Health Organization, 2000).

The term health insurance is basically used to describe that form of insurance which pays for almost all medical expenses. It is many times used much more broadly to include insurance covering long term nursing or disability care needs (Quaye, 1991). It is technically defined as a mechanism in which the risk of incurring health care costs are spread over a group of individuals or households (Arhin – Tenkorang, 2001). It may be provided through a private insurance company, agency or provider or from a government – sponsored social insurance program. It may also be on a group basis (e.g by a company to cover its employees) or bought by individual consumers.

In each of the above cases, the covered individuals or groups pay taxes or premiums to help protect them from an unexpected or a very high healthcare expense.

Similar benefits paying for healthcare expenses may also be provided through social welfare programs that are generally funded by the government. By calculating the total risk of the expenses of healthcare, a structure of routine finance (like annual tax or a monthly premium) can be made, ensuring that money is really available to pay for the benefits of healthcare specified in the agreement of the insurance.

The benefit is administered by a central organization, most often either by a private or government agency or non-profit organization that operates a health plan. The rationale for adopting the National Health Insurance policy in Nigeria was based on the huge cost involved in the provision of health care services.

Carrin(2004), carried out a research on the evolution of health care financing in Ghana and the finding review that financing of health care was mainly done through tax revenue and donors support. However, with the decline in the economy in the 1960s and 1970s sustaining free health care become a problem, as a result, in 1969 user fees was introduced at the public health facilities in the country.

In a study conducted by Tenkorange (2001) on the impact of Health Care development observed that the introduction of Health Care System has lead to the reduction of disease most especially malaria and maternal mortality. The use of Health Care System has made positive impact in reduction of diseases in Bomadi – Yenagoa. In a similar study in Owen North LGA of Edo State, Odion (2009) found out that of 200 respondents 15 percent agreed that health care service system has significantly impacted on the area through construction of road, provision of water, while 35 percent were of the opinion that the system has impacted their community through provision of immunization.

2.1.3 CONCEPT OF HEALTH CARE FUNDING

Health care funding over world has been of great concern to both developed and developing countries. Thus, policies on how to finance and provide healthcare to an entire nation include both the formal and informal sectors, rural and urban areas in low and middle income countries is a huge challenge for most developing countries. However, in sub-Saharan African countries, health care funding policies have been in crisis mainly because of the frequent occurrence of political instability coupled with severe economic constraint and lack of good governance (World Bank, 2004), over the last three decades, the perspective of health care funding has dramatically changed in developing countries.

During the sixties, health care policies focused on fighting major epidemics; thus, health care programmes were dedicated to reducing the threat to population. In the eighties, the economic approach became a major part of all health care policies. At that time, most of health care funding was related to cost recovery strategies. All attention was then drawn on how it worked: fee policies, distribution of revenues and efficient use of resources. In the late nineties, cost recovery was relegated to the back scene and health care funding policy then become a major matter for discussions (World Bank, 2004).

A wide range of mechanisms are used for financing both public and personal health care services. Whereas public health care services are usually financed by governments through taxation, foreign donors and development partners, personal health care financing involves community financing, health insurance (both social and private insurance schemes) with varying degrees of involvement by governments and non-governmental organizations. Such community-based financing covers different mechanisms of mobilizing resources such as micro-insurance, community health fund/ mutual health

organizations, revolving drug funds, and (Community involvement in user fee management.

2.1.4 THE "CASH AND CARRY" SYSTEM

The system is where the receiver of health services pays for the services rendered by the health personnel/institution.

According to Thomas and Gilson, (2004) cash and carry system, patients were required to pay for the full cost of medication and care. The rationale was that, there would be an increase in resources to finance health care facilities, improve access to health care, and improve patients' care and better efficiency due to the increased revenue from charges. It was also based on the presumption that the cost recovery would help reduce unnecessary visits to hospital by patients who were abusing the system because it was free.

Patients who did not have the ability to pay for medical services were turned away from hospitals only to die at home. The disabled, poor and accident victims were required to pay on the spot before getting medical attention. What worsened the conditions was that, this cost recovery System was introduced at a time when many people had been laid off from the public sector and income levels were extremely low. The poor were simply priced out of hospital care and a two-tier health care system came into operation with better facilities for those who could afford to pay.

2.1.5 COMMUNITY SOLIDARITY IN HEALTH CARE FUNDING

The term 'community' as used by both sociologists and geographers, refers to any set of social relationships operating within certain boundaries, locations and territories. The term has both descriptive and prescriptive connotation in both popular and academic usage (Jutting, 2002). Community health care financing can be referred to as any scheme that is

broadly characterized by the following three features: 1. It is voluntary in nature; 2. Payment for health care is made by the community members, and 3. Community control of resources and their management. The community gets together and finds ways of financing its unmet health needs. Such financing arrangements can significantly differ from each other in terms of their objectives, structure, management, organization, and institutional characteristics (Jutting, 2002). Community funding of health has evolved from different contexts essentially in response to prevailing circumstances which in turn depend upon the existing stage of development. For example, the Democratic Republic of Congo's Bwamanda scheme and Guinea-Bissau's Abota scheme were developed in response to the near collapse of government-funded health care (Jutting, 2002).

Traditionally, community enrolment onto a health insurance scheme is essentially based on ones membership of a social group where contributions are occasionally made in the spirit of solidarity.

2.1.6 CONCEPT OF NATIONAL HEALTH INSURANCE SCHEME

The National Health Insurance Scheme (NHIS) is a corporate body established under Act 35 of 1999 by the Federal Government of Nigeria to ensure access to health care by all Nigerians at an affordable cost. James (2003) defined the National Health Insurance Scheme as a social health insurance programme designed by the Federal Government of Nigeria to complement sources of financing the health sector and to improve access to health care by the majority of Nigerians. It is a form of social health insurance which pays for health care services through contributions to a health fund. Contributions, which are usually from both employers and employees, are based on payroll and ability to pay while

access to services is based on need. The fundamental rationale for health insurance is risk sharing. According to James (2003), the programme aims at:

- Ensuring that every Nigerian has access to good health care services.
- Protecting families from the financial hardship of huge medical bills.
- Limiting the rise in the cost of health care services.
- Maintaininghigh standard of health care delivery services within the system.
- Ensuring efficiency in health care services
- Ensuring the availability of funds to the health sector for improved services;
- Ensuring equitable patronage of all of health care.

The National Health Insurance Scheme was launched formally as a Public Health policy in 1997. The government recognizing the importance of the scheme as a good opportunity for mobilizing additional resources towards financing the health.

According to Okonkwo (2001), National Health Insurance Scheme (NHIS) has been introduced in Nigeria in response to inadequate provision of health facilities. The general poor state of the nation's health care services and the excessive dependence and pressure on government provided health facilities the inadequate participation of private health services. The scheme is at the initial phase of transition to universal coverage in Nigeria. The first phase is the implementation of the Formal-Sector programme that began five years ago. As a complementary or alternative source of health care financing, Mohammed (2008) reported that National Health Insurance Scheme has become important in developing countries. According to him it is implemented as part of health reform programmes and strategies towards providing effective and efficient health care for all citizens, most especially the poor and the vulnerable populace. Mohammed (2008) further

reported that the scheme (NHIS) which aims at providing risk sharing in health expenditures through the contribution of enrolled members is at the tail-end of its first-phase in Nigeria. As part of the health sector reform, the scheme's vision is "a strong, dynamic and responsive government parastatal that is totally committed to securing universal coverage and access to adequate and affordable health care in order to improve the health status of Nigerians (NHIS 2006).

As a complementary or alternative source of health care financing, National Health Insurances is seen as a key to attaining one main target of government, international organization and the whole community which is the attainment by all people of the world of a level of health that will permit them to lead a socially and economically productive life (Hamza, 2006).

Hamza (2006) noted that the need for good health care delivery system as part of an enlarged poverty alleviation programme makes National Health Insurance Scheme essential to all. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life.

According to NHIS (2006), the benefits of implementing the Compulsory Health Insurance Scheme include:

- The scheme provides the pooling of resources for cross subsidization of health costs where those in high-income bracket subsidize those in low income bracket the healthy subsidize the sick while the young subsidize the old.
- The burden of funding health care services is shared between government private employers and enrollees.

- Quackery is minimized due to standards for personnel and equipment set for providers by the scheme.
- Competition among health care providers to attract and retain clients leads to improvement in the quality of services.
- The scheme provides employment opportunities for health professionals in the health care delivery system and thereby reduces brain drain.
- Donor Agencies/Government will have the confidence to donate to rural communities or less privileged through the proposed vulnerable group fund.
- Improved services resulting from improved income reduces the need for overseas treatment, thereby conserving the country's foreign reserve.
- Improved access to health care services creates a healthier work force for increased economic activities and national prosperity.
- Communities and associations contribute for their health care services without viewing it as tax or levy, as they are the financial managers and administrators of their programme and reap the benefits from there.

Like all other types of health insurance, there are several issues in the National Health Insurance Scheme. These include inefficiency, high cost, adverse selection, moral hazard and fraud. In developing countries, other issues which can add up to the foregoing include underestimation of costs, revenue mobilization from the informal sector, free rider dilemma, social factor, poverty and political (Mohammed. 2008).

NHIS in Nigeria, from the policy point of view, could also stand as the regulatory body of the health insurance with a corporate headquarter at the country capital. Abuja which provides oversight functions to organs (Health maintenance organizations and

participating providers) that are involved in direct delivery of services to members. The health insurance is a single fund like that of France and Tanzania. The essence of the single fund is to enhance easy implementation and coordination of the scheme through the Health Maintenance Organizations (HMOs). It also provides easy planning for distribution of health services and at the same time reduces the chance of moral hazard**,** (Mohammed. 2008).

2.2 Awareness of National Health Insurance Scheme Services

According to Aviva et al (2000), initially Compulsory Health Insurance Scheme took shape in developing countries which reflected the social policies which had gained acceptance in Europe. They noted that since the social and economic context was different from the European one, developing countries had to adapt the approach to Health Insurance to their own situation, in particular with regard to coverage and the methods of delivering health care as benefits mandated by law. In Nigeria the National Health Insurance Scheme was launched formally as a public health policy in 1999. But the Formal Sector programme, one of the programmes under the scheme designed to cover employees in both the public and the private sector was only flagged off in 2005 (NHIS, 2006). This marked the commencement of access to the health care by enrollees in Nigeria. The launching of the Formal Sector Social Health Insurance Scheme sprung up series of activities under the scheme ranging from registration of enrollees, issuance of identity cards, registration of hospitals, banks and registration of HMOs to serve as the managers of the NHIS funds.

They are expected to collect contributions from employers, employees, and voluntary contributors, pay health care providers for the services they render and ensure the maintenance of quality assurance in health care delivery under the Formal Sector Social

Health Insurance programme (NHIS Annual Report, 2006). As part of health reform programmes and strategies towards providing effective and efficient health care for all most especially the poor and the vulnerable group, awareness of the Health Insurance Scheme/services are highlighted under some key indices as follows:

2.2.1 Implementation of National Health Insurance

According to Andrew (2007) the gradual implementation of compulsory health insurance according to geographical areas is perhaps the most frequent feature in developing countries. It is according to him the obvious response to the uneven distribution of medical infrastructure and personnel throughout the national territory and to the obstacles facing administrators in the identification, registration and control of paid employment or self-employment in rural areas or in regions where records and communication systems are not sufficiently reliable.

Sanusi, (2009) examined the level of awareness on NHIS in Oyo state, Nigeria; His results showed that 87.4 percent of the people were aware of the programme and 83.2 percent were registered under the programme and the people who enjoys the programme is just 58.9percent a similar study was conducted in Andrew et al (2007) on awareness of NHIS in Asaba Delta state, 92 percent of the awareness and utilization was related to education, media and campaign and concluded that mere people are becoming more exposed to the NHIS issue in the study area.

Andrew (2007) further explained that there might also be shortages of trained personnel which cannot be surmounted in the initial stages. He further noted that one often finds that the capacity of employers and employees to contribute is much lower outside the urban sectors of the economy, and that naturally the size of a country plays a decisive role.

Small states/countries have pattern of extending compulsory health insurance by geographical areas over a number of years.

Jibo (2011) used across sectional descriptive study with 152 respondents drawn from the public sector to examine the awareness and utilization of NHIS among public servants in Kano, his findings showed that more than half of the respondents were males 88 (62.99 percent) married (80 percent) had tertiary education (93.6 percent) and that awareness is high among male compared to femalesJibo further noted that there are obvious reasons for under awareness of the scheme in some rural areas because of low educational level, access to good health care and lack of information on the scheme.

Ndie (2013) assessed the awareness of National Health Insurance Scheme (NHIS) awareness by civil servants in Enugu and Abakaliki. The results showed that 64 percent of the nurses 20 percent of artisan, 28.1 percent of clerical officers and 20 percent of the teachers only 1 percentare registered members of NHIS. Nurses that know the health care facilities accredited for NHIS IS 56.1 percentwhile 12.5 percent, 20.88 percent and 8.5 percent of artisans, clerical officer and teachers respectively know health care facility accredited for NHIS. The author concluded that the result indicates that civil servants working with Ebonyiand Enugu state governments do not know much about the NHIS. Nurses have the greatest knowledge about NHIS when compared to artisans, clerical officers and teachers.

