

1 **STATE OF HEALTH FACILITIES IN COMMUNITIES DESIGNATED FOR COMMUNITY-**  
2 **BASED HEALTH INSURANCE SCHEME IN NIGERIA: A CASE STUDY OF KWARA AND**  
3 **OGUN STATES.**

4  
5 **ABSTRACT**

6 **Background:** Nigerian Government established National Health Insurance Scheme (NHIS)  
7 including Community Based Health Insurance Scheme (CBHIS) to reduce out-of-pocket health  
8 expenses of enrollees, strengthen and ensure access to quality healthcare services. The  
9 functionality of the schemes however, revolves round health facilities being able to meet the  
10 expectation of the enrollees.

11 **Study objectives:** The study assessed the adequacy of the designated health facilities in  
12 offering quality healthcare services to the enrollees or potential enrollees under the CBHIS, and  
13 to identify likely challenges.

14 **Study Design:** This is part of a larger prospective cross-sectional study that assessed the  
15 implementation of the Community-Based Health Insurance Scheme (CBHIS) in selected local  
16 government areas of Kwara in the north central and Ogun in the South Western part of Nigeria.

17 **Place and Duration of the Study:** Health facilities of selected wards from two Local  
18 Government Areas in Kwara and Ogun States were assessed between February and May  
19 2015.

20 **Method:** Semi-structured questionnaires and health facility assessment checklist were used to  
21 assess services rendered, manpower, training opportunities, available infrastructures and  
22 perceived challenges to smooth operation of health facilities designated for CBHIS.

23 **Results:** A total of twenty designated health facilities were visited and assessed (Seventeen  
24 public and three private). Services claimed to be available at the facilities included clinical,  
25 nursing, pharmaceutical and laboratory services. Seventeen (85%) had evidence of recent  
26 renovation while 3 (15%) had no evidence of renovation. Twelve (60%) had backup supply of  
27 electricity from generator or solar panel. Other challenges that could impede quality healthcare  
28 service delivery under the CBHIS were identified.

29 **Conclusion:** The study showed that inadequate personnel, paucity of training opportunities for  
30 health workers, poor infrastructures (inadequate ambulance services, poor electricity supply  
31 and lack of portable water supply) were the main challenges impeding delivery of quality  
32 healthcare services to the CBHIS enrollees patronizing the studied facilities.

### 33 **Keywords**

34 Health facilities, Community-Based Health Insurance Scheme, Nigeria

35

36

37

38

39

## 40        **1. INTRODUCTION**

41        Nigeria has a high population density but a weak health system [1]. Healthcare financing in  
42        most of sub-Saharan African countries is based on out-of-pocket payment from the rural  
43        dwellers. This out-of-pocket payment has caused a lot of health challenges such as premature  
44        deaths, maternal and child health issues, deficiencies in health issues in Sub Sahara African  
45        countries [1]. Nigeria's health performance has been one of the poorest in the world within the  
46        last two decades where out-of-pocket health expenditure is over 60% which makes it to be one  
47        of the highest in the world [2, 3, 4].

48        Quality health is a fundamental right of all Nigerians although primary health care (PHC)  
49        centers are relatively uniformly distributed throughout local government areas (LGAs) in  
50        Nigeria, yet rural people seem to underuse the basic health services [14]. It is also observed  
51        that over 70% of Nigerians live in rural communities [5] and are poorly served with healthcare  
52        services. This made the Federal government of Nigeria to establish National Health Insurance  
53        Scheme (NHIS) in 1999 and also established CBHIS in 2005[5]. According to the Nigeria  
54        constitution, each state of the Federation is to be the custodian of health of her people. It has  
55        been suggested that each community should design a feasible and attainable community-based  
56        healthcare financing scheme for the people so as to eliminate the constraints of high out-of-  
57        pocket healthcare expenditure [6].

58        Some States in the country, in addition to supporting NHIS, set up CBHIS to provide quality and  
59        affordable healthcare services in their communities [2]. However, the functionality of the  
60        schemes revolves round health facilities being able to meet the expectations of the people.

