THE IMPACT OF POLICY PROCESS, ECONOMIC GROWTH, SCHEME DESIGN AND MOBILIZATION ON HEALTH CARE SERVICES AMONG THE RURAL DWELLERS OF SOKOTO STATE, NIGERIA.

GARBA IBRAHIM TANKO

DOCTOR OF PHILOSOPHY (Ph.D)
UNIVERSITI UTARA MALAYSIA

2015

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GARBA IBRAHIM TANKO

A Thesis submitted to the Ghazali Shafie Graduate School of Governmentin fulfilment of the requirements for the Doctor of PhilosophyUniversiti Utara Malaysia

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ABSTRACT

This study examines the relationship between policy process, economic growth, scheme design and mobilization, and heathcare services among the rural dwellers of Sokoto state, Nigeria. This is done with the aim of providing the dwellers with healthcare services that are lacking in the countryside of Sokoto state. There are many factors which hinder the provision of these healthcare services to the delivery which include insufficient funds, lack of good governance, poor policies on healthcare services, poverty, poor scheme design, poor community mobilization and sensitization and corruption. Of these several problems, this research focuses on four major factors, namely policy process, economic growth, scheme design and mobilization as independent variables and healthcare services as the dependent variable. The study uses convenience sampling in which samples were drawn from the 23 local governments of the state that comprise 3,000,000 rural dwellers. Data was collected through the self-administered method by sending questionnaires to 800 rural dwellers in the state. A total of 54 items were captured in the questionnaire. The studyevaluates the relationship between healthcare services and these variables. Multiple regression analysis was used to predict the significant contribution of the four variables. All the instruments were adapted from the past studies. The Statistical Package for Social Sciences (SPSS) version 18 was used to analyze the data and test the hypotheses. The findings of the study show that a positive relationship between healthcare services and the four variables. The correlation coefficient between policy process and healthcare servicesas 0.251 while economic growth and healthcare services it was 0.166. For scheme design and healthcare services,it was 0.260, while formobilization and healthcare services, it was0.119. The Multiple regression analysis shows that the variables are correlated and have a uniquely significant role in providing healthcare services. This shows that the result of this study can be used to address the problems facing the rural dwellers in their demand for quality and affordable healthcare services in their areas.

Keywords: Healthcare Services, Rural Dwellers, Sokoto State, Nigeria

ABSTRAK

Objektif kajian ini adalah untuk membincangkan hubungan di antara proses dasar, pertumbuhan ekonomi, reka bentuk skema dan mobilisasi, dan perkhidmatan penjagaan kesihatan dalam kalangan penduduk luar bandar di negeri Sokoto, Nigeria, dengan tujuan untuk menyediakan penduduk luar bandar dengan akses kepada perkhidmatan penjagaan kesihatan yang kurang terdapat di kawasan luar bandar negeri Sokoto. Terdapatbanyak halangan dalam penyediaan perkhidmatan penjagaan kesihatan kepada penduduk luar bandar, antaranya dana yang tidak mencukupi, kekurangan tadbir urus yang baik, dasar-dasar perkhidmatan penjagaan kesihatan yang lemah, pembasmian kemiskinan, reka bentuk skema yang lemah, mobilisasi masyarakat miskin dan rasuah. Daripada masalah-masalah tersebut, kajian ini memberi tumpuan kepada empat faktor utama iaitu proses dasar, reka bentuk skema pertumbuhan ekonomi dan mobilisasi sebagai pemboleh ubah bebas, dan perkhidmatan penjagaan kesihatan sebagai pembolehubah bersandar. Persampelan mudah digunakan, yang mana sampel telah diambil daripada 23 buah institusi kerajaan tempatan di negeri sokoto yang terdiri daripada 3,000,000 penduduk luar bandar. Data dikumpulkan melalui kaedah tadbir kendiri dengan menghantar soal selidik kepada 800 penduduk luar bandar di negeri ini. Sebanyak 54 item telah digunakan dalam soal selidik. Kajian ini mahu menilai hubungan antara perkhidmatan penjagaan kesihatan dengan pemboleh ubah-pemboleh ubah ini. Analisis regresi berganda telah digunakan untuk meramalkan sumbangan utama daripada keempat-empat pemboleh ubah. Kesemua instrument disesuaikan daripada kajian lepas. Pakej Statistik untuk sains sosial (SPSS) versi 18 telah digunakan untuk menganalisis data dan menguji hipotesis. Dapatan kajian menunjukkan hubungan yang positif antara perkhidmatan penjagaan kesihatan dan keempat-empat pemboleh ubah. Pekali kolerasi antara proses dasar dan penjagaan kesihatan perkhidmatan adalah 0.251, manakala bagi pertumbuhan ekonomi dan perkhidmatan penjagaan kesihatan adalah 0.166, untuk reka bentuk skema dan perkhidmatan penjagaan kesihatan adalah 0.260, dan untuk mobilisasi dan penjagaan kesihatan perkhidmatan adalah 0.119. Analisis regresi berganda menunjukkan bahawa pemboleh ubah-pemboleh ubah tersebut berhubung kait dan mempunyai peranan penting yang unik dalam menyediakan perkhidmatan penjagaan kesihatan. Ini menunjukkan bahawa hasil kajian ini berguna untuk menanganimasalah yang dihadapi oleh penduduk luar bandar dalam permintaan mereka untuk mendapatkan perkhidmatan penjagaan kesihatan yang berkualiti dan berpatutan di kawasan luar bandar.

Kata Kunci: Perkhidmatan Penjagaan Kesihatan, Penduduk luar bandar, Sokoto state, Nigeria

AKNOWLEDGEMENT

I wish to first of all thank God Almighty – Allahfor sparingmy life, sustaining meand enabling me to complete my thesis write up, I wish to express my acknowledgement to many people whom Iam indepted to for being instrumental to the successful completion of my thesis. My special thanksgo to my formidable supervisor Associate ProfessorMadya Dr Azhar binHarun for teaching me the art of research and scholarly writing, l will like to express that He is a great teacher, father and model of scholarshipand excellence. Associate ProfessorMadya Dr Azhar binHarun is best describe as scholastic “leader”whose impact will ever remaingreen in my memory for his interest and genuineconcern.

I will like to express my appreciationtoAssociate Prof. Kamaruddin Abdulsomad, Dr Abdullah Sumrahadi and Dr Suria Saniwa Bin Wan Mahmood for their roles as reviewers during my Ph.D proposal defence. Their useful comments and suggestions have helpedin sharingand making this thesis a better one.

Additionally, l would alsolike to thank the management of Usmanu Danfodiyo University Sokoto, for all financially supporting my research. My appreciation goes to my Dad and my Mum, my wife, my children for their support and understanding. Also my appreciation goes to Prof Alti, Dr B.B Kasim, Dr Sunusi Ahmed, Dr M.M Kirfi and all my other faculty members for their prayers and support. I also wish to thank the staff of Graduate School of Government for their support and encouragement during the course of the study.

Also my gratitude goes to Dr Salihu A Adelabu, Dr Abdullahi Hassan Gorondutse, Dr Sanusi Lautech, Haliru Muhammad,my classmate, friends and other well wishershave wonderfully helped in my success.

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LIST OFABBREVIATIONS

NHIS	National Health Insurance Scheme
CBHIS	Community-Based Health Insurance Scheme
FSHIP	Formal Social Health Insurance Programme
USSHIP	Urban Self-Employed Social Health Insurance Programme
WTP	Willingness to Pay
NPC	National Population Commission
WHO	World Health Organization
WB	World Bank
FMH	Federal Ministry of Health
MDG	Millennium Development Goals
UHC	Universal Health Coverage
KPI	Key Performance Indicators
SPSS	Statistical Package for Social Sciences

CHAPTER ONE
INTRODUCTION

1.0 Background of the Study

Health care services are the act of taking preventive or essential therapeutic measures to improve a person's well-being. May be done with surgery, the ordering of medicine, or other alterations in an individual's existence. These services are naturally offered through a health care system made by hospitals and physician. It refers to the work done in providing primary care, secondary care, and tertiary care, as well as in public health.

Access to health care varies across country groups, and individuals, mainly prejudiced by social and economic circumstances as well as the health policies in place. States and authorities have different policies and plans about the personal and population-based health care goals within their societies. Health care systems are organizations recognized to meet the health needs of target populations. Theirs exert shape varies between national and subnational units. In some countries and authorities, health care planning is spread among market members, while, in others, planning happens more centrally among governments or other organizing bodies.

In all cases, according to World Health Organization (WHO), a well-functioning health care system requires a robust financing mechanism; well-trained and adequately paid workforce; reliable information on which to base decisions and

policies; and well maintained health facilities and logistics to deliver quality medicines and technologies (WHO, 2013).

An example of this was the eradication of smallpox in 1980, declared by WHO as the first illness in human history to be removed by deliberate health care interventions WHO, 2010). Therefore, the provision of health care services to the rural dwellers is first because about 70 percent of the Nigerian population resides in the rural areas. Where the delivery of health care services is run down or lacking, where the personnel and health care equipment are not there. Hence the introduction of health insurance as a strategy to provide these needed health care services to the rural dwellers with the aim of providing them with access to health care at their doorsteps through community-based health insurance scheme (CBHIS). Which is a prepaid health insurance mechanisms to complement the formal health insurance scheme that is for the formal sector and the private organize sector.

Therefore, community-based health insurance scheme (CBHIS) is any plan, managed and run by a community-based association. Rather than a private for-profit organization, that provides risk-pooling to cover the cost (or some aspect because of that) of health care service provision. Enrollees are associated or involved in the administration of the community-based health system, at least in the choice of the health services it encompasses. Hence, it's voluntary in nature organized by an ethnic of mutual aid and includes a variety of benefits packages. CBHIS can be led up to health facilities, trade unions, NGOs, local government, local populations or cooperatives and can be possessed and run by any of the associations (Jutting, 2002).

Hence, they may be established with geographic boundaries (cities, villages), skilled organizations (i.e. Trade unions or cooperatives) or around health care facilities.

They tend to be pro-poor since they support the demand for healthcare in the poor rural areas and enable low-income communities to eloquent their health care needs. . Several community finance schemes have evolved in the background of severe economic constraints, lack of sound self-confidence and political unsteadiness. Furthermore, the government taxation capacity is weak, formal mechanisms of social security for susceptible populations absent and the government misunderstanding of the informal health sector lacking. In such a complicated situation, community participation in funding healthcare provides a decisive first step near better access to health care by the poor rural dwellers and social security against the cost of illness.

Increasing right to use for health insurance is an essential component of an overall approach to achieving universal health coverage (UHC) through Community-based health insurance organization. UHC means right to use to and use of superior wellness care services by all populace and security for all masses from any catastrophic monetary occasion of all ill health. UHC can be a foremost deciding of improved health consequences for all people, particularly the poorest.

Every country faces difficulty in extending health care coverage. Several countries have committed themselves to achieving equity in health care coverage by including health care goals in human rights declarations, constitutions, and health insurance documents. Offering health insurance is an approach that countries use to ease the adverse health consequences for all people, especially the poor.

It is one of the methods that underdeveloped countries may believe to achieve universal health coverage (UHC) through CBHIS. UHC just ensured access to the use of high-quality wellness care services for all people, especially the poor rural dwellers, and security for all individuals from the catastrophic financial belongings of illness. Nigeria, one of the many African countries to begin expanding health insurance over the past five years, seeks to accomplish universal health care coverage by 2015.

The Nigerian National Health Insurance Scheme (NHIS) offer programs to distribute the formally employed, urban self-employed, tertiary students, armed forces, some pregnant women, children under five. And such populace as the disable and prison convicts. Beneath the National Health Insurance Act of 2008, in 2010, the NHIS in full swing a rural residential area-based social health insurance program (RCSHIP).

The NHIS is living through a period of assessment to reconsider the benefits package for its members and the diverse modes of the contribution of premiums. As a precedence, the Nigerian government would like NHIIS to cover more of the Nigerian population. Currently, based on the act of recognition cards issued, NHIS cover about 5 million members or 3 percent of the Nigerian population. One of the several proposals to increase coverage includes a plan to make NHIS registration mandatory for the federal government employees. At a broader level, Nigeria desires to study the track it will take to pass universal health coverage and the responsibility CBHIS may play in it.

Furthermore, a bill extensively known as the “NHIS reform bill” (table in the National Assembly in early 2013). Proposes the founding of a “health fund” that

would see the sums from an earmarked “health tax” on the luxury goods (at a rate of 2 percent). And any other funds set apart for this reason. The health, finance would be used to support the health insurance contributions of a definitive collection of people. Older people above 65 years, children under five years, prison inmates, physically challenged or disable persons, homeless individuals (NHB, 2008), as well as pregnant mothers expecting anti-natal care.

If this health support is winning, it might permit Nigerian to enlarge NHIS/CBHIS to cover a large quantity of the over 160 million Nigerian populations, in over 70 percent’s is in the rural areas. Entirely the same, extra tax on luxury goods and the size of the Nigerian general revenue per year. The option of a health fund to finance, insurance coverage intended for identifying groups. Moreover, the probability that NHIS contributions will become obligatory are all suggestions of a wish to enlarge health insurance in Nigeria further than its present small position. These reforms have precedents in other countries so as to have also extended health insurance in the hunt of UHC.

And then, from the previous discussion of the delay from the Nigerian National Assembly. And also, from the deficiency of political will on the side of the Nigerian government to implement health insurance in the informal sectors of the Nigerian communities were about 70 percent resides. That is why the rural communities have no option but to participate in the actualization of universal health care as proposed by the World Health Organization (WHO). World Bank (WB), and many other world bodies. The only way ahead for the informal sector is for the masses to adopt the concept of community-based health insurance system. At the same time as the rural

dwellers will be assisted in providing the much-needed health care services to the rural dwellers at an affordable price.

In Nigeria, out-of-pocket payment is the primary mean of paying for wellness care services by the citizenry. And these out-of-pocket expenses has pushed most households into poverty as a consequence of accessing health care, were people result in selling their personal belongings to care for their loved ones. Currently, the level of poverty in Nigeria is high coupled with high unemployment and a high incidence of mortality rate. Below is the poverty diagram showing the degree of the poverty index in Nigeria from 1980 to 2010. From Figure 1, we can observe that currently about 40 percent of Nigerians are "extremely poor" by several measures. In this case, having less than an entry per capita family spending per year, as defined by the National Bureau of Statistics (2010). The threshold was one-third of 66,802 Naira per year (US$428 at current exchange rates) or 28,132.00 Naira (US$141). Therefore, by this comparative poverty measure, 63 million Nigerians are incredibly weak.

Table 1.0
Relative poverty: Noon Poor, Moderate Poor and the Extremely Poor (%), 1980-2010

Year	Non - Poor	Moderate - Poor	Extremely – Poor
1980	72.8	21.0	6.2
1985	53.7	34.2	12.1
1992	57.3	28.9	13.9
1996	34.4	36.3	29.3
2004	43.3	32.4	22.0
2010	31.0	30.3	38.7

Source: Harmonized Nigeria Living Standard Survey (National Bureau of Statistics, 2010)

Particular the vast size of the "extremely poor" population by Nigeria's official measures. The projected taxes will be required to make available major revenue to fund financial security for this demographic part, which will find it hard to contribute to the community- based or other health insurance programs. Consequently, poverty prevents a lot of rural dwellers from accessing health care in their rural villages in Sokoto and Nigeria in common. It becomes inevitable to conduct a study on the workability of CBHIS on rural dwellers in Sokoto State.

Thus, this work intends to look at the policy process, economic growth, scheme design and mobilization of the rural dwellers as important factors that this thesis will discuss later on. Because these factors are very necessary and significant for sustainability and the successful implementation of CBHIS to provide healthcare services to the rural dwellers of Sokoto State. The survey of this field work was conducted in Sokoto state Nigeria.

1.1 Problem Statement

The problems of Health maintenance system in the least-developed and underdeveloped countries are weak, fragile and vulnerable. Millions of persons in Nigeria do not have right to use to quality community-based health insurance scheme or social insurance services. The reason is not strange. The poor cannot afford to pay medical/health measures. Rather they adopt different means of compensating for their health predicaments such as auctioning off individual paraphernalia like creatures, electronic apparatuses, land and landed property. At times, they resort to a loan from financial institutions, religious organizations, allies or neighbors. In the

illustration, the sick person is unable to source for the health bill; the option is to remain at home or probably visit the traditional healers.

The rural dwellers in Sokoto are mostly farmers and petty traders, they access health services through out-of-pocket spending's. And this is because of the failure of the government to provide health services to them. The rural dwellers are suffering from non-availability of any health insurance program. And because of this lack of access to health services, this has hampered any educational efforts of the rural communities in Sokoto and most of the rural communities in Nigeria.

Due to deficiency of transparent policy process in the legal transfer of health services by a government that constitutionally required providing these health services to the rural dwellers. They are left on their own to furnish wellness services for themselves through out-of-pocket which push them into poverty. Consequently, some of the most significant and economic policies are those that provide incentives to others to change their behavior, such as in providing subsidies to the vulnerable groups in accessing health care by the regime will go a long way in drawing more people to participating in the CBHIS among the rural inhabitants.

Economic growth of the rural dwellers has been considered as an important factor in the provision of health services to the rural dwellers of Sokoto State. Several studies have confirmed the positive relationship between economic growth and health (Leu, 1986; Parkin et al., 1987; Posnett and Hitiris, 1992; Prichett & Summers, 1996), there was little evidence to support the causal effect of health on income. A healthier workforce should be linked to human capital accumulation process (Behrman, 1990; Knowles & Owen, 1995; Currais & River, 1997). Thus, it appears to be a consistent

assumption that better health raises the economic productivity of the individual rural dwellers and countries economic growth rates. World Bank (1993) posited that improved health contributes to economic growth. By reducing yield losses caused by worker illness; it allows the utilization of essential resources that had been wholly or nearly inaccessible of illness. It increases the enrollment of minors in school and prepare them better capable of reading, and it frees alternative uses of resources that would otherwise have to be spent on caring for sickness. Hence, economic growth is related to the provision of health services through CBHIS among the rural dwellers of Sokoto State.

Due to lack of proper Scheme design in place, many new policies fail to achieve their goal because of a faulty design. To sheltered access to decent health care for all at a reasonable price, it will be essential to increase the degree of prepayment and reduce the reliance on out-of-pocket (Carrin & James, 2004; Carrin & Evann, 2005). Tax-based health financing and social health insurance, or a mix of them, are the most frequently used mechanism for achieving this goal. Economic and health sector reform in Nigeria has been leading to increased inequity in healthcare, especially in rural areas (Gu X, Blom, Tang, Zhu, Zhou & Chen, 1993). Lack of health insurance, among many other factors, has been one of the main reasons contributing to this inequality (Liu, Hsiao, Eggleston, 1999 & Tang, Meng, Chen, Bekedam, Evans & Whitehead, 2008). Therefore, having rural dwellers involved in the design process will make them feel a sense of belonging that the scheme is meant for them to. Hence, scheme design is vital to the successful implementation of CBHIS, which seek to reduce inaccessibility of health services by the rural dwellers.

The challenge of mobilizing vulnerable communities is a mainstay of growth policies and interventions seeking to encourage health in low-income settings (Rifkin, 1996, 2009). The community usually requires partnership amongst health workers and communities in performance looking for to 'allow 'them or 'make their capability' to use better authority over their happiness, throughout raising their chances for meaningful social involvement and building enabling relationships with helpful outsiders (Rifkin & Pridmore, 2001).

Therefore, Community mobilization, which is from time to time referred to as community action or community animation, is the procedure of assisting rural communities to identify and contract work on shared health concerns (Minkler, 1990). Since the late 1970s, community mobilization has come forth as a major health promotion strategy; conceptual documents, including the World Health Organization's Alma Ata Declaration on Primary Health Care (1978) and the Ottawa Charter for Health Promotion (1986). Have accentuated the importance of direct community participation in wellness-related plans and helps such as CBHIS among others.

So mobilization has been identified as an important factor in mobilizing the rural dwellers on ways to reduce them in accessibility to health services. Since community mobilization promotes consideration of the needs of specific populations and neighborhoods to partake in the new healthcare strategy. In specific, underserved populations, such as youth and men, can be achieved more effectively through community mobilization thereby educating them about the benefits of CBHIS on their general well-being.

Also, various scholars have identified CBHIS as a community-based approach that engages the community are becoming increasingly important in the disease prevention and health care promotion initiatives like CBHIS. Which seek to bring down the rural dwellers in accessibility to health services (Hawkin, Catalano, Miller, 1992; Israel, Schuiz, Parker & Becker, 1998). Hence, the need to create awareness among the rural dwellers will help in reducing the problems they face anytime they want to access health services. Presently, it is an on-going issue in Nigeria. Hence, this is what informed the researcher to conduct this research.

Therefore, this study intends to examine the relationship between policy process, economic growth, scheme design and mobilization in the provision of healthcare services to the rural dwellers of Sokoto state, Nigeria.

1.2 Knowledge Gap

Health systems can deliver health care services, curative or preventive, which will make a significant difference to the well-being of people's health. Therefore, accessing these health care services can lead to people having to pay catastrophic proportions of their available income thereby pushing many households deeper into poverty. Hence, the CBHIS concept is theoretically appealing regarding increasing health care access and providing protection from extreme poverty affects catastrophic health expenses for the developing countries populations the advantages are yet to be established. Furthermore, the impact of health insurance in low-and-middle-income countries have unfortunately been documented only partially. Previous reviews have evaluated the performance of CBHI regarding enrollment, financial management and sustainability (Carrin, et al., 2004; & Jakab et al., 2005).

The previous literature reviewed, relating to CBHIS as initiated by NGOs, Microfinance Institutions, was conducted among the rural poor not based on the impact on the individuals in these communities, but on the program.

Therefore, differences in the CBHIS institutional arrangements, health care benefits package and type of scheme design will have an influence on the achievement of any CBHIS coverage. On either the CBHIS has reduced catastrophic financial expenses or provide equitable health care access to the rural people. As differences among the rural dwellers populations in term of their socioeconomic status, attitude and social support are common hence different responses to the insurance might be expected in various situations. To my knowledge, there are no known studies on CBHIS impacts on health services amid the informal rural settlers of Sokoto state, Nigeria.

Thus, this research examines the impact of CBHIS on the supply of health services. Many studies that have considered the impact of CBHIS relied mainly on qualitative methods of investigations. And most reviewed the impact of the health care scheme or providers overlooking the implications for the rural dwellers. In the Sub-Saharan Africa, the literature on the CBHIS is conquered mainly by donor agencies or consultancy reports. Which are purposely concerned with the financial and managerial capacity of the existing CBHIS rather than thoroughly exploring the impact on the rural dwellers."

This study was carried out in all the twenty-three local government areas of Sokoto State. Where the various health, economic and social indicators have narrowed over time, as economic and the environmental conditions have drastically deteriorated due to bad governance by both the state and at the local government levels.

Evidence from previous research has shown that the rural dwellers lack most of the essential basic amenities. Most especially on health care accessibility because most of them, they have no formal employment and, therefore, cannot afford to pay for private health insurance premiums were it's available. Investigating the impact of CBHIS on the provision of health services in the policy process, the effect of economic growth, scheme design and mobilization. Offer the unique opportunity to provide reliable information on crucial aspects and allow policy makers to decide on the role of CBHIS in the national health care planning.

1.3 Research Questions

This thesis is going to examine a research question How is the impact of the policy process, economic growth, scheme design and mobilization on health care services? Therefore, the research questions are formulated below as:

1. In what ways are the policy process impacts the provision of health care services?

2. Of what value are the impacts of the economic growth in the provision of health care services?

3. Does scheme design have any impacts on the delivery of health care services?

4. Does mobilization of the rural community have impacts on the provision of health care services?

1.4 Research Objectives

Based on the previous research questions, the primary aim of this study is to examine the impacts of the policy process, economic growth, scheme design and mobilization on healthcare services. The objectives are as below:

1. Analyze the impacts of policy process for the provision of health care services.

2. Examine the impacts of economic growth on the provision of health care services.

3. Investigate the impacts of scheme design on the delivery of health care services.

4. Examine the impacts of mobilization on the provision of health care services.

1.5 Significanceof the Study

The study is expected to make contributions to the general body of knowledge theoretically by integrating policy process, economic growth, design scheme mobilization, and healthcare services in one study to see their relationship and how they contribute to the provision of health care services the implementation of community-based health insurance scheme.

According to World Health Organization assessments about 580,000 women of reproductive age die each year from pregnancy-related problems, and a high percentage of these deaths occur in sub-Saharan Africa. The ratio of maternal

mortality in the region is one of the uppermost in the world, getting to levels of 686 per 100,000 live births (World Bank, 1994). Previous studies have confirmed the high levels of maternal mortality and morbidity in emerging states. And research classifying causes of maternal deaths have consistently highlighted the need for antenatal care and Availability of trained healthcare personnel to attend to women during labor and delivery (Fauveau, Koeing, Chakraborty, Chowdhury, 1988 & Fortney, Susanti, Gadalla, Feldblum, Potts., 1988).

Furthermore, Sokoto healthcare indicators currently are in a weak state; crude birth rate accounts for 41.7 per 1000, child mortality rate account for 100 per 1000 live births while the death rate of children under five years is 166 per 1000 live births. Furthermore, maternal mortality rate accounts for 850 per 100,000. The use of contraceptives accounts for 2.1% using any method while using the contemporary practice account for 1.9%.

Additional, maternal health care indicators in Sokoto include 13.8% of women receiving Anti-natal care (ANC) from a medical professional, pregnant women account for 6.8% whose last live birth were protected NNT. While pregnancy delivered by a medical professional accounted for 5.1% and delivery in the health facilities in the state account for 4.4% (MICS, 2007 & NDHS, 2008). Hence, this has shown that the utilization of health care services is very poor in Sokoto State.

The study is also expected to make contributions to the states in most developing countries have not been able to fulfill health care needs of their poor population. Shrinking budgetary support for health services, inadequacy in public health provision, an improper low quality of public health services, and the subsequent

imposition of user charges are reflective of the state's inability to meet health care needs of the poor (World Bank, 1993). Therefore, this study will help in reducing the difficulties the rural dwellers face when accessing health care services by making these services available to them through CBHIS strategy.

1.6 Scope of the Study

The extent of this study is restricted to the four factors. These factors are policy process, economic growth, scheme design, mobilization and healthcare services. The study considers these factors as few of the major contributing factors to the provision of healthcare services to the rural dwellers of Sokoto state. Out of many numerous factors, which includes corruption, bad governance, political instability, out-of-pocket spending's, user fees, etc., this study considers only four factors and are treated as important.

The study covers twenty- three local governments in Sokoto state out of seven hundred and seventy-four (744) local governments in Nigeria. The researcher consulted all the stakeholders in the provision of healthcare services in Sokoto state. The stakeholders are Ministry of Health Sokoto state, Directors of health in all the twenty-three (23) local government councils, NGOs, and other donor agencies operating in the country. The consultations enable the researcher to identify the problems facing the provision of healthcare services to the rural dwellers.

The UN's Millennium Development Goals (MDGs). Which is about Goal 5 is to improve maternal healthcare services and findings reveals an improved delivery and use of maternal health services after the first appearance of a CBHI-type scheme in

Anambra State, Nigeria. In the setting of global population aging, with increasing number of older adults at risk of chronic non-communicable diseases, rapid rise demand for primary healthcare services is expected in both developed and developing countries (WHO, 2011 & Simmons, 2009). The World Health Organization (WHO) attributes the provision of essential health care services as an integral component of an inclusive primary health care strategy (MacLean, 2014).

The study is to cover the period from 2007 to Date. The justification for the choice of this time is that 2007 marks the year that User fees were abolished by Dr. Chang, Director General of WHO Stated seemingly that if you want to decrease poverty it makes sense to help government abolish user fees (Chang, 2007). Following the failure of members of implementing Alma-Ata Declaration (1978) and after that Bamako initiative (1987).

Hence, Sokoto state is selected because about 70 percent of the population of Sokoto state are living in the rural areas. The health status indicators of Sokoto state are among the worst in Nigeria. Infectious and parasitic diseases and vaccine-preventable disease continue to exert their toll on healthcare and survival of the Sokoto people, remaining the leading causes of mortality and morbidity (UNICEF, 2008 & UNFPA, 2007).

1.7 Operational Definitions

1. National Health Insurance Scheme

National Health Insurance Scheme (**NHIS)** is an incorporated organization set up under Act No. 35 on May 10, 1999, by the Federal Government of Nigeria to

improve the wellness of all Nigerians at a reasonable price. It's the organization that gives out an operational guideline for the health service providers. And they are also charged with the settlements of the supplier's health bills informal sector of Nigerian social protection of all the workers in the federal and private organize labor.

2. Policy process

Policy process as embracing courses of action (and inaction) that affect the set of institutions, organizations, services and funding preparations of the health system Buse et al. (2005). The private sector, for example, including for –profit and not –for-profit systems, large and small, has become an important factor in the health policy process. Furthermore, the policy is increasingly regulated and influenced by forces (such as local and global civil societies) outside state boundaries (Keck & Sikkink 1998). Therefore, providing the enabling rules and regulations by the various stakeholders in establishing CBHIS sustainability in providing health services to the rural dwellers.

3. Economic growth

The literature describes statistical associations between economic status and the utilization of health care services. However, the mechanism through which this association operates is not specified. Possibilities include (1) income constraints; and (2) characteristics of the healthcare facilities serving the poor that may discourage the use (Kloos, 1987; Favin, Bradford & Cebula, 1984). A healthier workforce should be related to the human capital accumulation process (Behrman, 1990; Currais & Rivers, 1997; Knowles & Owen, 1995). It seems to be a logical assumption that better health raises the economic productivity of individuals and

countries' economic growth rates. Therefore, in this contest economic growth refer to the income of the rural dwellers that are generated from their economic activities that include farming and petty trading. Besides, economic growth also results in improved nutrition, better environmental sanitation, innovations in medical technologies; all this increases the life expectancy, reduces the infant mortality rate. According to World Development Report 2007 depicts the situation is by concluding that the Average life expectation at birth worldwide increases from 51 years to 65 in less than 40 years. Likewise, Average life expectancy in the developing world was only 40 years in 1950, but this has increased to 63 years by 1990 (World Bank, 1993). Preston (1976), has analyzed various determinants of life expectancy, and he emphasized that economic growth is the most important factor.

4. Scheme design

Scheme design refers to as a plan of action to provide services needed by the people and such scheme as CBHIS, which is developed and financed by contributions from members, having strong community involvement in decision making and supervision. Also, it has a small financial contribution mainly to cover primary health care services. Has Membership been on a voluntary basis? And its active side of the scheme is trust and a feeling of ownership (Jakab & Krishnan; Arhin-Tenkorang, 2001 & Ekman, 2009). The designing people-oriented program, where the rural dwellers are stakeholders, is very vital to the sustainability of the program.

5. Mobilization of the rural dwellers

Mobilization refers to as a procedure of employing a broad pattern of people in joint action for achieving mutual goals through self-reliant hard work. Its immediate

expected outcomes are the mobilization of all possible resources and the supported adoption/ utilization of all policies, technologies or services through the modification of attitude and behavior of different societal actors (Cohen, (1996). While, Howard – Grabman, L., & Snetro (2003), view community mobilization as a capacity-building process through which community individuals, groups, or organizations plan, perform, and evaluate activities. On a participatory and sustained basis to improve their health and other needs, either on their initiatives or stimulated by others. Therefore, CBHIS could be used to address various health related problems face by the rural communities since most of the health related services are not available in the rural communities. But by mobilizing and through the participation of the rural dwellers CBHIS will inevitably reduce the inequality of the provision of health service.

5. Community-Based Health Insurance Scheme

Community-based health insurance scheme (CBHIS) is small-scale, voluntary health insurance programs, prepared and supervised in a participatory way. They are intended to be simple and reasonable, and to draw capital to social unity and solidity to conquer tribulations of small risk pools, moral hazards, fraud, exclusion, and cost-escalation.

CBHIS areformed by an ethic of mutual aid, commonality and the communal pooling of health risks, in which the enrollees contribute successfully in its administration and functioning (Atim 1998).

7. Impact

Itdefines as the consequences of establishing CBHIS among the rural dwellers. Besides, health provision is to improve the delivery of various health services that are not there in the rural communities. However, with the coming of CBHIS these health services are provided that it has improved on the way the rural dwellers access health services at an affordable cost. Also, thereby reducing their difficulties in accessing health care that is paying high medical bills whenever accessing health services.

8. Impact of Community-Based Health Insurance Scheme (CBHIS) **on Health Services**

CBHIS are a potential instrument of protection from the impoverishing effects of health expenditures for low-income populations. CBHIS are useful in reaching a large number of poor people who would otherwise have no financial protection against the coast of illness (Dror & Jacquier, 1999). CBHIS impacts, promote the use of healthy behavior and preventive care, reduces financial barriers to health care, as is demonstrated by higher utilization of health services and this lower out-of-pocket expenditure by the rural dwellers. CBHIS impacts on Improving access, coverage and quality of services.

1.8 Organization of the Study

The research work comprises of six chapters. The rest are organized as follows. Chapter two is about the overview of Nigeria, the overview of Sokoto State, Health Insurance in Nigeria and community-based health insurance scheme.

Chapter three discusses the literature review of the study, the healthcare services, the policy process, the economic growth, scheme design and mobilization, gaps in the literature, theories on health care, conceptual framework, hypothesis development, and summary. Chapter four discusses the introduction of the chapter, research design, population and sample unit of analysis, data collection procedure, scale dimensionality, measurement of mutation, questionnaires, pilot study, reliability and kmo/berletts test in the main study, reliability analysis, reliability and validity of the research instrument, reliability test. The method of data analysis, quantitative data analysis technique, multicollinearity, factor analysis, test of non- response bias, descriptive analysis. The data screening and editing, normality test, limitation of the study, and chapter summary.

Chapter five is premised on regression analysis, hypothesis, testing of hypothesis, conclusion and chapter summary. While the last Chapter discusses the introduction, summary, conclusion, research contribution (theoretical, methodological). The implication for future research and area for further research on a study of the impact of community-based health insurance scheme on health care services among the rural dwellers.

CHAPTER TWO
NIGERIA AND HEALTH INSURANCE

2.0 Introduction

This chapter will discuss the background of Nigeria, overview of Sokoto state, and health insurance in Nigeria

2. 1 Overview of Nigeria

Nigeria started to be as a country, a state in 1914 through the merger of the Northern and Southern protectorates. Before that time, there was diverse divide social, ethnic, and nationalities, for example, the Oyo, Benin, Nupe, Jukun, Kanem-Bornu, and Hausa- Fulani realms. These people groups "existed" in kingdoms and "Emirates" through conventional, however, confounded structures of government. There have been additionally other little yet substantial and in fact, contradicted to ethnic assemblies (e.g., Igbo, Ibibio, and Tiv).

The British created a crown state kind of government after the amalgamation. The undertakings of the provincial organization were held by the British until 1942 when a couple of Nigerians got included in the stronghold of the country. In the early 1950s, Nigeria attained halfway government toward oneself with an administrative assembling in which the majority of the parts was chosen onto the official gathering of which most were Nigerians. Nigeria got to be completely free in October 1960 as a league of three areas (Northern, Western, and Eastern) under a constitution that made a few bucks for a parliamentary arrangement of the government. The Lagos

range turned into the Federal Capital Territory. On October 1, 1963, Nigeria turned into a republic with diverse regulatory structures, social aggregations, and different social characteristics. There is something like 374 particular ethnic collections, with the Igbo, Hausa, and Yoruba as important gathering.

At present, Nigeria comprises up of 36 states and the Federal Capital Territory (FCT), assembled into six geopolitical zones: North Central, North East, North West, South East, South, and South West. There are likewise 774 naturally archived local government areas (Lgas) in Nigeria. The number of inhabitants in Nigeria is assessed to be 160 million individuals (NPC 2006).

Nigeria is in the West African sub-locale, lying between scopes 4º16' and 13º53' North and Longitudes 2º40' and 14º41' East. It is flanked by Niger to the north, Chad to the northeast, Cameroon the east, and Benin in the West. To the south, Nigeria is encompassed by giving or takes 850 kilometers of the Atlantic Ocean, extending from Badagry in the west to the Rio Del Rey in the east. With a total area range of 923,768 square kilometers, Nigeria is the fourteenth biggest country in Africa.