Naseem, (2013) observed that the implementation of NHIS in Ghana has a coverage of about 60% within 10 years of implementation and the implementation was to move away from financing mechanism and to incorporate those in the formal and informal sectors in a single insurance system. This study agrees with Chikwe (2011) who stated that

about 60 percent coverage was made in Imo state of Nigeria and has improved the standard of living.

With regards to implementation of the health care programmes and the benefits that the law entrusts to the sub-system, Andrew (2007) stated that ideally coverage in terms of persons protected should be as wide as possible, but most developing countries do not have the resources (infrastructure, human resources, ability to pay) to honour from the start all the mandated benefits in respect of large and often geographically scattered population groups. According to Andrew (2007) experience shows that a step-by-step approach has definite advantages, provided that it does not become, at a later stage, an 'excuse' for avoiding larger responsibilities and wider coverage. Andrew (2007) further stated that gradualism can be applied with regard to various criteria, such as:

- The size of the enterprise;
- Geographical area:
- Category of insured persons or of dependants automatically covered; and
- Type of benefit.

In the explanations of Aviva *et al,.* (2000), the principle of gradualism in implementation may affect the "package" of the benefits provided. For instance, the types of medical care benefits provided in the first stages of implementation are often limited excluding the less essential ones or those whose cost may be deemed high. Such limitations often apply to dental services, psychiatric care, cosmetic surgery, domiciliaryvisits, and so on. They further stated that alternatively**,** the initial limitation may be applied to selected types of diseases or to certain expensive treatments.

The World Health Organization (2003) noted that the danger in gradual extension is that progress in implementing desirable extension of coverage may be too slow. This may be due not only to economic and financial constraints, but also to the lack of dynamic initiatives from the social security management and their political leaders. The World Health Organization further stated that instability in the management has been identified in developing countries as a cause of their unwillingness to explore ways and means to extend coverage, particularly towards rural areas. The “sub-system” has therefore its boundaries in terms of coverage they are flexible and they should extend gradually; the final profile of coverage depends on the country, its ideology and its peculiar social and economic conditions.

To meet the needs of appropriate health care within the health insurance subsystem. James *et al* (2008) noted that the benefits must have certain essential characteristics. Equity is a basic principle and the factors that serve to provide this condition are primarily equitable accessibility and availability of services to all parts of the population covered.

They further noted that there are obvious problems in fulfilling these conditions, as apart from a general inadequacy of health careresources, we usually find very significant geographical inequalities, including urban - rural and central and peripheral regional differences. According to them within the health care resource supply one often find imbalances in the categories of professionals, with a disproportionate number of specialists, and high technology diagnostic services concentrated in cities that are at the same time sorely lacking in primary care providers needed to deal with the social welfare problems of rapid urbanization and industrialization.

2.2.2 Payment of Contributionfor Health Insurance

In the words of Haraldson (2005), it is common for compulsory health insurance to be applied first to selected categories of employees, leaving compulsory insurance for the self-employed for a later stage. Ability to pay is one of the main reason underlying this option, as well as, the problems connected with the identification of self-employed persons and with the determination of their earnings or income to which compulsory contributionsarenormally related. Haraldson noted that financial considerations are often advanced when coverage is restricted initially to the employee with the exclusion of his family dependants.

According to Naseem,*et al*(2002), unlike public health services, medical care under social security is a right granted against paymentof a specific individual contribution. It is argued therefore that the patient has already paid - by a deduction from his salary for the right to the medical carebenefit. Consequently cost sharing at the point of delivery is not so much imposed to raise additional revenue but to prevent abuse or misuse of available benefits (such as pharmaceutical products) when the benefit is provided free of charge directly by the insurance institution to the insured person. This disincentive, they noted, has however to be handled with great care among population group which are at subsistence level or who chronically lack cash, because cost-sharing may have the opposite result to prevent people who should be treated for illness or injury from claiming the service and aggravating their health condition, the treatment of which will later be more costly.

According to Mario (2004), under the compulsory health insuranc scheme all health care, except in emergency, is obtained by firstvisiting the chosen practice centre.

In other words, access to other doctors or to hospital can only be covered on referral from the practice with which the patient is registered. This ensures that the three levels of

health care system from primary to tertiary care is preserved. Mario (2004) further stated that there are important advantages for both the insured person and the doctors participating. Those using the services have advantage of building up relationships with the staff and are known bythem.

Moreover, their medical history is recorded by the practice and thus does not have to be repeated at subsequent visits. The doctor knows all prescribed medicine the patient is taking and thus there is less risk of a patient taking prescribed drugs by different doctors which could be dangerous when taken at the same lime. Mario (2004) further explained that continuity of care has also advantages from the doctor's point of view. Time is saved in taking medical histories; it provides the doctor with the professional satisfaction of seeing the long term results of past treatments. Moreover, having normally taken care of the whole family, physical symptoms due to emotional stress arising from family interaction can often be recognized and treated accordingly.

2.2.3 Public Expectations of NHIS

Al-Shammari, Khoja and Jaralla (2002) reported that in providing health care services under the compulsory health insurance scheme there are public expectations and preferences to deal with. According to them there tends to be greater reliance on hospital care, and unnecessary drug dependency, with the insured believing that any encounter with the health system at a time of illness must include drug prescription. For many, they reported, the transfer from a "free" public system to a regular contributor system creates a tendency to seek maximal use of the benefit covered. This "milking" of the system further complicates the attempt to reach rational and balanced utilization of health care. The solutions to these problems are often passed on to the patient (that is, the insured seeking

care at the time of illness) rather than the providers, for instance in the form of cost - sharing.

2.2.4 Cost of Insurance

According to the United State National Centre for Health Statistics Reports (2007), increases in the cost of health insurance in developed and developing countries leads to continuous dropping in the percentage of employers who offer health benefits to their employees. Of those employers who continue to offer health benefits to their employees, most are shifting more of the cost onto their employees by: (1) increasing the worker share of the premium, (2) raising the deductibles that workers must pay (3) increasing the co-payments for prescription drugs, and (4) increasing the number of items on the exclusion list.

Dutting (2002) assessed community financing in health care in Guinea – Bissau using both sociologists and geographers. The results of the finding include: 90 percent in the community enrolment of health care is based on membership and contributions made monthly while 10 percent are based on church groups.

2.2.5 Provider Attitude

The Health Insurance Scheme has over the years faced the problem of provider attitude and behavior to the beneficiary in operating the programmes. The age-long rivalry between various professionalgroups in the health care industry has found its way into NHIS provider network. While some providers withhold care to enrollees on flimsiest excuses, others charge additional fees on the pretext of non-inclusion of the services in the benefit package (NHIS Annual Report. 2006).

2.2.6 Economy

According to Mohammed (2008), poor economy hinders wide spread implementation and sustainability of Social Health Insurance in developing countries. Poor economy affects the spread of its coverage to the informal sector; it reduces spread to rural areas and weakens the ability of self-employed people to pay contribution.

2.2.8 Utilization of National Health Insurance Scheme Services

Andersen's behavioral model of health services utilization proposes that people's use of health care services is a function of their predisposition to use services, the factors enabling or impeding use, their need for care, and their satisfaction with services. (Andersen.1995). The utilization of National Health Insurance Scheme services varies across different cultures for a variety of reasons. But it appears, according to Nora (2005), that the determining factors are universal. Nora noted that utilization of National Health Insurance Scheme services is determined not only by its availability but by a number of other factors, some of which are highlighted as follows:

2.2.9 Location/Distance to NHIS Facilities

Nora (2005) reported that place of residence has been an important factor in the utilization of the services. The urban population make greater use of services than those in rural areas Nora (2005) further noted that distance from the health care service centre, education of the participants, as well as their age are the strongest determinants of service utilization among participants in developing countries.

2.2.10 Accessibility to Health care services

In the explanations of Fiedler (2003), access to health care services is considered as the link between the health care system and the population it serves; the volume and type of services, whether or not the service can be reached, the client's perceptions of the relative worth of the service and acceptability of services provided, all influence access and the utilization of services. In line with the postulates of the central place theory, health care facilities in Nigeria constitute a hierarchical system which is reflected in space by the geographical arrangements of service outlets in which a particular area tend to have numerous primary health facilities, much fewer secondary facilities and very few tertiary facilities if at all. Consequently, the findings of studies conducted by Okafor (2007) on the petroleum - producing region of Nigeria (the Niger Delta) revealed that inaccessibility of the available health care facilities in the region has obviously affected the utilization of health care services by a vast proportion of the beneficiaries who still depend on traditional medical care and self medication.

The need for health care varies in space and so the organization of provision necessarily has a spatial component. Neither population totals nor population characteristics such as age, sex,occupation is uniform in space. In a like manner, the physical environment varies in characteristics from place to place and this invariably has implication for the pattern of demand for health care. The spatial dimension is also important in utilization behavior since accessibility is a major determinant of the use of health care service (Okafor. 2007).The spatial pattern of utilization of service of the various categories of health establishments by the beneficiaries show marked differences between local governments where tertiary and secondary health establishments are

accessible and those where such facilities are not accessible. There is no doubt as reported by Okafor (2007), that many other factors influence the utilization pattern of health care services among beneficiaries in the Niger Delta region including the level of formal education, facilities available in the health establishments, availability of alternative medical attention in the locality, perception of the attention received in the health care centre and the distance to the centres in terms of travel cost and time of reaching the health centre.

2.2.11 Client's Perception of Services

According to Fiedler (2003), the clients perceptions of the relative worth of the services and acceptability of services provided, influence the utilization of NH1S services among participants. One of the most common reasons for not seeking care among participants and/or beneficiaries is a lack of satisfaction with services.

2.2.12 Self-Rated Health Status of participant

Geitona.(2007) revealed that the utilization of National Health Insurance services among participants depends on self-rated health status, age, gender, and region Individuals with moderate and poor self-rated health, older people, and women showed increased utilization of health care services in Epirus while individualswith better self-rated health status showed decreased utilization of health care services. The frequency of utilization of services depends on region and lower evaluations of health status among participants. In addition, factors influencing how symptoms and illness may be perceived such as commonality of the disease, familiarity of the symptoms or clinical physical changes are partly responsible for health care seeking behaviour among participants. According to Dibley*et al.,* (2003) the most common reason for not seeking care is the

expectation that the individual would recover. Other reasons include distance to provider or facility and lack of satisfaction with services.

2.2.13 Levelof Education

Riedel (2002) reported that though differences in access to rural and urban health care units also account for differences in utilization, tendencies towards higher utilization of the health care services emerge, first of all from education which is described as a major force in breaking down reliance upon traditionalistic worldviewsand folk practices, or as instrument in helping individuals cope with their needs by making intelligent use ofavailablesocial and health care services. Maternal education was identified as an important factor affecting utilization of the health care services, as higher educational levels have been associated with an increased self perception of health status and influence the use of both curative and preventive health care services.

2.2.14 Gender

According to Charles (2001), sex is one of the most influential variables affecting the use of the National Health Insurance Scheme services. Sex has influence on utilization of the health care services through itsassociationwith other predictorsof utilization such as tendency to use services anxiety and skepticism. Charles noted that levels of personal distress are an important trigger in the use of health care services; since women have higher levels of distress, they make more use of the health care services.

Charles (2001) further stated that another possible explanation for the higher rate of utilization among women is that they are more dependent and affiliated and thus seek interpersonal solutions to feelings of distress more than the men.

2.2.15 Culture

Swendson and Windsor (2004) defined culture as the values, beliefs, norms and practices of a particular group. It consists of all the things which socially characterize the group that is their language, food, music, religion, sculpture, painting and occupation.

According to Henry (2002), the health status of members of a society is positively correlated to their cultural practices. Culture determines what symptoms signs are recognized as illness, the cause to be associated with them, who has authority to assess and diagnose them and most importantly who should be consulted for treatment. Mohammed (2008) reported that cultural perception of ill health has been identified as a hindrance to health insurance. Cultural problems evolve with the belief of illness and risk which may be affiliated to religion or traditional norms. When illnesses are perceived ethnically or religiously by the society as punishment for certain misdeeds, it affects the rate of enrollment in health insurance; in the end, acceptance and participation in the health insurance is jeopardized. According to Windsor (2004), culture plays a very big role in the life of man specifically with regards to his medical life. This has also brought about positive impacts and sometimes bad impacts to the people who behold these cultures; this is with regards to different circumstances and the way the particular people think in relation to their culture which has a social, psychologicaland ethical impact in health care services.

Most often emphasis is placed on socio-economic conditions as the main determinants of people's willingness to enroll in a health insurance scheme, neglecting culture which also has much impact. Helman (2001) further reported that it is of paramount importance to note that illness and choice of health care services is shaped by cultural factors governing perception in the sense that how we perceive and cope with disease is based on our explanations of sickness, explanation specific to the systems of meaning we

employ. It is not surprising then that there can be marked cross-cultural variation in how diseases are defined and coped with in our societies.