61 Health facilities occupy central focus in a health system where health professionals with  
62 different skills, deliver integrated package of healthcare, provide employment opportunities,  
63 generate economic activities and promote health facility-community relationships [7]. Nigerian  
64 government is committed to Universal Health Coverage [8] hence, governments at both federal  
65 and state levels are implementing a number of initiatives which are efforts that would contribute  
66 to the attainment of Universal Health Coverage [8]. Health facilities are therefore essential to  
67 achieving the goals and objectives of the National Health Strategic Health Plan priority areas by  
68 creating the needed environment for healthcare delivery [6].

69 The National Healthcare system is built on the basis of the three-tier responsibilities of tertiary,  
70 Secondary and primary [6]. While the Tertiary health care is at the apex of health care delivery  
71 consisting of highly specialized services provided by teaching and other specialist hospitals,  
72 secondary health care level, provides specialized services to patients referred from the primary  
73 healthcare level [6]. The NHIS/CBHIS are parts of the health reforms of the federal government  
74 aimed at improving efficiency in both public and the private health facilities. This is to help  
75 minimize costs of healthcare services to the people [9]. NHIS was also designed to provide  
76 comprehensive health services to people at affordable costs covering employees of the formal  
77 sector, self-employed, rural communities and the vulnerable groups [10].

78 One of the challenges facing health systems strengthening (HSS) is the shortage of healthcare  
79 workers in countries confronted with the epidemics of HIV/AIDS, TB, and malaria which to  
80 World Health Organization (WHO), only 5 out of the 49 low-income countries meet its minimum  
81 recommendation of 2.3 doctors, nurses, and midwives per 1,000 people [11].

82 This paper therefore assesses the adequacy of the designated health facilities in offering quality  
83 health services to the enrollees or potential enrollees under the CBHIS, and also identified likely  
84 challenges in the selected health facilities in Ogun and Kwara States, Nigeria.

## 85 **2. METHODS**

### 86 **2.1 Study areas**

87 The study was carried out in two states, Kwara and Ogun in the North Central and South  
88 West, Nigeria respectively. In each State, health facilities in selected wards from two LGAs--  
89 Edu and Patigi in Kwara State; Abeokuta north and Ijebu-Ode LGAs in Ogun State were  
90 purposively sampled and assessed. These facilities were where CBHIS is either operational or  
91 earmarked for CBHIS. Seven Primary health care facilities were assessed in Kwara State (3  
92 from Edu LGA and 4 from Patigi LGA) while in Ogun State, five Primary Healthcare facilities  
93 were assessed each in Abeokuta north and Ijebu Ode LGAs. Three private health facilities  
94 designated to participate in the CBHIS were assessed-one in Abeokuta north and two in Ijebu-  
95 Ode LGAs.

96 Shonga in Edu LGA of Kwara State is located on Latitude  $9^{\circ} 1'$  north and Longitude  $5^{\circ}9'$  East.  
97 Lade in Patigi LGA of Kwara State is located on Latitude  $8^{\circ} 44'$  North, Longitude  $5^{\circ} 45'$  East.  
98 Lade is a small sub-urban settlement. Both Shonga and Lade communities are inhabited by the  
99 Nupe People who are mainly famers and traders.

100 In Ogun State, Abeokuta North LGA has its headquarters in Akomoje and lies between  
101 latitude  $7^{\circ}12'N$  and longitude  $3^{\circ}12'E$ . It covers an area of 808 square kilometres with a 2014  
102 projected population of 261,772 people based on the 2006 National Population Census at 3.5%  
103 growth rate [12]. Ijebu Ode LGA lies between latitude  $6^{\circ}49'15"N$  and longitude  $3^{\circ}55'15"E$ , it has

104 its headquarters in Ijebu Ode. The total projected population of the LGA, based on 2006  
105 National Population Census at 3.5% growth rate was 206,951 people [12]. It covers an area of  
106 192 square kilometres. The two LGAs are located about 100km north of Lagos and the Atlantic  
107 Ocean.