Nigeria is classified in the environment and geology, around uplands, something like 600 to 1,300 meters in the North Central and the Good Eastern countries, and marshes of under 20 meters in the beachfront regions. The swamps stretch out from the Sokoto fields to the Borno areas in the North, the waterfront marshes of Western Nigeria, and the Cross River waste region in the east. The level territory ranges incorporate the Jos Plateau and the Adamawa Highlands in the North; other topographic characteristics might be the Niger-Benue Trough and Chad Basin. Nigeria holds a tropical environment with several wet and dry seasons connected

with the movement of the two existing winds—the drizzle bearing southwesterly winds and the icy, dry, and covered in dust north “easterly” winds normally alluded to as the Harmattan.

The dry season happens from October to March with an enchantment of dry, fresh and dusty Harmattan wind felt for the most of the North blanket to the Obudu Plateau and Oban Hills in the South East., In December and January. The wet season happens from April to September. The hotness in Nigeria wavers between 25° and 40°c, and precipitation ranges from 2,650 mm in the southeast to under 600 millimeters in a few parts of the north, mainly along the outskirt of the Sahara wasteland.

Cultivating has been the establishment of Nigeria's economy. Before the discovery of oil, the Nation depended solely on agricultural processing for nourishment and aggro efficient crude materials for modest trade income through foreign exchange. At the time of state toward oneself, over 75 percent of the country's work energy was utilized in cultivating, which likewise given outstanding job and a decent job to finish 90 percent of the populace.

Through the years, the heading part of agribusiness in the financial framework, particularly as far as the countries outside trade profit, offered an approach to petroleum deals. The country's economic force is made principally from its oil and gas holds, which make up 99 percent of fare income, 78 percent of state income, and 38.8 percent of the GDP (2006). The commitments of different divisions to the GDP in 2006 were as takes after horticulture (32.5 percent), general sale and retail (13.5 percent), manufacturing, avoiding raw petroleum (2.9 percent) and different areas

(1.5 percent). Since 1980, oil processing has represented further than two-thirds of the GDP and, other than 80 percent of the sum state income (FRN, 2008).

Since the invasion of the new self-ruled organization in 1999, financial arrangements have gotten to be ideal to speculation. The advance has been moved in the direction of securing a commercial center based economy. Accordingly, there has been a development in the operation of the local financial framework. Nigeria's GDP growth rate was assessed at 2.7 percent in 1999, 2.8 percent in 2000, and 3.8 percent in 2001.

By 2006, the actual GDP growth rate was evaluated at 6.0 percent (Central Bank of Nigeria, 2002). When the appearance of the non-military person government in 1999, Nigeria had an extensive open division, incorporating over 550 social ventures in most sectors of the economy and overwhelming exercises in the electric force, telecommunications, petroleum, and steel segments. General society endeavor portion represents an approximated 50 percent of the aggregate GDP, 57 percent of speculations, and 33 percent of the formal area work (Central Bank of Nigeria, 2002).

Like other exceptional modern governments, the regular civilian state in Nigeria has acknowledged the essentialness of privatization in the rebuilding of its economy. Various strategies were placed set up to change, deregulation, and privatize key divisions of the economy, for example, electric energy, Telecommunications, and following oil sectors. In late years, Nigeria privatized the primary government-claimed petrochemical organization and sold its enthusiasm toward eight oil administration organizations. While it may be so early, it is possible not seeing the

effect of privatization and liberalization of the Nigerian economy. It was imagined that these investment strategy changes, consolidated with speculations in human capital and solid base, as effortlessly as the foundation of macroeconomic steadiness and great administration, are vital to attaining a high rate of fruitful, long haul financial growth. Figure 2.1 is the map of Nigeria.

Figure 2 .1: Map of Nigeria (Nigeria Demographic and Health)

Source (www.abujagalleria.com)

2.2 Overview of Sokoto State

Whereas, Sokoto state was cut out of the then Northern Region state on February 3, 1976. Its capital and major city are Sokoto. The state is called after its capital Sokoto, a town with a long history and the seat of the Sokoto Caliphate. Organized in the North Western corner of Nigeria, Sokoto State occupies 25,973 square kilometers (Tanko & Harun, 2015). The Sokoto State population is 3,702,676 (NPC, 2006). It signifies 2.3 percent of Nigeria's aggregate populace. A greater proportion of Sokoto inhabitants are rural dwellers (80%) with only 20% dwelling in the urban settlements. The state shares its borders with The Niger Republic to the North, Zamfara State to the East, Kebbi State to the South-East and The Republic of Benin in the West.

Surely, before the coming of the Fulani, the state knowledge had developed in Hausa land. Through this course, a percentage of the Hausa group dispersed over a broad zone had reformed themselves into meaningful units that are mentioned to as kingdoms. A share of the new kingdoms incorporates Kebbi, Zamfara, and Gobir, all forming part of Sokoto State. For purposes of the crucial acceptable proof, the individuals in every kingdom had recognizable names by which they are referred to, e.g. Individuals in The Kebbi Kingdom were known as Kabawa. Not just that, at later stage individuals in every kingdom began to wear distinguishable tribal marks that were unique to them (Tanko & Harun, 2015).

The Fulani rule under the leadership of Usmanu Dan Fodio started with the Jihad in the early years of the 19th Century. By 1809, most of the Hausa territories were

toppled and replaced by Islamic Government under a joint administration whose headquarters was in Sokoto. Hence, this sustained up to the coming of British.

The Sultan of Sokoto is a direct successor of Usmanu Dan Fodio and is the spiritual head of all Muslims in Nigeria. The majority of the populations is Sunni Muslim. In that respect is a little Shia minority. Sokoto state is in the dry Sahel, bounded by sandy savannah and isolated hills (Tanko & Harun, 2015).

Currently, there are twenty-three local government areas (LGAs) in Sokoto. Each local government has its executive serving as executive head. These local governments are Bodinga, Binji, Dange-shuni, Goronyo, Gada, Gwadabawa, IIIela, Isa, Kebbe, Kware, Rabah, Sabon birni, Silame, Shagari, Sokoto North, Sokoto South, Tangaza, Tureta, Tambuwal, Wamakko, Yabo, and. Wurno.

The area's life investor for developing harvests is the valleys of the Sokoto-Rima waterway system (see Sokoto River), which are tenable with rich muddy soil. For the rest, the general dryness of the district considers few products; millet maybe being the most abundant, complemented with rice, corn, different grains and beans. Separated from tomatoes few vegetables grow in the area. The common variety of foodstuffs available has resulted in the relatively dull local cuisine.

A great part of the city in the state is utilized for feeding cattle. Cowhides, sheepskins goatskins, and completed leather items are important exports, as are goats, cows, and fowl. The state has kaolin and limestone deposits and Sokoto City, the state capital, is home to a cement company plant, tanneries, and a modern abattoir.

During this process, some of the Hausa communities scattered over a vast area had reformed themselves into major units that are referred to as kingdoms. Some of the developmental territories include Zamfara, Kebbi, and Gobir, all forming part of Sokoto State. For the determination of key identification, the people in each kingdom had recognizable names by which they are mentioned too, e.g. People in the Kebbi Kingdom were known as Kabawa. Not only had that, at later stage people in each kingdom started to wear unique tribal marks that were exclusive to them (Tanko et. al, 2015).

Economically, the region's salvation for growing crops is the valleys of the Sokoto-Rima river system (see Sokoto River), which are enclosed with rich alluvial soil. For the rest, the general dryness of the region allows for few crops, millet possibly being the most abundant, added by rice, corn, other cereals and beans. Apart from tomatoes few vegetables grow in the region.

The standard selection of crops available has resulted in the relatively dull local cuisine. Considerable of the land in the state used for grazing cattle. Cattle hides, goatskins, sheepskins and finished leather products are noteworthy export, as are cattle, goats and fowl. The state owns limestone and kaolin deposits in Sokoto City, the state capital, is home to a cement factory, tanneries, and a modern abattoir. The following is the Map of Nigeria showing the location of Sokoto and the second Map is about the twenty-three local government areas in Sokoto State (Tanko & Harun, 2015).

Figure 2.2:The Map of Nigeria showing the location of Sokoto State. Source (www.abujagalleria.com)

*Figure 2.3:*The Map of 23 local government areas of Sokoto State, Nigeria
Source (cleenfoundation.blogsport.com).

Sokoto healthcare indicators currently are in a weak state; crude birth rate accounts for 41.7 per 1000, child mortality rate account for 100 per 1000 live births while the death rate of children under five years is 166 per 1000 live births. Furthermore, maternal mortality rate accounts for 850 per 100,000. The use of contraceptives accounts for 2.1% using any method while using the current method account for 1.9%.

Additionally, maternal healthcare indicators in Sokoto include 13.8% of women receiving Anti-natal care (ANC) from a medical expert, pregnant women account for

6.8% whose last live birth are protected NNT. While pregnancy delivered by a medical professional accounted for 5.1% and delivery in the health facilities in the state account for 4.4% (MICS, 2007 & NDHS, 2008).

The issues responsible for this maternal death and high infant child deaths in Sokoto are not different from that found elsewhere in Northern Nigeria. Among such issues are the poor utilization of available health care services, early marriage, shortage of health care personnel, high frequency of deliveries, early childbearing, low literacy rates among the female gender in the state, gender discrimination, and other cultural and harmful traditional practices. While, other fundamental aspects that contribute to the dismal picture of the state include poverty and low community awareness on health care service's existence as well as the poor attitude of the healthcare personnel providing the health care services. The health status indicators of Sokoto state are among the worst in Nigeria. Infectious and parasitic diseases and vaccine-preventable disease continue to exert their toll on health care and survival of the Sokoto people, remaining the leading causes of mortality and morbidity (UNICEF, 2008 & UNFPA, 2007). Therefore, the situation of healthcare in Sokoto is not encouraging and appealing to the rural dwellers that are in the majority in the state, looking for an alternative to the provision of health care services is whole.

Thus, this work intends to examine the impact of the policy process, economic growth, scheme design and mobilization on healthcare services among rural dwellers in Sokoto state, Nigeria through a non- probability sampling survey method.

2.3 Health Insurance in Nigeria

Health insurance, also known as medical insurance, helps you pay for medical care for presence in the hospital, having an operation, or seeing the doctor like any other kind of insurance to protect you from risk (Davis, 2015). Health insurance protects you from two of risk: You are protected from the risk of going broke due to medical expenses if you get sick; your health insurance pays, at least, part of the cost of your medical care. While the second type of risk is you are protected from the risk of not being able to get therapeutic care because you don't have enough money to pay for it. Health insurance works vary from country to country, sometimes even from region to region within a state, or from an insurance policy to insure policy. Health insurance can also be informed of social health insurance (SHI) or community-based health insurance scheme (CBHIS).

Concerning the similar topic of Social Health Insurance in Nigeria, it is first discussed in 1962 by Haevi Committee, which authorized the recommendation through the Lagos Health Bill presented to Parliament. The measure was not snuffed it, until 1984 when the campaign re-ordained. The desire to the hotspot for beliefs on social insurance managements prepared the National Council on Health under Admiral Patrick Koghoni, (the Minister of Health) set up a commission led by Professor Diejomoh, which recommended the government on the good-looking quality of Health Protection combined in Nigeria and agreed its approval as a means to fund the health sector (Tanko & Harun, 2014).

Within Nigeria, necessities incorporate lessening unpleasantness and death rates because of communicable infections to the barest least. Switching the expanding

commonness of non-transmittable illnesses; meeting the worldwide, focuses on the disposal and the eradication of sicknesses. And altogether expanding the future and personal satisfaction of Nigerians (Federal Ministry of Health 2004). Nigeria's over-riding objectives since independence in 1960 have been to achieve stability, material prosperity, peace and social advance. Nevertheless, this has been hindered as a consequence of domestic dilemmas (Tanko, Harun & Salihu, 2015). These comprise lacking human capital improvement, powerless framework, and an actual development Health Division, fabricating segment, being without a job, the poor administrative surroundings and blunder and abuse of assets.

The continuity of these troubles is not unrelated to the institutional failure. The organization is only the lack of or fragile capacity for efficient service delivery by organizations. It is a recognized fact that the level of growth of any society is predisposed by so many factors, including relevant institutions (Ubi, & MBA, 2011).

Establishments were realized like formal and unintended principles, requirement qualities of standards, and criteria of conduct that structure repeated social connection, between people, inside or between relations, through motivating forces, deterrents, requirements and improvement (North's, 1989). Therefore, the central component of some national, state or local government level is service delivery to its community from its conceptions.

Hence, due to the succeeding failure of the previous governments in Nigeria to provide its community with proper health maintenance services across all the three levels of government. There is a need to bring in health care reform in the rinsing of

social security in which importance should be laid along equally the official and informal sectors in Nigeria.

However, this nevertheless, is not the situation in Nigeria, as real failure has over the years made it almost impossible for these to be attained. It is hence understandable that with the mass depletion of the imaginations of the Nigerian state, predominantly by corrupt activities and by its corrupt ethnic leaders, some resources left for organizations to function effectively to promote employment generation potential of the economy vis-à-vis economic growth is very meager. So, such organizations, like Health, Education establishments, good water sources, transport institutions, financial establishments and other needed services institutions necessities to strengthen the economic system are significantly compromised.

The Nigerian Constitution of 1999 provides that health is on the concurrent list; thus, the federal, state and local government areas have similar obligations for the supplying of services such as health. In the present democratic era, these organs of government also have substantial autonomy and exercise considerable authority over the allocation and usage of their resources.

According to the National Health Policy, the federal government handles policy preparation, strategic direction, coordination, oversight, monitoring and evaluation of all levels. It also has functional responsibility for disease surveillance, essential drugs supply and vaccine management, as well for providing particular health care services at tertiary health institutions (university teaching hospitals and national medical centers).

Social Health Insurance policy is a social health security system in which the health care of employees in the public sector paid for from funds created by pooling from the contribution of workers and employers; the employees contribute 5 percent out of their salary (Executive Secretary, National Health Insurance Scheme, 2009). And the employers are contributing 10 percent of each employee per month to fund the system. Nearly one million people in Nigeria or 0.8 percent of the masses are covered with NHIS while many people had to pay medical care out of their pocket or do without health care. (World Bank Report, 2008).

However, preparing and putting through a sustainable health care funding, the strategic framework is a key success element of health sector reforms in Nigeria and in enhancing the health status of a majority of the masses, both in the instant, medium and long-term view. Such strategy aims at striking a strategic, sustainable and fair balance through state budget; social health insurance; individual health insurance and to include non-governmental and developing partners' help; each mark well as efficient and community-based health insurance scheme, with constrained out-of-pocket sources for health care services.

Previous studies have distinguished four types of financing community-based health insurance scheme (Dong, Kouyate, & Cairns, 2004). These are (i) Neighborhood prepayment plans where the community gathers contributions (in money or kind) ahead of time, control the requirements discharged, and pays the social insurance providers on the action of its subscribers. (ii) User fees managed by community contingent on out-of –pocket health services, contributions are at the point of social insurance usage. (iii) Connected group health is spinning trust. Hence, the

neighborhood serves as an executor of the state or social health protection in connecting with the local individuals and whatever were left of groups through some understanding or contracts. (Dong, Kouyate, & Cairns, 2004).

Nevertheless, taking into account the Nigerian national health protection plan (NNHPP) operational rules, and other assessment directed in group-based health insurance system. The group prepayment not-for –profit arrangement has been projected to be the most suitable in Nigeria and some Sub-Saharan countries (Palmer; Mueller; & Gilson; Mills; Haines; help: //www.nhis.gov.ng, 2010). Hence, it enables the rural residential districts that are interested in the scheme to settle on how and when to pay their premiums with the goal that the framework is suitable to their desirable requirements.

Of the current, the utilization of neighborhood prepayment plans has taken in a group of contributors, in general, health arrangement (Gondge, Molyneux, Russell, & Gilson, Hanson, 2007). Furthermore, in numerous plans groups took part at present deciding the profit programming framework to be incorporated ahead of time (what to incorporate, what to purchase and in what structure is strength of CBHIS (Bennett, Creese, & Monasch, 1998).

Upon the various benefits of CBHIS many operational difficulties such as lack of scheme designs, lack of institutional patterns, lack of creating knowledge, lack of mobilizing people for the various advantages of CBHIS. And also, a lack of recognizing the character of (MHOs) in CBHIS have limited the rural residential districts from taking part actively in CBHIS (Bennett, Creese, Monasch,

Pannarunothai, Srithamrongsawat, Kongpan, & Thumvanna, Preker, Dror, 1998, 2000, 2004).

Hence designing a benefits bundle that is impartial, competitive and maintainable that will carry on various people have turned out to be tested because most CBHIS give crosswise on the board only one profit bundle (Tabor, 2005). These situations comprise of uncomplicated deliveries, generic drugs and therapeutic services (Ab Associate Benthesda, 2004).

Because of this reason most of the backup plans are not ready to go for bankrupt for little plans fundamentally since it jeopardizes financial circumstance when some cases rise (Dror, 2002). As any effort by the insurers to build the profit, the group will lead to an expansion in the premium to be paid by the enrollee.

Efficient execution of policies meant to promote value will, subsequently, oblige a more enhanced outline of the arrangements it should likewise incorporate dynamic correspondence with, and administration of the extent of prominent members, made for better comprehension of the elements affecting their responses to new wellness strategies.

Therefore, in Nigeria, it's not clear if health upkeep suppliers and approach producers looked into the community perspectives when choosing the premium and profit bundle, and if the rural residential area has been adequately mobilized or sensitized on the different benefit of group-based health protection framework. The correct state of affairs is that most of the rural communities nothing known about the

community-based health insurance scheme even among the elites in the cities this is very improper.

While, Health Maintenance Organization (HMO) or private or public bonded organization enrolled in the scheme to administer the supply of wellness planning benefits through health care providers certify by the scheme. And this is done through capitation, that is payment in advance to a health care provider in admiration of services to be outfitted by him to a protected individual enlisted by the health care service provider, if the safeguarded individual uses the services or not. (NHIS, Operational Guidelines, 2005).

2.4 Community-based health insurance scheme (CBHIS)

Community-based health insurance scheme (CBHIS) is small-scale, voluntary health insurance programs, prepared and managed in a participatory manner. They are designed to be simple and inexpensive, and to draw resources on social solidarity and consistency to overcome problems of small risk pools, moral hazards, fraud, exclusion, and cost- escalation (Tabor, 2005).

Improving access, coverage and quality of services depend on these input resources being available; in the way services are prepared and managed, and on incentives influencing providers and users.

While the objective of poverty drop remains of central worry, there has been a shift of focus away from poverty reduction per se to the social risk associated. Such is the case because of the growing respect for the role that risk plays in the lives of the poor (Holzmann & Jorgensen, 2000).

Hence, all the risks facing poor rural dwellers, health hazards almost certainly pose the greatest danger to their lives and incomes. A health tremor leads to direct expenditures for transportation, medicine, and treatment, but also indirect costs regarding a reduction in labor supply and output (Asfaw, 2003). Given the tight link between health and income at low-income levels, a health shock usually affects the poor the most (CMH, 2001 & Morrison, 2002).

The countries in most developing nations have not been able to achieve health care needs of their poor people. Insufficiency of public health provision decreases budgetary support for health care services. And an unbearable low quality of public health care services and the resultant load of user charges. Are thoughtful of the government's inability to meet medical needs of the poor rural dwellers (World Bank, 1993). In the last years, as part of an income protection processor to fill the negated created by missing institutions (Gartler & Gruber, 2002; Jutting, 2000).

Neither the state nor the market is useful in providing health insurance to low-income rural dwellers in the informal sectors. The formal providers are often at an informational complexity and face high transaction fees. On both of these counts, community-based health insurance scheme well-established in local associations potentially score better than exchange health insurance schemes (Zeller & Sharma, 1998). Indeed, most of the CBHIS have either been initiated by the health providers, i.e., NGOs, Missionary hospitals or be inclined to providers themselves (Atim, 1998 & Musau, 1999).

Therefore, the significant benefits of these schemes Are seen not just regarding mobilization of resources, but also in the improvement and association of health care

services to the rural dwellers. The same as was the case before the introduction of CBHIS, most of the rural residents lack this basic health care facilities, thereby making them be exposed to catastrophic expenses anytime they need to access health care services.

Health insurance schemes are expected to reduce unforeseeable or expensive health care costs through estimable, and a regular base paid premiums. In difference to the history of social health insurance in most developed countries, where health insurance schemes were first established for formal sector employees in urban areas. Recently, promising health insurance schemes have taken the form of local initiatives of a rather small size that are often community –based with voluntary membership (Ahuja & Jutting, 2003).

They are either initiated by the membership-based association, cooperatives or health facilities and can be owned and run by any of these associations (Atim, 1998 & Criel, 1998). There are several possible ways to classify these schemes, according to; Type of benefits provided, Level of risk pooling, Situation of their creation, Financial support ownership, and management. The difference whether the scheme focuses on coverage for high-cost, low-frequency events or low-cost, high- frequency events. Correspondingly, characteristics of these systems are Voluntary membership, Nonprofit character, Repayment of contribution into a fund and entitlement of specified benefits, the vital role of the community in the design and running of the community- based health insurance scheme and the Institutional relationship to one or several health care providers.

CBHIS has emerged as an option to user fees. CBHIS are considered to ensure that adequate resources are made available for members to access effective health care (World Health Report, 2000). Contributions built up and managed to spread the risk of payment for health care among all scheme members.

Health funding is one of the top items on the international agenda. It is an area that we know the challenges are great, but the opportunities, if we get it right, are also enormous. One of the world's most urgent problems is providing and financing health care for the millions of poor people who live in low-and middle - income countries. Many poor people have no access to adequate and affordable services, drugs, surgery and other interventions, largely because of weaknesses in the delivery and funding of health care services (World Bank, 1997).

Conversely, developing and implementing a sustainable health care financing, the strategic framework is a critical success factor for health sector reforms in Nigeria. The complexity is particularly extreme in the low-income countries, in which health system struggle with not enough and inequitably distributed resources. Access to services for the most vulnerable is inadequate or unsatisfactory, further reducing the benefit of already scarce resources for those in need (Gwatkin, 2004).

The objective of health financing is to make funding available. Ensure choice and purchase of cost –effective interventions, give appropriate financial incentives to providers, and ensure that all individuals have access to efficient health care services (Carrin & James, 2005). Health care financing all over the world is based either on social health prepayment premium or through general tax revenues. Risk pooling is central in distinguishing between these systems, enabling health services to be

provided according to people's wants, rather than to their personal ability to pay for the provision of health care services. Due to small taxing fulfillment, the little organizational capacity to collect taxes that are due to absent of robust tax base systems by most of the governments in low and middle-income countries.

Therefore, in the current times, the agreement has grown that health care financing through risk pooling, whereby people regularly contribute to the cost of health care. Through tax payments or health insurance contributions refer to as the premium. And this provides greater financial protection to the households and is, therefore, preferable to out-of-pocket health care services funding (Carrin, & Preker, 2004).

According to Hjortsberg, (2003) and Preker et al., (2002), posit that out-of-pocket payment creates financial barriers that prevent millions of the people every year. From seeking and receiving the needed provision of the health care services. Furthermore, many of those who do seek out and pay for health care services are faced with financial catastrophe and impoverishment (Wagstaff, Doorslaer, 2003 & Xu K, 2003; Xu K et al., 2005). People who do not have access to health care services and those who suffer financial catastrophe are the irrelevancies. While, other people might give up only some health care services, or face less severe economic catastrophic imposed by user fees. The fact remains that people everywhere, at all levels, seek health protection from risks associated with sickness.

Carrin et al. (2008) argue that 13 percent of households face financially catastrophic in some particular year. Since of the user charges linked to accessing health care services and up to 6 percent, are pressed into the poverty line. Also, the results globally suggest that approximately 44 million families are facing harsh economic

difficulties. And 25 million are pushed into poverty every year basically for the reason that they need to access health care as well as disburse through out-of-pocket. The pertinent issue facing all countries is how to finances, their health care system effectively so that they can achieve or maintain universal health coverage

As shown in Figure 2:4, CBHIS are still not covering most countries in Africa. According to the African World Bank, estimates that less than 10 percent of the countries in Africa still depend on alternative insurance schemes that are locally based and formed around larger family ties. To some large extent, the setting up of community-based financing schemes are a reaction to this lack of social security. Therefore, CBHIS have a large variety of different funding mechanism. This emerging CBHIS are more concentrated in Sub-Saharan Africa, Rwanda, Republic of Democratic of Congo, Uganda, Madagascar.

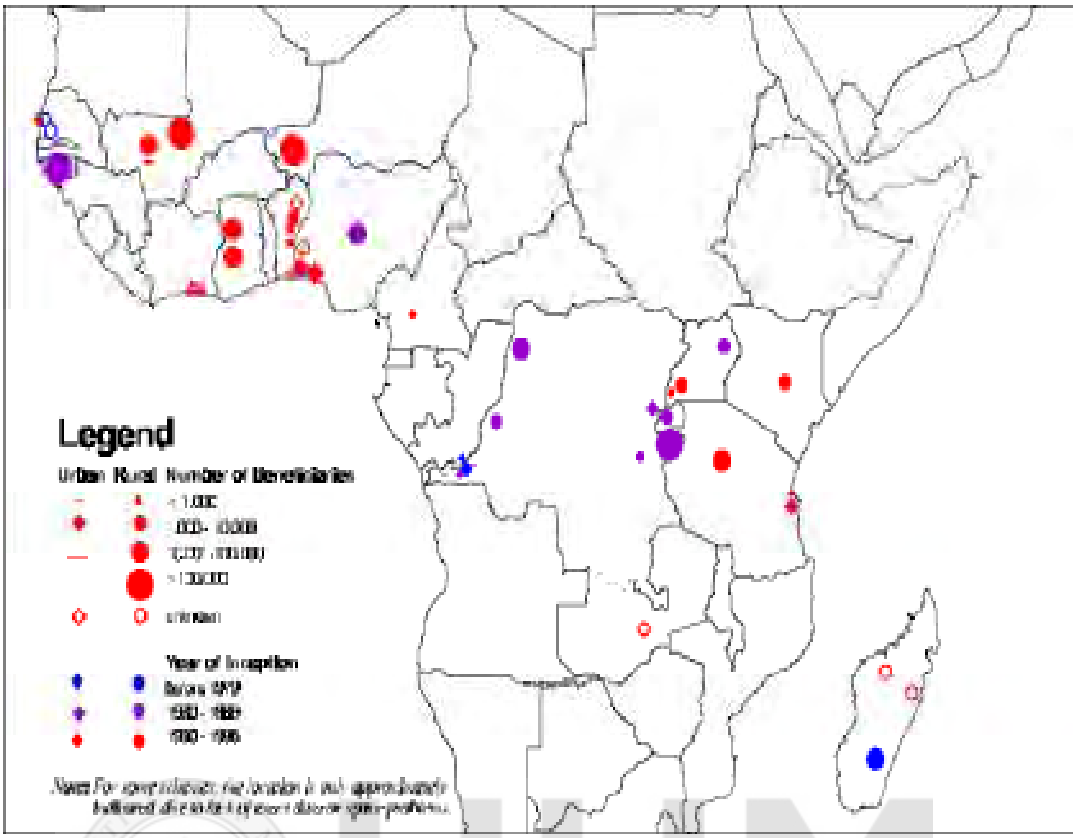

Figure 2.4: Urban & Rural CBHIS Schemes in Sub-Saharan Africa.
Source: Atim, 1998; Bennett et al. 1998; Debaig (1999) and Musau (1999)

Even though CBHIS is known to be predominantly susceptible to adverse selection, where uneven enrollment by low-risk contributors accompanies non-participation by low-risk individuals (WHR, 2000; Carrin, & Waelkens; Criel, 2005).

CBHIS operating in sub-Saharan Africa (SSA), including that of Nigeria, have been in a weak position by low enrollment rates. Weak sustainability and resource mobilization (De Allergri, Sauerborn, Kouyate, & Flessa, 2009). Health care provision in Nigeria is the duty of the three tiers of government, with the university teaching hospitals and federal medical centers (tertiary health care) being managed by the federal government while state governments administer public hospitals, and local government focuses on dispensaries (that are controlled by the central

government. Through National Primary Health Care Development Agency (Baba, & Omotara, 2012). While spending on health rose from 12.5 million Nigeria Naira in 1970 to 98.2 million in 2008, the health care system remains incompetent (Baba, & Omotara B, 2012).

After Nigerian independence in 1962, the Nigerian government was able to use oil revenues and general taxation to fund universal free health care services mainly through public amenities, all over the country (Odeyemi, & Nixon, 2013). However, the worldwide slump in oil prices during the 1980s, attached with economic and political unsteadiness while the poor state of Nigeria's health care services, leads to the need to rebuild Nigeria's health care infrastructure (Odeyemi, & Nixon, 2013).

In May 1999, the Nigerian government formed the National Health Insurance Scheme (NHIS), with formal enabling of private segment participation to reflect the Nigeria operation of a mixed economy and correct the previous unfortunate situation of private health facilities (Baba, Omotara, 2012; Odeyemi, & Nixon, 2013). However, the enabling law was signed in 1999; the Nigerian NHIS did not, in fact, become fully operational until 2005 (Metiboba, 2011).

Nigerian NHIS is an organization under the federal ministry of health, and it contains three main schemes: the first one is formal and the second is informal (Baba, Omotara, 2012; Odeyemi, Nixon, 2013; NHIS, 2012; & NHIS, 2013). Hence, the Formal Social Health Insurance Program (FSHIP) provides the public employees and organized private sector with insurance cover and is executed through managed care model funded by contributions from workers and employers.

While, the two other schemes, the Urban Self-Employed Social Health Insurance Program (USSHIP) and Rural Community Social Health Insurance Program (RCSHIP) are outside the formal sector and are non-profit voluntary schemes based on the CBHIS model. The revenue is sourced from the USSHIP members acquire the endorsement, according to their health needs and then decide benefits, with cash contributions being made as flat-rate monthly payments or in installments.

Funding is not associated with the ability to pay for either the USSHIP or RCSHIP, both require high levels of self- administration, and benefits packages are not entirely complete (Odeyemi, & Nixon, 2013; NHIS, 2013). Enrollment has been unsatisfactory, with around 5 million people in all the three NHIS programs (3% of the Nigerian population), (Metiboba, 2011; & NHIS, 2012). On the other hand, Executive Secretary of NHIS, Dr. M. O. Thomas, has lately assured all Nigerians of his strength of mind to attain the president's target of 30 per cent coverage by 2015 (NHIS, 2013).

The desire for reasonable health care that responds to the needs of the people of Nigeria has been emphasized recently by a cross-sectional study of the semi-urban Samaru community that showed over a quarter of families having complexity settling their hospital medical bills (Sambo, Idriss, Bashir, & Muhammad, 2013).

CHAPTER THREE
LITERATURE REVIEW

3.0 Introduction

The last chapter deals with the overview of Nigeria, an overview of Sokoto state, Health insurance in Nigeria and the impact of community-based health insurance scheme. This chapter surveys the literature on healthcare services, as its relate to the policy process, economic growth, scheme design and mobilization. The conceptual framework, hypothesis development was also discussed.

3.1 Healthcare Services

The act of taking preventive or necessary medical procedures to improve a person's well-being. Hence, this may be done with surgery, the administering of medicine, or other alterations in an individual's lifestyle. These services are typically offered through a health care system made by hospitals and physician. It refers to the work done in providing primary care, secondary care, and tertiary care, as well as in public health.

Access to health care varies across country groups, and individuals, largely influenced by social and economic conditions as well as the health policies in place. Countries and jurisdictions have different policies and plans about the personal and population-based health care goals within their societies. Health care systems are organizations established to meet the health needs of target populations. Theirs exert configuration varies between national and subnational entities. In some countries and

jurisdictions, health care planning is distributed among market participants, whereas, in others, planning occurs more centrally among governments or other coordinating bodies. In all cases, according to World Health Organization, a well – functioning health care system requires a robust financing mechanisms; well-trained and adequately paid workforce; reliable information on which to base decisions and policies; and well-maintained health facilities and logistics to deliver quality medicines and technologies (WHO, 2013).

Health care is conventionally regarded as an important determinant in promoting the general physical and mental health and well –being of people around the world. An example of this was the eradication of smallpox in 1980, declared by WHO as the first disease in human history to be eliminated by deliberate health care interventions (WHO, 2010). Therefore, the provision of health care services to the rural dwellers is vital because about 70 percent of the Nigerian population resides in the rural areas. Where the delivery of health care services is dilapidated or lacking, where the personnel and health care equipment are not there. Hence, the introduction of health insurance as a strategy to provide these needed health care services to the rural dwellers with the aim of providing them with access to health care at their doorsteps through community-based health insurance scheme (CBHIS). Which is a prepaid health insurance mechanisms to complement the formal health insurance scheme that is for the formal sector and the private organize sector. Where since the formal flagged off of the insurance scheme from 2005 only 3 percent or 5 million of the Nigeria population were covered (NHIS, 2009).

While the definition of the various types of health care services varies depending on the different cultural, political, organizational and disciplinary perspectives. There appears to be some consensus that primary care constitutes the first element of a continuing health care process; that may include the provision of secondary and tertiary levels of care (MacLean, 2014). Primary care often used as the term for the health care services that play a role in the local community. It can be provided in different settings, such as health post, urgent care centers, etc., which provides services to patients the same day with an appointment or walk-in basis.

Common chronic illnesses usually treated in primary care may include, for example, hypertension, diabetes, asthma, depression and anxiety, back pain, arthritis or thyroid dysfunction. Provision of health care services also includes many essential maternal and child health care services, such as vaccinations and family planning services. In America, the 2013 National Health survey found that skin disorders (42.7%), osteoarthritis and joint disorders (33.6%), back problems (23.9%), disorders of lipid metabolism (22.4%), and upper respiratory tract disease (22.1%, excluding asthma) were the most common reasons for accessing a physician (Sauver, Warner & Yawn, 2012)

In the context of global population aging, with increasing number of older adults at risk of chronic non-communicable diseases, rapid rise demand for primary healthcare services is expected in both developed and developing countries (WHO, 2011 & Simmons, 2009).

Scholars have offered suggestions on how to provide health care services, Gilks (2006) posited that implementing a public -health approach based on decentralized

operational procedures provided through community or district networks with treatment teams headed by doctors/medical officers. But primarily comprised of nurses, clinical officers, (train and paid) lay/community health workers (Gilks, 2006). Furthermore, Harries, Schouten, and Libamba (2006) posited that simplifying the provision of health services is essential to success. Hence, regular and secure supplies of drugs to the health facilities, good adherence with chemotherapy by patients and compliance with a follow-up to lower the chance to develop resistance are needed (Harries, Schouten & Libamba, 2006). In providing health care services to the rural dwellers through CBHIS because of the proximity of CBHIS to the rural dwellers, the chance of non-compliance with doctor's prescription will be small.

Therefore, community mobilization and local coordination are needed, and funding should be available locally and not allocated to predefined categories. Accountability and empowerment should also be promoted (Binswanger, 2000). Many low and middle –income countries face numerous problems in health care delivery, which include weak national health system, inadequate infrastructures, civil war, meager financial resources, and corruption. Health care personnel are lacking in most of the rural areas and this because of the non-availability of social amenities.

The impartiality of health care access in Nigeria has been discussed lately (Odeyemi, & Nixon, 2013). And the present review, therefore, will center on the impact of the policy process, economic growth, scheme design, and mobilization in the provision of health care services amongst the rural dwellers of Sokoto State. To answer the central research question, policy process is a critical aspect because if there are no any policy guidelines from either the government or stakeholders on how to provide

health care services to the rural dwellers through CBHIS strategy at an affordable price through community participation. Since CBHIS has been identified as prepayment mechanism that seek to complement the government role in providing health care services to the rural dwellers. Therefore, the policy process is a major factor in the provision of health care services.

While, the economic growth of the rural dwellers is related to having a vibrant and productive population. Here the income of the rural dwellers matters a lot because using CBHIS strategy to provide these health care services the rural dwellers has to belong to CBHIS and. Therefore, he has to pay premium regularly to enjoy health care access in his community, so therefore, he has to have the means to do that, if he is poor and cannot afford the premium he will be excluded from enjoying these access to health care in his community. Economic growth of the rural dwellers is related to reducing the difficulties the rural dwellers face when accessing healthcare services. According to, Gonzalez Paramo, (1992); Barro and Sala, (1995) in their empirical study of the determinants of growth, they posited that life expectancy is an important factor for growth: a 13- year increase in life expectancy is estimated to raise the annual growth rate by 1.4 percentage points.

Furthermore, as accounted by World Bank (1993) improvement in health contributes to economic growth in four ways: Improvement of the healthcare services reduces production losses caused by worker illness; Improvement of healthcare services permits the use of natural resources that had been wholly or nearly inaccessible because of disease. Growth in health care services increases the enrollment of children in school and make them better able to learn and Furthermore, improvement

in the provision of health care services frees alternative uses of resources that would otherwise have to be spent on treating illness.