Helman (2001) concluded by saying that it is obvious that culture and ethnicity are influential social determinants of willingness to enroll or use a health insurance scheme. The findings of a study conducted by Naseem*et al.,* (2002) on the use of National Health Insurance services by participants in rural communities in Saudi revealed that despite the availability of services, these groups tend to under use the services due to traditional conservatism and resistance to ideas from outside; deep rooted traditions and customs, including health beliefs and practices, which create a tendency to over utilize the services of traditional healers,Knutsen (2002) reported that it is well established that life - style and culture influence health seeking behaviors of women with ill children under the health insurance system in rural communities in Vietnam. Knutsen (2002) further reported that cultural perceptions about illness account for differences in seeking health care for children among female spouses of participants in rural communities. Dealing with cultural issues needs effective and efficient advocacy and series of awareness and Government may at the long run imposea compulsory participation.

2.2.16 Poverty in Health Insurance

According to Mohammad (2008) wide spread poverty hinders the spread of Social Health Insurance to rural areas in developing countries. Poverty weakens the ability of self employed people to pay contribution. Willingness to pay is positively correlated with income: wealthierpeople have higher willingness to pay than the poor. According to Sabriya (2006), analysisof poverty rates and health using surveying design examined analysis of poverty rate and health they found that 50 percent of people living in extreme

poverty tend to have more frequent and severe disease complications and make greater demands on the healthcare system. Sabriya (2006)furtherreported that fewer people in the US can claim that poverty does not affect them asmore individuals face layoffs and cutbacks, and are unable to afford health insurance. As financially strapped families struggle to cover basic needssuch as food, shelter and theincreasing cost of energy, health insurance often takesaback seat on the list of priorities of (Sabriya. 2006). A National Health Survey Conducted by the U.S. Centers for Disease Controland prevention (CDC, 2005) found that more than 40 million people of all ages went without insurance at some points in 2005. More than half remained uninsured specifically because they simply couldn't afford it. The U.S. CDC (2005) noted that poverty's impact is felt most by the nation's children.

Uninsured children are at greater risk of experiencing health problems such as obesity, heart diseases and asthma that continue to affect them later in adulthood. The prevalence of these illnesses does not bode well for future generations.

2.2.17 Social Factor in Health Insurance

The ethnic cultural and religious diversity of societies or people within a society reduce solidarity and people's willingness to enroll or pay premium. This is due to lack of homogeneity and close link to assemble mutual trust (Doherty, Mclyntyre& Gilson, 200).

2.2.18 Moral Hazard

Is a tendency of entitlement to the benefits of health insurance to act as a strong incentive for people to consume more and "better" health care and a weak incentive for them to maintain a healthy lifestyle (Atim, 2001). It also occurs on the side of the provider and vice versa. Moral hazard entails overuse of the insurance services provided which is

caused by both demand and supply sides (patients and health care providers). It occurs in all types of insurance, be it public or private (compulsory or voluntary), it always deter the purchase of very generous coverage against relatively high probability, low-costform of treatment. Reports from several case studies in different African countries such as Cameroon and Ghana by Atim (2001) on Mutual Health Organizations (MHOs) showed that moral hazard can be controlled by imposing co-payments or deductibles.

2.2.19 Fraud

The use of members identity documents by people not entitled to the benefits poses a real danger when the controls are not effective enough to prevent or minimize this. One way of handling this is to leave the task of checking identification to the hospital staff at the time of admission Atim(200I).

2.2.20 Adverse Selection

This is also known as biased selection. It is the likelihood that a person with a high risk of illness and a greater need for frequent health care would enroll in health insurance scheme than a person with a low risk of illness and less need for frequent health care use. This is common when enrollment of individuals into health insurance scheme is voluntary (Dorfman, 2000). Adverse selection occurs as a result of information asymmetry that arises when insurance subscribers have better information about their individual risks than the insurer. Higher risk individuals pay an average premium that is well below what an actuarially appropriate rate for their risk group should be. This destabilizes voluntary insurance markets since healthier individualseventually drop out as premiums rise. One prominent way of eliminating adverse selection is through compulsory membership of the target population (Dorfman, 2000; Atim, 2001).

Sule*et al.* (2008) reported that implementation of a National Health Insurance Scheme alone cannot guarantee improvement in the health status of people, it is their effective utilization of the health care services that can contribute to the health of the people. Utilization of the health care services is affected by a variety of constraints like availability, acceptability, accessibility and affordability. Factors of awareness a availability act as the main barriers to initial utilization. Once these have been achieved people may then begin to find the intensity and frequency of the utilizationlimited by accessibility and acceptability. They noted that first and foremost, for people to utilize the health care services they should be available. Even if they are available they should be acceptable to the people because utilization of any health care service depends, to a great extent, on cultural preferences. Riedel (2002) further reported that increased utilization is resulting from modernizing tendencies in the health care services themselves, described in terms of greater expertise in the health care institutions. Riedel revealed that health care facilities with greater range of competent personnel attract greater use of the health care services.

2.2.21 Provider-Related Factors

Just as certain users-related factors influence the utilization of National Health Insurance Scheme services, certain provider-related factors also play an important part. According to Jerome (2004), once the need for a certain type of health care service has been identified, the degree to which it is met may depend on the health care provider's desire to meet that particular need. More frequently, the study noted, the limiting factor is not whether the health care providers want to offer certain health care service, but whether the providers are able to offer it.

It is obvious that health care providers cannot offer a health service unless the necessary personnel, equipment and facilities, are available. Jerome (2004) further noted that the fact that the resources and ability to offer certain health care services are available at an accredited health care centre does not necessarily mean that the services will be offered in the optimal fashion by any mean. The manner and attitude with which those services are offered may seriously affect the utilization of those services. Similarly, the success of services offered depend on the degree to which it fits the lifestyle and needs of the users. Jerome (2004) recommended that the health care services should as much as possible be offered at a time and in a place that is compatible with the way users actually live. In the opinion of Johnson (2002), the entire atmosphere of the health care services should not be greatly at variance with the prevailing culture, lifestyle, language, or beliefs of the users. According to Johnson(2002), this provider-related factor that influences the utilizationof National health Insurance Scheme services is the provider's set of values, the reasons why the provider is offering the services in the first place. This is central because the reasons why a health care provider wants to offer a particular health care service may well decide how it is offered.

According to Hamza (2006), beneficiaries feel entitled to the best services available but are easily upset if treated rudely or roughly he further stated that the availability of a complete range of services in a given health care system does not necessarily mean those services will be used, let alone used well. There are certain factors in the users, the providers of the health care services, and in society in general that directly affect the utilization of services once they exist. Unless these important factors are considered, a good system of health care such as the National Health Insurance Scheme could be

designed and implemented but may never have the impact it should on the health of the population it is meant to serve.

CHAPTER THREE: THE STUDY AREA AND RESEARCH METHODOLOGY

3.1 STUDY AREA

3.1.1 Location

Edo State, lies between latitudes $6^{0}23'55N''$ to $6^{0}27'339'$ and longitudes $5^{0}36'18''E$ to $5^{0}44.130$ E. To the north Edo State is bounded by Kogi State, to the east, it is bounded by Anambra State, to the south, by Delta state and to the west, by Ondo State (see figure 3.1).

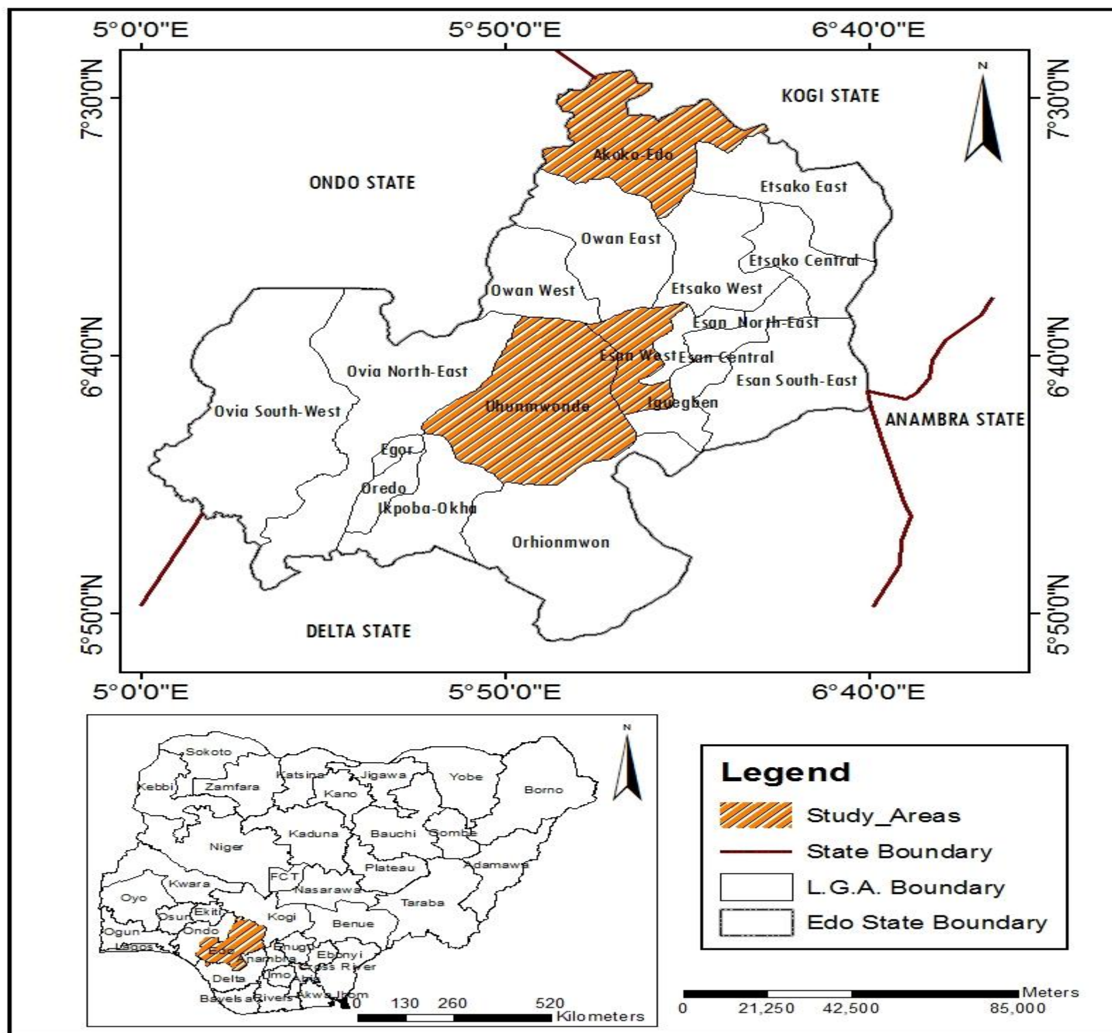

Figure 3. 1:Map of Edo State showing the study area

Source: Modified from the Administrative Map of Edo State

3.1.2 Relief and drainage

The regions in Edo State include the swamps/creeks;'theEsan Plateau, Orie Valley and the dissected up lands of Akoko Edo Local Government Area (Doin, 2011) there are six types of physical features which constitute the land scape of Edo State.

3.1.3 Climate

The study areas hasaTropical climate characterized by two distinct seasons, the wet and dry seasons, The wet season occurs between April to November and dry season from December to March; with a break in August. Rain fall intensity decreases from the south to the north. In the south, average annual rainfall is 152-254cm and in the north, average annual rain fall is 127-152. Edo State therefore enjoys abundant rainfall almost all the year round, except December to March when the dry season sets in, due to the influence of the north-east trade wind or the tropical continental air mass (Edo, State Government, 2013).

Generally, temperature across the state is relatively high with a very narrow variation in seasonal and diurnal ranges of 22^0C– 36^0C. The Temperature averages about 25^0C in the rainy season and 28^0C in the dry season.

3.1.4 Soils

The soil in the study area are generally the red yellow kind of ferrelsols,the formation is made up of top reddish clayey sand capping highly porous fresh water bearing loose pebbly sands, and sandstone with local thin clays and shale inter-beds which are considered to be of braided stream origin. Sands, sandstones and clays vary in colour from reddish brown to pinkish yellow on weathered surfaces to white in the deeper fresh surfaces. Limonitic coatings are responsible for the brown reddish-yellowishErhabor(1999) observed that the variation in Akoko Edo consist of Shallow/stony reddish clay at the feet

of inselbergy in the higher sections, lateritic clay and fine grained to sandy soil in the upper slope lateritic table lands and ferruginous soil on the crystalline acid rocks of the basement complex. In Orlevalley, the soil lateritic/gravelly sandy, while on the Esan Plateau, the soil is either clayey sand or porous red sand. Soil type in the Benin low land ranges from loose poorly productive sand in the south east close to the Niger the Osseand the Benin Rivers are alluvial and hydromorphic soil.

3.1.5 Vegetation

The vegetation in the Area consists of rain forest in the Benin low lands, Esan Plateau and savannah in the Orlevalley/Akoko Edo uplands (Ezemonye and Emeribe, 2014) an indication of digressions of the natural vegetation by human activities has however, led to the presence of plantations for rubber and oil palms as well as forest reserves Extensive Exploitation of forest resources, cattle grazing and persistent bush have combined to reduce areas of forest vegetation to derived degraded savannah.