## 108 **2.2 Study Tools**

109 Semi-structured questionnaires and checklist were used to assess the health facilities for  
110 manpower and training opportunities for clinical, nursing, pharmaceutical and laboratory  
111 services; the status of infrastructures- physical facilities (space), electricity supply, sanitation  
112 facilities, and availability of emergency services and referrals, bio-safety practices using the  
113 checklist containing the minimum requirements for health facilities registered with NHIS [2].

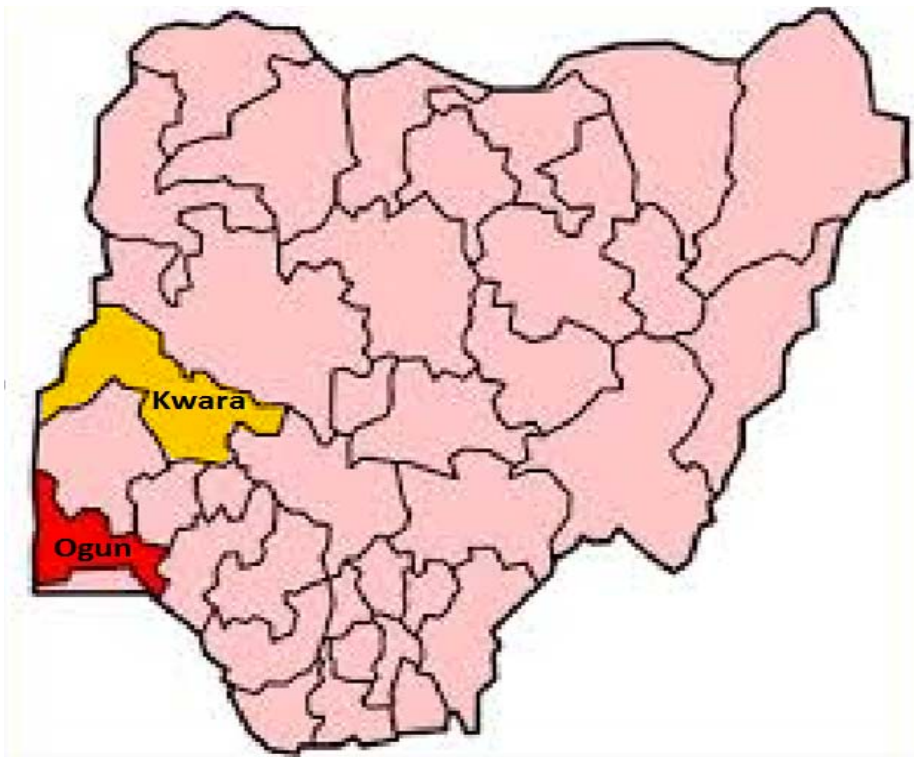
## 114 **2.3 Analysis of Data**

115 Descriptive statistics was used to present the data generated. Counts and percentages of  
116 relevant variables were generated and presented as tables.

117

118

119



120

121 **Figure 1: Map of Nigeria showing Kwara and Ogun States**

122

123

124

125

126

127

128

129

130 **3. RESULTS**

131 A total of twenty designated health facilities were visited and assessed (17 public and three  
132 private primary healthcare facilities) in the two states (Tables 1 and 2). The population of the  
133 catchment areas of the health facilities ranged from 9,394 to 24,076 in the two states. In Ogun  
134 State, Jogbo/Molipa community in Ijebu-Ode LGA which had a population of 24,076 had 3  
135 health facilities while Sabo community in Abeokuta North LGA with a population of 21,645 had  
136 two (2) health facilities. All other communities in Ogun state had only one health facility each  
137 designated for CBHIS. In Kwara State, all the communities visited had one health facility each  
138 designated for CBHIS.

139 **3.1 Services Rendered in the Health Facilities**

140 Results showed that all the 20 PHCs studied had ante-natal, peri-natal and post-natal services  
141 were offered in all the health facilities. Other services rendered were general nursing care,  
142 immunization, health education, limited laboratory services, drug prescriptions and treatments,  
143 family planning, nutrition counseling, HIV Counseling and Testing(HCT). Only 9 (45%) of the 20  
144 health facilities in two states had laboratory services.