Furthermore, having a good scheme design in establishing CBHIS to provide health care services to the rural dwellers is very necessary. Because having the knowledge of the disease distribution in an area will help in knowing which benefits package and what are the right medical facilities to provide to the rural dwellers in the form of health care services. Since if the rural dwellers see the program as their own and that when designing the scheme, they are hundred percent involve and at the same time they will be in charge of managing the CBHIS.

And with regards to the payment option, it's the rural dwellers and the organizers that will decide on how much is the premium will be and time for the payment will have to be agreed by the rural communities involved. Also, if there are going to be subsidies from the government or NGOs and other donors, agencies will also be-be added into the design, issues of moral hazards will also be looking into (or "intending to") dealing with it.

To answer the primary last research question of the study is the issue of mobilization of the rural communities to see a reason to enroll in CBHIS, which will serve as a strategy for providing the much-needed health care services to the rural dwellers. It's only when the rural dwellers are mobilized that they will be keen and educated to know the benefits of CBHIS. Here the role of mobilizing the rural dwellers is paramount because they will have to be mobilized and enlighten about the advantages of belonging to the membership of CBHIS since most of these rural dwellers farmers and petty traders they are mostly self-employed.

Since the concept of CBHIS is new to them and they know nothing about the concept, there is the need for the stakeholders and the government to educate these rural dwellers and also show them what they stand to benefit more from being members of CBHIS. The out of pocket expenses that they are used to anytime they are accessing health care services will be remove and replace by paying premiums as agreed with them. To help them ease the difficulty they faced during any calamity health faced by their families. So these variables will be used in answering the central research questions in the study.

Health strategy implemented in the SSA countries faces major public health problems such as widespread diseases, which include Tuberculosis, Cholera, Malaria HIV/AIDS. Some other long-existing health conditions include child death rate and maternal mortality rate are increasing, including the shock of inadequate nutritional intake among the poor in rural areas.

In the recent years, we have witnessed the appearance of novel public health challenges, such as Psychiatric problems, rises in non-communicable infections, and high payment increase in injuries among the masses. The spread of new diseases has placed serious pressures on theses SSA countries that already are scrambling to convey essential social insurance services to their masses.

For instance, HIV/Aids are a very severe disease condition that is killing more people every day in some low-income rural areas including Africa. Numerous governments have established to such occasions position tremendous and sudden interest for their wellbeing services. The macroeconomic arrangements, implanted in the neoliberal belief system, pointed fundamentally at diminishing government

wishing to address budgetary shortfalls, including expense recuperation instruments through user charges (Akin, Birdsall, & de Ferranti, 1987).

The experience of community health insurance dates back to the Alma-Ata convention in 1978 while "several" health minister present at the Conference prepared an obligation to give reform in health organizations and extend worldwide primary health care to deprive people in their different communities. But they fail to achieve this noble intention due to absent of political will and inadequate resources.

Therefore, the Bamako Initiative promoted the entry of user fees, charges and the participation of communities in managing primary care in Africa to achieve universal coverage (Gilson, Kslyalya, Kuchler, Lake, Oranga, & Oueno, 2000). However, these policies were progressively abandoned because of the policy of introducing user fees succeeded in expelling the most vulnerable group in the rural areas.

So as the CBHIS main concerned is to cross any barrier to access to healthcare services and to outfit a government-managed savings between individuals secured by the formal health protection framework and the someone's who need to return to their medicinal mind out of their own pockets. The World Bank claims that CBHIS is very efficient in protecting many moderate –income people against the high cost of sickness (Preker, Carrin, Dror, Jakab, Hsio, & Arhin, 2011). Therefore, CBHIS has an impact in providing health services to the rural dwellers by making provision of various health care facilities within their locality at a lesser cost.

WHO includes that a fundamental concept in health financing policy towards universal coverage is that of society or community risk pooling (Carrin, & James,

2004). So in most countries in SSA CBHIS is encouraged by various governments among their citizenry. Equally, this is yielding results in the States like Rwanda, the Democratic Republic of Congo, Mali, Burkina Faso, Tanzania, Ghana, Cameroun, and recently in Nigeria. There is a move by the Federal Government through its agency NHIS through the actual capacities of Health Maintenance Organizations (HMOs) to get the data needed for the rapid establishment of CBHIS among the informal sector of the Nigerian community. The formal sector is already taking care of through the National Health Insurance Scheme.

But after about nine years of the introduction of NHIS in Nigeria, no enough impact was visible, even in the formal sector that the scheme was meant to serve. Only three percent of the Nigerian population out of 160 million (NPC, 2006) was covered, Leaving the majority of the Nigerian populace without any form of insurance.

To begin with, a few families confront a "catastrophic" load of health awareness instalments, with consumption that goes past 10 percent of any family wage (Ranson, 2002) or 40 percent of non-nourishment, family unit use (Xu K, Evans, Kawabata, Zeramdini, Klavus, & Murry, 2002). For instance, it was approximated that 1.3 percent of families in Ghana practice "catastrophic" installments (which is above normal for an investigation of 59 nations) (Xu K, Evans, Kawabata, Zeramdini, Klavus, & Murry, 2002).

Furthermore, poorer gatherings are not equipped to gain from freely financed health services to the degree that their relative mass of declining health might infer as client expenses prevent their material consumption. Case in point, subsequently, the

poorest quintile of the individuals in Ghana in the 1990s gained 12 percent profit by utilizing available health benefits.

The wealthiest Quintiles accepted 33 percent; the relating numbers of the United Republic of Tanzania are 19 and 29 percent, respectively (Castrol-Leal, Dayton, Demery, & Mehra, 2000). The state of affairs in Nigeria is not different from the areas as mentioned above. When user fees were present in the Nigerian health sector "in the late 1980s. There is the gradual withdrawal of the majority of the Nigerian rural community because they could not afford the payment for the services that were turned over to them. "As a result" so many masses are dying from curative and preventive diseases in a higher dimension.

Pair with the problems and lack of political will of the Nigerian state at all layers, namely federal, province and local government. There is a demand to turn attention to a position where people will act as a reliable voice in their health care delivery organization through the risk-pooling process or community-established health insurance scheme. And these schemes will be in the informal sector where the majority of the Nigerian people resides. Thus, this call for support of the masses in the scheme acceptable and viable community-established health insurance system based on what the people in a diverse community want and desired.

The family economic load is made out from the expenditure of wellness maintenance. Elevated cost, health inspection, and repairs might not affect in any financial pressure for high-income families while even comparatively modest sums of spending for common illness can be economically devastating for the helpless. The family monetary amount is calculated in stipulations a households' ability to

compensate sooner than a whole quantity of out of pockets. A prepayment scheme can bring down a family financial saddle as the risk is public, and contributions are pooled across population groups somewhat than bear exclusively by an individual family (WHO, 2006).

Health insurance does not rapidly eradicate catastrophic expenses in practice. The individual has to make sure which inhabitants groups were enrolled, and what are the health care services that is covered by the program (benefits package). The fiscal load of paying for wellbeing services examined at the family stage and assessed as a part of out of pocket health reimbursement in a family strong ability to compensate. At any known episode, there at all times are some families that have no expenditure on health concern (WHO, 2006).

Health care expenditures arise precisely when the family has lost productivity and often the income from one or more adult. For instance, if a patient is hospitalized, other family members typically must provide meals and other care for the patient and may exercise less to have time to provide this care. The combination of low income and high spending can lead folks to sell assets or demand on debt. The market interest rate is high, so a loan, often contributes to asset sales at a later date (SKY, 2009).

Health insurance increases access and employment because of letting down the cost of health maintenance. Individuals will have better health if they are utilizing preventive and curative health care when needed and promptly. There is a positive impact on health insurance in the developing nations on access and utilization of health care services (AIID, 2013).

A potential additional impact of health policy is increased utilization among not-participating members because, in some case when the insurance is made available, participating facilities are promoted. We might also require people to sustain good health if the quality of the health care they get is improved (AIID, 2013). From the survey report in Nepal, the overall usage rate for health care services among members of a CBHIS is higher than among non- members, irrespective of whether it is a public or private system. These findings indicate that CBHIS do in fact offer financial security to their members, which enables them to utilize health care services more often than non-members (Giza, 2012)

A study conducted by WHO broadly examine that the impact of the health insurance scheme in low-income and middle-income countries in Asia and Africa on various fields. It is, therefore, the firm evidence that CBHIS can improve financial protection and enhance healthcare service utilization patterns (WHO, 2012). In line with WHO study, in the Ethiopian context, a survey done by Anagaw, (2012) indicates that 74 percent of the subjects (26 out of 35) finds positive and statistically significant CBHIS membership effect on the provision of health care use. The research also demonstrates that the schemes have registered strong evidence (88 percent of the cases) in preventing catastrophic health spending.

Conversely, success factors are too possible. Researchers in Nigeria and Cameroon have documented an apparent desire on the part of less prosperous families to join schemes. And over 3000 Nigerian survey respondents stated that CBHIS was an acceptable way of paying for wellness, irrespective of socioeconomic surroundings or location (Onwukwu, Onaka, Uguru, Tasie, Uzochukwu, Kirigia, & Petu, 2011).

Amusingly, the poorest households expressed the greatest willingness to enroll. Countries such as Rwanda and Ghana have shown key drivers of success to include uniform and inclusive benefits packages, sufficient financially by the government and removal or minimization of copayments.

Flat-rate payments are likely to depress the indigent (NHIS & Onwujekwe, Onaka, Uzochukwu, Okoli, Obikeze, Eze, 2009), and the use of funds from taxation has been established to be necessary to ward off the need for regressive member contributions. Even in the relevant lucky country such as Senegal, there has been trouble in accomplishing the very poorest members of the community, which has spotlighted the need for subsidies (Jutting, 2003).

Furthermore, targeted subsidies for the most underprivileged have a positive influence as long as adverse selection evaded (Adinma, Nwakoby, Adinma, & Onwujekwe, Okere, Onaka, Uzochukwu, Okoli, Obikeze, Kiriga, Petu, 2010). The contribution that CBHIS can make to the achievement of UHC is acknowledged by international arrangements, such as the WHO, the World Bank and the United Nations Children's Fund (UNICEF), despite its known shortcomings (UHC, 2013).

The evidence reviewed points to the CBHIS potential role in the accomplishment of outcomes related to the UN's Millennium Development Goals (MDGs). For instance, Goal 5 is to improve maternal health care services (Adinma, Nwakoby, & Adinma, 2010). Showed improved delivery and use of maternal health care services after the first appearance of a CBHI-type scheme in Anambra State, Nigeria.

In conclusion, from our preceding discussion, we can see that no one has discussed directly on the impact of healthcare services on the policy process among the rural dwellers. We then viewed that the impact of health care services is the gap among the factors that all the scholars above did not account for a substantial value. Thus, this thesis has tried to cover the gap of this literature review and accounted it as the most significant value and to be examined as the dependent variable in this thesis. Garter & Gruber, (2002); Jutting, (2000), and World Bank, (1993) observe that the countries in most developing nations have not been able to achieve health care needs of their poor people. Insufficiency of public health provision decreases budgetary support for health care services. And an unbearable low quality of public health care services and the resultant load of user charges. Hence, they posit due to thoughtful of the government's inability to meet medical needs of the poor rural dwellers.

Also, Giza, (2012) reported the survey in Nepal found that the overall usage rate for health services among members of a CBHIS is higher than among not- members, irrespective of whether it is a public or private system. These findings indicate that CBHIS do in fact offer financial security to their members, which enables them to utilize health services more often than non-members. Furthermore, Giza, (2012) posits that CBHIS offer subsidized premiums for the ultra-poor, marginalized, helpless and disabled beneficiaries. Such has improved the way the rural dwellers access health services at an affordable cost.

Another study of the impact is the work of WHO (2012); it conducted the study examining the impact of the health insurance scheme in low-income and middle-income countries in Asia and Africa on various fields. It resulted; the CBHIS can

improve financial protection and enhance service utilization patterns. Also, in the Ethiopian context, a survey done by Anagaw (2012), it indicates that 74 percent of the subjects (26 out of 35) find positive and statistically significant CBHIS membership effect on health care use. The research also demonstrates that the schemes have registered strong evidence (88 percent of the cases) in preventing catastrophic health spending. Regarding the CBHIS potential role, some scholars such as Adinma et al.; Adinma, Nwakoby and Adinma (2010), they argue that the evidence reviewed points to the CBHIS potential role in the accomplishment of outcomes related to the UN's Millennium Development Goals (MDGs). Which is about Goal 5 is to improve maternal health and findings reveals an improved delivery and use of maternal health services after the first appearance of a CBHI-type scheme in Anambra State, Nigeria.

While AIID (2013) indicated that there is little rigorous empirical evidence measuring the impact of health insurance on its ability to offer financial protection. Despite this shortcoming from the foregoing discussion, CBHIS has been shown to improve the provision of health services to the rural dwellers. Furthermore, the impact of health insurance in low-and-middle-income countries have unfortunately been documented only partially. Previous reviews have evaluated the performance of CBHI regarding enrollment, financial management and sustainability (Carrin, et al., 2004; & Jakab et al., 2005). Hence, this study will try to assess the impact of health care services as the dependent variable regarding the policy process, economic growth, scheme design and mobilizations on the provision of health care services.

3.2 Policy process and Healthcare services

According to McGinn and Reimers (1997), they view the policy as a declaration of the actions to preferred in the pursuit of one or more objectives of an organization. Some languages (e.g., Spanish) use the same word to refer to the policy as to politics. A recent trend is to define policy as what organizations do. While Kingdon (1984) considers public policy making as a set of processes, including at least (i) the setting of an agenda, (ii) the specification of alternatives from which a choice is to be made, (iii) an authoritative choice among those specified alternatives and (iv) the implementation of a decision. While, Buse et al. (2005) posit Policy process as embracing courses of action (and inaction) that affect the set of institutions, organizations, services and funding arrangements of the health system.

While, Anderson, Chris, (2005) posited that policy as an affirmation of intent and is carried out as a procedure or protocol. Therefore, from the views of the scholar's policy process is realized to be the action plan of government. That is what is meant to do for the people in countries that are thought to be of assistance to the people general well-being which may include adding new policies such as in Health (CBHIS), Education, Security, and socioeconomic well-being of the citizenry.

Scholars have defined policy in many different ways, Longest, (1998) refers to the policy as Authoritative decisions made in the legislative, executive, or judicial branches of government that are intended to direct or influence the actions, behavior, and decisions of others. In the same vain Subcommittee on Health and Environment of the Committee on Interstate Commerce (1976), view the policy as a course of action adopted and pursued by a government, party, statesman, or other individual or

organization. While, Hanley, (1998) refers to the policy as Authoritative decisions and guidelines that direct human behaviour toward specific goals either in the private or the public sector. The question to ask is whether private actors make policy or whether policy making is an activity for the government only. So based on the discussion, policy refers only to governmental policymakers, while subcommittee on health and environment on social commerce view policy making by both public and private decision makers and the third definition is unclear on the issue.

Of course, the government is a crucial player in any policy field, and it is certainly true that decisions by government entities represent public policy. On the other hand, in this study, l focuses on the individual players who make policy, such in CBHIS, private employers, influential people, and others who can be part of the health policy process. For example, when a prominent health insurance company decides to cover obesity or hypertension measures, etc., the insurance companies are making health policy decisions.

In spite of, whether the policy maker is a public or private, it is necessary that the decision made is an administrative decision. These are decisions made by an individual or group with the power to implement the decision, and there are a variety of levels where these kinds of decision take place. For example, within government, administrative decisions may be made by the president, cabinet officials, agency heads, members of Congress, governors, state legislatures, public health commissioners, and many others.

But all decisions by public and private individuals or entities are not necessarily policy decisions. The main subject in shaping whether a “decision” constituted a

“policy is whether the problem at hand is personal worry or a community policy dilemma. Communal policy predicament goes further than the individual field and affects the bigger neighborhoods. Hence, the problem of inequality of provision of health care services and the catastrophic nature of health care expenses by the rural dwellers is a problem that affects the greater rural communities in Nigeria and other developing countries. Therefore, the way out of these problems is to encourage the rural dwellers to organize themselves and establish CBHIS to cater for their health care needs.

Considered broadly, there are different ways to approach public policy problems. For example, some policy options are voluntary, whereas others are mandatory. It is important to recognize that executive decisions do not always require others to act or refrain from acting in a certain way. Therefore, some of the most significant and effective policies are those that provide incentives for others to change their behavior, such as in providing subsidies to the vulnerable groups in accessing health care by the government will go a long way in getting more people to participating in the CBHIS among the rural dwellers.

Health interests, ranging from professionals to the pharmaceutical industry, have traditionally been perceived to influence the policy process significantly. They are uniquely placed to do so because of their knowledge, technology, access to political processes and stake in life and death issues.

While this feature is distinctive, all scholars point out that they possess to be contextualized in both place and time. Health policy environments in middle and high-income countries, where for instance, there are weaker regulations, regulatory

capacity and monitoring systems; lack of purchasing ability as a leverage to influence cases and caliber of services delivered; more patronage in political arrangements, and more reliance on external donor funds, among many other disputes.

In spite of differences between high and low-income countries, however, it is more and more recognized that policy process focused on the state of the public or government sector by politicians, bureaucrats and interest groups (Hogwood & June 1984; Grindle & Thomas 1991). Over the past ten years, scholars have acknowledged a shift in policy and policy-making, which points to the involution of a much bigger array of actors in the policy process (Buse et al. 2005). The private sector, for example, including for –profit and not –for-profit systems, large and small, has become an important factor in the health policy process. Furthermore, the policy is increasingly regulated and influenced by forces (such as local and global civil societies) outside state boundaries (Keck & Sikkink 1998).

While the government and its hierarchical institutions remain important, all policy process must likewise take into account a range of flexible, more ad-hoc arrangements that increasingly affect decision-making. Wagenaar and Hajer (2003) talk about 'new spaces of politics' where there are 'concrete challenges to the practices of policy process and policies coming from below'. In their survey, policy process has become more deliberative: less top-down, making expanded networks, and more interpretative, taking into account values and feelings, their understandings and people's stories as expressed through words and conduct. So, policy should support the establishment of CBHIS towards the provision of healthcare services to

the rural dwellers. Since, provision of health services is the responsibility of the govern. It can be useful to think of health policy as embarrassing 'course of a natural process (and inaction) that affect the set of institutions, systems, services and funding systems of the health system (Buse et al. 2005). Without having policy on the operation of CBHIS by the government or the stakeholder, the rural dwellers will not have the interest to participate in establishing this strategy of providing healthcare services to community-based health approach. through

The best known public policy framework is the stages analytical (Lasswell's, 1956; Brewer & Dalton 1983). They classify the public process into four phases: agenda setting, preparation, execution, and evaluation. Agenda setting is the issue sorting step during which a reduced routine of many problems societies faces rise to the attention of decision-makers. And the issue here is the problem the rural dwellers faced such as in accessing health care in their community and the question of paying out of their meager resources that are draining their pocket and pressing them to poverty.

While, in the formulation stage, general assemblies and other decisions making bodies design and enact policies. Here the policy makers prepare a case for CBHIS and bringing away the benefits of insurance, passing the enabling law and also the financial freedom that the members will endure to gain including what are the rural dwellers are willing to pay a premium monthly or as may be accorded to them. Besides the nature of what type of benefit the rural inhabitants will care for, and likewise how the medical services and are going to be made available in their communities.

While, in the execution stage, is a place where all these issues noted above implemented. Here the people can immediately enjoy the services that CBHIS will offer to them, and if government provide subsidies to these CBHIS it will be determined and those that the subsidies is for will be utilizing it to access health care in their residential areas. While, in the evaluation stage the impact of the insurance scheme will be evaluated by both the rural dwellers, policy-makers, stakeholders and the central government.

Therefore, the policymaking process over the globe has perceived that equivalent access to health care administrations is vital for the whole populace and that this cannot be accomplished without a well-working health financing scheme. However, Member States of the World Health Organization (WHO) conferred in 2005 to create their health financing, planning with the goal that all individuals have access to health care services and without encountering financial hardship paying for them. (World Health Assembly's determination 58.33). Healthcare has funded arrangements over the world push risk pooling instruments with a particular end goal to impel far from immediate payment (out –of-pocket payment at the time of conveyance) and accomplish health care coverage universally. (James & Sawed-off 2010, WHO 2010).

Most developing states cannot provide health care protection because the majority of the rural residents is engaged in the "informal sector" (Bacchetta et al. 2009; Pratap & Quintin 2006). In any case, in this manner the motivation behind why these states cannot ultimately give subsidies to health care protection for all the individuals in the informal sector of the Nigerian population.

Accordingly, voluntary relationship to a contributory scheme like CBHIS or public health insurance protection is the mainly reasonable approach attain community-based health care policy strategy among the rural dwellers where governments fail to provide subsidies for health care services. For example, in Nigeria, the significant number of its population resides and, are working in the informal sector, which in most situations these rural dwellers do not pay their taxes regularly.

Despite a policy of providing health care support through the public sector, where these health care services typically are lacking in medical supplies and qualified medical health personnel, most notably in the rural dweller communities (Reddy et al. 20011a, & Peters et al. 2002, Berman, 1998).

Hence, the rural communities access health care through private health care service providers (NSSO 2006) and need to tolerate the cost of treatment through out-of-pocket at the point of social insurance use. As has been established that rural residents pay up medical services by selling their personal belonging or seeking for loans from people around them (Binnendijk et al. 2012c).

Besides, the rural residents were not able to get health insurance protection in their rural communities. Subsequently, the option is to become insured through CBHIS, which will offer ease (just halfway) community health care coverage (Bhat & Jain 2006, Devadasan 2006, Ahuja 2005, NCMH 2005). CBHIS schemes are organized mostly by NGOs serving poorer segments of society on a non-profit voluntary basis. One of the strengths of CBHIS is keeping transaction costs low and tailor the benefit from a premium subsidy. Consequently, the expenditure on benefits is limited to a premium income of private schemes.

It is self-explanatory that people will purchase health insurance voluntarily only if the package suits their needs if the premium is affordable, and if they expect the contract to be executed as promised. In estimating what people are willing to pay for health insurance (WTP) before the insurance can be launched, is thus essential because it defines the economic boundaries within which to design the package?

Contingent valuation is the means used to get data concerning WTP; rural dwellers are asked to state their WTP for something that is not so far obtainable in the marketplace (Dror & Koren 2012). Furthermore, it has been established, both in Nigeria and India, that WTP for health insurance differ considerably and substantially fixed locations still within in the same community or nation (Onwujekwe et al. 2010, & Dror et al. 2007b), signifying that it's essential to approximate WTP for each locality independently.

Various works have looked at components determining the stages of WTP for health policy in developing states, such as the financial and social-demographic position of respondents, financial exposure to health care cost, availability of health maintenance facilities. Also, variables that considerably explain WTP in one study were insignificant in other studies (Dror & Koren 2012. Family income turns out to be an encouraging predictor of WTP in several studies (Onwujekwe et al. 2010a; Gustafsson-Wrigth et al. 2009; Lofgren et al. 2008; Dror et al. 2007b; Barnighausen et al. 2007; Ying et al. 2007; Dong et al. 2005; Asfaw & von Braun 2004; Binam et al. 2004; Dong et al. 2003c; Dong et al. 2003a; Masud et al. 2003; Mathiyazhagan 1998 & Asenso-Okyere et al. 1997). Therefore, this result is not unexpected and tally with the common way of developing nations to value social health insurance

premium as a permanent fraction of family earnings (Saltman et al. 2004). The result regarding WTP for health insurance recommends that related to food; health insurance should be considered a 'prerequisite right' somewhat than a 'Lavishness good,' i.e. Commodities that persons cannot exist exclusive of and the requirement for which is not without doubt condensed even when times are harsh.

Most health care spendings in the developing world is borne by the health care seekers through out-of-pocket (OOP) spending. Nigeria and India are a good reference point: 70 percent of health care spending is through private, 86 percentages of which is through out-of –pocket expenditure (Karan & Selvaraj 2012, World Bank 2010). The rural dwellers in Sokoto state, Nigeria regularly finance such out- of-pocket spending, not only for outpatient but also for inpatient hospitalization, including maternity-related care costs, through dispersing their properties or through borrowing from friends or relatives (Binnenjijk et al. 2012c).

This inefficient and inequitable health care funding persists in other sub-Sharan countries as well (Kruk et al. 2009). Therefore, the solution provided by WHO together with other world bodies has been to strive for universal health coverage, most especially through risk pooling and prepayment mechanisms in place of payments at the point and the time of health care utilization by the rural dwellers. (James & Sawed-off 2010, WHO 2010). Despite this, the introduction of health insurance or CBHIS in the most of Sub-Saharan Africa and even the African continent remains slight (Staib & Bevere 2011);

Naturally, CBHIS do not benefit from the risk pooling subsidy. Therefore, these standing CBHIS alone must ensure that the benefits spending would be limited to

premium income (reflecting the willingness to pay). Therefore, this can be through the introduction of a threshold (the predetermined amount above which the insurance reimburses the rest of the health bill) and or a level (the fixed amount up to which the insurance reimburses the health care bill).

So the policy makers should consider the premium calculations when establishing CBHIS in the rural communities. Therefore, information is required on the prevalence of health care utilization by the insured rural dwellers of Sokoto state together with the cost of each health care provided. Since, consequences of applying thresholds or level of the expected average payment of the insurance, and on the premium, can be calculated only when the distribution of the costs of health care utilization is delivered.

Hence, it's logical that when small premium payments are possible, the efficient protection of insured people for the costs above the limit is diminished. The lower the premium, the more likely the situation a reduced insurance package, and this could lead to an insight that provided CBHIS will not provide the required health care protection to the rural dwellers who want to seek care. Therefore, such perception could significantly dampen willingness to join in the CBHIS among the rural dwellers of Sokoto state Nigeria. Therefore, the protection of the insurance scheme can be known in advance only if the distribution of costs is recognized.

Evidence from the previous research that confirmed the crucial need to obtain information locally from the rural people (Dror 2007) because locations differ considerably in the type and number of sickness episodes (Dror et al. 2009b). And the cost of medication (Dror et al. 2008) and furthermore, the willingness of the rural

people to pay (WTP) for the CBHIS in the communities (Binnendijk et al. 2013, Dror & Koren 2012, Dror et al. 2007b). Therefore, based on NHIS guidelines for setting up CBHIS in Nigeria is that the approved premium to pay into the scheme should be #150. 00 Naira per head per month and as for the NHIS guidelines, each CBHIS should at least not be less than 1000 enrollees so that at the end of each month #150, 000.00 will be realized as premium collected for that month. And where the membership is more than 1000 there will be more coverage and more benefits to the members.

Health insurance is not for its sake, but for enabling an Insured Person to seek health care services when in need. Health insurance is of little value if the supply position is weak. The state could take on an active part in matching up the provision of health Services. Presently, most CBHI schemes have little or no legal standing that tends to produce some hesitation in the minds of the public about the continuity of schemes. Providing legal status may motivate confidence among the local community, resulting in higher membership. Another way in which government could support the schemes is in providing some insurance mechanism against risks, as this can have an impact on health services. CBHI schemes might be successful in insuring against specific Health hazards and not for related risks. In the event of catastrophic risks, these schemes tend to crash. Such risks can best be insured against through alternate public financing. The state could aid in diversifying risk through social reinsurance (Dror, & Preker, 2002). Like user fees, insurance should be visualized as a measure that complements other steps in providing health security for the low-income families, thereby providing them with the provision of the essential health services

within their reach. More generally, insurance is only one of the Risk management strategies available to the people.

However, the state could improve its provision of providing loans and other credit facilities to CBHIS and other organizations to make them financially sound so that they will be able to carry out their desired objectives. Similarly, policies on health security need to be incorporated into other government programs proposed for building income and health protection for the poor and needy in the rural communities.

Health systems policy shapers have to answer to the modifications in the well-being of their communities and their policy surroundings, to innovations in technology and technical facts, societal, economic and political pressures. Policy designers across Sub-Saharan Africa (SSA) are scrambling to remain informed, but given rapid changes in health sectors and the community health needs of the masses. Despite the fact that there has been an enhancement in scientific examine data, "therefore," it is extra hard to point data on health systems consequences most especially for low-income and the developing nations, as it concerned the development of community-based health insurance schemes in these countries through health security.

Health security is progressively distinguished as necessary to any poverty reduction strategy. While the goal of deprivation, poverty stays of primary concern, there has been a movement in countries far from poverty alleviation in the kernel of social risk administration. Hence, this is so because of developing energy about the role risk plays in the lives of poor people (Holzmann & Jorgensen 2000), and given a

substantial active connection between health and poverty reduction, especially in the low-wage levels (Morrisson 2002, & CMH 2001).

The state in most developing nations had not had the capacity to satisfy medical services needs of its impoverished populace. Contracting budgetary backing for health care services, wastefulness in the broad daylight health provision, the limited unsuitable nature of public health services, and the resultant burden of client charges is reflective of state's powerlessness to help poor people. In the last decade, the "health care crisis" prompted the rise of CBHIS in diverse areas of developing nations, especially in Sub-Saharan Africa (Wiesmann, Jütting 2001, & Preker et al. 2001, ILO 2002).

The decentralization process unleashed these nations to engage a lower level of government and the neighborhood group further fueled their rise (Atim 1998, & Musau 1999). The achievement of group based micro-credit plans may have additionally helped the growth of group-based health activities intended to enhance the right to gain entrance through risk and resource sharing (Dror, & Jacquier, 2000, Brown, Churchill 1999, ILO 2000). Somewhere else, especially in the region of Asia and Latin America, community-based health initiatives have come about independently and as part of income protection measures or to fill the void created by missing institution scare needs (Zeller & Sharma 1998).

Immediate general provision of health care services for the individuals lacking resources is just one of the methods for helping. This technique attempted in the past under the conviction that the poor are so poor it would be impossible to save and contribute towards their health care requirement. This belief was addressed in the

past, and later there is presently a developing acknowledgment that indeed the poor can make little, specific commitments that can go towards meeting their health requirement through establishing CBHIS among the rural dwellers in their communities. Therefore, health protection is progressively being made out as a tool for financing social insurance provision in low-income countries.

Researchers and policymakers are of the opinion that an initiative that plays comfortably in one area might not possibly translate well in some other rural area. Therefore, an approval of circumstance is significant in building up health systems data for any policy maker. Insurances are not for all time grounded in data, particularly when the health systems, data are non-existent or shaky, as many leaders play a significant function in the policy-making procedure.

According to Lin and Gibson, (2003) the preparation of health policy requires a set up competing rationalities: political, technological and cultural. Stronger emphasis should be placed on translating knowledge into action to improve public health by bridging the gap between what was experienced and what is being managed (WHO, 2004: xv). Health policy shapers in the SSA nations face most significant public health problems such as widespread diseases, which include Malaria, Tuberculosis, cholera, HIV/AIDS. Some other long-existing health conditions include child death rate and maternal mortality rate are increasing, including the shock of inadequate nutritional intake among the poor in rural areas.

In the recent years, we have witnessed the appearance of novel public health challenges, such as Psychiatric problems, rises in non-communicable infections, and high payment increase in injuries among the masses. The spread of new diseases has

placed serious pressures on theses SSA countries that already are scrambling to convey essential social insurance services to their masses. For instance, HIV/Aids are a very severe disease condition that is killing more people every day in some low-income rural areas including Africa. Numerous governments have found that such occasions place tremendous and sudden interest for their health services. The macroeconomic arrangements, implanted in the neoliberal belief system, pointed fundamentally at diminishing government wishing to address budgetary shortfalls, including expense recuperation instruments through user charges (Akin, Birdsall, & de Ferranti, 1987).

The experience of community health insurance dates back to the Alma-Ata convention in 1978, where "several" health minister present at the Conference prepared an obligation to deliver reform in health systems and extend worldwide primary health care to deprive people in their different communities. Only they fail to accomplish this noble intention due to absent of political will and inadequate resources. Thus, the Bamako Initiative promoted the entry of user fees, commissions and the participation of communities in managing primary care in Africa to reach universal coverage (Gilson, Kslyalya, Kuchler, Lake, Oranga, & Oueno, 2000). Nevertheless, these policies were progressively abandoned because of the policy of introducing user fees succeeded in ejecting the most vulnerable group in the rural areas.

So as a choice to the user fees community-based health insurance, which is voluntary, non-revenue driven protection based on the ethic of mutual support emerged as a means of providing health care to the people (Atim, Criel, Basara,

Blaise, & Waelkens, 1998, 2004). CBHIS main concerned is to cross any barrier to access to human services and to outfit a government-managed savings between individuals secured by the formal health protection framework and the individuals who need to yield to their medicinal mind out of their pocket. The World Bank claims that CBHIS is very efficient in protecting many moderate –income people against the high cost of sickness (Preker, Carrin, Dror, Jakab, Hsio, & Arhin, 2011).

In spite of the fact that WHO includes that a fundamental concept in health financing policy towards universal coverage is that of society or community risk pooling (Carrin, & James, 2004). So in most countries in SSA Community-based health insurance program is encouraged by various governments among their citizenry. Equally, this is yielding results in the States like Rwanda, the Democratic Republic of Congo, Mali, Burkina Faso, Tanzania, Ghana, Cameroun. And recently in Nigeria, there is a move by the Federal Government through its agency (NHIS) through the real capacities of Health Maintenance Organizations (HMOs) to get the data needed for the rapid establishment of CBHIS among the informal sector of the Nigerian communities. The formal sector is already taking care of through the National Health Insurance Scheme.

To start with, a few families confront a disastrous load of health awareness installments, with consumption that surpasses 10 percent of some family wage (Ranson, 2002) or 40 percent of non-nourishment, family unit use (Xu K, Evans, Kawabata, Zeramdini, Klavus, & Murry, 2002). For instance, it was figured that 1.3 percent of houses in Ghana experience "catastrophic" installments (which is above normal for an investigation of 59 nations) (Xu K, Evans, Kawabata, Zeramdini,

Klavus, & Murry, 2002). Furthermore, poorer gatherings are not equipped to gain as of freely financed health services to the degree that their relative mass of declining health might infer as client expenses prevent their use. Case in point, subsequently, the most helpless quintile of the individuals in Ghana in the 1990s gained 12 percent of the profit by utilizing available health benefits. The wealthiest Quintiles accepted 33 percent; the remaining numbers for the United Republic of Tanzania are 19 as well as 29 percent, respectively (Castrol-Leal, Dayton, Demery, & Mehra, 2000).

The state of affairs in Nigeria is not different from the areas mentioned above. When user fees were present in the Nigerian health sector in the early 1980s. There is the gradual withdrawal of the majority of the Nigerian rural community because they could not afford the payment for the health care services that were given to them as a result so many masses are dying from curative and preventive diseases in a higher dimension.

Couple with the problems and lack of political will from the Nigerian government at all layers, namely federal, state and local government. There is the need to turn attention to the place where people will play a reliable part in their health care delivery organization through the risk-pooling process or community-based health insurance system, and these schemes will be in the informal sector where the majority of the Nigerian people reside. So this call for support of persons in the scheme acceptable and viable community-based health insurance system based on what the people in a diverse community want and desired.

By this arrangement, primary health care (PHC) in Nigeria is thought to be made accessible and usable to all Nigerians in their hamlets and towns. PHC covers

activities in health centers, dispensaries, clinics and health location, mainly providing general, preventive, therapeutic, and rehabilitative and referral care as the case may be. In Nigeria, most of the health care services are being provided at primary and secondary levels, the state government and local government have a significant purpose in shaping the health condition of the people in many local government areas and states in Nigeria. (World Bank, 2005)

The Federal Ministry of Health (2006), posited that in the approximate of 72% of deaths in Nigeria are because of transmittable infections, an Infant mortality rate in 2008 was 75 for every 1000 live births (NDHS, 2008). By WHO ranking Nigeria is reported to rank 187th in the midst of the 191 member states in the year 2000 and up till now that position did not change. While the Millennium Development Goals (MDG) report on Nigeria suggests that the nation is nevertheless fighting to conform to the MDG health goals (NPC, 2006).

What the above statements mean that the government should create policies that will reduce inequalities in the provision of health care services through supporting the establishment of CBHIS and providing subsidies to the vulnerable groups in the communities. As this will go a long way in encouraging the rural dwellers to have more access to available and affordable health care services, also, efforts should be made by government to support the implementation and by making policies on the mode of operation, Regulatory framework, among others.