Three vegetation belts are discernible from the south to the north, the mangrove swamp forest in the southern part, the rain forest at the middle while the northern part has the savannah vegetation. In the north, the area is mainly derived savannah. The oil palm grows in the wild. On higher levels the soil is gravelly, becoming sandy towards the Orle Valley. The Esan Plateau is made up of diverse vegetation, savannah in the north and forest in the south. Where deforestation has occurred, elephant grass and secondary growth take over. The soil is clayey or of porous red sand. Oil palm and rubber grow reasonably well. The Benin Lowlands used to be covered with a vast rain forest, but rubber plantations have displaced a lot of the original forests. Soil types range from low productive sand in the

southeast to fertile clayey soil in the northwest. The riverine communities in the south have mainly mangrove swamp vegetation (Edo People Forum, 2011).

3.1.6 Historical Growth of Edo State

Edo State was created out of Bendel State on 27 August 1991 Edo State has 18 Local Government Area which include Akoko Edo, Owan East, Owan west, Etsako central, Etsako east, Etsako West, Esan central, Esan North, Esan West, Esan South, IguebenIkpoba-okha, Oredo, Orhionmwom, Ovia Northeast, OviaSouthwest,Egor and Uhunmwode

The name Bendel was derived from the colonial heritage of the Benin and Delta provinces and Bendel State was the former mid-western Region of Nigeria carved out from the western Region on 9 August 1963 Bendel State was one of the oldest political entities in Nigeria, have started out life as the Midwest Region created by referendum, August, 9 1963, and Excised from the then western region.

It then became known as Midwest state and then as Bendel State contraction of phrase Benin Delta as time went on, the “federal character” provision for the sharing of federation was hampering the growth and development of the state. Federal employment and school admission policies were also guided by a quota system to ensure even spread Edo State is one of the more homogenous state in Nigeria.

The cultural and linguistic affinities that Exist among the communities in the state trace their roots to the ancient kingdom of Benin customs, burial rites, diet and traditional modes of dress, tend to be similar through out the state the political pattern and behavior were based on a system under which both monarchial and republican ideas flourished in an integrated manner (Ogbeifun, 2006).

3.1.7 Population of Edo State

The creation of Edo State with the headquarters in Benin has led to immigration of people from the remote Area to occupy the vast land. The study Area has a diverse population, the major tries include Edos, Esans, Afemas, Owans and Akoko Edo virtually all the group traced their origin to Benin City hence their dialects vary in intensity.

The further away they are from the centre. Benin city According to the census of 1991, Edo State has a population of 2,171,758 with males 115879 males and 1035879 female 17047141(NPC, 2009) and in 2004, national population census, the population was 3,209,434 with 1635145 for male's population and 1574289 for female (NPC, 2009) representing 66.0 percent increase. While Oredo, Egor and Ikpoba-Okha Local Government Area constitutes the core urban Local Government Area in the state. It has the highest population of 1,183, 170 or 36 percent of the state total while the remaining 15 Local Government Area share 2,11,3,229 or 64 percent.

3.7.8 Settlement Pattern of Edo State

The settlement pattern in the study Area reflects the physical environment as well as their history, varying in size from 30 inhabitants to more than 41000 larger villages are divided into quarters houses are constructed of mud and roofed with corrugated-iron sheets formerly residences were scattered but with the construction of Roads that started in the early part of twentieth century and with the establishment of Benin city as the state capital in 1963, villages have become increasingly aligned along the main roads. The farms are located away from the settlements. The capital of the traditional kingdom Benin City as well as modern Edo state is a large urban complex with a long history. Archaeological evidence indicates that there could have a population concentration in that Area as early as the end of the eleventh century. The European visitors in the fifteen century found a vast

palatial compound with countries courtyards, altars, halls and pass a always all richly decorated with brass, ivory and wooden sculpture, migration is changing the balance between rural and urban population, in pre-colonial times and through the early 1960s, most Edo lived in rural Areas. After the British conquest, Benin City suffered something of a decline this situation changed when it became the capital of newly created mid west state 1963 as a result. Government establishment, urban residential Area, and commerce and industry started to develop (Ahmed, 1982)

3.1.9 Transport System

Villages are inter-lithe with narrow paths. Communications between settlements are usually different because difficult terrain during the rainy season certain paths become impossible at certain points because of flooding. The federal high ways that pass through the state include:-Okene to Ibillo, Benin Ore, Ijebu Ode-Shagamu

Generally the road density is quite below the united Nations standard, a minimum of $10km^2$ for developing countries including Nigeria (Haggest, 1977) apart from the road density, there is also low traffic flow along these roads Okene – Auchi way, Benin ore Express way as a result of this there is high volume of movement of goods and services in the Area. Intra-town services are also provided by the Edo Municipal Transport Service, as well as by the many private transportation companies. Edo State also has an airport that is serviced by Nigerian Airways, ADC Airlines, EAS Airlines, Kabo Air, (Edo People Forum, 2011).

3.1.10 Economic Activities

Agriculture is the dominated Economic activities of the people and the bulk of Agricultural production in the Area is under taken by small-scale farmers most of whose

labour force, management and capital originates from the household. The common agricultural crops include cassava, rice, plantain, yam, sugarcane, cashew, groundnuts, tomatoes, cotton and tobacco, which are geared towards the local and national market with the vast forest belt, there are various supplies of economic trees such as Obeche, IrokoMahogany and Raphia Palms, the major export crops produced in the state are rubber, palm oil, and Mahogany and Raphia palms.

The major export crops produced in the state are rubber, palm oil and palm kernel timber and cocoa while fruits such as citruses, pineapple, guava, coconut, mangoes, pear and cheery are also grown. These products provide the incentive for agro-based industries to spring up in the state e.g.Bendel feeds, and flour mill in Ewu. The state is in the fore front of palm oil kernel production with oil-processing mills at okomu Nigeria institute for oil palm research (NIFOR), Presco oil palm plantation andobaretin.

Although the share of agriculture in the Economy of the state has been declining as is the case at national level particularly as it relates to export, yet it remains a sector of high potentials for local production and External markets. The main export are timber, rubber, cocoa, however in recent years, both state and federal Government have been focusing on Agriculture and much is being alocated in their budgets aimed at revitalizing it in the country. Government in Edo State has continued to devise measures to raise the level of agricultural production through the establishment of communal farm, granting micro-credits to small-scale farmers and fisher-men, provision of Extension services and small holder oil palm, cocoa and rubber projects.

3.1.11Traditional craft and modern industries

Traditional craft refers to those industries engaged upon by craft and women making use of the available raw materials found within their immediate Environment. These industries equally make use of simple tool thereby specializing in a particular product based on their artistic quality.

Though earthen pots are fading fast because of the introduction of plastic products produced by modern industries pottery products is still practiced in the Area and crafts such as basket making, weaving traditional cloth, molded statues dexterity and skills in traditional black smiting, ceremonial swords and furniture making modern industries on the other hand are mostly located in the urban and semi urban areas, there are relatively large firms which involve large amount of capital, using advanced technology, specialized management and skilled force in the area these industries include guamies, large poultry firms, Agricultural processing industries, flower mill, feed, cement factory, and Brewery

3.1.12 Social Organization

The basic organization principle which is both in the village and urban ward is the division of population in to age set every three years. Boys who reach the age of puberty are initiated through age grade whose main duties within the village include tasks as sweeping open spaces, clearing of bush path and fetching water. Between the ageof 25 to 30years, they pass in to the Ighele grade, which executes the decision made by the senior age grade.Thevillage is led by an elected senior elder (odionwere).

Pre-colonial Benin society had a clearly demarcated class structure; a mostly urban elite, comprising the government, religious, educational, and bureaucratic. A commoner group consisting lower status urbanites such as artisans and peasantry. Formerly, the king and chiefs had salves, primarily acquired through warfare, who constituted an agricultural

workforce for the elite. In contemporary society, factors such as the extent of one's western education and the nature of one's employment or lack plays a vital role in determining ones position in the multi-dimensional system of social stratification.

3.1.13 Health Care Facilities

Health care services in Edo state include: promotive health care, (Health Education, Proper Nutrition) and preventive, (i.e. survey of portable drinking water, control of diseases, routine of immunization, and basic education on sanitation and hygiene). Curative treatment of minor ailments, delivery service, child well fare and supply of drugs to children.

The area has four general hospital, 154 primary health care 63 private hospitals, 8 maternity, 2 school of health, 10 health center, 24 hospital, 3 community health, 3 nursing school, 5 missionary hospitals, 2 specialize hospital, 2 psychiatric hospital, health care facilities including pipe borne water, electricity, roads, wells, rivers and streams (ministry of health, 2011) all health care facilities are inadequate and most of the facilities are old and insufficient.

3.2 METHODOLOGY

3.2.1 Reconnaissance Survey

A reconnaissance survey was carried out in other to observe the health condition of the people and the availability of NHIS health facilities and how is being utilized and get a better perspective of the study area. Having overview the health care facilities and to collect information and data, which could be useful for the study was also collected in the process, also planning and gathering of relevant material and going round the study area to identify major health care facilities.

3.2.2 Sources of Data

The main source of data for the study was from primary and secondary sources.

3.2.2.1 The Primary Sourcesof Data

Where the questionnaires, and Focused Grouped Discussion (FGDS). The questionnaire consists of 3 sections, made up of close – ended questions. Section A focused on socio-economic and demographic characteristics of respondents such as age, marital status, religion, ethnicity, income, educational attainment and number of children, section B is concerned with NHIS service and accessibility and section c contains information on utilization and health seeking treatment. Focus group discussion (FGDS) were conducted in each of the three localgovernment areas which has eighteen people, three males and three females for each of the local government area for obtaining qualitative data and information on NHIS.

3.2.2.2 The Secondary Source of Data

Among others textbooks, journals, published papers, documented materials, pamphlet, magazines, conference articles, official gazettes, hospitals, bulletins, annual

reports and Nigerian Bureau of Statistics (NBS) was used for back ground information on distribution of health care facilities. Data were also obtained from the National Population Commission (NPC) and publications of WHO/UNICEF to server as guideline.

3.2.3 Sample Size and Sampling Technique

In order to select respondents for the questionnaires survey a multi-stage sampling procedure was used to select one LGA with the highest number of health care facilities in each of the senatorial zone. The systematic random sampling technique was used to select respondents sampled in each of the selected LGA in the state. To determine the sample size for this study the following formula was used. (Yemene, 1976)

$$\frac{N}{1 + N(0.05)^2}$$

So sample size = $\frac{488558}{1+488588(0.05)^2} = \mathbf{399.72}$

Approximately 400

Where N = Total population under study

0.05 Or (5.0%) is accepted error margin.

Therefore, since the total population of the three selected LG A's is 4885858 using the formula above 400 respondents were sampled. (See Table 1.1)

More so, to obtain the proportion of questionnaires to be administered in the selected LGAs Yamene (1976) sampling method for determination of respondents was used.

$$\frac{n \times 400}{N}$$

Where n = population of each selected settlement in each LGA

N = total population of selected settlement in the selected LGAs

However, since the study is supposed to be a detailed study which depend more on data collected from individual and hospitals, the purposive sampling techniques is therefore more appropriate for identifying specific cases for detail investigation (Abumere, 2002, Suleiman, 2009). Questionnaires were administered to the patients found in the hospital within the selected LGA of study until the total question assigned to such LGA is exhausted.

The 2006 population census figure is projected to 2013 and used in this study (see Table 1.1). The projection is done using Edo state growth rate of 2.7% using the formula (NPC, 2009)

$$Po = Pt^{ern}$$

Where

Pt = population in the later period

Po = Population in the earlier period

n = time interval between the two period

r = rate of growth

e = exponential sign

Table 3. 1:Population of the Study Area

Senatorial district	Senatorial district showing LGA	Population 2006	Projected population 2013	No of health care centre	Selected LGAs	Proportion of respondents
Edo North	Akoko Edo	261, 567	307566	30	Akoko Edo	151
	Owan East	154, 630	181823	28		
	Owan West	99, 056	116476	22		
	Estako Central	94, 228	110798	18		
	Estako East	147, 335	173245	21		
	Estako West	198, 975	233966	19		
Edo Central	Esan Central	105, 242	123749	22	Esan West	95
	Esan North	121, 989	143442	20		
	Esan West	127, 718	150178	24		
	Esan South	166, 309	195556	19		
	Igueben	70, 276	182634	14		
Edo South	Ipkobaokha	372, 080	437514	29	Uhunmwode	154
	Oredo	374, 515	440377	31		
	Orhionmwom	183, 994	216351	34		
	Ovia North	155, 344	155344	28		
	Ovia West	138, 072	162353	34		
	Egor	340, 287	400129	22		
	Uhunmwode	124, 749	143159	38		
		3, 23366				

Source: Projected from NPC 2006

3.2.4 Data Analysis

The data was analyzed using SPSS version 20.00, all statistical test were set at 0.05mm; Descriptive statistics describe the characteristic of respondents through use of frequency distribution tables and percentages. Tables and figures information on charts are used to present the summary information, cross tabulation and chi-square test (x^2) were used to test and establish the strength of relationship between awareness and utilization of National health insurance scheme.

CHAPTER FOUR: RESULTS AND DISCUSSIONS

4.1 INTRODUCTION

This chapter contains the results and discussions of the findings based on the field survey carried out to assess the awareness and utilization of National Health Insurance Scheme in Edo State. The importance of health to the advancement of a nation cannot be overemphasized.