145 **3.2 Evidence of Integrated Health Services**

146 Only1 (14.3%) out of the 7 health facilities assessed in the two LGAs of Kwara State had  
147 evidence of proper integrated health services encompassing clinical, nursing medical laboratory  
148 and pharmaceutical services in the health facilities assessed (Table 1) while 7 (53.8%) out of  
149 the 13 of the Primary healthcare facilities assessed in Abeokuta north and Ijebu Ode LGAs of  
150 Ogun State had evidence of integrated health services covering the mentioned service areas  
151 (Tables 1 and 2).



152 **3.3 Human Resources for Health**

153 **3.3.1 Personnel for Clinical Services:** In Ogun State, only 2 of the PHCs had a medical doctor  
154 each but all the 3 Private hospitals assessed had a medical doctor each while only 1 out of 7  
155 facilities in Kwara State had a medical doctor (Tables 1 and 2).

156 **3.3.2 Personnel for Nursing Services:** Personnel providing nursing services in the facilities were  
157 Nurses, Midwives, Senior and Junior Community Health Extension Workers (JCHEW),  
158 Community Health Officers (CHO) and Health Educators (Tables 1 and 2).

159 **3.3.3 Personnel for Laboratory services:** Out of the thirteen Health facilities visited in Ogun  
160 State, 7(53.8%) offered laboratory services while 6(46.2%) did not have laboratory services.  
161 However, the personnel were inadequate because only 1 out of the 7 (14.3%) of the facilities  
162 had Medical Laboratory Scientists, 4(57.1%) had Medical Lab Technicians while 2 (28.6%) of  
163 the PHCs had unqualified personnel working in the laboratory. In Kwara State, laboratory  
164 services were offered in two of the seven health facilities assessed and were manned by  
165 medical laboratory Technicians.

166 **3.3.4 Personnel for Pharmaceutical services:** Drugs seen on the shelves of all the health  
167 facilities assessed had evidence of NAFDAC registration and in-date expirations. However, in  
168 Ogun State 2(15.4%) out of 13 had licensed pharmacists while 11(84.6%) had CHEW or  
169 Pharmacy Technicians manning their 'pharmacy' section in the health facilities. In Kwara State,  
170 only one of the health facilities assessed had Pharmacy Technicians in the pharmacy section  
171 (Tables 1 and 2).

172

173

174 **3.3.5 Opportunities for Capacity Development**

175 Results showed that majority of the health workers /professionals attended at least one  
176 capacity development training. Most of the trainings were on Malaria, HIV and TB control  
177 programmes supported by President's Emergency Plan for AIDS Relief (PEPFAR) project. No  
178 evidence of capacity development trainings in non-communicable health challenges such as  
179 maternal and child health, anaemia, diabetes and hypertension. Most of the trainings were also  
180 sponsored by foreign Implementing Partners (IPs). No evidence of in-country ownership to  
181 enhance sustainability of the trainings.

182 **3.3.6 Evidence of Renovation**

183 Seventeen (85%) had evidence of recent renovation while 3 (15%) had no evidence of  
184 renovation. All the health facilities had incessant interrupted electricity supply and only 12(60%)  
185 had backup supply of electricity from generator or solar panel while 8 (40%) had no such back-  
186 up and relied only on re-chargeable lamp, lantern and touch lights in the night.

187 **3.3.7 Sanitation Facilities:** In Kwara State, only 2 (28.6%) out of 7 had modern toilet facilities  
188 while others had pit latrines. In contrast, all the health facilities Ogun State had modern toilets  
189 and pipe-borne water supply.

190 **3.3.7 Bio-safety Practices:** Evidence of good bio-safety practices were observed in all the health  
191 facilities. Presence of sharp containers, waste segregation, waste management in the health  
192 facilities assessed were in place.