The quality of health care protection in low-and middle Nations documented only partially. Former surveys have measured the performance of CBHIS in financial management, sustainability, and enrollment (Carrin, Waelkens, Cyril, Ekman, Jakab,

& Krishnan, 2005, 2004,). In Africa, the past study stems from just seven countries namely: Ghana, Rwanda, Uganda, the Democratic Republic of Congo, Kenya, Tanzania, and Senegal. The bulk of these studies reported a very high-quality information on CBHI. While in Asian countries, all previous research originated from China, Philippines, India, Viet Nam, and Thailand. In these studies, from Asia, the majority were on SHI were of medium quality or average. Few studies were on CBHIS and PHI.

Previous research conducted on the impact of CBHIS resource mobilization for health care services cost recovery ratios after implementation of CBHIS in DRC (Criel, Moens, Criel, Kegels, Shepad, Vian, & Kleinau, 1998, 1990, 2010, 1997, 1990). Also, previous research conducted on the policy process and workability of CBHIS in nine selected nations (Ghana, India, Nigeria, Indonesia, Philippines, and the Vietnam) depends progressively on charge incomes to reserve health awareness scope. These six countries offer subsidies to their target group, for example, destitute, mature pregnant person, females, and kids (JLN Ghana, Philippines, Vietnam, Nigeria, & India, 2011).

While in Indonesia, Vietnam, and India "on general taxes" to fund CBHIS for poor masses. In this direction, Nigerian government utilizes national incomes liberated through obligation help to support a pilot study program on CBHIS for pregnant ladies and Children (NHIS, & MDG Office, 2008). Moreover, research conducted on health care reforms 2003 in Ghana on the workability of CBHIS, reveals that the state extended use to charge by 2.5 percent and reserved the incomes for the NHIS

the income from this duty now provides 61 percent of their scheme budget (Makinen, Sealy, Bitran, Adjei, Munoz., NHIA, & NHIS, 2011).

In spite of the developing prevalence of expenses as a key source of income for funding various CBHIS in these six of the nine nations (Nigeria, Ghana, Mali, the Rwanda, Vietnam & Philippines). Keep on endeavoring to acquire free premiums from the informal household to have a workable CBHIS through risk-pooling. To fund their communities in term of provision of health care services to their people. Since collecting taxes can be difficult to obtain due to so many factors (JLN Ghana, Philippines, Rwanda, Kenya, & Nigeria, 2011).

Studies by Ajilowo (2007) show that about 74 percent of rural households lacked access to health care services in Nigeria, especially in Ondo state. The effect of this limited accessibility is the failure of these individuals to provide the cost of the healthcare service. According to Ajilowo, this has two implications; it is either the rural dwellers are poor (due to small income) to afford the cost of medical services or that medical treatment cost and services are too high for them to provide. Packer, et al. (2002) in supporting this point by Ajilowo that, for low-income countries of the world to leapfrog in their growth process from the general public, funding for health to private involvement, they need to design and implement a community-based health insurance system, particularly in rural regions. Thus, there is a need to have a workable CBHIS in Nigeria most especially among the rural population, which makes up approximately 70 percent of the total population.

The Nigerian health system, in general, is conceived to be considered by not only small community division financing, nevertheless as well deplorable staff incentive

and unfair right to use to health (UNICEF/FGN, 2001). Financing health care in Nigeria has remained to face formidable challenges to insurance experts, government, and academics (Ibukun, 1996). Therefore, this is to pronounce the need to deliver a workable CBHIS in place is paramount to cut the inequalities inherent in the provision of health maintenance facilities in the rural regions in Nigeria.

The opinion may vary on the origination of value fundamental of this perspective. Devoid of moving on this subject, the exact legitimacy of this sample for extensive involvement rests on if it does, move the health care services appropriation in the wanted way. The information shown with an independent level of reliability, that the poor actually accepts a lesser some piece of open health consumptions in processing local territories than the improved off (Castro Leal, Dayton, Demery, Mehra, Filmer, O'Donnell; van Doorslear, Eliya, Somanathan, Adhikari, & Harbianto D, et al. 2000, 2004,2007).

According to DAC guidelines, the development of equitable funding CBHIS through increasing prepayment and risk pooling is one of four priorities for the development of pro-poor health system delivering quality, accessible health care services to the poor through having a workable CBHIS in the rural areas (OECD, & WHO, 2003). The workability of CBHIS in the different communities will make available those healthcare facilities that are lacking and by so doing reduces the inequality of health maintenance facilities in the rural areas, thereby reducing the havoc course by communicable and preventives diseases commonly affecting the rural people in the residential areas.

Furthermore, having a workable policy on CBHIS in place will ensure utilization of health care services by the rural citizenry. Binagwaho et al. (2012) argue that Mutuelles modest increase the access to preventive and curative health care services to children in Rwanda Children covered by CBHIS were between 16-29 percent more likely to get treatment from a modern health facility or trained medical personnel when they are ill. Also, they were 5-8 percent more likely to obtain treatment with oral rehydration supplements when suffering from diarrhea.

Correspondingly, Fitzpatrick et al. (2011) observe that, amongst that offspring covered by Nicaraguan mutual protection Institute's health insurance system, the extent of visits to include health suppliers improved in general by 1.3 percent visits. Encouraging effects be likewise reported by Mahal et al. (2012) in a randomized experiment "in India." The scholars propose that been assign to a subsidize out-patient insurance grouping increase the public figure of sojourns to the enclosed supplier.

Adding support to these views, Gustafsson-Wright (2013) determines the Hygia Community Health Care (HCHC) in Kwara state scheme in Nigeria increased the use of health care utilization by over 15 percent. But contrary to these findings Dercon et al. (2012) find no substantial improvement in the operation of health care services on personal comfort between insured and uninsured families in Kenya. In the same vein, bearing in mind several ways for health care utilization performance.

Studies conducted on health care utilization in SKY CBHIS program in Cambodia discover different outcome in their grades "in their appraisal." Although the number of insurance schemes is greater than before with 18 percent utilization of community

health centers, since the foremost beginning of care and reduced by 11 percent the exercise with individual suppliers and drug traffickers. The health insurance scheme was not capable of supporting ensure persons to search for care instantly after a significant health occurrence nor do it lessen the desire to relinquish health care in universal compare to the command grouping. Furthermore, the effects of conditions of anticipatory care propose that the SKY CBHIS do not induce a noticeable result on the ratio of offspring whose immunization is up to date. Also, the pregnant women receiving prenatal care, post-natal checkups with delivering services, there was no substantial impact on the percent of their health care utilization.

Besides, Sheth (2013) contrasting results regarding the provision of healthcare services, were recently obtained in her analysis of the community-based health policy program, DAN, in rural Maharashtra, India. In her findings suggest more modest health care employment in response to health impacts, either when recalling the previous year or the last month. Hence, may partially be due to the lower incidence of health shocks observed among treated villages, simply since the administration is at the community level also implies peer control, as a result of this, it's also contributing to the decrease of the unnecessary utilization of health care services among the rural people.

It has observed that because the policy on the provision of health care services to the rural dwellers through CBHIS strategy the rural dwellers are exposed to paying for health care access through their merger income. Previous studies conducted by Elgazzar et.al (2010)observed thatout-of-pocket expenses for health care have become a policy anxiety for three reasons. First, rural dwellers may be pushed into

poverty as a result of paying directly for health services. Secondly, rural dwellers facing this health payment might slash back on previous necessary family expenditure such as foodstuff and clothes and thirdly, rural dwellers may choose to forego necessary health care services rather than face the steep financial consequences thereby creating a vicious cycle of disease, disability, and poverty. Therefore, the policy process is related to the provision of health care services to the rural dwellers

Health policy makers have extended concerned with defending people from the option that disease will lead to catastrophic fiscal spending and the resulting impoverishment. For example, estimates of the proportion of out of pocket spending in Morocco indicated that as much as 41 percent of health care expenditures came from households, 74 percent in BurkinaFaso (Saurerborn et al. 1995); 55 percent in Egypt (Berman 1997), 67.2 percent in Nigeria as at 2005 (Soyibo et.al, 2009). And nearly half of all health financing in the Middle East and North American Countries comes from private household spending (Elgazzar et.al, 2010).

This predominant of households out of pocket health expenditure in health care funding suggests that socioeconomic inequities may exist in health status and the use of health care services that may create adverse consequences of disease to the rural dwellers. Thus, adequate provision of health care services will make the rural dwellers enroll in CBHIS to have more access to health care services to reduce the inequality of the supply of wellness care services in their residential areas. However, previous studies were conducted on enrollment, financial sustainability, etc. While, this study is different from the other studies done in the field of the provision of

health care services through a CBHIS establishing a relationship between policy processes with the delivery of health care services to the rural dwellers.

In conclusion, from the foregoing discussion, we can see that the policy process is related to the provision of health care services to the rural dwellers. As a result, policy process is such as a statement of actions. A set of intellectual operations, including at least setting of a gender, the requirement of options, a reliable choice among those specified alternatives or completion of a decision (Lingest, & Hanley, 1998; McGinn, Reimers, 1997; & Kingdon, 1984). Therefore, having good lay-down plans and proper course of action is essential to the successful provision of health care services of CBHIS. Regarding the process of making policies on healthcare, the state of public or government sector or politicians, bureaucrats and interest groups are playing such important role that involves many stakeholders (Hogwood, & Sikkink, 1984; Grindle & Thomas, 1991; Keck & Sikkink, 1998).

Some said the policy process as substantial challenges in the practice of policy process and politics coming from the above and the grassroots (Wagenaar and Hajer, 2003). To this, another work on the policy process, it was found out that out-of-pocket spending on health care services has become policy worry for three reasons. Rural dwellers may be pushed into poverty, rural dwellers confronting these average health costs might slash back on another necessary family spending, and rural dwellers may choose to relinquish essential medical services rather than face the sharp financial consequence (Elgazzar et.al, 2010). Thus, creating a vicious cycle of ill health, disability, and poverty is concerned with the policy process. Therefore, there is a problem of having policy making gaps on how to provide the much-needed

healthcare services through CBHIS strategy. There is the need for the policy makers to provide an enabling environment for the growth and sustainability of community health insurance in reducing the difficulties the rural dwellers face when accessing healthcare services. Thus, this thesis has accounted that the policy process is a valuable asset, and it becomes one of our independent variables.

3. 3 Economic Growth and healthcare services

Economic growth defined as efforts that seek to improve the economic well-being and quality of life for a community by creating and retaining jobs and supporting or growing incomes. Economic growth concerned with the expansion of people's rights and their similar capabilities, morbidity, nourishment, literacy, education, and other social-economic indicators (Joseph, & Ursula, 2003). It has also been argued, that Asian and European proponents of infrastructure-based development, that systematic, long-time government investments in transportation, housing, education and provision of healthcare are necessary to ensure sustainable economic growth in the emerging countries.

Since, economic growth is likely to lead families, and individuals use their heightened incomes to increase expenditure, which in turn furthers human development. While at the same time, with the increased consumption and spending, on health care services, education, etc. Also, economic growth increases private incomes that will generate additional resources that can be used to access health care services. In this study Economic growth of the rural dwellers refers to a rise in the income of the rural dwellers since they engaged in farming and petty trading.

Health is one of the most important possessions a human being has. It permits us to develop our capacities fully. If this strength wears away, or not developed totally, it can cause bodily and sensitive weakening, causing obstacles in the lives of people. The past connection can be perceived as the relationship between income and health care services. Life cycle models have elucidated how one's health status can determine future income, wealth and consumption (Lilliard & Weiss 1997; Smith 1998; Smith 1999).

As could be said every person could expect to live a long and healthy life. Its economic value is enormous, and health gains had the economic consequences of widespread economic growth and an outflow from ill-health traps in poverty (WHO, 1999). Furthermore, health problems could be reflected as reductions and obstacle for economic progress. The previous study conducted on the impact of AIDS on African economic development found that AIDS is prevalent among young workers, affecting the productivity and domestic savings rates.

Previous studies carried out by Word Health Organization, Barro, (1962) view health as a productive capital asset and engine of economic growth. Therefore, by this argument, we can see health as a determinant of human capital. Also, as argue by Grossman (1972), Canning (2000) and Hamoudi and Sachs (1999) that there is a sequence of concurrent impact on health and wealth. Therefore, the income of the rural dwellers will determine the nature and manner through which they are going to utilize healthcare services.

Through productivity gains and increase man-hours of work. Since the productivity of labor depends on factors like physical and mental capabilities. Labour productivity

could also be shortened by the need to care for sick families or by decreasing years of schooling if parents are chronically ill. Whereas, progress in health can positively affect the knowledge level of the workforce by growing their life anticipation and good health status condition. Furthermore, Malenbaum (1970) posited that health schemes could change the situations of the life of the poor rural dwellers by taking their choices and have the feeling to influence the events on their everyday activities, which often accepted them as pre –ordered.

While in a study conducted by Bloom et al. (2001) using a Solow model with human capital. Although they find that Heath capital is a significant variable for economic growth under the two stage least squares method, the key variable such money and schooling are not necessary. Therefore, the findings are questionable. While, in Latin America, Pan American Health Organization, finds a high correlation between economic growth and the regional health, estimating regressions similar to Baro's (1996) where health is much more robust than schooling (Mayer et al. 2000).

Also, Bloom and Canning (2000) argue that healthy population tend to have higher productivity due to their greater human energy and mental clearness. Further, argue by Thomas and Strauss (1998) posited that there is a relationship between health and productivity, establishing a relationship between physical productivity and some health indicators. They focus mainly on those related to particular diseases or nutrition. Furthermore, Luft (1978) give an informal explanation of this connection: a portion of people who otherwise wouldn't be poor are, just because they are sick; however, few people who otherwise would be healthy are sick because they are poor. Therefore, according to this, Bloom and Canning (2000) explain this direction of

causality with education, indicating that healthy people live more and have higher incentives to invest in their abilities since the present value of human capital formation is higher. Hence, higher education creates higher productivity and consequently, higher income. So the healthier the rural dwellers, the more their productivity increases and this will translate into making use of healthcare services adequately. If people are healthy is a good sign that they make use of their healthcare facilities promptly.

While, Economic growth results in improved nutrition, better environmental sanitation, innovations in medical technologies; all this increases the life expectancy, reduces the infant mortality rate. According to World Development Report 2007 depicts the situation is by concluding that the Average life expectation at birth worldwide increases from 51 years to 65 in less than 40 years. Likewise, Average life expectancy in the developing world was only 40 years in 1950, but this has increased to 63 years by 1990 (World Bank, 1993). Preston, (1976) and Sachs and Warner, (1997), Lee and Barro, (1994), Canning and Bloom (2000) have analyzed various determinants of life expectancy, and they emphasized that economic growth is the most important factor as far as the provision of healthcare services is concerned.

Furthermore, in another study conducted in Britain by Fogel, (1994) on the relationship between economic growth and the delivery of health care services he concludes that estimated one-third of income growth in Britain during 1790-1980 may be attributed to improvements in health facilities and better nutrition. The study

also finds that public health and medical care must be documented as a labour-enhancing technological change.

Also in another study conducted in the tropical locations on the life expectancy of the people while taking into initial account poverty, economic policy, conclude that per capita GDP of the countries having an intensive prevalence of malaria grew 1.3 percent less compared with other states. Furthermore, the study also finds that a 10 percent reduction in malaria incidence would result in a 0.3 percentage increase in the growth rate per capita GDP. Therefore, this means that an increase in economic growth will translate into having more income coming to the rural dwellers and once the income is there the rural dweller will be able to participate in CBHIS, which will serve him in providing the necessary access to health care services. Therefore, the healthier the rural dweller is the more increase in their economic activities, thereby reducing the burden of poverty among themselves.

Also, previous studies conducted on the relationship between economic growth and health care services in the developing and under developing countries. Have concluded that there exists a positive correlation between health care services and economic growth, (Bhargava et al., Mayer, Weil, Zon; Arora 2001; Bloom et al.; Scheffler & Gyimah-Brempong, 2004; Eshiobo et al. (2007).

The maintainability and suitability of the nation's economic and social growth depend mainly on the vital health care services to that country. A single channel through which health care services affect social development is by improving living conditions. As living conditions improve, it’s required that the human lifespan is going to increase and vice-versa. Verifiable data have recorded that, within poor

areas, an increase in life expectancy was strongly correlated with the growth of productivity and income.

Potent labor strength needed in developing countries that depend on primary products mainly agricultural goods, raw materials and so forth Hence; individuals can invest their best by contributing to the development and economic growth if economically empowered through health status. Therefore, CBHIS offers the rural dwellers' way out of catastrophic health care expenses and reduce the inequality of the provision of health care services in their rural communities at an agreed cost of their ability to pay for their health care needs.

According to the WHO World Health Report (1998) Poverty is the main reason babies are not vaccinated, why clean water and sanitation were not provided, why curative drugs and other treatment are unavailable and why mothers die in childbirth. It is the underlying cause of reduced life expectancy, handicap, disability, and starvation. Poverty is a real contributor to mental illness, stress, suicide, and family disintegration. Every year in the developing world 12.2 million children less than five years die most of them from causes that could be prevented for just a few US cents per child. They die mainly because of the world indifference, but most of all they die because they are poor.

The seventy percentage of the total population in Nigeria still lives in rural areas. These rural areas blessed with abundant mineral resources, most of which have not been exploited. The few whose resources appear explored are living with extensive damage to the rural setting (Agbonoga, 1998). In Nigeria over 80 % of these rural residential areas are involved in the agricultural pursuit and the bulk of them are still

using unscientific methods characterized by low output. Aloba (1998) and Akinola (1997) affirm that only a few roads in the rural areas are partially motorable during the short peak time of the dry season. Hence, this will seriously affect the removal of agricultural production to urban centers.

As per World Health Report (2005), forty-four states of the WHO African Region used not exactly 15% of their annual national budget on health; 29 national governments used less than $10.00 for every individual for every year. Half of the sum consumption on health in 24 nations hails from government sources. The prepaid health financing instruments incorporate just a little extent of communities in the Region; privately using constituted over 40% of the sum use of healthcare services in 31 nations; guide out-of-pocket consumptions constitute half of the sole health use in 38 countries. The provision of healthcare services will be affected because the government that is supposed to provide these health care facilities are not provided because of the decrease government spending on health care.

Nevertheless, a thoughtful part of the literature on the microeconomics of health and economic outcomes examines the effects of varying health inputs on health outcomes themselves, human capital attributes that are contingent on health outcomes, and reward. Most of these studies have relied on micro-level data that focus on household and family members of the rural inhabitants. Such studies include Deolalikar and Behrman (1988) and Thomas and Strauss (1998). In many studies, more than one of these groups of the dependent variable is tested.

For example, Alderman et al. (2006) analyzed the long –range effects of child nutrition, utilizing a mixture of natural and man-made experiments that provide

exogenous variation in food, and found that better nutrition leads to improvement in school completion, the intelligent quotient (IQ), altitude, and reward. Likewise, Thomas et al. (2004) found positive effects of adult nutrition on labor input and reward. Therefore, improvement in the provision of health care services has an impact on the economic growth of the people. Hence, on that point is a significant relationship between the health of the rural dwellers and their economic actions for the provision of healthcare services.

On the other hand, previous studies on the relationship between economic growth and health care services reveal that at the macro level is inconclusive (Mitra & Gupter, 2003; World Bank, 2004). Surveys conducted in 15 states of India for the period of 1973/1974, 1977/1978, 1983, 1987/1988, and 1999/2000, Mitra and Gupter (2003) reveals that the per capita public health expenses positively influence the health condition of the rural dwellers. Which poverty goes down with more expert medical services, and that growth and health have a positive two-way relationship.

Also, in a similar study in India, the World Bank (2004) investigates the impact of per capita GDP. The findings from the study reveal that both per capita public spending on health per capita GDP inversely related to infant mortality rate, but the results were observed not to be very robust to alternative specification of the model.

Thus, by using the adult survival rate as a pointer of health status, Bhargava, et al. (2001) finds positive relationships between adult survival rate and economic growth among the rural inhabitants. Also, the results remain comparable when life expectancy replaces the adult survival rate. Hence, the fertility rate has a negative relationship with economic growth.

In the same vein, Heshmati (2001) studied the relation between the provision of healthcare services expenditures and gross domestic product in research through the generalized Solow model. He inserted healthcare services expenditure as the variable representative of health status in the growth function. Then he concluded that health costs make the impact of human capital on the economic growth insignificant.

Referable to the fact that growth in the workforce extremely influences life expectancy is mostly lower than population growth. As a result, a high fertility rate reduces the economic growth by putting the burden on the scarce resources of the rural dwellers. Therefore, the fact that the rural dwellers value having more population in their families does not mean that these rural households will suffer because the larger the family is, the more advantage they have in term of their farming capability. And so this will increase their expected yield in their farms and more income for the family by such also, this will enable the rural dwellers to enroll in CBHIS and can also be able to pay their premium as when due.

In Nigeria, most of the previous studies have related growth to poverty while omitting the human resources (both regarding education and health). Some of such recent studies include Addison and Wodon (2007), Aigbokhan, Ali (2000), Amaghionyeodiwe and Osinubi (2004). While there is any doubt that a possible relationship between health and economic growth could exist, a primary reason it's hard to reach a definitive conclusion regarding the link in the web of interrelationships that involved in the willpower of a nation’s income.

Good health is crucial in an economy, so also other factors such as investment and trade, etc. Therefore, commerce and investment will only flourish if the population is

healthy. And since most of the health care service facilities are located in the urban areas and not in the countryside. Therefore, the only way out to reduce this inequality in the provision of these most needed health care service is through the rural dwellers participation in CBHIS which will be located and managed by the rural dwellers themselves. So having CBHIS in the rural areas will inevitably reduce this major hindrance in accessing health care by the majority of Sokoto state and Nigerian population, in general.

Healthy employees work better and more than others and have a curative and more prepared mind. Besides, this direct impact health has indirect impacts on production as well. For instance, health improvement in the human force will be followed by the motivation to continue education and obtain better skills. For enhancement of health conditions will increase investment attraction in education and educational opportunities from one side, and will prepare the individuals to continue education and obtain more skills by enhancement of learning ability from the other side. Correspondingly, improvement of health and health indexes in the society will encourage individuals towards more saving through a reduction of mortality and increasing of life anticipation.

Following increased saving in the societal, physical capital is enhanced, and this issue will be active in directly on labor force productivity and economic growth (Weil. 2005). Through the services that the CBHIS will provide to the rural dwellers regarding their general health care services at a reasonable cost, where the women and children will be adequately taken care of will inevitably reduce the impact of the health care services inequality present in the rural areas.

Health is to provide total physical, emotional and social welfare that its meaning is not limited to just lack of disease realization or disfigure. But rather it includes three axes of the body, spirit and the society and thus any leak and damage that are incurred for each of these three axes will disturb the rural dwellers balance and is resulting in a lack of health. Everyone knows the importance of health as an essential right for life. Therefore, according to Amartya Sen, health is a kind of empowerment that gives value to human life. It will lead to individual growth capacity and economic security for the persons and rural families (Asefzade, 2008). Hence, the importance of having a healthy population cannot be played with because without health any human activity will be possible without having a vibrant and healthy society.

For the rural dwellers to actively participate in CBHIS their income matters, therefore, revenue is recognized as the most important factor determines the ability of the rural dwellers to enroll in CBHIS. Income determines the health status, and there is a usually high correlation between low income and hygienic poverty. Researchers have established that deterioration of the financial condition is leading to increased rates of disease and death in the rural communities.

Hence, the reverse relationship between the poor rural dwellers health and income level of the rural communities is real when different criterion like mortality, kind of dangerous diseases and degree of using health services and hospital admission are used to measure the health status of the rural dwellers except in exceptional cases. It is clear that access to sufficient income is the precondition to have access to other

factors determining health such as nutrition, housing and education and this issue doubles its significance (Javadipour & Mojitahed, 2005).

Substantiation shows that the amount of mortality, disease and injury rate are more prevalent among the rural dwellers than the society's everyday living in the urban areas. Therefore, it is perceived investment to improve the health status of the rural dwellers seems too necessary, through having a functional CBHIS among the rural dweller communities. Additionally, the evidence confirmed that relative poverty like abstract has a close relationship with ill health and studies which show the relationship between (relative) poverty and health status have been talented in more developed countries. Hence, since poverty impedes the rural dwellers from total participation in economic and social activities, it appears that the best way to remove the impacts of poverty on the health status of the rural dwellers is fighting with the poverty (Byrne, 2003).

More than a little evidence indicates that there is a high correlation between job and income level of individuals having a license. What is more, the existence of poor life conditions at the beginning of life will decrease the possibility of achieving higher scientific degrees (Javadipour & Mojitahed, 2005). Those individuals and societies that have a tertiary education level and enjoy a higher knowledge level will certainly pay more attention to observing health and set up suitable healthcare facilities. Such as CBHIS for themselves and their surrounding environment based on their learning and perceived importance of keeping physical and mental health care services (Rosen, 1982).

For the reason, that educational and technical degree are not misplaced indifferent to another officer, efficient shared components on health they would have a substantial impact on the rural dwellers health conditions so as the children with suitable education will most likely have a more healthy taste for existence in maturity. Notably, they observe security and work health issues more in working period. Evidently, there exists a positive and significant relationship between education level and health level of the rural dwellers. Although, school provide the opportunity of getting employment and earnings for the rural dwellers other for a different feature and might have an effect on the health level throughout this (Pedrick, 2001).

With an education, the rural dwellers will be able to appreciate to solve the equality of the provision of health care services in their rural communities and will be very easy for the initiators of CBHIS mobilize them adequately. And also if the rural dwellers were educated they will be able to provide job opportunities for themselves and by so doing they are empowering themselves economically.

Economic growth needs not only healthy people but also education and other additional investments, the proportion of the labor force in the private and public sectors, active and reasonable market, sufficient autonomy and institutional mechanisms of the communities are the primary factors of the technical advancements. The growth resulted from the profitable private sector must be completed by the activity of the government in various scopes such as supplying investment in health and education, ensuring the realization of rules and regulations and providing security and collaboration with the private sector for technical and scientific improvement. Of course, we can't claim that investment in the health

sector can solve the issues of development rather an investment in this sector should be in the central section of overall development and poverty eradication strategy for the rural dwellers. (Saches, 2001).

According to Currais and Rivera (1999) they revealed that those countries are having more health expenditures per capita had higher economic growth. Hence, health care expenditures per capita in their study were used as an index for the health of the rural communities. They estimated the relationship between health care services and growth of OCED member states in the period 1960 – 1990 using health spending as an eloquent variable and an index for the health in the growth regression. Furthermore, they considered an investment in health care as a particular variable for the output. Analysis of the health investment in the human capital build-up were referred in their study, and they have shown that education is not the only substantial factor in the labor force performance and its efficiency. Furthermore, in the same vein Canning and Bloom (2000) performs estimations based on various conducted researches about the developing countries. Their general conclusion is that in countries in which life expectancy is higher for a five-year growth rate of real income per capita is higher about 0.3 percent to 0.5 percent. They studied the impact of health on productivity from four ways: A better labor force grows more since it has more mental and physical capability and wants less in his workplace due to his illness or of his kinfolk. People with high life anticipation have more incentive for the asset in education and hold a high return on such savings. Rising individuals' age augments the measure of savings (for a retirement period) because of health enhancement and, as a result, investment procedure will help. And Health improvement in the course of advancing life and health care of children might be an

inspiration to reduce saturation; accordingly, persons partake more in the scheme market and acquire high income per capita.

Consequently, Canning along with Bloom measured the domestic production as a role of its inputs, for example, substantial capital, labor strength and individual assets using three essentials of education, labor skill, and health care. Therefore, the main result is that health care services have a substantial impact on economic growth. Thus, it means that one-year increase in life expectancy steered to 4 percent increase in national production and showed that increasing of cost to improve health is fair by the impact that it has on the productivity of the labor force. As a result, having CBHIS in place among the rural dwellers will boost their health care services by making access to health care available and within easy reach and thereby enhancing the economy of the rural dwellers by reducing their out-of-pocket spending whenever, they want to access health care services.

While, Bloom et al. (2004) regarding the impact of life expectancy besides other variables (labor force experience, physical capital, inventory, labor strength and average academic years) on economic growth confirmed this relationship too. His major finding of the study is that health has an important impact on economic growth so that rising of one year of the society's life expectancy is fixed to increase national product equivalent to 4 percent. The affirmative and high impact of health on efficiency and economic growth might give a good reason for growing of health spending and enhancement of health standing in the rural communities.

Therefore, any rural community that has a healthy population will surely prosper economically. Hence, the rural dwellers can be able to pay their premium regularly

as when due without any failures and the enrollment into the CBHIS is going to be large, thereby having more contributions which make CBHIS more viable and factions well.

In line with the above scholar, Mojitahed and Javadipour (2006) studied the impact of health expenditures on economic growth in the form of the case study of the selected developing countries as well as Iran. The practical statistical population consists of thirty-three developing countries in the period 1990- 1998. They examine the impact of healthcare on economic growth through widespread Solow's model and using inter-country move towards and panel data model. Their findings demonstrate that in adding to human capital, health capital that is specific to health care variable has a positive and significant impact on the economic growth.

Furthermore, from side to recent side tests they have revealed that the economic expansion inflates healthcare expenditure variable and encompass worried the point that the viewpoint that involves the dilemma of being short of substantial money as the most essential confront of emerging nation state in the course of expansion and growth discarded. Indifferent to the recent move towards that introduces human capital include education and health as the structure chunk of enlargement and growth established.

According to Taghavi and Mohammadi (2007) they analyzed the impact of the human capital index on economic expansion in Iran in a study entitled impact of human capital on Iran's economic growth during the years 1960- 2003. They confirmed the positive impact of these variables on economic growth using different indexes like percentage of knowledgeable individuals in the country as well as

average academic years of the labor force. Further, they also emphasized that importance of asset in the labor force is not less than economic plans and is one of the reasons for speculation failure in the country, lack of knowledge of the role and importance of human force in the growth and development process. Therefore, without having a healthy population, there wouldn't be any meaningful growth or development.

In line with Taghavi and Mohammadi (2009) Salmani and Mohammadi's about studying the impact of government healthcare expenditures on economic development in Iran tests the impact of government health expenditures as an index of health on Iran's economic development. They used Augmented Aggregate Production Function (APF) Growth Model on the footing of the growth accounting approach. The foundation of this model is a production function opinion move towards in growth accounting strategy during the period 1972- 2003. The outcome of this study supports the survival of an active association among the government's health spending and economic growth. Likewise, the survival of a long-term association and union relation in the middle of the government's health care spending per capita, previous variables of the model and economic expansion has been sustained. Furthermore,

Consequently, it's clear that for the rural dwellers to be able to participate actively in CBHIS a lot has to be done on enhancing their economic activities. In term of their income and also by educating them and mobilizing them on the need for them to enroll into CBHIS so that they will be able to reduce the inequality of the provision of the various health care services that they lack in their rural communities. And the

government should intensify effort in alleviating poverty among the rural dwellers by providing programs that will boost their economic activities or by providing basic infrastructures within their locality.

As participating in CBHIS, entails payment of agreed premium regularly the rural dwellers need to be economically capable. Since their primary occupation is farming the government and private investors, need to come in, providing the much needed modern way of farming and providing them with high-yielding crop seeds at an affordable price within their reach. Hence, this can as well boost their agriculture and have more income coming to them as a result of this enhancement by the government and private investors.

As it has been established there is a positive and significant relationship amid healthcare services and economic growth of the rural dwellers, you cannot have a vibrant, economically vibrant community without good health while you cannot have good health without a sound economy, they go hand in hard. One cannot be without another.

From the foregoing it's clear that there is a relationship between the provision of health care services and economic growth because there will be no economic growth without being healthy as most of the rural dwellers are engaged in farming, petty trading and many are even without jobs. Being healthy is very paramount because if a rural dweller is sick or any member of his family this will affect his productivity, whether he is a farmer or a trader and this will further put pressure on his meager resources to access health care elsewhere as this will have an impact on his household expenses. Therefore, it's important that the rural dwellers are healthy it's

only when they are healthy that they can be able to concentrate on their farming or trading, thereby increasing their economic growth whereby they will be able to have more resources to take care of their basic needs that include health and other social amenities.

Since, belonging to CBHIS entails paying regular premium from to time depending on what the rural dwellers are willing to pay. And they can only pay when they have the means of paying. And for them to be in a position to do that they need to be healthy, and that is what CBHIS stand for, that is providing affordable and accessible health care to the rural dwellers without resorting to paying through out-of-pocket which in most cases push the rural dwellers into catastrophic health care expenses.

Therefore, economic growth is related to health care services, because with CBHIS health care service is provided and as such the rural dwellers health access will be enhanced. Hence, boosting the economy of any community requires the populations to be in good health it's only then that there will be economic growth. The rural dwellers can only participate in CBHIS if they have the means to pay the premium, as the sustainability of CBHIS depends on premium as the primary sources of revenue through which the provision of health care services is reliant on with.

Hence, with the support of Sokoto state government in boosting the economic activities of the rural dwellers who are mostly farmers and traders in joining CBHIS and having access to basic health care at an affordable cost and within their reach. Therefore, an increase in rural dwellers' income will determine the way and manner they access health care services. Thereby, reducing the burden of poverty among the

rural dwellers. Hence, the importance of having a healthy population cannot be played with because without health any human activity will be possible.

In conclusion, in our preceding discussion, we can see that the economic growth of any nation is vital to its general wellbeing and development. And therefore, there is a relationship between economic growth on the impact of the provision of health care services among the rural dwellers (World Development Report, 2007). For example, the average life expectation at birth worldwide increases from 51 years to 65 in less than about 40 years. Also, the average life expectancy in the developing world was only 40 years in 1950, but this has increased to 63 years by 1990 (World Bank, 1993).

Furthermore, Gallup and Sachs (2002) conclude that per capita GDP of the countries having a reduced occurrence of malaria grow 1.3 percent fewer compared with other states. Thus, the study also finds that a 10 percent decrease in malaria incidence would result in a 0.3 percent increase in the increase rate per capita GDP. Regarding the relation between wellness and economic growth as health, it is necessary because it is effective, for a higher labor force for the initiation and sustenance of the nation's wealth (Bhargava et al., 2001 & Bloom et al., (2007). Therefore, for the rural dwellers to participate in CBHIS they need to have the means as enrolling in CBHIS requires paying premiums regularly for the sustainability of CBHIS. With economic growth, the impact of health on output from four different ways. A better workforce produces better productivity, persons with high life anticipation have more incentive for the asset in education, some investments are greater than the previous time, and

health improvement such as health care of children that all might be an incentive to reduce fertilization (Bloom, 2000).

In the foregoing findings clearly shown that the influence of economic growth is related to the provision of health care services through the establishment of CBHIS among the rural dwellers is a significant value. Hence, this thesis then accounted it as one of its independent variables.

3.4 Scheme Design and Healthcare Services

Scheme design is concerned with the how health care services programs are developed and sustained to provide the much-needed healthcare services to the rural dwellers with the view to reduce their inaccessibility to health care services. The Nigerian health care services have suffered several downfalls (HERFON, 2010; Asangansi & Shaguy, 2009). Despite Nigerians strategic position in Africa, the country is greatly underserved in the health care sphere. The provision of healthcare facilities (health center, personnel, and medical equipment) is inadequate in Nigeria, especially in the rural areas (HERFON, 2010). The rural dwellers who are in the majority in Nigeria are facing serious problems regarding access to healthcare services in their communities. They obtain health care services through out-of-pocket because they lack any form of health insurance scheme. Therefore, to solve this problem, community-based health insurance scheme remains their best option, CBHIS can reduce their inaccessibility to health care services through designing an insurance program that is community-based. The principle of insurance is sharing the risk by pooling assets from the contributions of the enrollees to provide health care

services to the sick once. Health insurance mechanism is well-known in the developed nations and regularly used for apportioning health care and funding.

In that respect are serious contentions for an overall capacity of health protection that might be passed on about by required enrollment, this sort of health protection was not suitable for an environment anywhere most individuals are either informal sector workers, independently employed (Creese & Bennett 1997). Rather than social welfare actualized in Germany, current development in health insurance schemes in Africa have engaged the type of neighborhood openings of a rather less size insurance scheme that are a community built with unpaid enlistment.

They started by NGOs, health amenities, cooperatives or nearby local residential areas and might be claimed and run by any of these associations to provide health care services to the rural dwellers (Atim 1998, & Criel 1998b).

A rapid appreciation of health care costs that is not harmonized by an increment in the scheme's fund is a serious risk to its financial feasibility. The initiators of the scheme can prevent this problem to a significant level by learning into account common insurance-related problems when the CBHIS are designed. Foremost, the benefits package should be affordable and include essential services modified to the health care services needs and preferences of the rural inhabitants. Though health insurance funds can replace public subsidies and outside support only to a limited extent in low-income countries, thus, the real costs of the health care services provided through community health should systematically be taken into account when the premium is considered (Musau, 1999).