Health decisions are very important decisions that affect virtually every other aspect of human life and endeavor. The mental and physical activities of an individual depend on the health condition of that individual. In other words, people with low quality health hardly have the physical and mental ability to engage in economic activities hence, constituting liability to themselves and others (Ebun, 1997).

4.2 DEMOGRAPHIC AND SOCIO ECONOMIC CHARACTERISTICS OF RESPONDENTS

Table4. 1:Distribution of Respondents according to Age

Age Group	Frequency	Percentage
10-19 years	58	14.5
20-29 years	100	25.0
30-39 years	95	23.8
40-49 years	46	11.5
50-59 year	74	18.5
60 years and above	27	6.8
Total	**400**	**100.0**
Religion		
Islam	120	30.0
Christian	247	61.8
Traditional	33	8.3
Total	**400**	**100.0**
Ethnic Group		
Yoruba	58	14.5
Igbo	98	24.5
Hausa-Fulani	55	13.8
Northern minority	40	10.0
Southern minority	149	37.3
Total	**400**	**100.0**
Education		
None	89	23.5
Primary	69	17.5
Secondary	98	25.8
Tertiary	144	33.3
Total	400	100
Occupation		
Public/Civil servant	172	43.0
Business/trading	136	34.0
Farmer	59	14.8
Others	33	8.3
Total	**400**	**100.0**

Source: Field Survey, 2014

4.2.1 Age

Table 4.1 shows the distribution of respondents by age A total of (6.8%) of the respondents are 60 year and above. Those within the age bracket of 30-39 years are about (23.8%) followed by the age bracket of 20-29 years (25.0%).

This is a clear indication that the population sampled is a youthful one. This pattern of age distribution is normal because the younger age groups are more open to information.

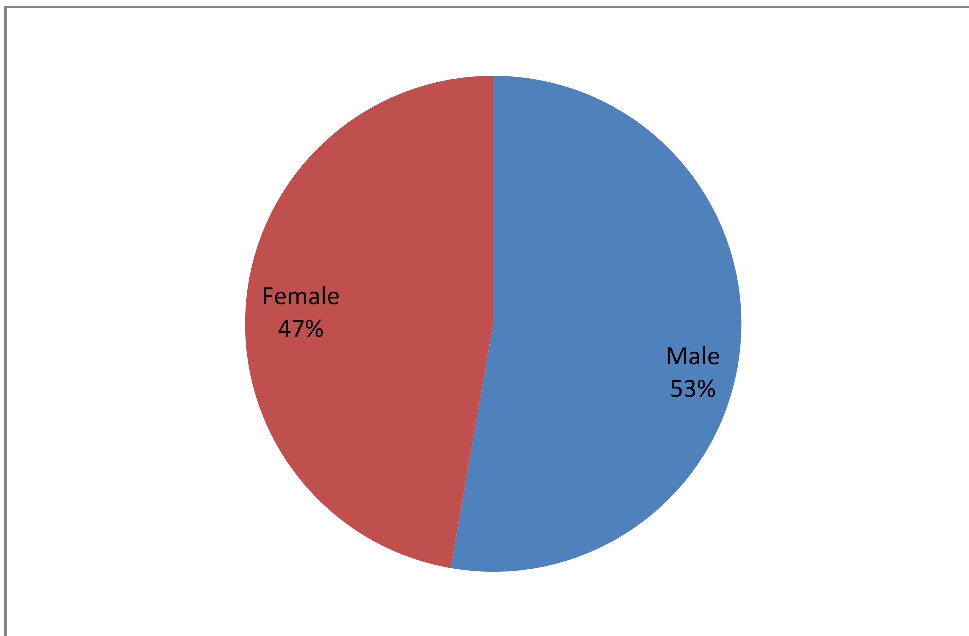

Figure 4. 1:Percentage Distribution of Respondents according to gender

Source: Field Survey, 2014

4.2.2 Sex

Sex is one of the most influential variables affecting the use of National Health Insurance Scheme Service. Sex has influence on utilization of the health care service through its association with other predictors of utilization such as tendency to use services, anxiety and skepticism. Figure 4.1 shows that 53% are males, 47% are females.

Data from NPC (2009) shows that Edo state has more males than females also men were more accessible than women at the time of the survey.

4.2.3 Religion

Information on religion in Table 4.1 shows the highest proportion of the sampled population are Christians (61.8%) followed by Muslims (30.0%), the traditional religion have the least population of (8.3%).

The relatively high Christian population is because of the early encounter they had with the missionaries which led to more Christians in the study area. A study by Mekonon (2000) in rural Ethiopia revealed that religion emerged as an important predictor of ante-natal care utilization. Perceptions of events may tie followers of various religious groups to the use of formal system only when the traditional option fails.

However, we can expect that some traditional beliefs obviously have negative effect on the use of modem health care services in the country. In this study, this is not seen presumably because of the increased awareness and the ease of access to health facilities.

4.2.4 Ethnicity

The highest proportion of the sampled population are southern minorities with 37.3% followed by 24.5%, of Igbos, the northern minority have the least population of 10%.Ethnicity is usually assumed to affect choice of health care services/enrollment in health insurance through such factors as health related behaviour and beliefs (Wind Sor, 2004).

4.2.5 Level of Education

Table 4.1 shows that 33.3% of the respondents have tertiary education, 25.8% have secondary school certificate and 17.5% have primary education, this corresponds with the findings of Eze (2012) in Imo State were 33% of respondents had tertiary education 28% had secondary education and 16% had primary education.

Education plays a vital role in any society; it is a key factor of societal enhancement, it does not only provide opportunities for personal awareness of social opportunities and higher non-familiar aspirations but also new outlooks, freedom from tradition, willingness to analyze institutions, values and patterns of behaviour and growth of rationalism.

The high proportion of secondary school education is due to the introduction of Universal Basic Education (UBE) in Nigeria which allows direct transition from junior secondary school with or without any form of examination.

4.2.6 Occupation

The distribution of respondents by occupation is shown in Table 4.1. A general over view of Table 4.1 shows that as high as 43.0% of the respondents are civil/public servants, followed by business/trading 34.0%, the least occupation is others which constitute 8.3%.

The most important indices in demographic analysis is occupational level, when it comes to assessing its impact on the health care behaviour of the people. More than 97% of the respondents are doing one form of job to generate income as observed.

Table4. 2:Distribution of Respondents according to level of Income

Income	Frequency	Percentage
Less than N10,000	179	44.8
N21,000-N20,000	63	15.8
N21,000-N30,000	44	11.0
N31,000-N40,000	16	4.0
N41,000-N50,000	27	6.8
N51,000 and above	47	11.8
None	24	6.0
Total	**400**	**100.0**
Marital Status		
Married	149	37.3
Divorced	20	5.0
Separated	12	3.0
Single	137	34.3
Widowed	70	17.5
Others	12	3.0
Total	**400**	**100.0**
Number of children ever born		
None	63	15.8
1-2	134	33.5
3-4	119	29.8
5-6	52	13.0
7-8	18	4.5
9 and above	14	3.5
Total	**400**	**100.0**
Number of children surviving		
1-2	110	27.5
3-4	138	34.5
5-6	47	11.8
7-8	32	8.0
9 and above	11	2.8
None	62	15.5
Total	**337**	**100.0**
Type of accommodation		
One-two bed room	135	33.7
Three room apartment	94	22.4
Compound house	93	22.1
Flat	4 9	11.7
duplex	22	5.2
Others	7	4.9
Total	**400**	**100.0**

Source: Field Survey, 2014

4.2.7 Income

Table 4.2 shows that (11.8%) of the sampled population are in the highest income range of 51,000 and above, followed by (6.8%) income range of 41,000 – 50,000 and the lowest category of incomes earning less than 10,000 is (44.8%) .

About 60% of the respondents earn below the minimum wage of N18,000.00 per month. This indicates that the respondents are generally poor. However, a cursory review of the literature suggests that lower income individuals tend to have poorer health and are likely to have a greater demand for a variety of health care services. Low income status is the most reliable indicator of poor health, thus the need for access to health care for low income group is critical for their overall well-being.

4.2.8 Marital Status

Table 4.2 shows that 37.3% of the respondents are married and 34.3% are single, followed by 17.5% widowed the average life span of men in Edo state is 52 year (Odion 2012) high percentage of the widows is a result of short life span, disease and accident. The incidence of divorced appears rather low 8.0%.

Marriage is a population phenomenon and is known to be universal in Nigeria as revealed by the results of 1991 census (NPC, 1998). Marital status constitutes a demographic characteristic which involve biological, cultural, and legal. It is a very important factor in population dynamics since it affects fertility (Mamman, 1992).

4.2.9 Types of marriage

Figure 4.2 shows the type of marital union of the sampled respondents. About 69% of the respondents are in to monogamous union and 31 in polygamous union

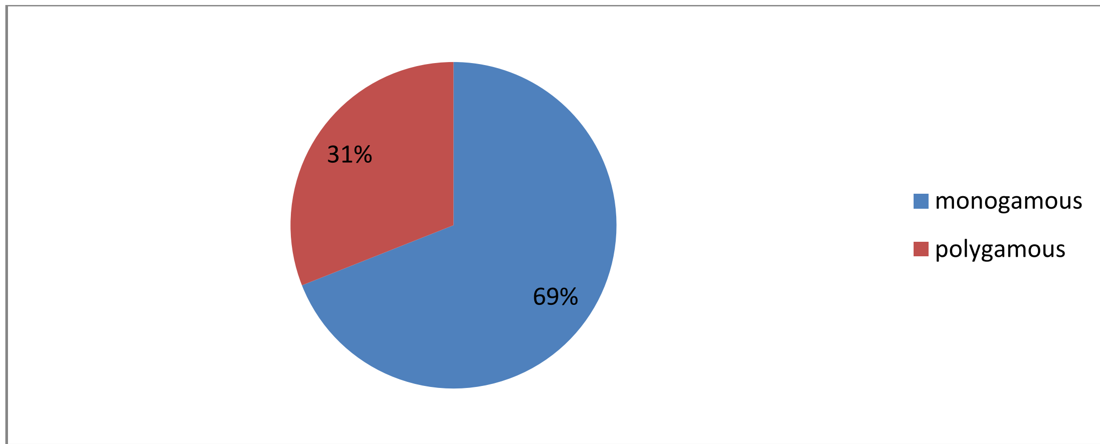

Figure 4. 2:Percentage distribution of respondent according to type of marriage. Source; field survey,2014.

Majority of the survey are in monogamous because the study area is dominated by Christians, as such it allows and encourages monogamous. Similar studies have found that the proportion of monogamous house hold, where more than the polygamous (Odion 2012).

4.2.10 Children Ever-Born

Table 4.2 shows the number of children ever born. About 15.8% of the sampled populations have no children, the relative high percentage of childlessness is due to the fact that 34.3% of the respondents are single and procreation takes place mainly in marriage. Also the tendency of childlessness among the married couples is seen as another factor that contribute to the high percentage of childlessness, 33.5% have 1-2 children, 29.8% have 3-4 children the least is those with 9 and above number of children with 3.5%.

4.2.11 Number of Children Surviving

Table 4.2 indicates the distribution of respondents on the number of surviving children. Some 34.5% of the respondents have 3-4 children surviving.

About 29.2% have 1-2 children surviving and the least is those with 9 children and above with 2.8%. The relative high percentage of surviving children compared to the percentage of ever born as presented in Table 4.2 could be an indication of improvement in access and utilization of health care services among respondents which helped to minimize rate of infant and child mortality. This is further supported in a similar study in Owen North LGA of Edo State by Odion in 2009 where it was found that out of 200 respondents sampled majority (35%) were of the opinion that the introduction of health care system has impacted their community through provision of immunization.

4.2.12: Types of accommodation

Table 4.2 shows the distribution of respondents according to type of accommodation. From Table 4.10 it shows that majority of the respondents that comprise of 33.7% live in one/two bedroom apartments.

The reasons could be the cost of rented house, hence some people prefer to live in such houses in order to save enough money to build their personal houses, about 22.4% live in three bed rooms and 22.1% live in compound house.

Table4. 3:Distribution of respondents by household size

Number of people	Frequency	Percentage
1-2	49	12.3
3-4	57	14.25
5-6	106	26.5
7-8	70	17.5
9-10	68	17.0
10 +	50	12.5
Total	**400**	**100**
Toilet facilities		
Water system	27.3	68.3
Pit/latrine	101	25.5
Bush	20	5.2
Bucket	6	1. 5
Water system	27.3	68.3
Total		100
Source of water		
Pipe bore	63	15.7
Well	02	0.5
Bore holes	117	29.2
River	94	23.5
Rain Harvested water	127	31.0
Total	**400**	**100**
Household gadget		
Television	272	68.0
Radio	97	23.1
Fridge	18	4.3
A/C	13	3.1
Total	**400**	**100**
Type of health facility		
Government hospital	134	33.5
Teaching Hospital	25	6.25
Private hospital	63	15.75
Clinic	40	22.5
Pharmacy/chemist	40	10
Herbalist/traditional healers	48	12
Total	**400**	**100**

Source; Field Survey, 2014

4.2.13 Household Size

Table 4.3 shows the distribution of respondents by household size. It shows that 12.3% of the respondents live in a household comprising of size of one-two (1-2) people, while 14.2% of the respondents indicate a house hold size of three-four (3-4) people.