193

194

195 **TABLE 1: STATUS OF HEALTH FACILITIES ASSESSED IN KWARA STATE**

State	Local Government area	Name of the Health facility	Workload/month	Health workers/professionals	Status of the lab services	Status of the pharmacy
Kwara	Edu	Comprehensive Health centre, Shonga	392	Med doctor (1); MLTs (3Nos) Senior CHEW Junior CHEW Nurses	Polyvalent Laboratory present within the health facility	Designated Pharmacy present within the health facility
		Maternity Centre, Shonga	118	Nurses and Midwives CHEW (2) Health educator (1)	No laboratory but does Malaria Parasite, HIV and Pregnancy tests	No pharmacy within the health facility
		Kanko Modern Health Centre	90	Snr CHEW, Jnr CHEW MLT	Laboratory available but with limited services	No pharmacy within the health facility
Kwara	Patigi	Edogichapa Health post/clinic	168	Only Junior CHEW present	No laboratory within the health facility but does Malaria Parasite test using rapid kit	No pharmacy within the health facility
		Sakpefu Primary Health centre	116	SURE-P staff (CHEWs) employed by FGN ( 4 Nos)	No laboratory within the health facility but does Malaria parasite test using rapid kit	No pharmacy within the health facility
		Lade Cottage Hospital	480	Junior CHEW (4), Senior CHEW(2), CHO (1) Nurses(3)	Designated lab space But no lab personnel	Pharmacy manned by with CHEW
		Sunkuso Health post/Clinic (abandoned) CHEW using his room apartment	60	Junior CHEW	No laboratory within the health facility	No pharmacy within the health facility

196

197

**TABLE 2: STATUS OF HEALTH FACILITIES ASSESSED IN OGUN STATE**

State	Local Government area	Name of the Health facility	Workload/ Month	Health workers/ Professionals	Status of the laboratory services	Status of the pharmacy
Ogun	Abeokuta North	Iberekodo PHC	400	No full time medical doctor, 2 medical laboratory scientists MLTs(3Nos), Senior CHEW	Polyvalent Laboratory present within the health facility	Designated pharmacy present within the health facility
		Totoro PHC	180	Nurses and Midwives CHEW (2) Health educator (1)	No laboratory within the health facility but does Malaria Parasite, HIV and Pregnancy tests using rapid test kits	No pharmacy within the health facility
		Igosun/Oke Ago Owu	200	Senior CHEW, Junior CHEW	No Laboratory within the health facility	No pharmacy within the health facility
		Enugada PHC	180	Nurses, Junior CHEW	No laboratory within the health facility but does malaria Parasite test using RDT kit	No pharmacy within the health facility
		Sabo PHC	318	MLT-1 Nurses CHEW	Polyvalent laboratory within the health facility	No pharmacy within the health facility
		Private Hosp	60	1 Medical doctor Nurses, CHEW	No laboratory but does Malaria Parasite, and Widal tests	No Pharmacy within the health facility

Ogun State	Ijebu-Ode LGA Ijebu-Ode	Obalende Ita-Alapo PHC	480	1 Med doctor Junior CHEWs (4), Senior CHEW(2),CH O (1) Nurses(3)	Polyvalent Laboratory with P-P-P (only 1 MLT, 2 other unqualified lab personnel	No pharmacy within the health facility
		Isiwo PHC	60	Junior CHEW	No laboratory within the health facility	No pharmacy within the health facility
		Ita-Osun PHC	140	Nurses CHEWs	Polyvalent Lab with MLT only	Pharmacy present with pharmacist
		Oke Oyinbo PHC	165	Nurses CHEWs	Polyvalent Laboratory with Medical Laboratory Technician only	No pharmacy within the health facility
		Jogbo/Molipa PHC	180	Nurses CHEWs	Polyvalent Laboratory with P-P-P (only 1 MLT, 2 other unqualified laboratory personnel	No pharmacy within the health facility
		Private Hospital	45	2 medical doctors	No laboratory within the health facility	No pharmacy within the health facility
		Private Hospital	40	2 medical doctors	No laboratory within the health facility	No pharmacy within the health facility

199

200 **Abbreviations**

201 PHC-Primary Health Centre

202 CHEWs= Community Health Extension Workers

203 CHO= Community Health Officer

204 MLT= Medical Laboratory Technician

205 FGN=Federal Government of Nigeria

206 P-P-P+ Public Private Partnership

#### 207 **4. Discussion**

208 A Primary Healthcare facility is expected to serve catchment area population of 10,000-30,000  
209 people [6].This implied that the citing of the health facilities assessed in the two states  
210 conformed to the standard requirement of one Primary Healthcare facility to serve catchment  
211 area population of 10,000-30,000 people [6] as shown in the results.