Furthermore, the problem knows as moral hazard should be well thought-out: as insurance lowers the price of upkeep at the level of use and gets rid of barriers to access to health care, the use of wellness care services will increase (Manning et al. 1987). Nevertheless, health care costs may rise far more quickly than the resources mobilized through payment of premiums, an event that can quickly put at risk the scheme's financial capability.

Hence, any pre-payment method like fee-for-service repayment give incentives for the supplying of the avoidable and expensive treatment to the insured rural dwellers (McGuire et al. 1989). These sorts of effort can be solved by a suitable provider payment method and by imposing small co-payments at the point of healthcare utilize by the rural dwellers (Criel 1998b; Musau, 1999; Bennett & Creese, 1997; Criel, 1998b). So, when designing CBHIS care should be contracted to check and obtain the acceptable way of dealing with this moral hazard among the CBHIS enrollees.

Also, CBHIS or voluntary insurance is prone to the so-called adverse selection problem: here the rural dwellers most likely to participate in CBHIS are high- risk people such as those that are seriously sick, who await a great demand for healthcare services. Due to this self-selection, the claims made to the CBHIS will go beyond its revenues by far if premiums are based on the average risks in the rural residential communities. At the same time, the consequence is that the premiums paid by the rural dwellers into the system would have to be elevated. And the insured rural dwellers with a relatively lower health risk than other enrollees would drop out of the CBHIS, and thereby would, therefore, increase the payment of the health care cost

per insured enrollees (Lewis & Chollet, 1997). And this withdrawal will affect the provision of these needed health care services because of lack of patronage on the part of the rural dwellers.

So, to prevent CBHIS market failure caused by adverse selection, that the rural dwellers should be asked to join as groups, e.g., that all family members are enrolled into CBHIS, making sure that membership composed of both sound and sick rural dwellers. Likewise, waiting period should be introduced to forbid people from joining just after they have fallen ill (Musau, 1999). An evaluation of the Community Health Fund in rural Tanzania (Musau, 1999) found that 52 percent of the sample members of rural dwellers reported, at least, one individual suffering from chronic disease. But as only 6 percent of the target rural population was insured and premiums pooled with revenues from user fees paid by the non-insured (Musau, 1999). Also, the impact of adverse selection was also a problem during the initial stage of CBHIS implementation to provide health care services for the Masisi Health District scheme in the Democratic Republic of Congo.

At the beginning phase, the subscription took place on an individual basis, and pregnant women preferentially chose the insurance option. After the house have been defined as a unit of membership in the second year, the proportions of pregnancy-associated health problems among hospital admissions dropped because of the lack of adequate health care services (Criel, 1998b).

Furthermore, since CBHIS are normally of little size and cover only a circumscribed area of health care making them especially expose to covariant risks. A rural dweller risk of falling ill is correlated, particularly in examples where natural calamity or

epidemics hit a certain area or a small town. The fact that such devastating events can quickly bring down the financial reserves of the CBHIS. Therefore, there is the need to call for a public-private partnership where possible either in the form of reinsurance contracts with private insurance organizations or as an accord with the public institutions that will offer subsidies to minimize in providing the much-needed health care services (Jutting, 1999).

Thus, in that respect is the need for involving other people or organization that is genuinely quick to serve so that the CBHIS financing made available for the pooling of premiums are always not just because of the lower premium paid by the rural dwellers. And sometimes the number of enrollees is relatively small, this will affect the type of care given to the rural dwellers and the quality too.

Some other significant issue is that the degree of rural dwellers community involvement in the planning and managing of the CBHIS can vary widely. And is usually larger if funds are owned and overseen by the members of CBHIS themselves than if CBHIS run by the health amenities in their rural dwellers (Garba, & Cyr, 1998). Hence, if the rural dwellers can identify themselves with their systems because they hold the finances and have decision-making power, the rural dwellers will tend less to the unnecessary use of health care services (moral hazard). By introducing a waiting period of three months after registration by the enrollees will reduce these moral hazard effects on the provision of health care services.

Thus, high rural dwellers community participation can facilitate health education and sensitization of the rural dwellers to encourage healthy behavior and utilization of preventive health care services, as the rural dwellers share a mutual stake in making

sure that the costs of health maintenance are low. According to Garba and Cyr, (1998), the rural dwellers of a self-governed CBHIS comprising several communities in the Republic of Benin realized that many examples of sickness and a considerable amount of the health care costs reimbursed by the scheme developed from one community. Hence, the CBHIS members of that community together with a nurse organized sensitization sessions on good hygiene, water and encouraging vaccination among the rural families. Furthermore, the rural inhabitants of the Kisiizi Hospital Health Society in Uganda cited health education on preventive medication as one of the primary benefits of the CBHIS among their rural people. (Musau, 1999).

In that respect are some factors that contribute to success or failure of the provision of health care services related to health care providers. For example, the health maintenance facility that will provide services to the insured the way and manner they provide wellness care will have an impact on mobilizing the demand for CBHIS likewise on the financial equilibrium of the CBHIS. Hence, it's very necessary to make sure that quality health maintenance services provided to the people. And that the health personnel sensitized on the need to change their attitude towards their patients while they are seeking for health care services as, if not it will have an impact on the healthcare utilization of the rural dwellers.

As if no payment charged for the use of health care, no incentive for joining an insurance scheme exists, except if the rural consumers will take the chance to press for quality improvement or an expansion of the health care services if they bring up additional resources. So, if user fees are high, probably not many people will be willing to contribute to the provision of health care services through community

efforts. CBHIS were frequently initiated because health care fees are so high that large rural dwellers could not afford them, and consequently, their admission to health care utilization rates will decline (Creese & Bennett1997). There is the need for the CBHIS initiators consider the amount the rural dwellers can afford to pay regularly before fixing the premium. As their ability to use the health care services depend on their capacity to pay through these health insurance mechanisms.

Besides the quality of the health concern that will be offered to the rural dweller has to be of better quality. As it will not be possible to put up a feasible CBHIS and rally demand before the value of maintenance is not improved, because if the rural dwellers feel that they will receive no value for money at the health care facility, they will be unwilling to pay up their agreed premiums. Hence, it's very significant for the CBHIS to make sure that quality care provided which include providing qualified health personnel, adequate provision of drugs, cleanliness of the health facility, and the security of the installation is very essential. Therefore, such issues have to be provided first, and the quality improvement should not be certain as a matter of resource mobilization via CBHIS. Hence, this has been considered as a requirement for the successful preparation and realization of CBHIS among the rural inhabitants providing health care services to reduce the inequality that exists before the introduction of CBHIS.

In reality, the concept of CBHIS was at first misunderstood at Kisiizi Hospital in Uganda. Where insured rural dwellers were seen as nuisances by the medical staff because they did not conform to the standard procedure or even viewed as people who were not paying their way as they did not pay fees at the level of usage.

Consequently, the more staff sensitization was carried out to change these misconceptions about the CBHIS rural dwellers by the health care professionals. (McGaugh, 1999).

With the prevailing widespread poverty among the possible rural dwellers can be a severe hindrance to the successful implementation of the CBHIS. In a state of affairs where the rural dwellers are stressed to make it every day, they will be less willing to pay a CBHIS premium in advance to use health care services at the next spot in time. The position where the majority of the rural dwellers finds it difficult to afford CBHIS membership fees even, calls for providing subsidies to some of these poor rural dwellers so that they are not excluded from accessing health care services.

Here, the Sokoto state government can do more in this direction by providing subsidies to the poorest rural dwellers and the indigent, children under the age of 5 years and the pregnant mothers. For instance, a buoyant local economy has been named as one of the fundamentals leading to the success of the Bwamanda CBHIS in Zaire. That reached a coverage rate of approximately 60 percent of the target rural dwellers and the CBHIS achieved recovery of approximately 80 percent of the hospital's operating costs and this has increased their health care service utilization (Bennett, Creese, 1997; & Criel 1998b).

Furthermore, previous studies conducted on cultural habits play a significant role in the designing a successful CBHIS among the rural inhabitants. In delivery for the risk of illness, culture can manipulate the requirement for participation in CBHIS among the rural dwellers. For example, in the Republic of Benin, the rural dwellers are used to keep money aside for anticipating the events like funerals, and spousal

relationships while the rural dwellers in Benin believed that laying aside money for eventual health care costs meant wishing oneself to be disturbed. Luckily, this attitude change after a CBHIS had come into existence because they have seen that the provision of health care services has appreciated tremendously in their community (Garba & Cry 1998).

Hence, the rural dwellers will need to be educated not to think of participating in health insurance as one is wishing himself to be sick, but rather to reduce the suffering that the rural dwellers face anytime they desire to access health care. Consequently, before designing the CBHIS intensive sensitization is vital for the success of CBHIS among the rural inhabitants in providing healthcare services.

In Sokoto state, a lot of sensitization embarked upon by the state government through mass media, using local town crier, and also through open public mobilization about the advantages of belonging to CBHIS as being a member of this program will inevitably reduce the inequality of accessing health care by the rural dwellers. As a result of this sensitization on the importance of CBHIS, it has significantly improved the provision of health care services.

Nevertheless, if solidarity is strong, the rural dwellers will not bother much if the benefits of the premium they paid will accrue to themselves or other rural inhabitants in the residential areas. For instance, in another study conducted in Bwamanda CBHIS in Zaire, the rural residents in this scheme expressed their opinion that if they would not use the health care services themselves, at least, they had made out something right for their rural community by giving to the insurance fund (Criel 1998b). So, it's vital in designing CBHIS to take cognizance of the degree of

solidarity and shared faith that exist among the rural dwellers. Because mutual trust and solidarity are higher in homogeneous, close-knit rural communities than in scattered and diverse rural populations comprising rural dwellers of different ethnic descent, culture or religion as this can have effects on the rural dwellers health care service utilization (Bennett & Creese, 1997).

It is likewise significant to acknowledge the existing traditional institutions of mutual service and risk-sharing can on one hand, facilitate the successful CBHIS design and execution. Because health insurance will be built upon these groups, as has being done with Engozi societies in Uganda by Kisiizi Hospital Health Society (Gilson, 1998 & Musau, 1999). For better result the initiators and managers of CBHIS to do meeting of rural community sensitization about the several advantages of CBHIS to the rural dwellers. And also, to pay more attention to the rural dwellers satisfaction, preferences and perceptions about health insurance and the provision of health care services because these are essential elements for any successful design and implementation of CBHIS among the rural inhabitants.

The sustainability of a CBHIS to provide health care services somewhat depends on outside factors that can barely be influenced by the scheme such as a Nigerian legal and policy framework (Criel, 1998b). But, however, the function of the organization and its functioning, as well as community support, are vital factors of sustainability. The best size of a system to ensure sustainability and adequate risk pooling and possible threshold levels of membership needed to realize substantial savings on the scale are not yet known (Debaig, & CIDR, 1999). In that respect, there are no any

general rules for the minimum size can be given either because the proper size of the risk pool mostly depends on the value and nature of risks between the insured.

The recent addition to health maintenance costs that are not met by an increment in the scheme's trust is a genuine risk to its financial reasonability. The initiators of the scheme can forestall this issue to a considerable degree by perusing into record general protection related issues when the CBHIS is recommended. The profit programming framework might as well incorporate essential services towards health awareness necessities and should be affordable to the masses. While health insurance funds can supplant public subsidies and outside help just to a constrained degree in low-pay nations, the real expenses of the health profit bundle ought to consider when the premium is assessed (Musau, 1999).

Furthermore, the issue regarded as ethical riches ought to be carried into thought. As an insurance scheme brings down the expense of medical health care services for the purpose of gaining entrance to social insurance and uproots hindrances to obtaining access to, utilization of wellness facilities will expand (Manning et al. 1987). Furthermore, health care services expenses may develop significantly more quickly than assets activated through premiums an impact that can rapidly undermine the insurance program in providing health care services.

Community-based health insurance is a guaranteeing latest instrument, used to provide better health care services for country individuals in low-income nations, especially in SSA (Creese, & Bennett, 1997). It is established that there are four well-identifiable types of community-based health care financing schemes in the developing countries. There are community-managed user-fees; here resource

mobilization relies mainly on out-of-pocket payments at the point of contact with providers, but the members of the community are actively engaging in creating these fees and taking off their collections, pooling, and distribution of the trusts prepared like this in paying for the healthcare access. In neighborhood supplier based health protection, suppliers serving a particular group gets the prepayments theirs.

In community health fund or revolving reserve, the community gesture as executor to arrive in rural and deprived communities to provide healthcare services for the benefit of the official state or social health protection framework through contracts or plans. While, in community-based prepayment schemes, the community gathers, premium ahead of the time of medication and after that deal with these resources in paying the providers of health care services.

In designing the insurance scheme for the rural dwellers, the members of the communities will be involved as their endorsement is essential to the success of the scheme. So that at the end of the day the poor rural dwellers will not be exposed to the catastrophic expenses that in most of the time make them more wretched. And also with CBHIS the inequality of the provision of the health facilities of the body politic in the rural areas will drastically reduce most especially when treating for minor or common diseases.

According to Kouyate B, Sanou M, Mugisha F et al. Dong H, Sauerborn R, (2004), said the emphasis should be placed on the price of health care services and likewise determination of the benefits package. While, this is an important issue in the establishing health insurance scheme, for providing health care services the stakeholders have to agree on the coast of services that are going to be delivered and

what type of package will be included as far as health care is concerned. A recent study in The Chad Republic has indicated that gain access to community-based protection system can help to moderate hazard. Even though, this was particularly significant in regions where risk markets do not exist, and open projects are not made accessible or available (Weinberger & Jutting 2000).

Prepaid plans are continuously hailed universally as a component of health care services, financing, and outline in low-wage nations (Bennett 2004; & Schneider 2004). However, scholars have put up a bit of opening with such frameworks that toss the question on their suitability. What's more such issues are exclusively insufficient and those in need of health maintenance and also the purpose of individual coverage (Ekman 2004; Jutting 2004; Murthy, & Klugman, 2004). The absence of limits by the scheme heads to oversee strategy and arrange with providers for better quality care (Bennet et al. 1998; & Derrienic et al. 2005); and stresses by rural dwellers if their commitments to the scheme will be used for their profit in accessing health care services (Murdoch, 1995).

In Nigeria, people don't have any more trust for the insurance companies because of their past encounters most especially. As a result, of the bad experiences, people have about the insurance industry in Nigeria. So for the rural dwellers have confidence in participating in any insurance scheme they will have to be sensitized that this time around they are the once that will be in charge of their program, since this program is directly their own which will be managed by themselves to provide health care services. The call for UHC by WHO of all well-meaning people is achievable if people are adequately sensitized.

The essential component of worldwide health coverage (UHC) should include payment mechanism and that it supports risk pooling, and this guarantee the rapid increase of risk throughout individuals in the rural communities.The word UHC does not mean a particular health system business as it can include both the national health systems, i.e. National health insurance model Funded and manage by the state while the SHI are funded through the contribution of employers and the employees.

According to these scholars, this program is suitable for countries that have a large number of enrollee's bosses in the SHI base with an efficiency of funds administrations (Usoroh, 2012). Third, while the purpose of risk pooling and prepayment is CBHIS. Which is frequently named as health insurance scheme in the informal sector, mutual health insurance, or micro-health insurance, etc. Hence it is only CBHIS that share the three general features: namely not-for-profit prepayment plan, voluntary registration and community empowerment. Therefore, many Asian nations like Thailand, Colombia and SSA use this kind of design because the risk pooling and savings schemes create enabling conditions for the program to provide health care services to the rural communities (Usoroh, 2012).

In another study conducted in Tanzania, Shaw, (2002) posited that Tanzania community health fund experience low enrollment rate of the target group after more than ten years of process, which at 10 percent falls far short of the 70 percent stake visualized via the organizers. And reason given for this low enrollment is as a result of the complete inability to pay enrollment obligations. Dissatisfaction around the residential areas to see the requirement for protecting against the risk of disease, inadequate quality of health care services and absence of trusts in CHF

administrators to provide these health care services have been emphasized in their findings (Kapinga, Kiwara 1999; Chee, 2002; Shaw, 2002; & URT 2003).

In Africa, the salary-based social insurance, and private health insurance have had a very limited impact because they failed to cover the informal sector. The majority of the rural dwellers and those that are self-employed are not having any form of social security; that is why the need to design and implement CBHIS among the rural dwellers to reduce the wide gap of the stipulation of health care services and to reduce the high rate of out-of-pocket health care expenses. The discussion about the potential of CBHIS to improve the provision of healthcare services and access to social protection is still ongoing while many CBHIS have been emerging during the nineties to date in the rural and urban areas of the Sub-Saharan Africa.

Despite the fact that, health insurance is a new idea largely inspired by European past and random values, this does in no way prevent its acceptance by the rural dwellers. Acknowledged the sole lingual, ethnic, and cultural diversity within the African countries. Therefore, the CBHIS approach may be particularly promising for this continent because it's the strategy of providing the rural communities with health care services based on their needs and aspiration.

Furthermore, the running of a CBHIS requires a not clearly defined to have a minimum of knowledge of organizational capacity within the rural communities as well as based on the reason organization of health care provisions among the rural dwellers. These fundamentals seem to be lacking in many CBHIS in the Sub-Saharan Africa (Criel 1998a). Consequently, the actual designing and implementation of CBHIS to provide health care services to the rural communities has had mixed

results so far. With success and ability widely depending on the design and organization of the CBHIS, quality of health care services, community involvement, regulations on the level of health care provider, and on the socioeconomic and cultural situation.

In conclusion, from our foregoing discussion, we can see that scheme design through CBHIS is necessary for the provision of health care services to the rural dwellers. According to the work of Musau (1999) and Manning et al. (1987), they concluded that health insurance funds can replace public subsidies. The real costs of the health care services should be taken into account when the premium are considered. In this matter, however, Lewis and Chollet (1997) argue that CBHIS or voluntary insurance is prone to the so-called adverse selection problem. For example, all family members are enrolled into CBHIS, making sure that membership composed of both sound and sick rural dwellers. Regarding rural dwellers, Criel (1998b) found that if solidarity is strong, the rural dwellers will not bother much if the benefits of the premium they paid will accrue to themselves or other rural inhabitants in the residential areas. However, the scheme design is also related to ethnicity and cultures too. It has been found that when designing CBHIS to take cognizance of the degree of solidarity and shared faith that exist among the rural dwellers is significant because mutual trust and solidarity is higher in homogeneous, close-knit rural communities than in scattered and diverse rural populations that are comprising rural dwellers of different ethnic descent, culture or religion as these will have impact on their health care service utilization (Bennett & Creese, 1997). Thus, this thesis has accounted that the scheme design factor is paramount and adopted as one of the independent variables of the thesis.

3.5 Mobilization and Healthcare Services

The concept of "community" is universal and varies by discipline (e.g., Public health, psychology, sociology) and by an emphasis on prevention/intervention initiatives (e.g., Targeting communities, entire cities, or exceptional social or ethnic groups). One broad definition of community used in the public health and social science literature (Haglund, Weisbrod, Bracht, 1990; Jewkes, & Murcott, 1981), refers to people who share a concern, geographic region, or one or more population characteristics (e.g., Age, culture).

According to Jarry Gana (1987), indicates community assembly is the procedure of pooling mutually, tackling completing and using possible individual benefit with the end goal of improving. It is the methodology whereby people are made familiar with the resources available to them and likewise inspired and energized to aggregately use what funds for the progress of their profound natural states of livelihood.

Thus, community mobilization is more often than not named as individuals taking action organized around specific community issues (Fawcett, & Francisco, Hyra, et al. 2000). As posited by the influential works of Cloward and Ohlin, (1961), Alinsky, (1971), Amstein, (1969), and Freire, (1972), early community mobilization efforts attempted to see the individual in relationship to the community (e.g., Kin, community). Better to see the relationship of single characteristics, health conditions and environmental agents. In the same vain Also, as per Rana (1995a:5) Mobilization may be characterized as the procedure of putting aside poor people, reduced and dissatisfied portions of social order created and deal with their association, and in

this way partake in choices influencing their day-to - day lives the utilization of their resourcefulness.

Besides, Cohen, (1996) argues that mobilization as a procedure of employing a sound pattern of people in joint action for achieving societal goals through self-reliant efforts. Its immediate expected outcomes are the mobilization of all possible resources and the supported adoption/ utilization of all policies, technologies or services through the modification of attitude and behavior of different societal actors.

The challenge of mobilizing vulnerable communities is a mainstay of growth policies and interventions seeking to encourage health in low-income settings (Rifkin, 1996,2009). The community usually requires partnership amongst health workers and communities in performance looking for to 'allow ' them or 'make their capability' to use better authority over their happiness, throughout raising their chances for meaningful social involvement and building enabling relationships with helpful outsiders (Rifkin & Pridmore, 2001).

Furthermore, Howard –Grabman., and Snetro, (2003), view community mobilization as a capacity-building process through which community individuals, groups, or organizations carry out, and evaluate activities on a participatory and sustained basis. To improve their health care services and other needs, either on their initiatives or stimulated by others. Therefore, CBHIS could be used to address various health related problems faced by the rural communities since most of the health related services are not available in the rural communities. But by mobilizing and through the participation of the rural dwellers CBHIS will undoubtedly reduce the inequality

of the provision of health care service among the rural dwellers of Sokoto state, Nigeria.

Community mobilization assumes diverse forms. Influential approaches, observe communities as servants of biomedical and behavioral know-how, serving to put into practice programs conceptualized by doctors or scientist. Dialogical ways encourage connections amid health professionals and communities, promoting dialog among laymen and specialist understandings of health to create services that resonate with user's understandings of their wants and happiness. Social capital approaches enlarge involvement in neighborhood community groups (e.g. Faith group or youth groups), particularly the links amid a collection of enrollees and special health reimbursement. Through dialogical and social capital approaches, the rural dwellers were encouraged to embrace the concept of CBHIS as the way of providing themselves with a way out of the difficulties they face whenever they are accessing medical care services.

Significant ways surround these hard work inside a broader necessary or political prominence, considering community mobilization as a path to collective activity to dispute (or 'resist') the societal differences that place the person's welfare at risk. Furthermore, the attempts to decrease disparity have to encourage the ability of the power to insist their constitutional rights to health care services, and expand community environments anywhere the powerful are likely to heed their demands. Because most of the health facilities located in urban and semi-urban centers, leaving the rural areas without these services. Even the medical personnel are not too keen to work in the rural areas because most of the social amenities are lacking. Therefore,

for the rural dwellers to enjoy the provision of the modern healthcare facilities, mobilization of the rural dwellers is paramount in the utilization of the various health care services.

Community mobilization has certainly been victorious in the particular period and places, of them amongst comparatively wealthy and specific groups with substantial pre- active individualities, or in circumstances where broader forces were accommodating of radical community transformation at peculiar early moments. Still, many programs have not contributed to the sustainable health-enhancing social change. Authorities continue to carry out these exhausted old methods. There is a vital motive to revisit the broader 'theory of change' that informs such hard work. What forms of community mobilization are mainly possible to go forward social change in the direction of more equivalent and health-enabling social associations?

Most community mobilization practitioners determined by the effort of Paulo Freire, (1970, 1973), developed in the background of his work with communities combating next to poverty, social differences and extremely tyrannical governments in Latin America in the 1950s and 1960s (Freire, 1992). For Freire, community mobilization requires the procedure of dialogue and serious thoughts by marginalized people (Vaughan, 2010), helped by a remote change management, and giving a reflection-action sequence that 'induces' vulnerable communities to obtain and manage their healthcare services (Rifkin & Pridmore, 2001).

All the way through the dialog, the relegated expand conclusive agreement of the lovely family of their ill-health, an improved consciousness of their privileges and a wisdom of solidarity and communal organization that limbs collective act to confront

health-detrimental social differences. For Freire, the organization is communal and cooperative (to a certain extent than individual). Hence, community mobilization programs anticipated the development of the organization of the marginalized throughout the processes of public indication and accomplished by groups combined with a general sense of keeping out and unity. Hence, the mobilization of the rural dwellers will encourage them to utilize health care services within their reach.

For Freire, the procedure through which a group comes to see it in a different way (indicating) is just the initial period, the catalyst for real numbers of confrontation (action) to undertake the material drivers of their suppression. Such drivers might comprise inadequate right of entry to food or life-saving health care, which impact on peoples' very access to 'life itself' in numerous settings (Nguyen, 2005 & Seckinelgin, 2012).

However, Escobar, (1995), critics posits that Freire's ideas have been hijacked and weakened to frame the schedules of influential global development agencies somewhat than residential areas. Furthermore, such critics talk of development as a unique variety of colonialism, upholding global inequalities through defining ill-health as a difficulty solvable through neutral scientific results, followed out in local contexts, without awareness of the broader economic and political differences that force them. Harcourt (2009), contends that the Millennium Development Goals (MDG) defined attention away from the impacts of women's oppression on deprived reproductive health. Emphasizing the requirement for biomedical services (opening up markets for western health and pharmaceutical comfort), by means of little consideration to components that excluded women from gaining from these.

Community mobilization, a key strategy for increasing demand for and use of health care services, is a process that helps rural communities to identify their needs and to respond to and address these needs. Gaining the participation of the rural community members can help providers to raise awareness both of health issues at the rural community level and of social and cultural issues that may promote or inhibit use of information and services, as well as improve enrollees understanding of the methods or services offered. Concrete barriers to service access and use can be addressed, and service utilization increased. For ACQUIRE Project, community mobilization is important in linking health institutions and structures to communities, fostering greater access to and equity in health services among the rural dwellers.

The ACQUIRE Project has successfully undertaken community mobilization interventions in several places. For example, in Nepal, ACQUIRE has a pilot project to improve the reproductive healthcare services of young married couples an overlooked and underserved population through participatory approaches that engage community members in supporting the reproductive needs of married adolescents. ACQUIRE's activities in Nepal include: having young married community members undertake outreach and peer education; increasing family and community support for married youth through information and education; training health care providers in more active and friendly service delivery for their young married clients; and establishing relationships with district health office and private providers.

Therefore, community mobilization or community participation is very vital to the establishment of CBHIS and its depend on these for its acceptance and sustainability. Also, the amount that the rural dwellers are expected to pay will be determined by

the community interaction and also the type of coverage by the scheme will be known through this process.

While, in the Haute Guinea region of Guinea, ACQUIRE is addressing myths and concerns about the IUD through work with existing community health agents and community groups that have organized around the issue. The village health committees (VHCs) are involved in participatory learning and action exercises and work with their communities in developing action plans for increasing the use of the IUD, as well as of other long-acting and permanent methods. Combining community mobilization and communications and marketing activities can be advantageous where there is significant misinformation or lack of understanding of particular services. To address these challenges, ACQUIRE has also designed and produced a media communications campaign promoting IUD and family planning services, which are implemented in conjunction with the VHCs and community action plans. Therefore, for the ACQUIRE to achieve these laudable objectives in introducing the use of IUD devices and showing the rural dwellers their benefits. They have to use community mobilization and also encourage the rural people to participate in educating them on the various advantages of using an IUD as part of the family planning strategy and means to provide health care services.

It was not until the 90s, all the same, that scholars and specialists more and more put on community mobilization approaches to public healthcare issues such as the community established health insurance scheme (CBHIS). In the same vein, mobilization is seen as a methodology and apparatus that empowers individuals to

compose for group activity, by pooling assets and solidarity needed to take care of their health care needs and work towards community progression (UNDP, 2002).

Informed to a large extent by the previous literature on community empowerment (Fawcett; Paine-Andrews; Francisco, et al., 1995; Kieffer., 1984). Community participation (Bracht; Finnegan; Russel, et al. 1994; Florin; Wandersman, 1990). Capacity building (Easterling, Gallagher, Drisko, Johnson, 1998; Hawe, Noort, King, & Jordens, 1997). Community Alliance (Gilles, 1998; Butterfoss, Goodman, & Wandersman, 1996), and community organization and development (Gittll, Bockmeyer, Lindsay, Newman, 1996; & Minkler, 1997). Community mobilization offered support for non-individualized, community-based strategies like CBHIS to improve health care service outcomes within the rural dwellers.

This change was apparent in the international arena where the concept of community mobilization relies considerably on the new health promotion (CBHIS) philosophy and the exercise of enabling people to increase control over and to improve their healthcare services through CBHIS' (WHO, 1986). In this context, community health emphasizes a social, ecological approach that calls for wide-based changes in the social and economic environment to improve rural dwellers' health., by centering on community mobilization on establishing CBHIS and engagement, in the new health promotion to provide the rural dwellers with healthcare services. (Robertson, & Minkler, 1994).

Therefore, Community mobilization, which is from time to time referred to as community action or community animation, is the procedure of assisting rural communities to identify and contract work on shared health concerns (Minkler,

1990). Since the late 1970s, community mobilization has come forth as a major health promotion strategy; conceptual documents, including the World Health Organization's, World Bank, etc.

Participation of community members in health care is not new. An obvious example is a participation of rural dwellers in the provision of health care to family and community in their cultural settings. Also, rural dwellers have been involved in the delivery of allopathic healthcare services for the last one and a half centuries. One of the most remarkable experiences is the experiment of the Rockefeller Foundation in Ding Xian, China in the 1920s where local people helped deliver services in an area lacking doctors trained in Western medicine (Chiang 2001). King also records similar experiences in Africa using locals as doctor's assistants (King 1966) in colonial Africa.

Universal experiences, published by the World Health Organization (WHO), argued for the importance of community mobilization in health care services (Newell 1975). However, these experiences based on selected case studies produced assumptions rather than evidence of the value of participation. These assumptions included: (a) people will be more supportive of health care services if they are involved in decisions about how services are delivered thus promoting sustainability. (b) People will provide resources (time and money) to contribute to healthcare improvements in their community. (c) People will change risky health behaviors when they have been involved in decisions about change. (d) People will be authorized by gaining opportunities for knowledge, skills, and confidence by being involved in community healthcare services (Cueto 2004). Rifkin (2009) has analyzed the consequences of

building programs on these assumptions. The results show that many studies present advocacy rather than evidence.

With the recognition of Primary Health Care (PHC) as the official policy of the member states of WHO in the Alma Ata Declaration in 1978, the importance of community participation entered the global health policy arena. The Declaration said that health is a human right, that the inequalities in existing health status are 'politically, socially and economically unacceptable' and that essential health care services must be made 'accessible to individuals and families in the community through their full participation' (WHO 1978). The document highlighted social justice and linked it to equity and involvement as principles of the provision of healthcare services.

Mobilization is a crucial strategy for increasing demand for, and usage of health care services is a procedure that assists rural communities to distinguish their needs and to respond to and address these needs. Taking in the participation of the rural community members can help providers to raise awareness both of health matters at the community level and of social and cultural issues that may promote or inhibit use of data and services, as well as improve clients' understanding of the methods or services provided. Concrete barriers to health care service access and function can be addressed, and health care utilization increased. Community mobilization is important in linking health institutions and structures to residential areas, fostering greater access to and equity in the provision of health care services to the rural dwellers.

Community mobilization promotes consideration of the needs of specific populations and neighborhoods. In particular, underserved populations, such as youth and men, can be achieved more effectively through community mobilization thereby educating them about the benefits of CBHIS on their general well-being. Mobilization also leads to greater sustainability, as the rural dwellers are empowered and capable of addressing their demands. Some previous studies shown a sense of ownership in any community efforts are crucial to building sustainability to provide health care services.

CBHIS as a community-based approach that engages the community participation are becoming increasingly important in the disease prevention and health care promotion initiatives like CBHIS. Which seek to bring down the inequality in health care service among the rural dwellers (Hawkin, Catalano, Miller, 1992; Israel, Schuiz, Parker, & Becker, 1998). Similarly, community-based approaches have addressed adolescent drug and alcohol use, smoking, teenage pregnancy, and crime and violence. (Paine-Adrews, Vincent, Fawcett et al. 1996; Rowe, 1997; COMMIT, 1995; Nezlek, Galano 1993; & Chavis, 1995). Community mobilization and participation strategies facilitate a broader, collective response to the community-defined social and health care services needs and give the rural communities an active voice in program delivery, service, and policy. (Roussos, & Fawcett, 2000).

The rural dwellers also need to be sensitized to what they are willing to pay as a premium since payment of enrollees is one of the primary sources of financing CBHIS most especially if the CBHIS members are large. The more the high the members are the most financial footing of the CBHIS. The evidence of health

associated trouble entrenched in the social, economic, political and the environmental circumstances at hand in the rural communities, as well as the structure of the community values and sustain systems influencing their happening. The community mobilization strategy helps to lessen health trouble that the rural dwellers are facing by dealing with the fundamental causes present in the rural residential area itself (Bracht, 1991 & Perry, 1986).

Furthermore, as well-known before, make possible the process of rural community empowerment is the primary purpose of CBHIS of neighborhood mobilization efforts. Community growth and, to a lesser extent, community-based programs have enabled the rural dwellers to exercise a greater measure of mastery more than their surroundings. For the rural dwellers to vigorously participate in CBHIS, they need to be empowered, as previous studies have recognized empowerment as health-enhancing.

In addition, Wallerstein, (1993) identifies three circumstances related to empowerment and health care services: social networks; community participation; and community competence. Evaluation of community intervention promoting these conditions has exposed some positive health impacts, including enhanced helping abilities among the rural dwellers. Increased levels of social sustain, improved coping capacities, improved life contentment and decrease vulnerability to sickness amid the rural dwellers (Israel, 1985; Cohen, Syme, 1985; Gottlieb, 1987; & Eng, 1989).

From the foregoing the need to encourage people of the rural areas on the advantage of coming together in order to face the problem of inadequacy of the provision of

health care service facilities in their different communities, through participating in CBHIS as the only way out of catastrophic expenditure. Which most of the household faces any time they desire to seek for health care services is paramount.

By rallying to draw together to pool resources and share risk among themselves, whereby the poorest of the poor can cater for, and even the vulnerable groups involved. So establishing CBHIS through mobilizations of the rural dwellers is very substantial. Community mobilization frequently viewed as spontaneous developments began from the grassroots, which take the type of self-improvement and small scale ventures (Prusad, 2003).

According to Delgado-Gaitan, Concha (2001), community mobilization is a process that is called forth by a community itself, or by others. That planned ran out, and measured by the community's individuals, groups, and organizations on a participatory and sustained basis to improve the health, hygiene, and education. So as to enhance the overall standard of living in the residential district. Furthermore, mobilization can be attended as were a group of people has transcended their differences to match under identical conditions to facilitate the participatory decision-making process. In other words, it can be seen as a procedure that starts out a dialogue among members of the community to find out who, what and how issues are adjudicated, and likewise to provide an avenue for everyone to participate in decision-making that affects their lives.

Therefore, for CBHIS to have an impact on the provision of health care services to the rural dwellers, there is the need for the initiators are well trained in creating awareness. Educating community members to strengthen health-related

communication through social (face-to-face) communication is an efficient and reasonably priced way to fortify the impact of community-based health advancement programs such as CBHIS, etc.

Interpersonal communications by community members were one of the key change strategies working with the Program A Su Salud (To Your Health), a health encouragement project implemented in Eagle Pass, Texas. The project was developed to assess the impact of health message campaigns using ethnically relevant role models selected from the local neighborhood (Amezcua et al., 1991). Therefore, through this way the rural dweller can understand the message well and articulate what CBHIS stands for regarding providing the much-needed health care services at an affordable cost, thereby reducing the high bills they pay when accessing health care through an out-of-pocket mechanism that is most prevalent in the rural communities.

The objectives of A Su Salud were to promote healthy habits and lessen risks to low-income persons in Southwest Texas. Purposely, the project aimed to: reduce the occurrence and prevent the beginning of cigarette smoking; modify eating habits related to cancer risk; reduce alcohol abuse; increase the use of suitable preventive services and practice; increase physical activity, and encourage the use of automobile seat belts.

To achieve these outcomes, A Su Salud depends on two main strategies: the use of media messages based on culturally relevant community role models, and the strengthening of these messages through print materials and face-to-face communications with skilled neighborhood volunteers. Hence, by using media were

available and trained rural community mobilizes to educate and enlighten them about this emerging concept of providing access to medical health care at an affordable cost within their communities without having to go too far places for care which by doing so they have to incur additional expenses.

Two sets of television programs produced for the project. In the initial series, community role models presented health information in a news format, with well-known community physicians serving as project spokespersons.