A total of 26.5percent of the respondents agreed that they have between five to six (5-6) people and above currently living in their houses .the average household size in Edo state is 6 per house hold.

The dominance of 5-6 people per household among the respondents in the study area collaborates the report by Child Labour Survey (2000/2001) of an average of 6.2 persons per household in Edo state, Nigeria.

4.2.14 Type of Toilet facilities

From data presented in Table 4.3, majority of the sampled population (68.3%) use water system. About 25.5% use pit/latrine and only 1.5 % use bucket. A general look at the findings shows that Edo State has a good sewage disposal system judging from the percentage that use modern flush toilets and pit/latrine.

4.2.16 Access to water

Table 4.3 shows the distribution of respondents on source of water supply, from where it shows that the dominant source of water for domestic use is through rain harvest which accounted for 31.0%.

Moreso, borehole source followed closely with 29.2%, while rivers and wells accounted for 23.5% and 0.5% respectively. The dominance of harvested rain water source

is not surprising as it is a common practice in the area owing to high amount of rainfall per annum which is between 1524mm and 2540mm lasting between 8-9 months in a year.

4.2.15 Household gadgets

The availability of household gadgets such as television, radio, refrigerator, air conditioner is an indicator of socio-economic status of the household. Access to radio or television exposes household members to innovative ideas (Abel, 2010).

From Table 4.3 can be seen that a large proportion of the respondents have television (68.0%) followed by radio 23.1%, own fridge (3.1%)s have air conditioners, The national population commission study in 2003 found that 75% of households are much more likely to own these goods than those in rural households (NPC, 2003).

4.3 Types of Health Care Facilities Available in the NHIS Centres

Table 4.3 shows that majority (33.5%) of the respondents say that the major health care facilities in their community is the government clinic, 15.75% say that they have private clinics in their area, while 10% indicate that they have chemist/pharmacy. A total of 12% also indicated that they have herbalist and traditional healers.

From this analysis, it is clear that there are more government hospitals in the study area.The people patronizes the government hospitals more than the private owned hospitals because the study area is mainly an urban setting with so many government hospitals to provide services for the population.

Table4. 4:Distribution of Respondents by Choice of Centre

Choice of Centre	Frequency	Percentage
Proximity to residence	92	34.7
Only available health care	98	37.0
Easy to afford	30	11.3
Quality service	45	16.0
Total	**265**	**100.0**
Number of Visit Per Year		
Once	78	29.4
Twice	104	39.3
Thrice	51	19.3
Above three times	32	12.0
Total	265	100.0
Types of illness		
Malaria fever	18, 007	33.0
Diarrhea	8001	14.6
Tuberculosis	1620	2.96
Cough	1,800	3.43
STDs/STLs	9000	16.4
Hepatitis	8890	16.2
Dracuncubasis (Guinea worm)	940	1.72
Others	18,007	33.0
Total	**54546**	**100**
Distance to Clinic/Hospital		
Less than 5km	120	45.3
5-10km	42	15.8
More than 10km	103	38.9
Total	265	100.0
Means of transportation		
Personal car	114	28.2
Commercial car/bus	207	51.8
Foot	2	1.2
Bicycle	6	4.8
Motorcycle	48	14.0
Total	**400**	**100**

Source Field Survey, 2014

4.3.1 Reason for Choice of the Center

Majority of the respondents reasons for preferring treatment in various health centres in Table 4.4 is the only available health care (37.0%) followed by proximity to residents with. (34.7%) and next it is easy to afford treatment with. 11.3% preferring treatment in various health centres.

This corresponds with a similar study by Hour (2004), in Ghana on accessibility and utilization of health care, where it was reported that majority of the respondents gave their reasons for choice of treatment in a particular hospital as closeness to their community as well as quality of treatments and availability of qualified doctors.

4.3.3 Number of Visits to the Hospital/Clinic in a years

The data in Table 4.4 shows that 39.3% of the respondents visit the centre twice in a year , 29.4% visit the centre once, the least (12.0%) of the people visit the centre three times and above.

The need for frequency of visits to health care services cannot be overemphasized because of the health benefits derived (World Bank, 1994). A research carried out in Nairobi, Kenya (2004) revealed that majority make very few visits to health care services mainly, because of lack of access to institutionalized care and the inability to meet user charges. Yet in another study in Ghana, the average number of visits has been stagnant, about 3 visits per woman in 5 years (Bour, 2004).

4.3.4 Types of Illness Treated

Table 4.4 shows the distribution of patients by the type of illness treated. It shows that 33.0% of all the patients treated in the selected NHIS facilities suffer from Malaria fever, 14.6% account for diarrhea, 2.96% account for tuberculosis 3.43% account for

cough, Sexually Transmitted Diseases/Sexually Transmitted Infection (STDs/STIs) represent, 16.4%, hepatitis, 16.2% dracumcuhasis 1.72% and 33.0% represent others.

These findings confirm to what is known from other sources on the endemic nature of malaria, being one of the major causes of ill-health in sub-Saharan Africa (WHO and UNCEF,2009) Cholera and typhoid fever, are common in the area, this is because of inadequate access to safe drinking water, because some of the inhabitants in the study area depend on unhygienic source of drinking rain from harvested water, rivers and streams.

4.3.5 Distance to the Clinic/Hospital

Table 4.4 provides information on the distance to clinic/hospitals where about 45.3% live less than 5kms from the clinic/hospital, 38.9% indicate that they have to travel more than 10km to the clinic/hospital while only 15.8% respondents travel 5-10kms.

The place of residence has been an important factor in the utilization of the services. The urban population makes greater use of services than those in rural areas were some equipment is not found. (Okafor 2007)

4.3.6 Means of Transportation to the Hospital

Table 4.4 provides information on the means of transportation to the hospital. about 51.8% use commercial car/bus

More than 28% use their personal cars and 1.2% go by foot to the hospital. The high percentage of respondents who use their personal or commercial car/buses to the health care centres while those that go by foot is a clear indication that the distribution of health care centres where NHIS services is obtainable is not closely located, hence are not within a trekable distance from respondent's place of residence.

Table4. 5:Distribution of respondents according to time spent to access treatment

Time spent	Frequency	Percentage
< 1 hour	14	5.2
1-2 hours	20	14.7
3-4 hours	109	41.1
5-6 hours	81	30.5
7-8 hours	22	8.30
9 hours and above	10	3.7
Total	**265**	**100**
Hospital		
Ikpobaoha	14	3.7
Oredo	42	11.1
Igara	16	4.2
Ekpesa	21	5.5
Ewu	34	8.9
Opoji	63	16.6
Ubiaja	54	14.2
Ikhideu	30	7.9
Okuor	28	7.9
Ozala	28	7.4
Iguogbe	48	12.6
Total	**378**	**100**
Attitude of health workers		
Friendly	108	40.7
Harsh	90	33.9
Sympathetic	49	18.4
Patient/understanding	18	6.7
Total	**265**	**100.0**

Source: Field Survey, 2014.

4.3.6 Time spent at hospital

Table 4.5 shows the distribution of respondents by how long it takes to be attended to during visits to the health care centers. The time it takes a patient to be attended to by the health care providers at the center is very important. The study considers the waiting time

by patients as an important parameter, and the time given for diagnosis by the health care personnel is very crucial.

About 41.1% of the respondents indicate that the patients have to wait for 3-4 hours before they are attended to by the health care personnel, 30.5% have to wait for 5-6 hours while 5.2% have to wait for 1 hour This analysis shows that there is a long waiting time for patients in the hospital this could be as a result of lateness to work by the medical personal, registration procedure, organization of waiting hall and waiting at the pharmacy stores to collect medications.(Olumide and Ajayi, 1999).

4.3.7 Number of patients treated daily

Table 4.5 shows the distribution of NHIS facilities by daily attendance of patients. Attendance to particular hospital or clinic could be influenced by the quality of treatment, income, educational level, accessibility, relationship between providers and patient's satisfaction, dedication of health staff to duty, their cleanliness comfort and privacy and the physical appearance of hospital facilities and daily attendance of patients to NHIS facilities

Table 4.5 shows the distribution of respondents on daily attendance of NHIS facilities. About 16.6% attends Opoji NHIS facilities, 14.2 % attends Ubiaja NHIS facilities and the least is Ikpobaoha with 3.7%

Judging from the records, It is clear that the daily attendance of patients to the NHIS facilities in the study area is low, This could be because of high cost of treatment, long distances from home to hospital, lack of good transportation to facility centers.

Table4. 6:Distribution of Health Care Personnel Carders

Hospital	No. of Drs.	Nurses/Mid wives	Matron	Pharmacist	Medical/Record staff	Lab scientist	Others	Total
Ikpobaoha	2	4	4	-	3	2	7	22(10.9%)
Oredo	8	27	3	4	3	1	18	61(30.3%)
Igara	-	3	-	-	7	-	12	22(10.9%)
Ekpesa	-	1	-	-	3	1	7	12(6.0%)
Ewu	3	7	2	1	3	1	7	24(11.9%)
Opoji	-	2	-	-	2	-	4	8(4.0)
Ubiaja	1	6	-	-	-	-	7	14(7.0%)
Ikhideu	-	2	-	-	-	-	3	5(2.5%)
Okuor	-	2	-	-	-	-	6	8(4.0)
Ozala	1	5	1	-	3	1	7	18(9.0)
Iguogbe	3	1	1	1	-	1	-	7(3.5%)
Total	18	60	11	6	24	6	78	201(100)

Source: Hospital Record, 2013

4.4.7 Type of personnel available at NHIS facilities

The various carders of workers involved in health care delivery system can be found in any of the three levels of health care in Nigeria, they include the physicians, pharmacist, Nurses and mid-wives, laboratory technicians, community health extension workers (CHEWS) and record clerks, clerks, cleaners security men and drivers. Whatever the carder or level of an health worker is operating, they all have many objectives and that is to improve the health of the members of the community, this implies that, health workers must work as a team in others to achieve this objective.

Table 4.6 shows the distribution of health care personnel by status it shows that out of 201 health care personnel from the selected NHIS facilities in the study area, 18 are doctors, 60 nurses/mid wives, 11 matron, 6 pharmacist, 24 medical/record staff, 7 lab scientist and 78 others.

From this analysis, it is quite obvious that there is acute shortage of health care staff especially doctors and pharmacists in the study area. This agrees with studies by Daton (1988): Kuti *et al* (1991) where shortage of health personnel especially physicians was reported as one of the major problem affecting NHIS in the study area.

4.3.9 Attitude of Health Workers to Patients

Table 4.6 shows that 40.7% of the respondents classify the attitude of the health workers as friendly, while 33.9% see the attitude of the health workers as harsh,18.4%sypathetic and 6.7% are patient. Attitudes and service satisfaction may have a greater influence on health seeking behaviour than cost and access. Patients satisfaction increased when provider inform, explain and instructs patients. In the same vein, confidence and trust are enhanced when nurses take charge and appear to enjoy their work.

However, improving the quality of services to ill-persons does not involve providing purely clinical service but also includes good human relation skills.

The attitude with which users are treated also has an effect on how the health care services are utilized. The findings of studies conducted by Hamza (2006) on the attitudes of Nigerian civil servants towards the National Health Insurance Scheme in Sokoto state revealed under-utilization of services by beneficiaries and went on to attribute this to the way in which staff at health care centers treat patients as the nurses were described as being impatient and unsympathetic. The dominance of friendly attitudes from the hospital attendance among the respondents is further supported by the opinion of a discussant during a Focus Group discussion session, where it was noted thus;

The relationship between the medical personnel and the people in our area is good, they are friendly and they encourage us to visit the health centre whenever we are sick. They counsel us and encourage us on how to live a healthy and happy life. (Helen Omo Osa April 2014).

CHAPTER FIVE: FACTORS DETERMINING AWARENESS AND UTILIZATION OF NHIS SERVICES

5.1 INTRODUCTION

This chapter is focused on the cross-tabulation and discussion of the factors that determine awareness and utilization of NHIS services. The cross-tabulation is done based on the dependents variables of type of health care centres and utilization of NHIS services by the respondents and independent variables of availability of medical facilities, specific types of available facilities as well as selected socio-economic variables of the respondents.

5.2 Awareness of NHIS

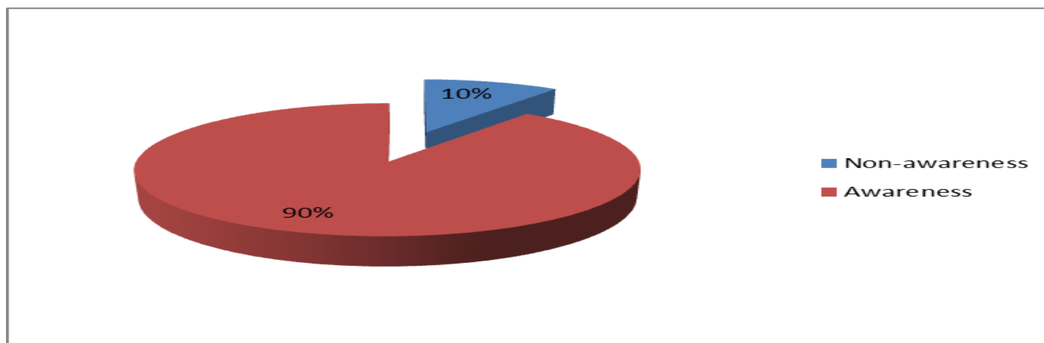

Figure 5. 1: Percentage Distribution of Respondents on Awareness of NHIS

Field Survey 2014.