212 Majority of the renovations carried out in the facilities laid emphasis on the renovations of the  
213 building without serious emphasis on the adequacy of equipment and personnel especially in  
214 the professional services. The renovations may be attributed to political intensions because  
215 most of the plaques indicated which government in power did such renovations.

216  
217 The inadequate health professionals, inadequate laboratory and pharmaceutical services in  
218 most of the health facilities in this study are serious challenges to effective implementation of  
219 Community Based Health Insurance Scheme. This finding agreed with the report of [16] who  
220 reported that most enrollees were dissatisfied about the National Health Insurance Scheme  
221 (NHIS) because of increasing out-of-pocket payment for drugs and diagnostic tests and that  
222 55.7% of Healthcare services most frequently accessed by enrollees under NHIS were

223 treatment and general care followed by about 8.6% antenatal care. The results of the study  
224 showed inadequate health professionals in the health facilities especially in the rural areas of  
225 the states. This finding agreed with that of [11] who reported similar challenges and stated that  
226 shortages of Health Worker lessen the likelihood of proper diagnosis and supervision once a  
227 patient is receiving medication and this increases the potential for poor adherence and eventual  
228 drug resistance. The reasons for the limited workforce are many; but experts point to factors  
229 such as “brain drain”; chronic underinvestment in health workforces, including frozen  
230 recruitment and salaries; and work environments with few supplies and limited support [11].  
231 The erratic power supply (electricity) is inimical to quality service delivery especially in  
232 emergency situations such as pregnant women in labour and road traffic accidents which could  
233 be rushed to the health facilities in the night.

234  
235 Sanitation facilities in the studied health facilities in Kwara State were generally poor with  
236 majority of the health facilities relying on pit toilets. The lack of adequate water supply in the  
237 health facilities could promote nosocomial infections [14]. Unavailability of ambulance by  
238 majority of the health facilities could hinder effective referral of emergency cases because delay  
239 in emergency referrals could promote mortality especially during antenatal and child health  
240 requiring emergency higher level of cares.

241  
242 The observed good biosafety practices in all the assessed health facilities is encouraging. This  
243 could be attributed to the training exposure on making medical injections safe attended by most  
244 of the health workers in the facilities, was having the desired impact.

245 The laboratory and pharmaceutical services in the health facilities need to be strengthened  
246 because outsourcing of these services as observed in some of the facilities assessed would  
247 contribute to high out-of-pocket expenses by patients. This would defeat the essence of CBHIS.

248  
249 Many of the health workers would need retraining on other areas of healthcare services such as  
250 non-communicable health challenges (eg anaemia, diabetes and hypertension) and maternal  
251 and child health, given that majority of the health workers /professionals attended more  
252 trainings on HIV, TB, malaria, safety and use of sharps. Also, most of the trainings were  
253 sponsored by the foreign implementing partners and no evidence of in-country ownership to  
254 enhance sustainability. In-country ownership for capacity development of human resources for  
255 health is very crucial in resource-poor countries that have been reported to have the highest  
256 disease burdens and suffer from widespread lack of educational and training opportunities [11].  
257 Health challenges therefore, require training attentions and updates in knowledge on  
258 prevention, diagnosis and treatment for quality service delivery.

## 259 **5. Conclusion/Recommendation**

260 The challenges of the health facilities in the selected communities designated for CBHIS ranged  
261 from inadequate manpower especially the human resource for health, improvement in the  
262 services rendered to allow for integrated health services, provision of constant electricity supply,  
263 adequate capacity development trainings in communicable and non-communicable health  
264 challenges in the communities. There is also the need to provide adequate ambulances for  
265 emergency referrals. These are to



266 **Ethical considerations:** Institutional Review Board (IRB) approval for the study was obtained  
267 from NIMR IRB with assigned number IRB/13/237 for the research protocol while consent was  
268 obtained from the head of the assessed health facilities.