The second round featured community residents who had recently made health-promoting changes. Over the course of the broadcasts, these individuals discussed what made them decide to change, how they changed and how they felt now because of the change. Changes built-in going in for medical checkups, stopping smoking, weight loss and the commencement of workout regimens, etc. Consequently, as a result of these, the rural dwellers will be stimulated and have an interest in CBHIS and be willing to participate and also willing to pay their premium regularly without failure.

Volunteers for the face-to-face communication component of the project recruited from randomly selected areas of the community. The basic requirements for participation as a volunteer included: respected within their communities or other social networks, willingness to serve their community, leadership, personality and a high degree of personal organization. All volunteers received training in social reinforcement skills (i.e., encouraging positive actions) and community outreach techniques.

Qualified volunteers were more likely to perform three essential tasks: contact other neighborhood residents and tell them about the television programs and other media, appeals; draw attention to the community role models, and strengthen health promoting behaviors. Volunteers spread, printed guides containing the schedules of television programs and newspaper articles featuring the role models. A viewing guide was issued at six-week intervals to allow opportunities for re-contacting community members, particularly to argue the health issues addressed in the television appeals. Volunteers make use of all likely social systems of interpersonal communications, including churches, mosques, civic groups and sports clubs.

A sample of the most active volunteers (166) interviewed as part of a preliminary evaluation of A Su Salud. These persons, who contacted an average of more than twenty persons, asserted that the community members they spoke with had viewed an average of nine programs featuring role models. Among the contacted community residents, 21 were reported to have quit smoking, 10 reduced their alcohol consumption, 328 increased their use of preventive care services, 368 changed their diet and 353 increased their level of bodily movement.

Therefore, the role of interpersonal communication plays a significant role in the mobilization of the rural dwellers on accepting to see reason in participating in CBHIS as the only way of reducing the prolong inequality of provision of health care services in the rural dweller communities in Sokoto State, Nigeria. As these CBHIS can provide the much-needed health care services that are necessary to the needs of the rural dwellers, thereby alleviating them from the high medical health care bills that they are exposed to when accessing health care services.

Some social scientist regards mobility as producing a lack of connections, commitment, trust and emotional nearness (Albrow, 1997 & Cresswell, 2002). Mobilities undermine communities and social capital, as recently argued by Putnam, (2000). Human geographers have argued that movement destroys the real senses of place by turning them into place fewer sites of speed and general consumption.

The use of priority group members to deliver health messages is an essential strategy for health promotion programs involving rural communities. Lacking trusted community members to provide health information in a responsive and suitable manner, cultural barriers to the statement may deter the taking of health-related ideas and practices of members of the rural dwellers. Succeeding studies of families, communities and social capital have followed this steer in taking close to mean near or frequently interacting face- to- face; and by extension, significant, relevant, meaningful (Fennell, 1997, 90)

The Women's Health Centre in Brisbane, Australia trained members of ethnic, racial groups to communicate the importance of pap smears and breast self-examinations. The need for this intervention emerged when women from various ethnic, ethnic groups attend a series of meetings held to recognize their health needs. These sessions exposed that many women did not know about breast and cervical cancer. Discussing these health issues in group sessions was difficult due to language and cultural barriers, as well as the open nature of the information. While, those face with this problem, the health center staff decided to organize awareness-raising sessions on breast and cervical cancer (Prasad, & Shinwari, 1993).

Women belonging to the ethnic, racial groups taking part in the program were asked to identify bilingual women in their communities who could serve as educators. Mothers who decided to believe this role attended a day-long training gathering, which rendered data on breast and cervical cancer and helping small group treatments.

Educators were given promotional material -- flyers, newspaper advertisements, and radio ads -- for translation.The health center then printed flyers in twelve languages. Educators recorded radio announcements in their individual language. Also, the principal members of every ethnic, racial neighborhood were asked to make known the sequence of small-group educational sessions.

The courses presented in circumstances available in the community, such as communal clubs, church halls, mosques, own homes and ethnic-racial groups. Eighty sessions were conducted over a six-week time. Over seven hundred women took part in these groups.

The opinion of the community educators long-established that participants responded to the information in a positive way. Participants were willing to experience pap smears and mammograms, but they were unwilling to access these services by themselves: language, lack of transportation and negative experiences with health services in the past cited as significant barriers. In reply to these concerns, the health center prepared group visits to local viewing services. The community educators harmonized the visits, offering sustains and support to the participating mothers.

Several of the neighborhood educators are the satisfaction that they had individually benefited from the scheme. They recognized that their involvement had increased their levels of self-esteem and self-assurance, predominantly since the project had involved them in meaningful communication with their peers (Prasad & Shinwari, 1993). This surprising outcome demonstrates that participatory social communication projects can give way positive health benefits for the rural dwellers in participating in CBHIS and bring relief on their hard earn resources, which is not adequate for their needs. And Sokoto state being Muslim dominated state the lmams needs to mobilize their followers in accepting to participate in CBHIS will go a long way in enlarging the enrollment, thereby pooling more resources to provide the much-needed health care facilities within their rural communities.

Community-based participatory mobilization seeks to identify and build on strengths, resources, and relationships that exist within the rural communities to address their shared health concerns. These may include individual skills and assets - sometimes called human capital; networks of relationships characterized by trust, cooperation, and mutual commitment - sometimes called social capital; and mediating structures within the community such as a mosque, churches and other organizations where community members come together. Community-based participatory research explicitly recognizes and seeks to support or expand social structures and social processes that contribute to the ability of community members to work together to improve health through participation in CBHIS and to build on the resources available to community members within those social structures.

The notion of social capital represents a way of thinking about the broader determinants of health and about how to influence them through community-based approaches to reduce inequalities in health and wellbeing (Gillies, 1998).

A focal point on social capital ropes a balance of strategies that address conducts and those that center on the circumstances in which people live, work and play. The insinuation for included health encouragement is that more prominence is needed for the hard work to reinforce the ways by which individuals come mutually, act together and, in some cases, take action to support healthcare services. The straightforward process, such as given that space for people to meet, maybe as health promoting as providing health awareness for modifying behavior (Gillies, 1998).

Participating in social and civic activities, such as community group meetings, child care arrangements with neighbors, neighborhood watch schemes and voting, all work to produce a resource called social capital. Social capital is critical to the health, wealth and wellbeing of populations (Putnam, 1993). It is a crucial indicator of the building of healthy communities through collective and mutually beneficial interaction and accomplishments (Baum, F 2000). Recent research has linked these types of activities to improve health outcomes (Putnam, Kawachi., Kennedy., Lochner, Prothro-Smith., Baubm, Palmer, Murray, Modra, Bush., Berkman, & Syme, 1993, 2000, 1979, 1997, 1996).

There is increasing empirical evidence that a complex set of contextual factors (including social, economic and physical environmental factors, such as poverty, air pollution, racism, inadequate housing, and income inequalities) plays a significant role in determining the health status of the rural dwellers. These factors contribute to

the disproportionate burden of disease experienced by marginalized rural communities.

There is also considerable evidence suggesting that numerous resources, strengths, and skills exist within communities (e.g. Supportive interpersonal relationships, community-based organizations) that can be engaged in addressing problems and promoting healthcare and well-being of the people. This understanding of the factors associated with health and disease has contributed to calls for more comprehensive and participatory approaches to public health research and practice, and a rise in partnership approaches, variously referred to as participatory action research'', participatory research'', action research'', and community-based research''.

Policy changes at the organizational, community and national levels are needed to help address barriers and challenges to the adoption of such approaches and to support their increasing use. Therefore, that can be engaged in solving problems and promoting health and well-being of the rural dwellers in Sokoto State, Nigeria through CBHIS will go a long way in reducing the inequality of health care services to the rural dwellers. There are approaches to health promotion that can be used to mobilize the rural dwellers to participate actively in CBHIS. The approaches are as follows: How can one move from doing health promotion?

The following strategies, which are frequently complex, were usually put into practice: Creating supportive environments: Activities aimed at establishing policies that support healthy physical, social and economic conditions (WHO, 1998). Health education: Consciously constructed opportunities for learning designed to facilitate changes in behavior towards a predetermined goal, and involving some form of

communication intended to improve health literacy, knowledge, and life skills conducive to individual and community health (PAHO, 1996; WHO, 1998). Health Communication: A strategy to inform the public about health concerns and place significant health issues on the public agenda achieved through the use of the mass and multimedia. And other technological innovations that disseminate useful health information to the increase public awareness of particular aspects of individual and collective health, as well as raise awareness of the importance of health in developing countries (WHO, 1998).

Self-help: Actions taken by a laypersons to mobilize the necessary resources to promote, maintain or restore the health of individuals or communities through self-care activities such as self-medication, self-treatment and first aid in the usual social context of people's everyday lives (WHO, 1998). Organizational development: A process typically used in the industry although applicable to other settings. Such as communities, to improve performance, productivity, and morale issues, and attain an optimally functioning organization, with a high level of cohesion, well-being and satisfaction on the part of all those involved (Raeburn, & Rootman, 1998). Community development /action: A process of collective community efforts directed towards increasing community control over the determinants of health, improving health and becoming empowered to apply individual and group skills to address health priorities and meet individual health needs (WHO, 1998).Healthy public policy: Formal statements that demonstrate concern for health and equity and which make healthy choices possible or easier for citizens, through creating supportive social and physical environments that enable people to lead healthy lives (PAHO, 1996; & WHO, 1998).

Advocacy: A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or program (PAHO, 1996; & WHO, 1998).Research: Information that links theory and practice through the investigation of the real world and which is informed by values about the issue under investigation, follow approved practices, is sensitive to ethical implications, asks meaningful questions and is systematic and rigorous (Naidoo, & Wills, 1998).Assessment study is a formal or nonviolent action, where the appraisal is related to unique purpose and is fed back into the preparation procedure (Naidoo, & Wills, 2000).Medical approach: Determined by diseases and biomedical explanations of health. The conservative idea of illness (ignore social/environmental dimensions) e.g. Immunizations, screening.

Incorporated health promotion service delivery can be organized from one or more different angles. Depending on the key priorities identified and the problem definition, including: Disease priorities or health, for example, nerve disease, mental wellness, diabetes, oral health Factors. Lifestyle such as physical movement and nutrition, tobacco usage, safe sex, Groups Population, for example, culturally and linguistically diverse groups, same-sex attracted youth, adolescents, older people living alone and Settings, for the lesson, health promoting schools, health promoting workplaces, health promoting hospitals, council estates.

The means a prerequisite for value exercise is how programs planned, executed and assessed. By definition, quality practice is: Enable it is done by, with and for people, not for them; it encourages involvement, Involve the population in the circumstance of their everyday lives, rather than focusing just on the simple lifestyle risk factors of

a particular illness. Directed to improving people's control over the determinants of their wellness and a procedure - it leads to something, it is a means to an end (Oliver, 1996).

The community mobilization theory has been proven as useful for health promotion especially when people are reluctant to respond positively to the health program. In the case of CBHIS, the rural dwellers need to be mobilized to understand and to adhere to the program given the fact that most of the people do not see direct benefits of health insurance (time inconsistency problem).

Hence, social mobilization is a multi-level, dynamic approach that can be initiated either top-down or bottom-up. Therefore, the community is perceived in its broadest sense to include all those who have a role and responsibility in effecting change. As the information is made available and understandable to both the experts and rural dwellers, full ownership and popular support are established (Russel & Levitt-Dayal 2003).

Community mobilization refers to the use of planned actions and processes to reach, influence, and involve all stakeholders across all relevant/significant/involved/concerned sectors, including the national and the community level to raise awareness, change policy, demand a particular development program, or reallocate resources or services.

A CBHIS like any other health program, to be effective, needs a multi-pronged approach of social mobilization that encompassed communication through dialog at multiple levels and among various audiences. Therefore, community mobilization

refers to a process of problem identification and problem solving stimulated by community itself or facilitated by others that involve local institutions, local leaders, community groups and members of the community (CEDPA, 2000).

Community mobilization uses deliberate, participatory processes to involve local institutions, local leaders, community groups, and the members of the community to organize for collective action toward a common purpose. Community mobilization characterized by respect for the rural community and its needs.

For CBHIS communication to be successful and to put together this foundation of well-liked support, contact wishes to be a procedure of dialog, information input, and communal indulgent and collective act. Harmonized communication is used to encourage a dialog inside the neighborhood as intact (Aubel 2001). According to Neil, (1992) he listed five major ways of mobilizing individual and monetary resources: Political mobilization, Government mobilization, Community mobilization, Corporate mobilization and Beneficiary mobilization.

Hence, in this study emphasis is on community mobilization and community participation, for providing the rural dwellers with health care services within their reach. Through mobilization, the attention of policymakers, community members, and media representatives are motivated to take action on a particular health care issue such as immunization, family planning or literacy.

Community mobilization amplifies advocacy activities, strengthens rural communication, and allows many more general partners to participate in the program. Therefore, for CBHIS to be successful in Sokoto rural communities needs

to mobilize and encourage the people to take part in mobilizing both financial and human resources to achieve large enrollment among the rural dwellers of Sokoto state, Nigeria.

Champions for change such as rural community health workers are concerned with building consensus and educating people to energize and empower them to take focused action. They share information and stimulate many stakeholders around an issue. The stakeholders then agree on a goal, develop key themes and messages, and exert political pressure for policy changes and increased appreciation of a community-wide problem. Therefore, a sense of community is built around the issue, and more people join the movement. This bandwagon effect leads to the increased resources and formation of new social norms, creating a climate that supports the individual behavior change, as well as social change (Russel & Levitt-Dayal, 2003).

The challenge of mobilizing vulnerable communities is a pillar of development policies and interventions seeking to promote health in low-income settings (Rifkin, 1996, 2009). The community usually involves collaboration among health workers and communities in activities trying to 'empower 'them or 'build their capacity' to exercise greater agency over their well-being, through increasing their opportunities for meaningful social participation and building enabling partnerships with supportive outsiders (Rifkin & Pridmore, 2001). Therefore, establishing CBHIS is seen as seeking to promote the provision of health care services to the disadvantaged population of the rural dwellers who lack these basic facilities.

Howard –Grabman., and Snetro, (2003), view community mobilization as a capacity-building process through which community individuals, groups, or organizations

plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their initiatives or stimulated by others. Therefore, CBHIS could be used to address various health related problems faced by the rural communities since most of the health related services are not available in the rural communities. But by mobilizing and through the participation of the rural dwellers CBHIS will undoubtedly reduce the inequality of the provision of health care service among the rural dwellers of Sokoto state, Nigeria.

Community mobilization takes various forms. Instrumental approaches view communities as handmaidens of biomedical and behavioral expertise, helping to implement programs conceptualized by doctors or psychologists. Dialogical Approaches promote interactions between health professionals and communities, facilitating dialog between lay and expert understandings of health to create services that resonate with user's understandings of their needs and interests.

Social capital approaches increase participation in local community groups (e.g. Faith group or youth groups), given the links between group memberships and particular health benefits. Through dialogical and social capital approaches, the rural dwellers were encouraged to embrace the concept of CBHIS as the way of providing themselves with a way out of the difficulties they face whenever they are accessing health care services.

Critical approaches embed these efforts within a wider critical or political emphasis, viewing community mobilization as a route to collective action to challenge (or 'resist') the social inequalities that place the person's well-being at risk. Furthermore, the efforts to reduce inequality should promote the capacity of the power to demand

their rights to health, and develop social environments where the powerful are likely to heed their demands. Because most of the health facilities located in urban and semi-urban centers, leaving the rural areas without theses services. Even the medical personnel are not too keen to work in the rural areas because most of the social amenities are lacking. Therefore, for the rural dwellers to enjoy the provision of the modern healthcare facilities, CBHIS remains the only hope for the common man.

Community mobilization has indeed been successful in particular times and places, of them among relatively affluent and confident groups with special pre- existing identities, or in contexts where wider forces were supportive of progressive social change at particular historical moments. However, many programs have not led to sustainable health-enhancing social change. Agencies continue to implement these tired old methods. There is an urgent need to revisit the wider 'theory of change' that informs such efforts. What forms of community mobilization are most likely to advance social change towards more equal and health-enabling social relations?

Most community mobilization practitioners influenced by the work of Paulo Freire (1970, 1973), developed in the context of his work with communities battling against poverty, social inequalities and highly oppressive governments in Latin America in the 1950s and 1960s (Freire, 1992). For Freire, community mobilization involves the processes of dialogue and critical thinking by marginalized people (Vaughan, 2010), facilitated by an external change agent, and generating a reflection-action cycle that 'empowers' vulnerable communities to take control over their health (Rifkin & Pridmore, 2001). Through establishing CBHIS among the rural dwellers and showing their willingness to pay for healthcare services at an affordable price.

Through dialog, the marginalized develop critical understandings of the social roots of their ill-health, an enhanced awareness of their rights and a sense of solidarity and collective agency that spurs collective action to challenge health-damaging social inequalities. For Freire, the agency is collective and relational (rather than individual). His community mobilization programs envisage the development of the agency of the marginalized through processes of collective reflection and action by groups united by a common sense of exclusion and solidarity. Hence, CBHIS efforts are the process of collective actions of the rural dwellers to provide themselves with the much-needed health services at the small cost of their communities.

For Freire, the process through which a group comes to view it differently (reflection) is only the starting point, the springboard for concrete acts of resistance (action) to tackle the material drivers of their oppression. Such drivers might include limited access to food or life-saving health care, which impact on peoples' very access to 'life itself' in many settings (Nguyen, 2005 & Seckinelgin, 2012).

However, Escobar, (1995), critics posited that Freire's ideas have been hijacked and emasculated to frame the agendas of powerful international development agencies rather than communities. Furthermore, such critics talk of development as a new form of colonialism, perpetuating global inequalities through defining ill-health as a problem solvable through neutral technical solutions, implemented in local settings, without attention to wider economic and political differences that drive them. Harcourt (2009) argues that the Millennium Development Goals (MDG) drew attention away from the impacts of women's oppression on poor reproductive health, emphasizing the need for biomedical services (opening up markets for western

sanitation and pharmaceutical interests), with little attention to factors that prevented women from benefiting from these.

Community mobilization, a key strategy for increasing demand for and use of healthcare services, is a process that helps rural communities to identify their needs and to respond to and address these needs. Gaining the participation of the rural community members can help providers to raise awareness both of health issues at the rural community level and of social and cultural issues that may promote or inhibit use of information and services, as well as improve enrollees understanding of the methods or services offered. Concrete barriers to service access and use can be addressed, and service utilization increased. For ACQUIRE Project, community mobilization is important in linking health institutions and structures to communities, fostering greater access to and equity in health services among the rural dwellers.

The ACQUIRE Project has successfully undertaken community mobilization interventions in several places. For example, in Nepal, ACQUIRE has a pilot project to improve the reproductive health of young married couples an overlooked and underserved population through participatory approaches that engage community members in supporting the reproductive needs of married adolescents.

ACQUIRE's activities in Nepal include: having young married community members undertake outreach and peer education; increasing family and community support for married youth through information and education; training health care providers in more active and friendly service delivery for their young married clients; and establishing relationships with district health office and private providers. Therefore, community mobilization or community participation is very vital to the

establishment of CBHIS, and it depends on these for its acceptance and sustainability. Also, the amount that the rural dwellers are expected to pay will be determined by the community interaction and also the type of coverage by the scheme will be known through this process.

While, in the Haute Guinea region of Guinea, ACQUIRE is addressing myths and concerns about the IUD through work with existing community health agents and community groups that have organized around the issue. The village health committees (VHCs) are involved in participatory learning and action exercises and work with their communities in developing action plans for increasing the use of the IUD, as well as of other long-acting and permanent methods.

Combining community mobilization and communications and marketing activities can be advantageous where there is significant misinformation or lack of understanding of particular services. To address these challenges, ACQUIRE has also designed and produced a media communications campaign promoting IUD and family planning services, which are implemented in conjunction with the VHCs and community action plans.

Therefore, for the ACQUIRE to achieve these laudable objectives in introducing the use of IUD devices and showing the rural dwellers their benefits, they have to use community mobilization and also encourage the rural people to participate in educating them on the various advantages of using an IUD as part of the family planning strategy. So also, for the rural populations to accept CBHIS community mobilization and participation is very necessary for the scheme survival and sustainability to provide them with health care services.

In conclusion, for any new program to be successful the rural dwellers have to be sensible and converse their support for the new concept. From our foregoing discussion, mobilization and provision of health care services to the rural dwellers are vital for reducing inequality of health care access. Therefore, community mobilization is strongly related to the impact of health care services among the rural dwellers. Regarding the mobilization that are concerned with CBHIS, some scholars such as Hawkin, Catalano, Miller, (1992) and Israel, Schuiz, Parker, Becker, (1998) have concluded that CBHIS as a community-based approach that engage the community participation is becoming increasingly important in the disease prevention and health care promotion initiatives will help to bring down the inequality in health care service among the rural dwellers. And, on community mobilization, Roussos, and Fawcett, (2000) found that community mobilization and participation strategies facilitate a broader scope in educating the rural dwellers on the benefits of utilizing health care services. It's a collective response to the community-defined social and health needs and give the rural communities an active voice in program delivery, service, and policy. Three circumstances related to empowerment and health care: social networks; community participation; and community competence (Wallerstein, 1993). While, Israel and Syme (1985), Cohen and Gottlieb (1987) and Eng, (1989) have argued that there are positive health impacts, including enhanced helping abilities among the rural dwellers. Increased levels of social sustainability, improved coping capacities, improved life contentment and decrease vulnerability to sickness amid the rural dwellers. They added some interesting question. It is What forms of community mobilization are most likely to advance social change towards more equal and health-enabling social relations? (Stressed mine). In this study community, participation and mobilization are seen as

the most important aspect of bringing the much-needed change of providing healthcare services to the rural dwellers of Sokoto state, Nigeria. Thus, this thesis accounted this mobilization factor is paramount and adopted as one of its independent variable.

3.6 Gaps in Literature Review

Based on the literature review, it has been discovered that previous studies conducted were on managerial, and sustainability of healthcare services and most of the these were done by the international donor agencies such WHO, World Bank, UNICEF, ILO, etc.

Although CBHIS have been introduced and implemented in Nigeria and despite the widespread recognition that CBHIS can increase the rural dwellers access to health care services. And also, CBHIS provide financial protection by reducing catastrophic health care expenses among members that enroll in CBHIS. There has been no empirical evaluation of CBHIS in Sokoto state, Nigeria. To date, no research in Sokoto state that has investigated and documented the impact of the policy process, economic growth, scheme design and mobilization on provision of health care services for the rural dwellers of Sokoto.

In this study also, the researcher notes there is a lack of demographic data and statistics on health care financing and insurance in Sokoto State. Most studies carried out are on Malaria control, Tuberculosis control, Polio, eradication, HIV/AIDS, and other infectious diseases. But there are no known studies on how the provision of

health services is financed individually among the rural dwellers of Sokoto state who economically are challenged.

The picture in Asia and Africa is very different, with large heterogeneity in institutional designs and organizational models and the enormous difference in population exposure, services covered and costs achieved. No universal reviews are available on the impact of Social health insurance (SHI), Private health insurance (PHI) and CBHIS, which limits a direct comparison of their options and limitations. Also, health insurance is known to have effects on domains beyond those reported in existing reviews, such as social inclusion (Preker & Carrin, 2004). Furthermore, most studies available on the rapid development of health insurance in- low and middle – income countries are somewhat old.

The importance of the policy process is very vital to the provision of health care service because without having a plan in place to provide the much-needed facilities the inform of personnel, provision of medicines, building infrastructures, hospital /clinic equipment, etc. The delivery of health care services to the rural dwellers will not be possible to archive.

Economic growth of the rural dwellers in term of their income is necessary because the rural dwellers have to have the means to be able to access healthcare services. Since most of these rural dwellers are farmer and traders the income they generate from their means of lively hoods determines the way and the manner they access healthcare services in their communities.

Scheme design is very vital to the success of any intervention that tend to improve the welfare of the people regarding their health care service provision, and for any scheme design to be successful, it has to be people oriented scheme. Where people engage from the beginning to the end and by so doing the people will see the scheme as their own and therefore, will do anything to make it successful. While, mobilization is a necessary ingredient in any development efforts, the people need to mobilize and sensitize it's only then that the people will see a reason to participate and support the program.

Hence, it is from the above statement that the researcher sets out to examine the relationship of the policy process, economic growth, scheme design and mobilization as independent variables with health care services as the dependent variable in the study.

3.7 Theories on Health care

Many theories have been applied by scholars on how to provide health care services. One of such theories is ‘The better lifestyle alternative’. In this theory, Falk (1977) propounded that there should be less emphasis on medical care; instead, the greater emphasis should be on ’preventive services’. The scholar advocated that the alternative health insurance scheme is to prevent against infectious diseases, accidents, injuries, etc. Instead of looking for ways of financing health care services. This particular theory does not favor the insurance industry because it always emphasizes the idea of preventive services instead of insurance services.

According to Kamien and Schwartz (1973), there are two forms of the health care delivery system, namely service-preventive attention and treatment of disease. Preventive care interpreted as those services that touch on the possibility of illness while the other involves disease. The two kinds of services affect cost. The centering of the theory has to do with the minimization of the total expected cost of delivering adequate health care to the rural dwellers. The theory advocated alternatives for assessing the payment of insurance premium by members, ranging from full payment at one end and fee-for-service at the Lord's table. The theory major concern around the relationship between the choice of payment and execution of economic efficiency.

Advanced by Putnam (1993), the assumption of social capital in which everybody in the organization contributes to the development of healthcare services to the rural dwellers. Hence, this is mulled over as a free variable (i.e. Communitarian perspective of social capital). The impact is to carry out its commitment to gain access to the primary health concern for rural inhabitants. The range of the hypothesis is to use social networks, trust or associations better the health situation of the rural residents.

On the same page, there is the theory of contingent valuation. Scholars in the field of health insurance plan are of the belief that this hypothesis nearly connected with the theory of buyer requirement. Ascribing value to public goods such as health care has been a serious problem for economists. In fact, according to consumer theory, the law of supply and demand states that the market equilibrium price and quality of a good are at the intersection of consumer demand and producer supply. However,

health care is not a good traded on the market. Consequently, determining the value of health care can be complex. Therefore, resolving this problem, economists have developed the contingent valuation method (CVM), which mainly consists of estimating the value a person places on a good, usually one that's are not sold in the market.

The CVM was pioneered by Davis in 1963 and has been used extensively in health care fields. The theory of contingent valuation premised on the maximum amount an individual is willing to pay a premium. Which in return provides the value different places on the goods under deliberation and the reservation price for the good (Ataguba et al., 2007). According to the scholar, the premium paid is assumed to be additive across individuals within a particular household and community.

Ataguba et al. (2007) postulated further that if an individual who is at risk, unwilling on income in demanding health care service on one hand, and employing the utility income mapping. Then the health of that person is dependent on the premium paid into the community insurance scheme. The hypothesis of contingent valuation is most frequently utilized. To measure the ability of family units and people to pay for the community insurance scheme (Dong et al., 2005, 2004a, 2004b, 2003a, 2003b). The willingness to pay is a technique of (CVM) to assess how much is the rural dwellers of Sokoto state are willing to pay for participating in CBHIS.

The WTP methodology, though initially applied in the area of environmental economics has been utilized for a long time in assessing health benefits and dates back to 1970 (Asgary et al., 2004). Its purpose, though not limited to developed countries. Is alleged to be comparatively few in the area of health insurance in

developing countries (Diener et al., 1998; Asgary et al., 2004). WTP responses have also been identified used in ordering preferences and aid in decision-making. For policy makers in the light of alternative interventions. And in deciding on an intervention program (Asgary et al., 2004; Olsen et al., 2004; Cranfield & Magnusson, 2003; Dong et al., 2004b).

Most of the surveys carried out in the of health economics have focused on measuring the benefits of healthcare interventions and services plans. Using the Willingness to pay (WTP) approach such as Onwujekwe et al. In southeastern Nigeria is valuing treatment of mosquito nets with insecticide in four rural communities, valuing community-based ivermectin distribution. Bala et al. Assessing health benefits; Walraven evaluates WTP for health care services in a district hospital in Tanzania. Weaver et al. Valuing the WTP for child survival in the Central African Republic, etc. (Walraven, 1996; 1997; Weaver et al., 1996; Stewart et al., 2002; Olsen et al., 2004; & Onwujekwe et al., 1998, 2000, 2001, 2005; Bala et al., 1999).

In the area of CBHIS and health policy, studies carried out include Binam et al. (2004) in rural Cameroon. Dong et al. (2003a) in Burkina Faso is estimating WTP for CBHIS, Dong et al., (2004b) analyzing the differences in WTP of household heads for CBHIS premiums for themselves and other members of the family. Using the large informal sector of Ghana to value WTP for health insurance (Asenso-Okyere et al. 2003), Dong et al., (2003) comparing gender effects of WTP in Burkina Faso for a CBHIS, Asgary et al., (2004) in Iran estimating rural household's WTP for health insurance, etc.

So, many CBHIS in low and medium income countries have taken up the CVM as the best to use in knowing what are the enrollees willing to contribute as premium in CBHIS. Out-of-pocket (OOP) spending for the provision of healthcare services concern in the Nigerian constitute over 70 percent of health care expenses which impoverishes poor rural dwellers households who barely manage to live on basic survival. Hence, CBHIS has been shown in some resource-poor nations have been offered as a viable alternative as a way of protecting the rural inhabitants from an immense load of disease and forced medical bills. So CBHIS prepayment schemes can serve the function of increasing the rural dwellers access to wellness care and thereby reducing the burden of illness which frequently contributes to the alleviating poverty trap occurrence.

Sokoto state being the majority of its rural dwellers are living in the rural regions and in most of these rural communities, the provision of health care services is not enough to cater for the rural inhabitants. And equally, there is inadequate access to health care facilities. But with the CBHIS, some of these facilities are supplied, and the rural dwellers now can access healthcare services in most of the community health office and clinics within their vicinity. Thereby increasing their access to healthcare services in their communities.

This inquiry premised on the theory of contingent valuation because of the peculiarities and socioeconomic background of Nigerian society. As earlier said, the people population is approximately 3 million people of Sokoto state Nigeria. The preference of the subject area intentionally based on the researcher's prior knowledge

and closeness of the geographical region. This will enhance the accuracy of the information elicited from respondents.

3.8 Conceptual Framework

Based on the foregoing discussions a framework is developed to examine the relationship between policy process, economic growth, scheme design and mobilization on health care services among the rural dwellers of Sokoto state, Nigeria. According to Sekaran, (2003) the research framework is the central foundation whereby other research structures extend the front line of knowledge. The research framework for this study shown in Figure 3.1

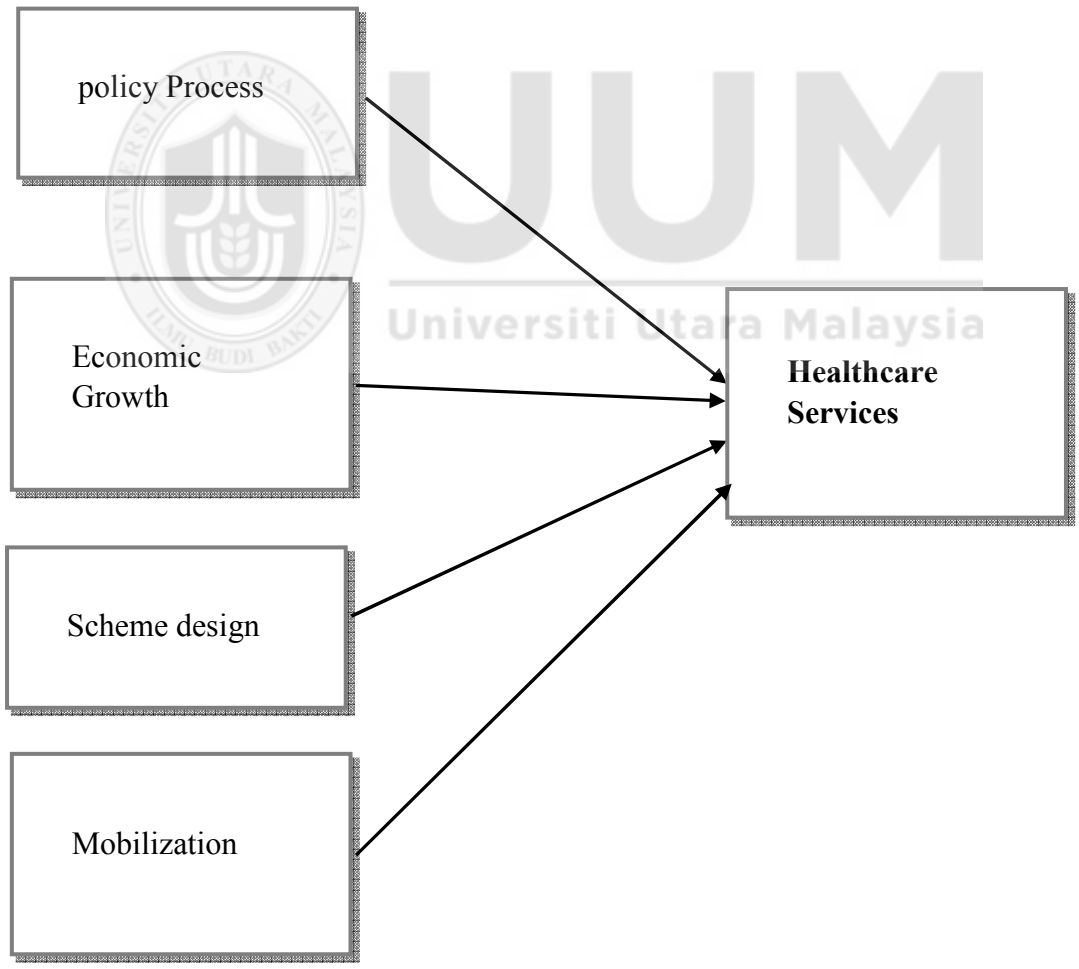

Figure 3.1: Theoretical framework

The above research framework arrives at based on the problem statement that outlines the research gap and the suggestions for future studies to see the relationship between policy process, economic growth, scheme design and mobilization and healthcare services.

3.9 Hypothesis Development

3.9.1 Policy Process and Healthcare Services

Based on the literature review, the policy process is very necessary for improving or bringing new policy on the provision of health care services to the rural dwellers. The responsibility of providing theses healthcare facilities rest with the government. When the Nigerian government introduces health insurance in the formal sector, the informal sector was neglected, living them without any form of insurance mechanism, this has affected the rural dwellers access to health care services. They are left on their own to furnish wellness services for themselves through out-of-pocket which push them into poverty.

Therefore, providing policy on the provision of healthcare services in the informal sector of Nigeria in the form of community health insurance will go a long way in addressing the lack of access to healthcare services for the rural people. Consequently, some of the most significant and economic policies are those that provide incentives to others to change their behavior, such as in providing subsidies to the vulnerable groups in accessing health care will go a long way in drawing more people to access health care services. Therefore, the relationship between policy process and healthcare services is strong, because there won't be any provision of health care services without a policy either by the government or stakeholders in

healthcare provision. Therefore, on the basis the study looks at whether policy process is associated with health care services, leading to the following hypothesis:

H 1 Policy process is positively related to the Healthcare Services of the Rural Dwellers.

3.9.2 Economic Growth and Healthcare services

Base on the literature review Economic growth of the rural dwellers has been considered as an important factor in the provision of health services to the rural dwellers. Several studies have confirmed the positive relationship between economic growth and health (Leu, 1986; Parkin et al., 1987; Posnett and Hitiris, 1992; Prichett & Summers, 1996), there was little evidence to support the causal effect of health on income. A healthier workforce should be linked to human capital accumulation process (Behrman, 1990; Knowles & Owen, 1995; Currais & River, 1997). Thus, it appears to be a consistent assumption that better health raises the economic productivity and income of the individual rural dwellers. Therefore, by this studies highlighted in the literature, economic growth was found to have a positive relationship with health care services as hypothesized below,

H 2 Economic growth is positively related to health care services.

3.9.3 Scheme Design and Healthcare Services

Good scheme design is necessary for the sustainability and progress of any program, many new policies fail to achieve their goal because of a faulty design. To provide access to adequate health care for all at an affordable price, it will be necessary to increase the extent of prepayment and reduce the reliance on out-of-pocket (Carrin

&James, 2004; Carrin & Evann, 2005). Tax-based health financing and social health insurance, or a mix of them, are the most frequently used mechanism for achieving this goal. Economic and health sector reform in Nigeria has been leading to increased inequity in health care, especially in rural areas (Gu X, Blom, Tang, Zhu, Zhou & Chen, 1993). Lack of health insurance, among many other factors, has been one of the main reasons contributing to this inequality (Liu, Hsiao, Eggleston, 1999 & Tang, Meng, Chen, Bekedam, Evans & Whitehead, 2008). Therefore, having rural dwellers involved in the design process will make them feel a sense of belonging that the scheme meant for them. Hence, scheme design is vital to the successful implementation of CBHIS, which seek to reduce inaccessibility of the rural dwellers in accessing health care services. Therefore, on this basis, the study looks at scheme design is associated with health care, as hypothesized below

H 3 Scheme design is positively related to healthcare services of rural dwellers.