Figure 5.1 shows the percentage distribution of respondents on the awareness of NHIS existence in the study area. Where out of the entire sampled respondent majority that constitutes 90% are aware of the existence of NHIS, while about 10% are not aware of NHIS.

However, high levels of awareness among the respondents is relatable to the high level of awareness campaign by the government at all levels in Nigeria. Through the

internet print media, as well as audio and audio-visual mediums in enlightening the citizens on the benefits of NHIS services.

5.3 Types of Services and Frequency of Visits

Table5. 1Distribution of respondents by types of illness treated and frequency of visit to the health care service per month

Type of Treatment Available	Number of Visit								Total	
	Once		**Twice**		**Thrice**		**Above three times**			
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Malaria Fever	14	7.9	14	7.9	11	6.2	3	1.7	42	23.6
Immunization	37	20.8	17	9.6	7	3.9	2	1.1	63	35.4
Tuberculosis	0	0.0	15	8.4	3	1.7	2	1.1	20	11.2
Cough	1	0.6	8	4.5	2	1.1	1	0.6	12	6.7
Hepatitis	2	1.1	11	6.2	9	5.1	3	1.7	25	14.0
Dracuncubasis (guineaworm)	4	2.2	5	2.8	2	1.1	5	2.8	16	9.0
Other	5	1.1	4	1.8	2	1.2	6	1.9	18	9.8
Total	**58**	**32.6**	**70**	**39.3**	**34**	**19.1**	**16**	**9.0**	**178**	**100.0**
Calculated X^2=57.965 D/F	**=15 P value= .0.01**									

Field Survey 2014.

Table 5.2 shows the distribution of responses on the types of illness treated on frequency of visit to health care service per months. Out of the entire stated types of services rendered at NHIS facilities, immunization, malaria fever and hepatitis are ranked the highest top three with 35.4%, 23.6% and 14.0% in that order.

Comparatively, among respondents utilizing the Malaria fever services, the highest frequency visits made by the respondents is between once and Twice Monthly which is

totaled 7.9% each, while the least number of visited times by respondents is above three times per month with 1.7%.

On the other hand, immunization services which is ranked the first on the types of services mostly utilized by the respondent shows that the most number of visits by the respondents per month is between once and twice which accounted for 20.8% and 9.6% respectively, while the least number of visits by the respondents is above three times per month.

Moreso, hepatitis which is ranked the third among the types of treatments mostly utilized by the respondents, with most respondents visiting health facilities for this purpose visiting twice and thrice per month which accounted for 6.2% and 5.1% respectively, while the least number of visited times per month is once with 1.1%.

The higher frequency of utilization and number of visiting times to Malaria Fever treatment, immunization and hepatitis treatment by most respondents visiting NHIS facilities signifies high level of poverty and high susceptibility of respondents to diseases and infections. This can be justified with the finding by Sabriya (2005), who in an analysisof poverty rates and health published in the September 2006 edition on issues of the American on Preventive Medicine found that people living in extreme poverty tend to have more frequent and severe disease complications and make greater demands on the healthcare system. (Sabriya, 2005)

A chi square analysis to establish a relationship between type of illness treated and frequency of visit to NHIS facilities at 0.05 shows that there is relationship between type of illness treated and frequency of visit. (x^2) = 57.965 p=.0.01 d/f = 15)

5.4 Types of Health Care Centres and Availability of Facilities

Table5. 2 Distribution of Types of Health Care Centres by the Available Facilities

Type of Health Care Centres	Availability of facilities				Total	
	Yes		No			
	No.	%	No.	%	No.	%
Primary health centre	7	1.8	46	11.5	53	13.2
Teaching hospital	120	30.0	60	15.0	180	45.0
Private hospital	102	25.5	14	3.5	116	29.0
Specialist hospital	20	5.0	10	2.8	39	10.0
Haberlist/traditional healers	12	3.1	9.0	2.9	12	2.8
Total	261	65.2	139	34.8	400	100.0
Calculated x^2	1.27532	P=.0.01	d/f=9			

Field Survey 2014.

Table 5.3 reveals the type of health care centres where NHIS services are rendered and availability of facilities in the centres. From the presentation, it is clear that health care facilities are relatively more available (65.2%) across all health centres, compared to non-availability with 34.8% as indicated by the sampled respondents.

A further health care type and availability of facilities overview from Table 5.3 also reveals that there is shortage of health care facilities in primary health care centres than those in general and private hospitals. This is indicated that as little as 1.8% of respondents attests to the availability of health care facilities in primary health centres, compared to 30.0%, 25.5% and 5.0% of attestations for facility availability in general, private and specialist hospitals in that order. This is not surprising as it is generally known that primary health centres in most developing countries are mostly underfunded, neglected and

understaffed, hence are mostly unable to deliver to the intended communities, thereby forcing rural dwellers to sort for health care services where their health needs can easily be met. This is with reference to Nora (2005) finding which revealed that availability of facilities is determined not only by its availability but by a number of other factors, which are distance, accessibility, client's perception of service self-rated health status.

No significant relationship was found between type of health care centres and type of facilities $p < 0.05$ ($x^2$1.27532 p-value = .0.01, d/f=9)

Table5. 3Hospital records showing type of health Facilities

Hospital	Wards	Ambulance	Generator	Blood Pressure device	X-ray machine	Fridge/ Freezers	Cold boxes	Bore hole	Screenin g machine	Diagnostic Set	Total
Ikpobaoha	4	-	1	2	1	4	4	-	2	3	21(21.6%)
Oredo	3	1	1	2	1	4	2	1	2	6	23(23.7%)
Igara	-	-	1	1	-	1	-	-	1	2	6(6.2%)
Ekpesa	2	1	-	1	-	-	1	1	-	1	7(7.2%)
Ewu	4	1	2	2	1	3	-	-	-	3	16(16.5%)
Opoji	1	-	-	-	-	1	-	-	1	1	4(4.1%)
Ubaija	3	-	-	1	-	-	-	-	-	-	4(4.1%)
Ikhideu	-	-	-	1	-	-	1	-	-	1	3(3.1%)
Okuor	-	-	1	1	-	-	-	-	-	1	3(3.1)
Ozala	-	-	-	1	-	-	-	-	-	1	2(2.1%)
Iguogbe	3	1	1	1	-	1	-	1	-	-	8(8.3)
Total	20	4	7	13	3	14	8	3	6	19	97(100%)

Sources: Hospital Records, 2003-2013

From the data above there are 20 wards, 4 ambulance, 7 generators, 13blood pressure devices 3 xray machines, 14 fridge/freezers, 8 cold boxes, 3 bore holes, 6 screening machine, 19 diagnostic set

The availability of the various facilities are attributed to the type of services rendered in a particular centre (NHIS 2012).

5.5 Religions and Utilization of NHIS Facilities

Table5. 4 Distribution of Respondents on Religion and Utilization of NHIS Services

Religion	Utilization of NHIS Facilities				Total	
	Yes		No			
	No.	**%**	**No.**	**%**	**No.**	**%**
Muslims	93	23.2	27	6.8	120	30.0
Christian	157	39.2	90	22.5	247	61.8
Traditionalists	15	3.8	18	4.5	33	8.2
Total	**265**	**66.2**	**135**	**33.8**	**400**	**100.0**

Calculated x^2 =13.973 d/f =2 P=.001

Field Survey 2014.

Table 5.5 shows the distribution of respondents by religious affiliation and utilization of NHIS services. It is obvious in Table 5.5 that majority of the respondents (66.2%) utilizes NHIS services, compared to those who do not utilize the services that constitutes 33.8%.

Among respondents utilizing NHIS services, Christians with 39.2% outnumbered the muslims and traditional worshippers which accounted for 23.2% and 3.8% respectively. However, the dominance of Christians among respondents utilizing the NHIS services is attributable the dominance of Christians in the sampled areas compared to other religious groups. Moreso that religion plays an essential role in the lives of people and has great impact on the

acceptance or rejection of particular healthcare facilities in any society, especially in Nigeria where people are deeply rooted in their religious beliefs(Odeh, 2007).

Interestingly, it is also clear from the presentation in Table 5.5 that there are more traditional worshippers who do not utilize NHIS services which represent about 4.5% compared to those utilizing the services that make up 3.8%. This finding can be justified with the study conducted by Naseem*etal.,* (2002) where it reported that traditionalists tend to under use the services of modern health centresdue to traditional conservatism and resistance to ideas from outside; deep rooted traditions and customs, including health beliefs and practices, which in return creates a tendency to over utilize the services of traditional healers.

Religion influenced awareness and utilization of the respondents a cross tabulation on religion and utilization of NHIS shows that there is a significant relationship with p <0.05(x^2 = 13.973,p-value.001 d/f= 20

5.7 Occupation and utilization of NHIS Services

Table5. 5:Distribution of Respondents by Occupations and Utilization of NHIS Services

Occupation	**Utilization of NHIS Services**				**Total**	
	Yes		No			
	No.	**%**	**No.**	**%**	**No.**	**%**
Public/Civil servant	121	30.2	51	12.8	172	43.0
Petty Trader	86	21.5	50	12.5	136	34.0
Farmer	39	9.8	20	5.0	59	14.8
Others	19	4.8	14	3.5	33	8.2
Total	**265**	**66.2**	**135**	**33.8**	**400**	**100.0**

Calculated x^2= 2.956 d/f=3 p- value =0.089

Field Survey 2014.

Table 5.6 shows the distribution of respondents by occupational status and utilization of NHIS services. There is higher proportion of respondents in one form of occupational status or the other utilizing NHIS services which accounted for 66.2%, compared to those who are not utilizing the services with 33.8%. This shows that occupation is a predisposing factor to utilization of health services.

Public/civil servants with 30.2% dominated among the respondents utilizing NHIS, compared to those with occupational status of petty trading, farmer and "others" categories of occupations such as housewives, apprentices that accounted for 21.5%, 9.8% and 4.8% respectively. The reason for high proportion of respondents in public or civil service utilizing the NHIS services is an indication that occupational groups with a different income have a differential effect on the utilization of the modern healthcare, since petty trading and farming are often times considered as low income occupations, hence those in these type of occupations may likely be unable to pay for the services accruable from utilizing NHIS services.

In other to establish a relationship between occupation and utilization of NHIS x^2 analysis was carried out the result indicted that at 0,05 significant level there is relationship between occupation and utilization of NHIS with $p < 0.05$ ($x^2 = 24.029$ d/f = 16,P=0.089).

5.8 Ethnic Group and Utilization of NHIS Services

Table5. 6:Distribution of Respondents on Ethnic Groups and Utilization of NHIS Services

Ethnic Group	Utilization of NHIS Services				Total	
	Yes		**No**			
	No.	**%**	**No.**	**%**	**No.**	**%**
Yoruba	34	8.5	24	6.0	58	14.5
Igbo	67	16.8	31	7.8	98	24.5
Hausa-Fulani	42	10.5	13	3.2	55	13.8
Other North Minority	18	4.5	22	5.5	40	10.0
South Minority	104	26.0	45	11.2	149	37.2
Total	**265**	**66.2**	**135**	**33.8**	**400**	**100.0**
Calculated $x^2 = 13.4$	d/f=4	P-value	=.011			

Field Survey 2014.

Table 5.6 shows the distribution of Respondents according to Ethnic Groups and by utilization of NHIS services. Among various ethnic groups identified in the study area, respondents from the southern minority of the state with 26.0% dominated among those utilizing the NHIS services, while the least ethnic group are those from other Northern minority which accounted for 4.5%. This is also due to high number of health facility distribution in the southern part of the state than other parts of the state.

It also shows that there is higher proportion of northern minorities who do not utilize NHIS service that comprise of 5.5%, compared to those who utilizes the services that constitute 4.5%.

Also, among the respondents from the three major tribes in Nigeria resident in the study area, Igbos with 16.8% surpassed the yorubas and Hausa-Fulani that constitutes 8.5% and 10.5%

respectively among those utilizing NHIS services. This variation in patronage of NHIS among the various ethnic groups is further elaborated by Wind-Sor(2004) who noted that one's ethnic group is usually assumed to affect the choice of healthcare services and enrolment in health insurance through such factors as health related behaviours specifically with regards to the medical life.

5.9 Marital Status and Utilization of NHIS Services

Table5. 7:Distribution of Respondents by Marital Status and Utilization of NHIS Services

Marital Status	Utilization of NHIS Facilities				Total	
	Yes		**No**			
	No.	**%**	**No.**	**%**	**No.**	**%**
Married	89	20.0	39	10.0	109	27.2
Divorced	21	5.2	11	2.8	32	8.0
Separated	10	4.2	13	3.0	40	10.0
Single	99	24.8	38	9.5	137	34.2
Widowed	30	8.0	24	5.5	60	13.5
Others	18	4.0	10	3.0	32	7.0
Total	265	66.2	135	33.8	400	100.0
Calculated x^2	=4.491	p-value 3		d/f.231		

Field Survey 2014.