269 **Competing Interest:** Authors have declared that no competing interests exist.  
270

## 271 **References**

272 (1) Garba, Ibrahim, T. 1, Azhar Harun, Salihu, Abdulwaheed A: The Way forward for  
273 Community-Based Health Insurance Scheme in Funding Health Care among the Rural  
274 Communities of Sokoto State, Nigeria. *Research on Humanities and Social Sciences*, 2015.  
275 [www.iiste.org](http://www.iiste.org) ISSN (Paper)., 2224-5766 ISSN (Online) 2225-0484 (Online) Vol.5, No.8, 2015

276 (2) National Health Insurance Scheme. Operational guidelines. Revised October; 2012. Abuja  
277 Nigeria. (Revised). Available: [http://www.ghmlnigeria.com/download/NHIS\\_OPERATIONAL](http://www.ghmlnigeria.com/download/NHIS_OPERATIONAL_GUIDELINES)  
278 [\\_GUIDELINES](http://www.ghmlnigeria.com/download/NHIS_OPERATIONAL_GUIDELINES).

279 (3) World Health Organisation. The world health report 2000 health systems: Improving  
280 performance. Geneva: World Health Organization, 2000.

281 (4) The World Bank: Out-of-pocket health expenditure (% of private expenditure on health).  
282 Available at: <http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS>.

283 (5) National Population Commission (NPC) [Nigeria] and MEASURE DHS ICF Marco. *Nigeria*  
284 *demographic and health survey 2008*. Calverton, Maryland: National Population Commission  
285 and MEASURE DHS ICF Macro; 2009.

286 (6) Usman Aishat Bukola, Preferred Mode of Payments for Community Based Health Care  
287 Financing Scheme among Households in Osun State, Southwestern Nigeria. *Journal of Natural*

- 288 Sciences Research (2013). Vol.3, No.1. [www.iiste.org](http://www.iiste.org) ISSN 2224-3186 (Paper), ISSN 2225-  
289 0921 (Online)
- 290 (7) Federal Ministry of Health (FMOH). A Directory of Health Facilities in Nigeria. 2011
- 291 (8) Federal Ministry of Health. National Strategic Health Development Plan 2010-2015. 2005
- 292 (9) Sanusi RA and Awe AT. Perception of national health insurance scheme (NHIS) by health  
293 care consumers in oyo State, Nigeria. *Pakistan Journal of Social Sciences*. 2009., 6(1): 48-53.
- 294 (10) Ononokpono, E. NHIS and the Challenges of Healthcare Delivery. Available  
295 at:<http://www.dailytrust.com/content/view/4297/8> Accessed June 6, 2014.
- 296 (11) Alexandra E. Kendall. The Global Challenge of HIV/AIDS, Tuberculosis, and Malaria.  
297 Global Health. 2012 February.
- 298 (12) Inter agency Task Team on Human Resources for Health (IATT), 2012.
- 299 (13) Nigerian National Medical Laboratory Services Policy, 2009.
- 300 (14) Ken Inweregbu, Jayshree Dave, Alison Pittard. Nosocomial infections. The British Journal  
301 of Anaesthesia Continuing Education in Anaesthesia, Critical Care & Pain. 2005., Volume 5  
302 Number 1. Online ISSN 1743-1824 - Print ISSN 1743-1816 Pp. 14-17.
- 303 (15) Abdulraheem I. S, Olapipo A. R and Amodu M. O. Primary health care services in Nigeria:  
304 Critical issues and strategies for enhancing the use by the rural communities. *Journal of Public*  
305 *Health and Epidemiology* 2012. Vol. 4(1), pp. 5-13.
- 306 (16) B. Adewale, A. K. Adeneye, S. M. C. Ezeugwu, E. E. Afocha, A. Z. Musa, C. A. Enwuru, et  
307 al. A Preliminary Study on Enrollees Perception and Experiences of National Health Insurance

308 Scheme in Lagos State, Nigeria. *International Journal of TROPICAL DISEASE & Health* 2016.  
309 18(3): 1-14, 2016, Article no.IJTDH.27309.

310

311

UNDER PEER REVIEW