3.9.4 Mobilization and Healthcare Services

Therefore, Community mobilization, which is from time to time referred to as community action or community animation, is the procedure of assisting rural communities to identify and contract work on shared health concerns (Minkler, 1990). Since the early 1970s, community mobilization has come forth as a major health promotion strategy. Conceptual documents, including the World Health Organization's Alma Ata Declaration on Primary Health Care (1978) and the Ottawa Charter for Health Promotion (1986), have emphasized the importance of direct community participation in the provision of health care services plans and helps such as CBHIS among others. The challenge of mobilizing vulnerable communities is a

mainstay of growth policies and interventions seeking to encourage health care services in low-income settings (Rifkin, 1996,2009).

So mobilization has been identified as an important factor in mobilizing the rural dwellers on ways to reduce their inability to access health care services. Subsequently, community mobilization promotes consideration of the needs of specific populations and neighborhoods. Similarly, Hawkin, Catalano, Miller, (1992); Israel, Schuiz, Parker & Becker, (1998) posited that mobilization is positively related to the provision of health care services. Therefore, on this basis of this, the study looks at whether mobilization is associated with health care services, as hypothesized below:

H 4 Mobilization is positively related to health care services for the rural dwellers.

3.10 Summary

This chapter provides a review of the literature on the policy process, economic growth, scheme design, mobilization and healthcare services. This chapter provides the framework for the study. The chapter also explains the gaps in the literature, underlying theories and hypothesis development.

CHAPTER FOUR
METHODOLOGY

4.0 Introduction

This chapter discusses the research design, the population, and sample, the instrumentation, the methods used for data collection and the methods of data analysis. It highlighted research model, developed the hypotheses from the framework and justified each statement.

4.1 Research Design

The research design defined as a master plan identifying the methods and processes of collecting and analyzing the desired data (Zikmund, 2000). There are three types of business research, which include exploratory, descriptive and explanatory (Zikmund, 2000; & Sekaran, 2003). The decision about the method to use depends on an individual understanding and clarity of the research problem. Exploratory research is conducted to enable the understanding of a new occurrence, which further studies will be carried out to gain certification and convincing proof (Zikmund, Babin, Carr, & Griffin, 2009). The descriptive design conducted in particular situations where there is just a little knowledge of the nature of a problem. It is conducted, therefore, to provide a more precise description of a problem (Zikmund, 2000; & Sekaran, 2003). While the explanatory design is performed to provide further specific knowledge and description of the nature of relationships among the variables being investigated (Zikmund, 2000; & Sekaran, 2003). This study considered explanatory because it is required to explain the relationships between

policy process, economic growth, scheme design and mobilization on healthcare services. This study covers all the twenty-three local government of Sokoto State, Nigeria. Hence, a field survey was conducted to include the local governments. The research work is cross-sectional because the data collected from the respondents within certain periods of time to meet the research objectives (Sekaran & Bougie, 2010), not like a longitudinal study in which data was collected for a longer period.

Leedy and Ormrod (2005) said that resolving queries related to relationships among measured variables; the quantitative method is used because it receives the capability in explaining, predicting and controlling phenomena. So, based on Leedy and Ormrod (2005) explanation, a quantitative method is employed in the field to serve the research questions. Creswell, (2003) also stated that the quantitative approach is better and the most suitable method due to its fast turnaround in data collection.

Quantitative research is based on the assumption that anything that exists does so in certain quantities, and it can be measured numerically. Quantitative research methodology is appropriate where quantifiable measures of variables of interest are possible, where hypotheses can be formulated and tested, and inferences drawn from samples to populations (Adamu, 2006).

Among the major reasons for using a quantitative method in research is because of its power of generalization, the predictive capability and full explanations of the causal relationship (Tashakkori & Teddlie, 1998). Adamu (2006) identified three general types of quantitative methods as Experiments, Quasi-Experiments, and Surveys. This study will be based on survey design, Fowler (1988) state that a survey design can also provide a quantitative or a mathematical explanation of any portion

of the populace (sample) through the process of data collection or of asking the inquiry of people. This process of data collection, in going round to make the researcher take a broad view the result from an illustration of responses to a populace.

As Crotty (1998) demonstrates, one of the problems here is not only the bewildering array of theoretical perspectives and methodologies, but the fact that the terminology applied to them is often inconsistent (or even contradictory). Crotty suggests that an interrelationship exists between the theoretical stance adopted by the researcher, the methodology and methods used, and the investigator's view of the epistemological. Figure 4:1. Illustrates this:

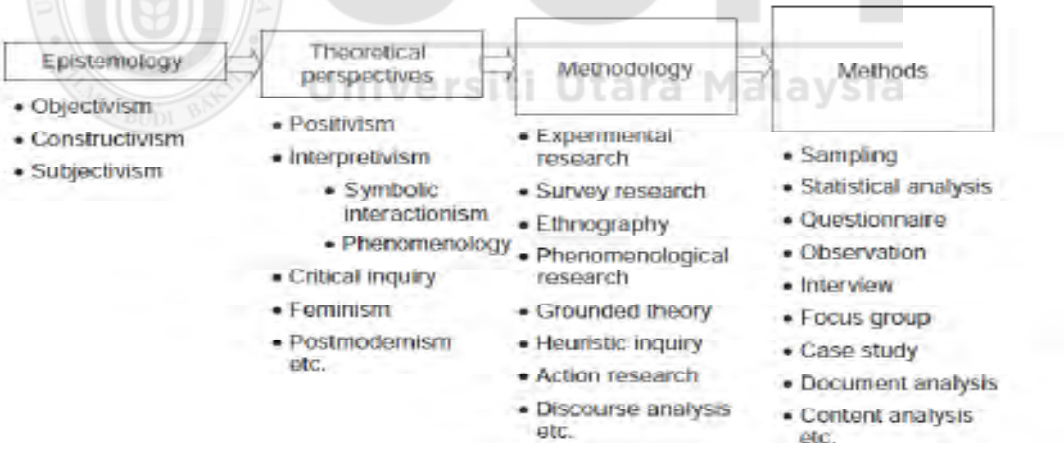

Figure 4.1: Relationship Between Epistemology, Theoretical Perspectives, Methodology and Research Methods.
Source (Adapted from Crotty, 1998)

Based on these suggestions the survey methods were in use in this research. The study involved independent variables (Policy process, economic growth on health

care, scheme design and mobilization) and the dependent variable (health care services).

The research is designed using quantitative techniques to collect data on the healthcare service delivery to the rural dwellers in Sokoto State, Nigeria. All information elicited from respondents will be processed through the use of the Software known as Statistical Package for Social Sciences (SPSS) version 18. In the case of any eventuality, other software may be sought to analyze data that cannot be processed with SPSS to justify the findings of the study.

A questionnaire was designed and adapted to obtain primary data from respondents. The data was processed using descriptive analysis to get the inference of the subject. To pull out the required data from respondents, the researcher created items (questions) for demographic data, the impact of Healthcare services, policy process, economic growth, scheme design, mobilization on the delivering health care services to the rural dwellers of Sokoto state, Nigeria. The items adapted in this study are based on their high reliability of their Cranach's Alpha Coefficient in previous empirical studies.

The dependent variable of the study is the healthcare services while other variables are independent variables. Multiple regression analysis is being used to draw an inference on the identified variables for testing the four hypotheses formulated in the study.

Likewise, the frequency distribution was used for demographic data. On the same page, the instrument is designed for the rural dwellers of Sokoto state Nigeria.

Information obtained from respondents will give the room for the comprehensive investigation of the impact of CBHIS on rural dwellers.

4.2 Population and Sample

Cabana et al. (2001) define community as the entire collection of the subject of interest to be examined in a research. Hair et al. (2010) and Cavana et al. (2001) community as a collection of data and information whose properties are to be examined in a constant field.

Nigerian population is approximately 160 million. Over 70% of the Nigerian population is classified as rural dwellers because the agricultural settlers are more than those who are living in the urban centers and the metropolis. Therefore, the population of this work is 3 million people of Sokoto state (NPC, 1991).

In research examination involving several hundred and even thousands of essentials, it can be virtually impracticable to collect data from or review or even look at all aspects. Even if it were possible, it would be extreme in conditions of time, cost and other human resources, (Sakaran & Bourgie, 2010). In this regards, they emphasized the need for researchers to view sample size determinations and issues critically with non-response as an essential condition in any quantitative survey design (Bartlett et al. 2001).

Before the factor analysis, one of the conditions to be satisfied is the sample size of the study. Hair *et al.,* (2010) asserted that the sample size required for factor analysis should be around 100 and above. Based on the above discussion on sample size, the sample size of this study met the requirement for factor analysis. Therefore, factor

analysis was conducted in this study with the intention of reducing a large number of related items to smaller and manageable quantity. After the factor analysis, a reliability analysis was also conducted to determine the Cranach Alpha of each variable.

On the other hand, the researcher intends to utilize non-random sampling technique, Convenience sampling because of some of the following reasons, initially non-probability is suitable and has a smaller amount of expenses not costly as against the probability (Cooper & Schindler, 2003: Sekaran & Bougie, 2010). If carefully, guarded non-probability sampling may surely give a welcome feedback (Copper & Schindler, 2003).

Next it is probable that the non-probability sampling may be the only choice. The list of the population or sample frame might not be readily accessible. Two kinds of the nonprobability of sampling are convenience sampling and purposive sampling (Copper & Schindler, 2003: Sekaran & Bougie, 2010). Therefore, from the above, this study will use convenience sampling method because there is no sampling frame for the population of the study. The sample size for a given population of 3,000,000 is 400 (Waston, 2001). To ensure the sample size is enough in addressing the objective of the study. The sample can also be computed using the formulae suggested by Yamane, (1967). The method for calculating sample size is as

Below $N = \frac{N}{1 + N (e) 2}$

Where n = Sample size; N = Population of the study; e = Level of precision

Thus: N = 3,000.000; e = 0.05

$$n = \frac{3,000,000}{1 + 3,000,000\ (0.05)2}$$

$$n = \frac{3,000,000}{1 + 3,000,000\ (0.0025)}$$

$$n = \frac{3,000,000}{1 + 7500}$$

$$n = \frac{3,000,000}{7501}$$

$$n = 399.9$$

$$n = 400$$

However, in this research five hundred and ninety-six (593) respondents used, with the intention of over-sampling to yield a large enough response rate to quantify the results and approach an answer to the research questions. Determining the sampling size that is appropriate to produce statistically significant results depended on several factors. These factors included goals, the precision of outcomes, confidence level and the degree of variability (Watson, 2001).

4.3 Unity of Analysis

As defined, a unit of analysis is who or what that is studied in a given research. Evidence from the social science research has established a unit of analysis as an organization, an individual, social interaction or a group of organization/individual

(Hair et al., 2010). Unit of analysis is consistent with the research problems and research question and objectives of the study. The target working populations for this

research work are from the 3,000,000 of the people of Sokoto State. The unit of analysis for this study are the individual rural dwellers of Sokoto State.

4.4 Data Collection Procedure

The researcher administered the questionnaire through hand delivery. It has been reported hand delivery of the questionnaire is more obtainable than Mail question. (Asika, 1991). Thus, the questionnaires were administered and collected through the use of the research assistance employed from the local government areas to assist quick responses and also to facilitate the realization of high response rate.

Consequently, the data used in the study were rendered by respondents from varied socioeconomic settings.

Number of questionnaires distributed	800
Number of questionnaires returned	700
Responds rate	90%
Total of valid questionnaires (valid response)	593

For this study a total of 800copies questionnaires was distributed, and the objectives were to achieve at least 50 percent response rate that is 400. The response rate was set in an organized way to ensure that non-response bias and non –response rate did not have an effect on the result. Moreover; this proportion was calculated in line with responses rate of preceding studies such as Ravichandran, Mani, Kumar, and Prabhakaran, (2010); Zafar, Asif, Zafar, Haunjra, and Ahmad, (2010) that employed

non-probability sampling received 36 percent, 85 percent, and 38.4 percent respectively.

Equally, the present response rate is considered sufficient going with the suggestion that a sample size should be within the range of 5 and ten times the number of study variables (Bartlett, Kotrlik, & Higgins, 2001; Hair et al., 2010). More importantly, 90% response rate falls within the range of typical response rate of 40-50% in social science study in Nigeria (Linus, 2001). Also, a response rate of 30% is considered adequate for a survey (Sekaran, 2003; & Hair et al., 2010).

4.4.1 Scale Dimensionality

The 5-Point Likert Scale with anchors ranging from strongly agree", "agree, disagree," "strongly disagree" to "not applicable" were used in the designing of questionnaires. Because this kind of scale can make concession between the contradictory goals of contribution choice (since only two or three alternatives means evaluating only path somewhat than the power of view). Thereby making things convenient for respondents, because not many individuals have a distinct thought of the disparity of eight and ninth Likert point on eleven-point agree-disagree scale also it is recommended from previous studies by (Fink, 1995; Dillman, 2008; & Dawes, 2008).

The questionnaires asked questions regarding policy process, economic growth, scheme design, mobilization and healthcare services. It also tested the relationship between the impact of PP, EG, SD, and MOBLIZ in the provision of health care services among the rural dwellers of Sokoto State, Nigeria. All the questions were

guided by key selection points to ensure that the responses collected were properly analyzed within the scope of this research. The constructs used in the questionnaire component of this study are coded, itemized, and at the same time showing their originality with justifications.

4. 4. 2 Measurement of Mutation

Four constructs were used to measure the impact of health services (IHS) namely policy process (PP) Adopted from Uzochukwu, Onwujekwe, Eze, and Solude, (2009). Economic growth (EG) Adopted from (Sachs and Warner, 1997; Gallup and Sachs, 2000; and Jamison, 2003). Scheme design (SD) Adopted from Obinna Onwujekwe, (2010). And Mobilization (Mobliz) Adopted from Uzochukwu, Onwujekwe, Eze, and Ezuma, Obikeze, Onuka, 2010 and Johnnes, 2003).

Statistical software (SPSS) 18 was used to test the reliability of the instruments utilized in the questionnaire for the main study. The variables within the research framework include policy process, economic growth, scheme design, mobilization on health care services as the dependent variable.

4.4.3 QUESTIONNAIRES

This study adapted questionnaires with modification for the study with the intent of responding to the four research questions. The target respondents were provided with a questionnaire to fill for most favorable reliability and validity of the result. The questionnaire was divided into two components in which the first part consisted of five sections comprising questions relating to the policy process, economic growth,

scheme design, mobilization, and the impact of health services while the second consist of demographic information of respondents.

4.4.4 Pilot Study

A pilot study was conducted in the main study to see whether the items measured what is supposed to be measured. It was also carried out to evaluate whether questions were framed in a way that would yield a better response, and to find if respondents could supply the needed data. Similarly, a pilot study is carried out to determine which best suits the respondents, because the primary aim is to receive feedback and use it to improve and adjust the data collection process. A pilot study was shown to confirm the reliability of the instruments in the study. According to Brooks and Johnson (2010), a total of 30 respondents is a reasonable minimum recommended for a pilot study of the population of interest. Therefore, in- line with this, a pilot test of 45 questionnaires was administered to the rural dwellers of Sokoto North, Sokoto South and Wamakko local government areas of Sokoto State.

These 45 questionnaires were distributed to the individual rural dwellers by the researcher through hand delivery and were fully completed and returned, representing a response rate of 100%. The pilot was carried out within 14 days (Table 4.1) for the result of the pilot test). According to Sekaran and Bougie, (2010), and Pallant (2001) posited that Cronbach's Alpha values are relatively affected by the number of items in the scale. The Cronbach's Alpha coefficient was carried out in this study to measure the internal consistency of the instruments. The 45 questionnaires as discussed earlier were coded using statistical package for social sciences (SPSS) version 18. The reliability test was run from the data, and the result

of the data was right, thereby indicating that only six variables were found to be reliable having Cronbach's Alpha coefficient of 0.5 which is in line with Kaiser, (1974) who posited that minimum standards greater than 0.5 as satisfactory. As indicated in Table 4.1 below:

Table 4.1
Summary of Reliability Test for Pilot Study

S/N	Variable	No. of items	Cronbach Alpha
1	Policy process	17	.749
2	Financing medical/ health services	5	.042
3	Economic growth	5	.593
4	Delivery of healthcare services	5	.539
5	Institutional design	6	.052
6	Scheme design	5	.643
7	Communication	6	.393
8	Mobilization	11	.656
9.	Health maintenance organization	6	.678

Source: (Tanko, 2015)

4. 5 Reliability and KMO / Bartlett's Test in the Main Study

From the pilot study, only three independent variables were shown to be significant and acceptable for the main study items on these instruments are appropriate enough to measure what they are supposed to measure with a positive level of reliability. While, the instruments, economic growth variable with Cronbach's Alpha 0.593 were not significant in the pilot study. So this instrument is subjected to further review by the experts, academics, and my senior colleagues to check and improve questions under the instruments so that they could be able to assess what they are believed to evaluate. The minimum Cronbach's Alpha required ranges from 0.50 to 0.70; Hair et al. (1998) 0.50 is required, while Churchill, (1999) recommended 0.60 and both Nunnally (1979); Venkatesh, (2000) suggested for a minimum Cronbach's Alpha Coefficient of 0.70.

Table 4.2
Reliability Measurement

Constructs	No. of Items	Cronbach's Alpha	KMO	Bartlett's Test
PPROCESS	17	0.761	0.708	.000
EEGROWTH	5	0.658	0.654	.000
SD	6	0.635	0.700	.000
CBHIS MOBL	11	0.592	0.539	.000
IMPACTCBHISHEALTH	8	0.665	0.756	.000

Source: (Garba, 2015)

Policy process (PP) as one of the independent variables with seventeen items (PP1, PP2, PP3, PP4, PP5, PP6, PP7, PP8, PP9, PP10, PP11, PP12, PP13, PP14, PP15, PP16 and PP17 were subjected to reliability test and the Cronbach's Alpha is 0.761 which is acceptable to be used in the main study. During the sampling adequacy, KMO is 0.708 also acceptable, with a significance level at 0.000 for all the seventeen items.

The economic growth has four items as (EGROWTH1, EGROWTH2, EGROWTH3, and EGROWTH4. Cronbach's Alpha is 0.658, and the KMO is 0.654 at the significance level 0.000, which is adequate for the main study. The third independent variable is Scheme design in CBHIS (SD) with six measuring items (SD1, SD2, SD3, SD4, SD5, SD6) the test of reliability is 0.635 Cronbach's Alpha while the KMO is 0.700 at 0.000 s revealing positive significance level. CBHIS mobilization is the last independent variable with eight measuring items (MOBILIZ1, MOBILIZ2, MOBILAZ3, MOBILIZ4, MOBILIZ5, and MOBILIZ6, MOBILIZA7, MOBILIZ8, MOBILIZ9, MOBILIZ10, and MOBILIZ11 are tested for reliability the test shows 0.592 Cronbach's Alpha while KMO is 0.756 revealing a positive significance at 0.000 levels.

The next is the dependent variable the Impact on Healthcare Services comprises eight measuring items (IMPACTHEALTHS1, IMPACTHEALTHS2, IMPACTHEALTHS3, IMPATHEALTHS4, IMPACTHEALTHS5, IMPACTHEALTH6, IMPACTHEALTHS7, and IMPACTHEALTHS8 the Cronbach's Alpha is 0.665 while KMO is 0.756 with an appreciable positive significance at 0.000

From the Cronbach's Alpha test it clear that (PPROCESS, GROWTH, SD, and MOBIL independent variables are reliable and acceptable to be used in the main study. They are also suitable constructs to the achievement of the research objectives. By and large, the Cronbach's Alpha for all the independent variables in the questionnaire ranges from 0.592- 0.761 which is acceptable for the main research study, while the KMO sampling adequacy test shows a higher level of partial correlation among the various variables ranging from 0.539- 0708. Finally, all items were subjected to the Bartlett's test of sphericity at 0.000 showing high significance.

In this field, all the particulars making the exogenous variables (independent and dependent variables) were submitted to PCA by SPSS software (Bryn, 2010, Hair et al., Raykov, & Marcoulides, 2006). The idea became necessary, although the steps are adapted from preceding research; on the other hand, the standards were not merely employed in the diverse background but were also prepared to order and costume the study ends. Additionally, Kaiser-Meyer-OLkin (KMO) measure of sampling adequacy was from 0.654 to 0.756 far above the recommended value of 0.6 (Maiyaki, & Moktar, 2011; Kaiser, 1970, 1974). Therefore, the value of 0.654 –

0.756 in this study is great values and for this reason, the data are considering fitting for factor analysis.

Likewise, in this study, the Bartlett's Test of Sphericity was revealed to be statistically significant at P >0.001 satisfying the factorability of the correlation matrix. The outcome shows that there exist some associations bounded by the variables under inquiry. PCA reveals the existence of eight mechanisms with eigenvalues of above 1 explaining the cumulative variation of 67.7%. Also, communalities in this study signify the amount of the variation in the original variables that described for by the factor solution.

Consequently, the factor solution should give details, at least, half of each original variable's variance, so the commonality value for each variable should be 0.50 or higher (Kaiser, 1974). Captivatingly, all the items have had a commonality value of 0.5 or greater apart from in the case of MOBL6 that has 0.385, thus, it has been noted for deletion and in line with (Kaiser, 1974). As a result, a respectable number of the items show simple structures by loading highly on only one component. However, a few items, in adding together, the items have commonality below 0.5; have been well thought-out for deletion during Confirmatory Factor Analysis (CFA) and reliable with (Gorondutse & Hilman, 2014; Maiyaki & Mouktar, 2011).

4.5.1 Reliability Analysis Results

In measuring the consistency of the scale, Cronbach's alpha was used as a measure of reliability. The reliability scores for all variables extracted were acceptable for the study. The lowest range of Cronbach's alpha for Mobilization variable was 0.592,

and the highest was 0.761 in the policy process. Nunnally, (1967) suggested that a modest reliability range from the variable mobilization instrument of between 0.5 and 0.6 would suffice. Therefore, the result of Cronbach's alpha of mobilization dimension values fulfills the minimum requirement level of reliability.

Furthermore, the Cronbach's alpha for policy process and economic growth were 0.761 and 0.658 while the variable impact of health care services and scheme design which were comparatively high and exceeded the proper cutting off point of 0.60 (Nunnally, 1978). Consequently, all items are reliable and good enough. Table 5.10 displays the Cronbach's alpha score for all item measures.

Table 4.3
Cronbach's Alpha Scores

Variables	Number of items	Cronbach's Alpha
Mobilization	11	0.592
Economic growth	5	0.658
Policy process	17	0.761
Scheme design	6	0.635
Impact of health care services	8	0.665

Source; (Tanko, 2015)

4.5.2 The Reliability and Validity of Research Instrument

In assuming a quantitative research, it becomes inevitable to think about the trustworthiness and the strength of the scale the researcher aims to use in the study. Reliability can be defined as the degree to which measurements are free from error and, therefore, yields consistent results (Carmines & Zeller, 1979). The reliability of measures is an indication of stability and consistencies in which the instrument measure concepts and help to assess the goodness of items (Sekaran, 2003). Reliability and validity are two significant characteristics that can undoubtedly

include the nature of the information the researcher gets to the research study. Consistent with Pallant (2011), the researcher may as well recognize the scales intended for the study, and guarantee the reliability and solidness of the study. A researcher might as well note that regardless of how great discoveries on the reliability and validity of the scales, it is essential for the researcher to pilot the instrument(s) planned for the study.

The two most often utilized pointers of reliability are test-retest reliability and internal consistency reliability. The test-retest reliability of the weighing machine measured by administering a test to a sample of the same individuals, on two distinctive standard parts, and getting out the correlation between the two scores acquired (Salihu et al., 2011). On the same page, high test-retest associations show true to scale as noted by Pallant (2011).

Then again, inside consistency measures the degree to which the things that make up the scale measure the same underlying property. The most regularly utilized statistics for measuring inner consistency is Cranach's coefficient alpha. The statistic typically gives an evidence of the proper relationship between all things that make up the scale

Cronbach's alpha value regularly relies upon the amount of spots on the shell. While, special purposes of reliable quality are acknowledged in examination studies, contingent upon the nature and use of the scale, Kaiser (1974) recommends accepting values greater than 0.5 as acceptable.

Furthermore, Nunnally (1978) recommends a minimum score of 0.7 Cronbach's alpha values, regardless of the numbers on the scale. Briggs and Cheek (1986), on

the other hand, recommend the correlation values ranging from 0.2 to 0.4. The 0.50 minimum acceptable values were applied in the study to evaluate the constructs in the framework.

Validity means the extent to which any measuring instrument measures what it is intended to measure (Carmines & Zeller, 1979). Therefore, it refers to the degree in which construct measured is the unbiased and consistent measurement across time and several items in the instrument.

Cohen et al., (2007) put that convergent evidence of constructing validity could be made by the use of factor analysis, in that such an examination is specially planned to recognize variables that are set out to pass on upon or represent test performance.

In pair with Cohen et al., (2007), Sellitz et al., (1976) opined that the generosity of the plate is examined as the degree to which differentiates in scores reflects exact complexities around individuals on the qualities that the researcher looks to measure.

Neumany, (2000) posit that validity refers to the extent, which a test measures what we wish to measure: it is based on the adequacy with which the items in an instrument measure the attributes of the study. Do we measure what we think we are? Three types of validity addressed in this work.

Face validity – the probability that a question would be misconceived or misinterpreted; **Content validity** – whether an instrument provides sufficient coverage of a theme; and **Construct validity** – relates to the theoretical practicalities underlying a particular measurement. The responses from the pilot study conducted

were used to address face validity with items rewritten if they were found to be misinterpreted or are removed entirely.

(a) The content Validity

The content validity of the instrument was determined as follows. The researcher discussed the items in the questionnaire with my supervisor from my Universiti for his input on the questionnaire if it measures what it is supposed to measure or not. Experts in the field and my senior colleagues are also contacted for their opinion on the instruments, and their input and correction was noted and corrections made. A coefficient of above 0.5 suggests that the questionnaire is valid.

(b) Construct Validity

The solution for the construct validity, Mugenda, and Muganda, (1999) that the following steps considered on the construct validity of

i. Establish a chain of evidence.

ii. Use multiple means of information.

Set up a sequence of confirmation was performed in three ways

i. The questionnaire as an instrument for data collection.

ii. The literature review, which provide an emerging framework.

iii. The Pilot study, which filled the gap between the emerging conceptual framework and later field research.

Furthermore, these results were validated in statistical studies.

Multiple sources of information used in the form of two kind ways:

i. From Primary data in the form of questionnaires on health care services.

ii. A thorough review of Literature of previous empirical studies.

Through Key respondents considering the survey report: Therefore, several respondents were requested to comment on some of the findings. Therefore, in the design of some survey instruments, there is the likelihood of coming across uncertainties that were adequately being taken care in this study. The subject will, thus, ensure the reliability and strength of the shells before the administration of the instrument on the respondents by conducting a pilot test on the right respondents in Sokoto State, Nigeria.

4.6. Reliability Test

Reliability is mainly talking about consistency in measure and it allows for estimation of error. Cronbach's alpha was used to explain how well the items in a set positively correlated with each other. Nunnally (1979) asserted that the nearer the value of the Cronbach's alpha to 1 the higher the internal consistency and between 0.6 as sufficient for research. On the other hand, Bartlett's test of sphericity was also

conducted to test sample adequacy of the factor analysis, and 0.50 is considered adequate Kaiser, (1974). Also, Bartlett's test was conducted into whether the correlation matrix has an identity matrix and the significance at p<. 000 or not.

4.7 Method of Data Analysis

There are technicalities in conducting data analysis for a quantitative research study. The researcher will ensure that all the measures followed to obtain accurate and precise findings at the end of the study. Data received from the study will be analyzed to satisfy the multivariate analysis requirement. Data coded into the Statistical Packages for Social Sciences18 (SPSS) software. The data was broken down into levels. Stage one will check the respondents' general profile, which has to do with frequencies and unique examination of the respondents, this study goes a long way to distinguish biases, feelings in the reaction of the respondents. While analyzing the data collected from the field, the need arises to note the observations that do not logically fit variables of the study were removed. These observations must be accounted for during the analysis of the findings of the study.

This example of reflections is called missing values, and it may occur for some reasons such as no response, no reply from the Respondent, encoded answers, incorrect measurement and loss data or incomplete data. All these data will be reported in the table note. The number of missing data will be added to the valid responses to account for all the answers in the sample of the study. Information on all the variables will be exemplified with data and illustrated with frequencies and group information. However, this can easily be made out through computer programs.

Therefore, the order will work along the technical sequence of conducting research using quantitative techniques.

4.8 Quantitative Data Analysis Techniques

In the analysis of quantitative data collected through questionnaires embossed of variables of the policy process, economic growth, scheme design, mobilization on the impact of health care services were analyzed using regression analysis to test the association between independent variables, and dependent variable.

Descriptive statistics is conducted to see the mean and standard deviation. According to Pallant, (2001), descriptive statistics have some uses that comprise:

- To explain the features of the sample
- To verify variables for any infringement of assumptions inherent with the statistical technique that will be used to address the research questions
- To deal with specific research questions.

Besides that, correlation analysis was guided to observe the interrelationship between the variables in the research study. Correlation results point out whether there is a significant relationship in regression analysis (Pallant, 2001). Correlation values that are 0.9 and above show that there is multicollinearity (Hair *et al.,* 2010). Additionally, correlation analysis was also carried out through bivariate correlations to display the direction and significance between the variables used in the study. They are explained in detail in the next chapter.

Multiple regression analysis provides an avenue for neutrally assessing the degree of the relationships between independent and dependent variables (Sekaran & Bougie, 2010; Hair, Money, Samovel & Page, 2007). The regression coefficients are used to indicate the relative importance of each of the independent variables in the prediction of the dependent variable.

When the control variables and independent variables jointly regressed against the dependent variable in an attempt to explain the variance in it. The size of each regression coefficients will show how much increase in one unit in the particular variable would affect the dependent variable, taking into cognizance that all other individual variables and dependent variable cave into multiple correlation coefficients (Sekaran & Bougie, 2010; Zikmund, Babin, Carr & Griffin, 2009).

By a regression technique, the relationship of the proposed research model and the properties of the scale were analyzed using Statistical Package for Social Sciences (SPSS) version 18. This thesis is going to examine a research question How is the impact of the policy process, economic growth, scheme design, mobilization on health care services? Therefore, the questions are formulated below as:

A response to research, question one regarding the question of In what ways is the policy process impacts the provision of health care services? Was generated by computing means and frequency for each survey item were statistically analyzed.

A response to research, question two, regarding the question of Of what value is the impacts of economic growth in the provision of health care services? Was also statistically analyzed. A response to research, question three, regarding the question

of Does scheme design have any impacts on the provision of health care services? Was also statistically analyzed. A response to research, question four, regarding the question of Does mobilization of the rural community impacts on the provision of health care services? Were statistically analyzed.

This study used multiple regression analysis techniques to analysis the association amid the policy process, economic growth, scheme design, mobilization impact on healthcare services as depicted in the research model.

4.9 Multicollinearity

Multicollinearity is a dilemma that occurs when the independent variables were tremendously interrelated to as high as 0.9 and above (Tabachnick, & Fidell, 2007). As soon as two or above constructs are extremely unified, they surround redundant information, and for that reason, not all of them are necessary for the same analysis, since they improve or raise the size of error terms, and thus, grow weaker the analysis. If the multicollinearity problem observed, it could be determined by deleting the offending variables(s). For screen for multicollinearity, Variance Inflator Factor (VIF) and Tolerance level are examined via regression results from the SPSS.

The universal rule of cutoff points is that the VIF and the Tolerance values should not go beyond 10 and be supposed to not less than 0.10, correspondingly (Hair et al., 2010). From the Table 4.3, it clearly shows that tolerance ranges between 0.52 – 0.63 considerably > 0.10. Similarly, VIF ranges from 1.58 – 2.18, and therefore, is good adequate as being < 10 (Tabachnick, & Fidell, 2007). As a result, it is resolved that there is no multicollinearity dilemma amongst the independent variables.

Table 4.4
Multicollinearity Test based on Tolerance and VIF Collinearity Statistics

Independent Variables	Tolerance	VIF
Policy process .45	.45	2.18
Economic	.52	1.89
Scheme design	.53	1.88
Mobilization	.63	1.58

Source: (Tanko, 2015)

4.10 Factor Analysis

Factor analysis as a statistical modeling approach was first formulated and employed by an English psychologist called Charles Spearman in studying unobservable hypothetically existing variables (Raykov, & Marcoulides, 2006). Like the course analysis, available literature has shown that factor analysis also has a lengthy history in business research (Hair et al., 2010; Hau, & Marsh, 2004). Although, Raykov, & Marcoulides, (2006) argues that Spearman, (1904) proposed the known individual's ability scores that are the manifestations of the general capability now called the general intelligence and several other similar abilities such as the verbal or numerical skills.

These general and specific factors were both combined to produce the currently known ability performance. An idea that are later labeled the two-factor theory in human abilities. Paramount is that as more and more researchers become interested in this factor approach, the theory was later extended to accommodate many factors and its corresponding analytic approach resulted in what we now called "factor analysis (Raykov, & Marcoulides, 2006).

More often than not, the use of factor analysis could explain as a modeling approach that is employed in considering hypothetical construct through various indicators or

open proxies that can be measured openly (Byrne, Hair et al., 2010; Raykov, & Marcoulides, 2006). Factor analysis seen as exploratory factor analysis (EFA), if the issue of interest is related to recognizing how many latent constructs or factors are needed efficiently to explain the ties that exist among a lot of observable measures (Hair et al., 2010; Hu and Bentler, 1995).

The following is factor analysis result in Table 4.5

Table 4.5
Factor Analysis Result for Policy Process (PP)

Codes	Loading(s)	Communalities	Cronbach's Alpha	Anti-Image Matrices
PPROCESS1	0.662	0.427		0.895
PPROCESS2	0.710	0.508		0.744
PPROCESS3	0.666	0.444		0.598
PPROCESS7	0.525	0.299	0.761	0.72
PPROCESS12	0.757	0.599		0.735
PPROCESS13	0.853	0.741		0.687
PPROCESS14	0.807	0.655		0.651

Note: Likert Endpoint: = Strongly Disagree and 5 = Strongly Agree (N = 593)

The result of factor analysis for Policy Process independent variable (PPROCESS) indicated that the loading ranges from a minimum of 0.525-0.807, and this is above the recommended 0.5 cutoff principle by Kaiser, (1974). While, the communality is the variance explained by the extracted factors. Therefore, the communality for seven measuring items for (PPROCESS) ranges from 0.427-0.741, which is above the cutoff principle of 0.50 as recommended by Kaiser (1974) is obtained. Therefore, all the seven items are capable of explaining the variance among the variables in the study. Hence Cronbach's Alpha of 0.761 the anti-image matrix was used to ascertain the degree of sufficient correlation among the variables.

Those items that have communality below 0.5 have been well prepared for deletion through Confirmatory Factor Analysis (CFA) and reliable with (Gorondutse & Hilman, 2014; Maiyaki & Mouktar, 2011). Therefore, in this study, the anti-image of PPROCESS ranges from 0.651-0.895 indicating that there is a sufficient correlation between the variables in the study. The second independent variable is the Effect of Economic Growth on CBHIS (EEGEOWTH) following is the factor analysis result presented below:

Table 4.6
Factor Analysis Result for Economic Growth (EGROWTH)

Codes	Loading(s)	Communalities	Cronbach's Alpha	Anti-Image Matrices
EGROWTH1	0.814	0.675		0.677
EGROWTH2	0.796	0.675	0 .658	0.635
EGROWTH3	0.851	0.732		0.635
EGROWTH5	0.779	0.634		0.683

Note: Likert Endpoint: = Strongly Disagree and 5 = Strongly Agree (N = 593)

Table 4.6 above the result of factor analysis of the Economic Growth on CBHIS (EGROWTH) shows that the loading ranges from 0.779- 0.851 above the recommended minimum cutoff principle by Kaiser, (1974), Hair et al. (2007). Also, the communalities range from a 0.634- 0.732 which is an acceptable showing variance among the variables. While the Cronbach's Alpha coefficient of the variable is 0.658 also acceptable Churchill, (1999), the anti-image matrices correlate ranges from 0.635- 0.683 signifying that the Economic Growth (EGROWTH) can adequately correlate with the other variables in the study. Also, Scheme Design (SD) in CBHIS variable was subjected to factor analysis. The following is the table 4.7 factor analysis of scheme design.