Table 5.9 shows the distribution of Respondent's marital status and their utilization of NHIS services. The presentation show that singles constitutes the majority with 24.8% among those that utilize NHIS services, with the least being the others which make up 4.0%.

Additionally, among respondents who are not utilizing the NHIS services, those that are married (10.0%) outnumber their counterparts who are either divorced, single or widowed that constitute 2.8%, 9.5% and 5.5% accordilly. This result is surprising as it is generally expected that those who are into a marital union will have more numbers of people in the family and may likely frequent the health centres for one treatment or the other.

Marital status was not associated with the ultilization of NHIS as those who were not married had the highest proportion of 34.2% when comared with other marital status (x^2= 4.491 d/f = 3 p- value .213)

5.10 Level of Education and Utilization of NHIS services

Table5. 8:Distribution of Respondents according to Level of Education and Utilization of NHIS Services

Level of Education	Utilization of NHIS Facilities				Total	
	Yes		No			
	No.	**%**	**No.**	**%**	**No.**	**%**
Primary Education	58	14.5	12	3.0	70	17.5
Secondary education	63	15.8	40	10.0	103	25.8
Tertiary Education	90	22.5	43	10.8	133	33.2
None	54	13.5	40	10.0	94	23.5
Total	265	66.2	135	33.8	400	100.0
Caudated x^2 13.203	d/f =3	p- value =.004				

Field Survey 2014.

Presentation in Table 5.9 reveals that utilization of NHIS services is higher among respondents with tertiary education qualification which constitute 22.3%, compared to those with no formal education, primary and secondary education that make up 13.5%, 14.5% and 15.8% in that order.

The finding on the dominance of respondents with tertiary education among those utilizing the services of NHIS area is not surprising as it is expected that educated people are more likely to have higher awareness about healthcare services as well as seek modern healthcare services than those who are not educated. This is further buttressed by Wickleby (1992) who noted that education pave way to improve the general healthcare, build up confidence to make decisions about one's own health. A cross tabulation of level of education and utilization of NHIS gives the following x^2 values of 13.203 p- value =.004 d/f 3.

5.11 Utilization of NHIS Services and Challenges of NHIS Utilization

Table5. 9:Distribution of Respondents on Utilization of NHIS and Challenges facing NHIS Utilization

Challenges of NHIS Utilization	Utilization of NHIS Services				Total	
	Yes		**No**			
	No.	**%**	**No.**	**%**	**No.**	**%**
Inadequate facilities	23	5.8	55	13.8	78	19.5
High Transportation Costs	86	21.5	3	0.8	89	22.2
Poor Infrastructural facilities	124	31.0	67	16.8	191	47.8
Inadequate staff	15	3.8	4	1.0	19	4.8
Poor management	10	3.1	4	1.1	18	3.8
Others	7	1.1	2	0.5	5.1	2.0
Total	265	66.2	135	33.8	400	100.0
Calculated x^2 = 86.007 p- value =.002	d/f=4					

Field Survey 2014.

From Table 5.8 it can be deduced that the major challenge faced by the respondents who utilize the NHIS services is poor infrastructure which accounted for 31.0%, followed closely by high transportation costs with 21.5%.

On the other hand, among respondents who are not utilizing the services of NHIS in the study area, poor infrastructures and lack of man power dominated their reasons with 16.8% and

13.8% respectively. This situation is confirmed by the finding from Bisallah (2002) that stated that most of the healthcare centres in Nigeria today suffer dearth of medical personnel and infrastructures with the situation worsened at the local government level as most of them did not have record of medical staff, coupled with unconducive working environment of the hospitals.

The chi square value of 86.007 p-value of .002 and d/f show that there ishigh correlation between challenges and utilization of NHIS

CHAPTER SIX: SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 SUMMARY

The aim of this research is to determine the awareness and utilization of National Health Insurance Scheme in Edo state. Three Local government area (LGAs) were selected for the study based on the one with the highest care facilities. One from each senatorial district in the state this include Akokoedo, Esan west and Uhunmwode LGAs. Data and information for the research was obtained using structure questionnaires and focus group discussion. The study reviews that NHIS plays an important role in health decision pertaining to reproductive health matters in Edo State. From the findings:

i. it indicates the awareness and utilization of NHIS is positively influence by socio – economic variables like religion, income, education, marital status, number of children, types of accommodation, household size and access to water.

ii. it was found that 90% of the entire sample respondents revealed that they are aware of NHIS while 10% are not because of accessibility, lack of health care facilities and cumbersome nature of the scheme.

iii. the majority of the sample population have tertiary education with 33.3% followed by 25.8% with secondary education and those without education is 23.5%.

iv. occupation plays a vital role because most people utilizing the scheme are in one form of employment or another.

A chi – square ($_x{}^2$)analysis was also use to determine the relationship within two independent variables of type of health care facilities and utilization of NHIS services by respondents and independent variables of availability of medical facilities.

6.2 RECOMMENDATIONS

The principles underlying the operation of NHIS requires both governmental and non – governmental participation their active partnership with health care facilitators and other sector professionals will ensure adequate and efficient service provision. NHIS programme in Edo state has not made any significant impact due to the poor implementation of all the component of NHIS. In other to achieve any appreciable degree of enhancing NHIS implementation.

The following recommendations are offered

1. Adequate permanent infrastructure and training need to be provided to the scheme personnel even before the scheme becomes operational as NHIS infrastructures are still lacking in Edo state
2. Also, it is necessary to design a monitoring and evaluation unit that is able to keep corruption under control. There should also be periodic clinical audits in collaboration with provides groups
3. Although, awareness is high, however there should be intensive sensitization and mobilization on utilization by the health department and these should be a strategy to target low – income groups as they are one of the major benefits of the scheme.
4. In the short term, strategies such as re – evaluation of reward systems to ensure that health workers are provided with incentives sufficient to discourage migration and encourage health workers to go to the rural areas of Edo state and the use of substitute workers (taking into consideration quality concerns) may be considered. In the long term, more workers will need to be trained and condusive working environments provided for them

6.3 SUGGESTION FOR FURTHER RESEARCH

- There is need for further research to NHIS facilities in different part of the country to see the extent of the coverage.
- Further research should be carry out on the availability of NHIS facilities

6.4 CONCLUSION

The study has attempted to examine the awareness and utilization of NHIS programme in Edo state. the study has discovered number of variables that fail to provide basic health facilities, infrastructures and personnel, which has led to a situation where access to NHIS is a problem, most of the people in the study area are aware of the programme but do not utilize it because of poor road network, time spent to access treatment and inadequate health care facilities. NHIS has failed because of couple of facts brought out by the analysis shows that the impact made by NHIS programme on the general health condition of the people in the study area is very insignificant. This include; high transportation cost, poor infrastructural facilities, poor management and inadequate staff.

The quality and volume of services offered is insufficient to the beneficiaries and cumbersome as such they prefer to seek medical care outside the NHIS centre or alternatively visit pharmacy or chemist; it is on this basis that government has to put resources together and intensify effort to strengthen the capacity for the successful implementation and utilization of NHIS.

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APPENDICES

DEPARTMENT OF GEOGRAPHY

AHMADU BELLO UNIVERSITY

Dear Respondent,

This questionnaire is designed as part of M.Sc, Research on assessment of awareness and Utilization of national health insurance scheme in Edo State.

This exercise is purely academic and so any information supplied would be used strictly for that purpose and thus treated as confidential.

Demographic and socio – economic characteristics of respondent

SECTION A:

1. Age (a) 10 – 19 [ ] (b) 20 – 29 [ ] c) 30 – 39 [ ] d) 40 49 [ ] e) 50 – 59 [ ] f) 60 and above [ ]
2. Gender a) Male [ ] b) Female [ ]
3. What type of treatment is available in the clinic/hospital a) Physiotherapy services [ ] b) immunization [ ] c) Family planning education [ ] d) eye examination [ ] e) preventive dental care [ ] f) Mental health [ ]
4. How many times do you go to hospital/clinic in a month? a) once [ ] b) twice [ ] c) thrice [ ] d) More than three times e) Others specify _______________
5. Why the choice of the center? _______________________________________
6. What are the facilities available in the place?
7. Marital status a) Married [ ] b) Divorced [ ] c) Single [ ] d) Widow [ ]
8. Educational qualification a) primary [ ] b) secondary [ ] c) tertiary [ ] d) None [ ]

9. Ethnic group a) Yoruba [ ] b) Igbo [ ] c) Hausa – Fulani [ ] d) Other northern minority [ ] e) Other southern minority [ ]
10. Occupation a) public/civil servant [ ] b) petty trader [ ] c) full time house wife [ ] d) farmer [ ] e) Others specify ______________________________
11. Number of children ever born a) 1-2 [ ] b) 3 – 4 [ ] c) 5 – 6 d) 7 – 8 [ ] e) 9 – 10 [ ] f) 11 + [ ]
12. Number of children surviving a) 1 – 2 [ ] b) 3 – 4 [ ] c) 3 – 4 [ ] d) 5 – 6 [ ] e) 9 + [ ]
13. Income per month a) less than N10, 000 [ ] b) N10, 000 – N20, 000 [ ] c) N21, 000 – N30, 000 [ ] d) N31, 000 – N40, 000 [ ] e) N41, 000 – N50, 000 [ ] f) N51, 000 and above [ ] g) None of the above [ ]
14. What type of accommodation do you live

a) One – two bedroom b) Three room apartment c) compound house d) duplex e) others

15. What is your house hold size a) 1 – 2 b) 3 – 4 c) 5 – 6 d) 7 – 8 e) 9 – 10 f) 10 +
16. What type of toilet do you have ?

a) Water system b) Pit Latrine c) Bush d) Bucket

17. Were do you source your water supply from

a) Pipe borne b) Well c) Boreholes d) River d) rain harvested water

18. What type of household gadgets do you have in your home

a) Television b) radio c) fridge d) Air conditioner

19. How do you transport yourself to the hospital

a) Personal car b) commercials/bus c) foot d) bicycle e) motorcycle

20. Time spent at the hospital to access treatment

a) 1 hour b) 1 – 2 hours c) 3 – 4 hours d) 5 – 6 hours e) 7 – 8 hours f) 9 hours and above

SECTION B

Information on available NHIS service and accessibility

21. Do you have NHIS clinic in your locality? a) Yes [ ] b) No [ ]

22. If yes, have you ever visited the center for any treatment? a) Yes [ ] b) No [ ]

23. What is the distance from your house to the clinic/hospital? a) less than 5km [ ] 5 – 10km [ ] c) more than 10km [ ] d) duplex e) others

24. Are you satisfied with the treatment given a) Yes [ ] b) No [ ]

SECTION C

Utilization of NHIS and health seeking treatment

25. Were do you go for NHIS treatment a) primary health centre [ ] b) general hospital [ ] c) private hospital [ ] d) specialist hospital [ ]

26. What are the nature of the facilities? a) Manual [ ] b) Automatic [ ]

27. What type of facilities are there? a) scanning machine [ ] b) x-ray machine c) blood pressure device [ ] d) diagnostic sets [ ] e) other specify [ ]

28. Are there facilities in the centre? a) Yes [ ] b) No [ ]

29. If yes, are these facilities adequate? a) Yes [ ] b) no [ ]

30. Are you always given prompt attention during visit? a) Yes [ ] b) No [ ]

31. Who attends to you whenever you visit the hospital a) doctor [ ] b) nurse [ ] c) mid-wife [ ] d) specify other [ ]

32. Do you waste time before accessing treatment? a) Yes [ ] b) No [ ]

33. How genuine and efficacy are the drugs? ______________________________

34. What is the attitude of health workers during visit?

a) Friendly [ ] b) harsh [ ] c) sympathetic [ ] d) patient/ understanding

35. Do you pay for services rendered during visit? a) Yes [ ] b) No [ ]

36. If yes, how expensive? a) Very expensive [ ] b) expensive [ ] c) not expensive [ ]

d) can't say [ ]

37. What is the major challenge you faced during visit?

a) Transportation to health centre [ ]

b) Delay health personal [ ]

c) High cost of services [ ]

d) Un conductive environment [ ]

e) Others specify ____________________________________

38. With your knowledge of NHIS services, which area do you think need improvement?

____

____

FOCUS GROUP DISCUSSION GUIDE
TOPIC ASSESSMENT OF KNOWLEDGE AND UTILIZATION OF NATIONAL HEALTH INSURANCE SCHEME IN EDO STATE NIGERIA

S/No	General Questions	Probe for
1.	Are you aware of NHIS in your LGA	How do you know about it
2.	Do you utilize the service of NHIS?	How often
3.	Do you pay for services rendered during visit?	Amount being paid
4.	Were do you go for NHIS treatment?	Why the choice of the place
5.	What type of NHIS facilities do you have access for?	Access and utilization of facilities
6.	What is the nature of services rendered to you during visit?	Efficiency of services
7.	What do you think are the factors effecting knowledge and utilization of National health insurance scheme services?	Problems encountered
8.	Who attends to you visit the hospital?	Health professionals
9.	Are you encourage by the treatment given?	Who encourages you.
10.	How has NHIS visit affected your life and that of your family?	Visit
11.	What are your suggestions to Government in improving the quality of NHIS service?	Benefit of NHIS visit