Table 4.7
Factor Analysis of Scheme Design (SD)

Codes	Loading(s)	Communalities	Cronbach's Alpha	Anti-Image Matrices
SD1	0.843	0.715		0.659
SD2	0.801	0.687		0.653
SD3	0.620	0.447	0.635	0.718
SD4	0.702	0.497		0.761
SD5	0.753	0.568		0.688
SD6	0.600	0.385		0.742

Note: Likert Endpoint: = Strongly Disagree and 5 = Strongly Agree (N = 593)

Scheme Design factor loading indicates higher loading of 0.600- 0.843, and this is considered the most appropriate value in exploratory factor analysis (Nunnally, 1978). While, the communalities of the variables range from a lower value of 0.385-0.715 Neil, (2011) recommended that communalities from 0.350 and above are adequate to explain the variance. Furthermore, the Cronbach's Alpha for Scheme Design (SD) for CBHIS is 0.635 and the values for anti-image matrices are within 0.653 to higher 0.761 which indicate sufficient correlation with the other variables in the study. Mobilization (MOBILIZA) for CBHIS is the last independent variable for factor analysis in this study.

Table 4.8
Factor Analysis Result for Mobilization (MOBILIZA)

Codes	Loading(s)	Communalities	Cronbach's Alpha	Anti-Image Matrices
MOBILIZ1	0.882	0.777		0.520
MOBILIZ2	0.870	0.760		0.523
MOBILIZ3	0.524	0.295	0 .592	0.524
MOBILIZ10	0.765	0.601		0.541
MOBILIZ11	0.773	0.616		0.543

Note: Likert Endpoint: = Strongly Disagree and 5 = Strongly Agree (N = 593)

Mobilization (MOBILIZ) for CBHIS factor loading result as indicated in Table 4.8 above shows a higher loading value ranging from the lower of 0.524 to the higher 0.882 which is above the recommended value cutoff principle by Hair et al. (2006).

While the communalities for MOBILIZ from a low of 0.295 to the higher of 0.777, this means that there is proof of higher communalities, and the variables are all duly enough to explain the variance. Furthermore, the Cronbach's Alpha Coefficient for MOBILIZ is 0.592 as suggested by Hair et al. (1998) that Cronbach's Alpha 0.5 to 0.70 as acceptable. Therefore, all the items are sufficiently correlated with other variables and appropriate to be included in the analysis while the next variable is the dependent variable Healthcare Services (IMPACTHEALTHS).

Table 4.9
Factor Analysis Result for the Impact of Healthcare Services (IMPACTHEALTHS)

Codes	Loading(s)	Communalities	Cronbach's Alpha	Anti-Image Matrices
IMPACT HEALTHS3	0.992	0.991		0.856
IMPACT HEALTHS 4	0.664	0.441		0.788
IMPACT HEALTHS5	0.601	0.408	0 .665	0.791
IMPACT HEALTHS6	0.749	0.585		0.711
IMPACT HEALTHS7	0.749	0.585		0.711
IMPACT HEALTHS8	0.707	0.508		0.736

Note: Likert Scale Endpoint: 1 = Strongly Disagree and 5 = Strongly Agree (N=593)

In the table above the result of factor analysis for the Impact of Healthcare Services (IMPACTHEALTHS) shows a higher loading ranging from a low of 0.601 to 0.992 indicating the appropriateness of the variance of the dependent variable exploratory factor analysis. The communalities result in ranges from the minimum of 0.363 to a maximum of 0.991, and this shows the evidence of higher communalities among the variables and is suitable enough to explain the variance while Cronbach's Alpha Coefficient for IMPACTHEALTHS is 0.665 which is above the acceptable value. Also, anti-image correlation matrix ranges from the low of 0.711 to 0.856 which

means that all items possessed the sufficient correlation with other variables and where appropriate to be included in the analysis.

In the main study 700 (N=700) completed questionnaires were used to determine the reliability of the measuring instruments. Reveals that 22.0% were Female heads of household, Male head household, 38.1%, were Wives, 13.9%, were Grandmother, 1.9%, were Representative of household, 24.1%. Descriptive statistics shows that the respondents male head of household participated more, follow by the representative of the household, and then follow by the female head household, follow by wives and lastly by a grandmother. It's evidently seen that the majority of the respondents are the male head household follow by the others. Whereas the descriptive statistic reveals that 35% were not the primary income earner among the respondents, while 64.8% were household principal Income earners in the household.

The descriptive statistics on the principal income earner in the family it reveals that, yes 251 35.8%, while no 449 64.2%, it means that 251 respondents are the primary income earner in their family while, 449 respondents are not the income earners in their family. The descriptive statistics on the Number of people living in the household it reveals that, 1-5 36.6%, 6 – 15 44.0%, 16 – 25 11.6%, 26 – 35 4.1%, whereas 35 and above are 3.7%. This means that the respondent living in the household 6 - 15 is in the majority, follow by 1-5 people living in the household, next is 16 – 25, and then 26-35 and from 35 and above. It means that household with 44% participated more in this survey than others. Similarly, the descriptive statistics reveal that from the age group 0 – 18 6.4%, 19 – 25 54.4%, 25 – 35 29.6%, 35 – above 9.6%. Here, the respondent in the age group from 19 – 25 years participated

actively in the survey, follow by those in the age group of 25 – 35 years with 29.3%, meaning that the middle age group participated more than the young and old in this survey.

Furthermore, the descriptive statistics on the sex of the respondent reveals that female respondent was 52.4% while male respondent were 47.6%. It means that male respondents participated more in the survey than their female respondents with 47.6% participated. Hence, this reveals that male respondents participated more than female respondents.

Furthermore, the descriptive statistics on the highest educational status. The analysis shows that respondents who have never attended school were 53.4%., follow by respondent with primary school certificate were 44.4%, follow by those respondents who only attended secondary school were 0.4%, follow by respondent with vocational college certificate were 1.4%, then lastly, those respondents with a university or higher degree with 0.4%. The result reveals that respondents who have never attended school participated more in this research follow by those respondents with primary school certificate, follow by those with a vocational certificate and lastly by those respondents with a university or higher certificate. It means that rural dwellers who are not educated participated more in the survey than the other groups.

Whereas, the descriptive statistics of the Occupation of the respondents were those Unemployed 76.6%, follow by those respondents who engaged in petty trading were 14.6%, follow by those respondents who were Self-employed professional were 4.3%, follow by those respondents who were farmers were 4.1%. And then lastly those respondents engage with the private sector was 0.4% (Tanko et al. 2015).

Therefore, it means that respondents who are unemployed participated more in the survey, follow by those respondent doing petty trading, self-employed professionals, farmers and lastly those employed in the private sector. Following is the table 4.10 the survey respondent's demography.

Table 4.10
Survey Respondents Demography

S/N	Items	Frequency	Percentage
1	**What is your status in your household**		
	Female heads of household	154	22.0
	Male head household	267	38.1
	Wives	97	13.9
	Grandmother	13	1.9
	Representative of household	169	24.1
2	**Are you the principal income earner in your family?**		
	Yes	251	35.8
	No	449	64.2
3	**How many people live in your household**		
	1- 5	256	36.6
	6 –15	308	44.0
	16 – 25	81	11.6
	26 -35	29	4.1
	35 – above	26	3.7
4	**How old are you**		
	0 – 18	48	6.4
	19 – 25	379	54.4
	25 – 35	206	29.6
	35 – above	67	9.6
5	**Sex**		
	Male	367	52.4
	Female	333	47.6
6	**What is your highest education status**		
	Never attend school	374	53.4
	Primary school	311	44.4
	Secondary	0.3	0.4
	Vocational college	0.9	1.4
	University or higher	0.3	0.4
7	**What occupation is your a major source of income**		
	Famer	29	4.1
	Unemployed	536	76.6
	Petty trading	102	14.6
	Self-employed professional	30	4.3
	Employed in the private sector	3	0.4

Source: (Tanko, 2015)

Based on the above, it might be conscious that the respondents who took part in the research rendered acceptable variance concerning their settings. For this reason, the information used in the survey was supplied by respondents from various commercial settings.

4. 11 Tests of Non-Response Bias

Non-response has been defined as the mistake a researcher expect to compose while forecasting a sample feature since some types of survey respondents are under-represented due to non-response (Berg, 2002). It is easily explicated in the literature that there is no minimum response rate below which a survey idea is necessarily biased and, conversely, no response rate above which it never bias (Singer, 2006, p. 641). No matter small the non-response, there is a possible bias that must be looked into (Pearl, Fairly, 1985; & Sheikh, 1981), hence the need for taking the non-response bias analysis for this survey.

At the same time as shown Table 2, respondents were regarded as into two independent samples based on their reaction to the questionnaires concerning five primary survey variables (Policy process, Economic growth, Scheme design, Mobilization and Healthcare services).

The most ordinary the criterion ways to test for non-response bias in this inquiry is to contrast the reactions of those reacted to the questionnaires circulated early before the end of April 2014 and those who answered the questionnaires circulated after April 2014 (Tanko et. al., 2015). Presented in the table below, it might mostly seen

that range mean and standard deviation of early response and previous answer are distinctly separate.

The 2 tailed t-test result (Table 3 shows that there is no significant difference with respect to early respondents and late once based on Policy process (t 1.084, p<. 075), Economic growth (t. 002, p<. 300), Scheme design (t. 001, p<. 002), Mobilization (t. 135, p<. 140) and Impact of community health (t. 044, p<. 060) (Tanko et. al, 2015).

For that reason, based on the t-test results it can be satisfied that there is approximately no difference among the previous participants and the past participants, and accordingly no problem of non-response bias.

Table 4.10.1
Group Descriptive Statistics for Early and Late Respondent

Response bias	N	Mean	Std. Deviation	Std.	Error Mean
Policy Process	1 EARLY RESPONSE	466	3.4077	.52165	.2417
	2 LATE RESPONSE	233	3.4780	.47423	.03107
Economic	1 EARLY RESPONSE	466	3.2501	.76494	.03544
	2 LATE RESPONSE	233	3.4268	.66311	.04344
Scheme Design	1 EARLY RESPONSE	466	3.3569	.65985	.03057
	2 LATE RESPONSE	233	3.5200	. 59451	.03895
Mobilization	1 EARLY RESPONSE	466	3.5447	.52046	.02411
	2 LATE RESPONSE	233	3.6080	.53935	.03533
Impact of HCS	1 EARLY RESPONSE	466	3.4271	.78165	.03621
	2 LATE RESPONSE	233	3.5383	.63273	.04145

Source: (Tanko, 2015)

Table 4.10.2

Independent Sample T-test for Equality of Means Levens' Test for Equality of variance

		Leven's Test for Equalityof Variances		t- test for Equality of Means						
									95% Interval Confidence the of Difference	
		F	Sig	t	df	Sig.(2-tailed)	Mean Difference	StdErrorDifference	Lowe	Upper
Policy Process	Equal variances (Assumed)	2.865	.091	1.730	697	.084	07029	.041	.150	.00948
	Equal variance (Not Assumed)			1.786	505.375	.075	0729	.03936	.14762	.00704
Economic	Equal variances (Assumed)	7.191	.008	3.006	697	.003	.17672	.05878	.15006	.06131
	Equal variance (Not Assumed)			3.152	527.023	.002	.17672	.05606	.14762	.06659
Scheme Design	Equal variances (Assumed)	4.509	.034	3.182	697	.002	.16313	.05126	.26376	.06249
	Equal variance (Not Assumed)			3.295	509.397	.001	.16313	.04951	.26039	.06586
Mobilization	Equal variances (Assumed)	.940	.333	1.496	.697	.135	.06323	.04227	.14622	.01976
	Equal variance (Not Assumed)			1.478	449.686	.140	.0632	.04278	.14730	.02084
Impact of HCS	Equal variances (Assumed)	1.138	.287	1.885	697	.060	.11123	.05901	.22709	.00463
	Equal variance (Not Assumed)			2.021	558.806	.044	.11123	.05504	.21934	.00312

Source: (Tanko, 2015)

4.12 Descriptive Analysis

Descriptive statistics is used to summarize data, similarly is often used to describe phenomena of interest (Sekaran & Bougie, 2010). The primary descriptive statistics are the mean, median, range, mode, variance, and standard deviation (Sekaran, & Bourgie, 2010; Tabachnik, & Fidell, 2011). the mean is the sum amount scores in a data circulation separated by the number of scores. The median is the center point of a data division. The range is the difference between the highest to lowest scores in a data allocation. The mode is the maximum repeated score for the mean of a data sharing. Standard deviation is the square root of the variance (Ticehurst, & Veal,

2000). The most frequently used measurements for inferential statistics is the Pearson correlation between samples (Sekaran, & Bougie, 2010; Sekaran, 2003).

The Standard Deviations were noticed to be small (ranging from 0.80 to 1.28) which represents that the data are well dispersed and jointly distributed to the mean, whereas the mean seems to be more various (from 3.60 to 4.99).

Table 4.11
Illustrates the Findings

	Mean	Standard Deviation
Impact of health care services	3.4781	.64593
Policy process	3.4627	. 49184
Economic growth	3.4331	.71397
Scheme design	3.4463	.61849
Mobilization	3.5838	.48005
N	593	

Source: (Tanko, 2015)

4.13 DATA SCREENING AND EDITING

4.13.1 Coding

The burden of coding is to make it easy for identifying the particulars. Thus, an exploit was created while designing the questionnaire to assure that all items had a number to help when keying in the information. The coding based on the number and exclusive variable name. Following that, the code will be recorded in the code book comprising all the constructs in the questionnaire.

4.13.2 Editing Data

The brought back questionnaires were checked for rawness the questionnaire that was unanswered were unwanted and marked as blank. In the same way, questionnaires with a considerable number of items (for example25%) left

unanswered were all unwanted, for a question with only two or three items left blank, the conversation is in the missing data section. All were correctly filled as instructed.

4.13.3 Missing Data

Given the effect of missing data in the analysis, the researcher took preventive achievement right from the field of data collection to decrease their rate. On receiving of finished questionnaires, the researcher/research assistant quickly checked from the commencement to end to make sure that all questionscorrectly answered. In the box, a participant unseen a question(s) he/she was immediately required to fill the questionnaire gently correctly (Maiyaki & Moktar 2011;Gorondutse & Hilman, 2014).

Therefore, this helps considerably in lessening the figure of missing data in the research. Subsequent placing the data into SPSS software, first round descriptive statistics was run to distinguish whether or not there were missing data. The descriptive statistics are showing that two cases had important missing values and appeared to be at random, and, consequently, were removed from further analysis (& Moktar & Maiyaki, 2011; Gorondutse & Hilman, 2014). Therefore, this is in line with the recommendation of Hair et al. (2010). That any situation with more than 50% missing data should be removed as widespread as the sample sufficient (Maiyaki & Moktar, 2011; Gorondutse & Hilman, 2014). Moreover, a process for treated missing data is basically to drop the case (Tabachnic and Fiddel, (2007).

4.13.4 Assessment of Outliers and Treatment

Aside from missing data, another considerable step in data screening is the assessment and handling of outliers, which are the unnecessary case loads that may most likely suffer a significant negative impact on the outcomes (Gorondutse & Hilman, 2014; Maiyaki & Moktar, 2011). Outlier cases characteristically have an unusually high or low value, a construct or a typical variety of values across several constructs, which demonstrate the examination stand out from the remaining (Bryn; 2010, &Hair et al., 2010).

Therefore, using multivariate analysis may confirm the detection and handling of outliers accordingly. Hence, all the two; univariate and multivariate outliers were found out in this survey. Univariate outliers were checked using SPSS by discovering cases with large z-score values. Therefore, the case with standardized z-score values of more than 3.29 is reckoned to be potential univariate outliers (Tabacnic & Fiddle, 2007). Additionally, about the suggestion of Tabachnic and Fiddle (2007) Mahanalobis Distance (D) was conducted to recognize and deal with multivariate outlying cases (Hair et al., 2010).

The method is to run Mahalanobis in the SPSS and then pass judgment on the values with that of the Chi-square table (Tabachnick & Fidell, 2007).Known that 49 items were adapted, signifying the degree of freedom in the X2 table with $P<0.001$, so the standard is 85.35 (Tabachnick & Fidell, 2007; Gorondutse & Hilman, 2014). This means that any figure with a Mahalanobis Distance of 85.35 and above, and as a result, multivariate outlierwere removed from contention in the analysis. Therefore,

an aggregate of 46 univariate outliers was removed while 63 multivariate outliersalso removed respectively.

4.14 Normality Test

Normality is the mainly necessary deduction in multivariate analysis (Tabachnic & Fidell, 2007; Hair et al., 2010). It deals with the nature of data flow for an individual commonly construct and its association with the normal distribution (Tabachnic & Fidell, 2007). Additionally, when the final aim of the research is making an assumption, then screening for normality is a significant step in almost all multivariate analysis (Tabachnic & Fidell, 2007; Hair et al., 2010). Consequently, all the two; the univariate and multivariate normality were analyzed.

The initial test of normality reveals that there was a sign of non –normality, which was made known by calculating the Z-score values for each item. As a few cases had a Z-value of more than +2_ and extended above the variables. Consequently, following the transformation, the Skewness and Kurtosis of all the items are within the acceptable range of < 2 and < 7 correspondingly. For example, skewness values are less than 2; equally, the kurtosis values, are less than 7. Conceivably this is in line with the assessment of Tabachnick and Fidell, (2007) that data transformation improves outcome, and that normality should be re-checked after standardization.

Significant that homoscedasticity testassociated with the assumption of normality, if the data are justly standard, then the relationships among the variables is supposed to be homoscedastic and. Thus, heteroscedasticity is absent (Tabachnick, & Fidell, 2007). The circumstance that, both the multivariate and univariate

normalityestablished in this research work, it could be decided that the assumptions of homoscedasticity and the nonappearance of heteroscedasticity are accomplished.

4.15Discussion on Quantitative Findings

The following discussions of the studybased on the research objectives as presented in chapter one as follows:

1. Analyze the impacts of policy processes for the provision of health care services.

2. Examine the impacts of economic growth on the provision of health care services.

3. Investigate the impacts of scheme design on the provision of health care services.

4. Examine the impacts of mobilization on the provision of health care services.

From the regression analysis, the result found that the policy process is significantly related to health care services (β= 0.251, P= 0.000). However, no previous studies were conducted to test the relationship between Policy Process and the Impact of Healthcare Services among the rural dwellers of Sokoto State, Nigeria. The policy of health insurance and its promotion is related to the provision of healthcare facilities to contain a significant result on consequences.

The idea of micro insurance and payment of premiums in advance to meet the cost of health care is not known in many emerging countries(Dror et al., 2007, & Meghan, 2010). Therefore, it is important to have apolicy in place that encourage the establishment of health insurance/CBHIS in the rural communities as well as to support the effort made by scheme proponents to create awareness and market community-based health insurance among the rural communities.

Because providing knowledge of the policy is a requirement to encourage individuals to apply for membership and thereby enhance the risk-sharing capacity of the community-based health insurance system. Defourny and Failon, (2008) posited that creating awareness is very imperative from the perspective of developing a sense of ownership, thereby engaging the rural communities in the collection of premium, resource mobilization, scheme administration, and supervision activities by the policy makers.

Also, it's the responsibility of the state government to provide enabling legal framework which will serve as a guideline to the setting up of the CBHIS. And also for the state government to formulate policy onsubsidies to the vulnerable groups in the various communities to boost membership so that there will be massive pooling of resources that will make the CBHIS provide the most needed health care services.

The regression analysis also revealed that economic growth is significantly related to the impact health care services (β= 0.166,P= 0.000).This result is consistent with (Sauerborn et al. 1996; OECD & WHO 2003; Scheil-Adlung et al. 2006; Asfaw and Jutting, 2007. Considering the fact that people in sub-Saharan African rural areas rely mainly on their labour productivity and assets as livestock for income

generation, a severe decline in income can be prevented through community-based health insurance scheme.

Former studies have shown that demand for health care at the community level of health care is inclined by the ability of the rural people to pay (Gertler & Van der Gaag, 1990).In line with the above, Tallinn, (2006) uses adult mortality rate, fertility rate, and life expectancy to examine the economic costs of ill health along with benefits from improving it for Estonia. The study finds that fertility rate and adult mortality rate have a significant and negative impact on both OLS and Fixed effect model specification.

Furthermore, by using survey data, the study also concludes that ill health has a statistically healthy and negative impact on labor supply and efficiency at the individual level. Hence, being healthy isimportant for the rural dwellers as that will make them boost their labor productivities thereby increasing their economic activities.Thus, on that point is a substantial relationship between the economic growth of the impact on healthcare services among the rural dwellers of Sokoto state Nigeria.

The regression analysis reveals that scheme design is significantly related to the impact on healthcare services (β= 0.260, P= 0.000). Community-based health insurance in some form has been identified to play a major role in rural communities' access to healthcare and turns the unexpected health expenditures into expected payments in the form of insurance that in turn encourage rural dwellers to invest further in their well-being (Asgary et al. 2004; OECD & WHO, 2003). The appropriateness of a CBHIS partly depends on outside determinants that can hardly

be influenced by the scheme such as a country's legal and policy framework (Criel, 1998b). But, however, the function of the organization and its functioning, as well as community support, are vital factors of sustainability.

The best size of a system to ensure sustainability and adequate risk pooling and possible verge levels of membership needed to realize substantial savings on the scale are not yet known (Debaig, & CIDR 1999). Therefore, the way health insurance is designed would determine its success, and design people-oriented health insurance will lead to its success, and more people will enroll thereby pooling more resources to reduce out-of–pocket expenses whenever accessing health care services by the rural dwellers of Sokoto state Nigeria.

The result from the multiple regression analysis shows that there is a positive relationship between mobilization and health care services (β= 0.119, P= 0.002). According to Delgado-Gaitan, Concha (2001), community call-up is a procedure that is called forth by a community themselves, or by others. That is planned, ran out, and measured by the community's individuals, groups, and systems on a participatory and sustained basis to improve the health care, cleanliness and learning degree to intensify the overall standard of livelihood in the rural residential districts.

Establishing CBHIS through mobilizations of the rural dwellers is very substantial. Community readiness for helpoften regarded as spontaneous developments began from the people, which describe the type of personality improvement with little scale ventures (Prusad, 2003).Therefore, Community mobilization is necessary for the participation of the rural dwellers in providing the much-needed healthcare services

in the rural areas to have relief of difficulties families face when accessing healthcare services.

Interpersonal communications by community members was one of the key change strategies employed by the Programa a Su Salud (To Your Health), a health promotion project implemented in Eagle Pass, Texas. The scheme was developed to assess the impact of health communication campaigns using culturally relevant role models selected from the local community (Amezcua et al., 1991). Therefore, through this way the rural dweller can understand the message well and articulate what CBHIS stands for regarding providing the much-needed health care services at an affordable cost, thereby reducing the high bills they generally pay when accessing health care through an out-of-pocket mechanism that is most prevalent in the rural communities.

A Women's Health Centre in Brisbane, Australia trained members of ethnic, racial groups to communicate the importance of pap smears and breast self-examinations. The need for this intervention emerged when women from various ethnic, racial groups attended a series of meetings held to identify their health needs. These sessions revealed that many women did not know about breast and cervical cancer.

Talking about these health effects in group sessions was difficult owing to language and cultural barriers, as glowing as the responsive environment of the information. To deal with this problem, the health center staff decided to organize awareness-raising sessions on breast and cervical cancer (Prasad, & Shinwari, 1993).

Women belonging to the ethnic, racial groups taking part in the program were asked to identify bilingual women in their communities who could serve as educators. Women who approved to suppose this role attend a day-long training session rendered information on breast and cervical cancer and encouraging small group talks.

Educators were given promotional material -- flyers, newspaper advertisements, and radio ads -- for translation. The health center then printed flyers in twelve languages. Teachers recorded radio announcements in their respective language. Also, key members of each ethnic, racial community were asked to publicize the series of small-group educational sessions. The sessions were obtainable in settings easy to get to the community, such as social clubs, church halls, private homes and ethnic, tribal organizations. Eighty sessions were carried out over a six-week period. Above seven hundred mothers took part in these groups.

Feedback from the community educators confirmed that participants responded to the information in a positive way. Participants were keen to experience pap smears and mammograms, but they were unwilling to access these services by themselves: language, lack of transportation and painful experiences with health services in the earlier periodcited as primary barriers. In reaction to these fears, the health center prepared group visits to local screening services. The neighborhood educators harmonized the visits, available help and confirm to the entering mothers.

Several of the community educators stated that they had personally benefited from the project. They acknowledged that their participation had increased their levels of self-esteem and confidence, particularly since the project had involved them in

meaningful communication with their peers (Prasad & Shinwari, 1993). This surprising outcome showed that participatory social communication projects can succumb encouraging healthcare benefits for the rural dwellers in participating in CBHIS and bring relief on their hard earn resources, which is not enough for their needs.And Sokoto state being a Muslim-dominated state, the lmams needs to mobilize their followers in accepting to participate in CBHIS will go a long way in enlarging the enrollment, thereby pooling more resources to provide the much-needed health care facilities within their rural communities. Furthermore, the position of community educators cannot be played with, most especially when it comes to a new health care strategy like the CBHIS concept.

Neighborhood-based participatory mobilization seeks to recognize and build on strengths, resources, and relationships that exist withinthe rural communitiesto address their shared healthcare concerns. Hence, these could comprise person skills and possessions - now and then called human capital; webs of associations considered by trust, collaboration and communal obligation - now and then called social capital; and liaising structures inside the neighborhood such as a mosque, churches, and other organizations anywhere village members move towards each other.

Community-based participatory research openly recognizes and seeks to sustain or expand social structures and social processes that contribute to the capacity of community members to work together to improve health care through participation in CBHIS and to build on the income available to community enrollees inside those community structures.

4.16 Limitations of the study

There is a lack of information on the impact of the policy process, economic growth, scheme design, mobilization on health care services in Sokoto State, Nigeria. Couple with the fact that there are no reliable data in existence about CBHIS in Sokoto states Nigeria. The study could only document the existing situation regarding access of the rural dwellers to health care and financial protection for the rural dwellers. Show results from this study were compared with other studies conducted in Sub-Saharan African countries.

4.17 Chapter Summary

This chapter offers an overview of the research design, population and sample, unit ofanalysis, data collection procedure, reliability and Kmo/Bartletts test in the main study. Method of data analysis, quantitative data analysis technique, multicollinearity, factor analysis, test of non-response bias, profiles of respondents and statistical results, including descriptive statistics of the primary constructs involved in the field. Furthermore, this chapter discussed the quantitative research findings on the relationship between policy process, economic growth, scheme design and mobilization with the dependent variable the health care services among the rural communities of Sokoto State. The next is chapter five consisting of quantitative data analysis.

CHAPTER FIVE
RESULTS AND DISCUSSION

5.0 Introduction

This section presents the study results and interpretation of findings. Data analyzed and presented is based on the study objectives, regression analysis result.

5.1 Regression Analysis

Multiple regression analysis was used as the statistical technique to examine whether a relationship exists between the independent variables (PPROCESS,EGROWTH, SD, MOBILIZ on Health Care Services as the dependent variable. Multiple regression analysis is best suitable for this study because it confirms whether the suppositions developed are correct and appropriate (Zikmund, 2003).

Table: 5.1
Results of the Regression Analysis
Regression Model for Predicting Impact of CBHIS on Health Services (IMPACTHEALTHS) from PPROCESS, EGROWTH, SD, MOBILIZ and their Interactions.

Variables	Beta	R Square	F	Sig.
PPROCESS			.251	.000
EGROWTH	.166	.438	114.414	.000
SD			.260	.000
MOBILIZ			.119	.002

Dependent Variable: Healthcare Service

The results from Table: 5.1 Comprise of the correlation among four variables (PPROCESS, EGROWTH, SD, and MOBILIZ with the dependent variable IMPACTHEALTHS. Here the correlation between these variables ranges from a minimum of (. 468) to a high of (0.571). While the regression fit is(R^2=0.44) Which means that the model has accounted for only 44 %of the variance in the dependent

variable,while the overall relationship using the enter method indicated that the overall model is significant statistically (F= 114.414,P <0.001). Therefore, all the independent variables in the study are significantly significant (PPROCESS =0. 000, EGROWTH = 0.000, SD = 0.000, and MOBILIZ = 0.002.

The result from the model revealedthat Policy Process (PPROCESS) independent variable is significant and positively influence Impact on CBHIS on Health Service (β= 0.251). Effect of Economic Growth on CBHIS (EGROWTH) is significant and positively influenceHealthcare Services (β= 0.166), Scheme Design (SD) is significantand positively related to Health Care Services at (β= 0.166), While, Mobilization(MOBILIZ) is significant and positively influence Health Care Services at (β= 0.119).

5.2 HYPOTHESIS

H1: Policy process (by policy makers) is positively related to healthcare services on the rural dwellers.

H2:The economic growth of the rural dwellers is positively related to health care services.

H3: Scheme design is positively related to health care services.

H4: Mobilization of rural dwellers is positively related to health care services.

5.3 TESTING OF HYPOTHESIS

This study undertakes a multiple regression analysis to determine the relationship between the variables of the Policy Process (PPROCESS), Economic Growth (EGROWTH), Scheme Design (SD), and Mobilization (MOBILIZ) and the dependent variableHealthcare Services (HEALTHS).

H1: Policy process (by policy makers) is positively related to healthcare services of the rural dwellers.

The analysis reveals that Policy Process (PPROCESS) is positively related to the Healthcare Services (HEALTHS) (β= 0.251, P= 0.000).Though, no previous studies were conducted to test the relationship between Policy Process on Health Care Services amongst the rural dwellers of Sokoto state Nigeria. The provision of policy towards providing the needed health care services to reduce the inequality of these health facilities is necessary throughhealth insurance and promoting the concept of CBHIS to potential beneficiaries. The idea of micro insurance and payment of premiums in advance to meet the cost of health care is not known in many emerging countries(Dror et al., 2007, Meghan, 2010).

Therefore, it is important for the health care policy makers to provide policies on health insurance/CBHIS in the rural communities as well as analyze the effort made by scheme proponents to create awareness and market community-based health insurance among the rural communities.Because creating awareness of the policy is a requirement to encourage individuals to apply for membership and thereby enhance the risk-sharing capacity of the community health insurance scheme.

According to Defourny and Failon, (2008) posited that having a policy is very imperative from the perspective of developing a sense of ownership, thereby engaging the rural communities in the collection of premium, resource mobilization, scheme administration, and supervision activities by the policy makers.Also, the pilot study and the main study conducted in the study area by using the same instruments, shows a higher reliability of the policy process and valid to use.

Therefore, there is a positive relationship between the policy process and the impact of health care services amid the rural dwellers of Sokoto state Nigeria. Thus, the hypothesis is positive.

H2: The economic growth of the rural dwellers is positively related to health care services.

The result from the multiple regression analysis reveals that the Economic Growth (EGROWTH) is significantly related to health care services (HEALTHS) (β= 0.166, t,P= 0.000).This result is consistent with (Sauerborn et al. 1996; OECD/WHO 2003; Scheil-Adlung et al. 2006; Asfaw and Jutting, 2007. Considering the fact that people in sub-Saharan African rural areas rely mainly on their labour productivity and assets as livestock for income generation, a severe decline in income can be prevented through community-based health insurance scheme. Former studies have shown that demand for health care services at the community level of health care is influenced by the ability of the rural dwellers to pay (Gertler, & Van der Gaag, 1990).The significant relationship between economic growth on health care services amid the rural dwellers of Sokoto state Nigeria. Therefore, the hypothesis is supported.

H3:Scheme design is positively related to health care services.

Community-based health insurance in some form has been identified to play important role in rural communities' access to health care, and turns the unexpected health expenditures into expected payments.In the form of insurance which in turn encourage rural dwellers to further invest in their well-being (Asgary et al. 2004; OECD, & WHO, 2003). The appropriateness of a CBHIS partly depends on outside determinants that can hardly be influenced by the scheme such as a country's legal and policy framework (Criel, 1998b).

But, however, the function of the organization and its functioning, as well as community support, are vital factors of sustainability. The best size of a system to ensure sustainability and adequate risk pooling and possible verge levels of membership needed to realize significant savings on the scale are not yet known (Debaig,& CIDR 1999).

The multiple regression analysis reveals that Scheme design (SD) is significantly related to health care services (HEALTHS) (β= 0.260, t, P= 0.000). Therefore, the way CBHIS is designed will determine its success and design people oriented CBHIS will lead to its success, and more people will enroll thereby pooling more resources to reduce out-of –pocket expenses whenever accessing health care services by the rural dwellers of Sokoto state Nigeria. Therefore, the hypothesis is positive.

H4: Mobilization of rural dwellers is positively related to health care services.

The multiple regression analysis on the relationship between Mobilizations for CBHIS (MOBILIZ) and the impact of CBHIS on health care services (HEALTHS) (β= 0.119, t, P= 0.002). There is a significant relationship between mobilization and healthcare services.

Community mobilization is more often than not named as individuals taking action organized around specific community issues (Fawcett, Francisco, & Hyra, et al. 2000). Establish and run by the influential works of Cloward and Ohlin, (1961), Alinsky, (1971), Amstein, (1969), and Freire, (1972), early community mobilization efforts attempted to see the individual in relationship to the community (e.g., Kin, community).Better to see the relationship of single characteristics, health care service conditions and environmental agents. It was not until the 90s, all the same, that scholars and specialists more and more put on community mobilization approaches to public health care services issues such as the community established health insurance scheme (CBHIS).

Informed to a large extent by the literature on community empowerment (Fawcett, Paine-Andrews, Francisco, et al, 1995;& Kieffer., 1984). Community participation (Bracht, Finnegan, Rissel, et al. 1994; Florin, & Wandersman. 1990), Capacity building (Easterling, Gallagher, Drisko, Johnson, 1998; Hawe, Noort, King., & Jordan, 1997). Community Alliance (Gilles, 1998; Butterfoss, Goodman, & Wandersman, 1996), and community organization and development (Gittll, Bockmeyer, Lindsay, Newman. 1996; & Minkler, 1997). Community mobilization

offered support for non-individualized, community-based strategies like CBHIS to improve health care service outcomes within the rural dwellers.

This transformation was apparent in the international arena where the concept of community mobilization relies considerably on the new health promotion(CBHIS) philosophy and the exercise of enabling people to increase control over and to improve their healthcare services through CBHIS' (WHO, 1986). In this context, community health emphasizes a social, ecological approach that calls for wide-based changes in the social and economic environment to improve rural dwellers' health care services.Therefore, the hypothesis is positive.

Table5.2
Summary of Results from Tested Hypotheses

	Path of Relationship	Results
H1	PPROCESS ⟶ HEALTHCARE SERVICES	POSITIVE
H2	E GROWT⟶ HEALTHCARE SERVICES	POSITIVE
H3	SD ⟶ HEALTH CARE SERVICES	POSITIVE
H4	MOBILIZ ⟶ HEALTHCARE SERVICES	POSITIVE

Source: (Tanko, 2015)

5.4 Conclusion

From the foregoing, this study concludes that all the four variables in the study are all significant, and they are positively related to health care services that are the dependent variable. The chapter ended with testing of hypotheses which revealed that, out of 4 tested hypotheses, the entire four hypotheses were positive. The results from Table: 5.1Comprise of the correlation among four variables (PPROCESS, EGROWTH, SD, and MOBILIZ with the dependent variable IMPACTHEALTHS. Here the correlation between these variables ranges from a minimum of (. 468) to a high of (0.571). While the regression fit is(R^2=0.44) Which means that the model has accounted for only 44 %of the variance in the dependent variable,while the overall

relationship using the enter method indicated that the overall model is significant statistically (F= 114.414,P <0.001). Therefore, all the independent variables in the study are significantly(PPROCESS =0. 000, EGROWTH = 0.000, SD = 0.000, and MOBILIZ = 0.002.

5.5 CHAPTER SUMMARY

This chapter provides an overview of the results of regression analysis conducted in the study, a restatement of the hypothesis. This chapter also presented the empirical results and tested the hypothesis of the study.Next chapter is the six and the last chapter, which is dealing with the conclusion and implications of the study. mprov013.

CHAPTERSIX
SUMMARY, CONCLUSION, AND IMPLICATION

6.0 Introduction

This thesis is going to examine How is the impact of the policy process; economic growth, scheme design and mobilization on health care.This chapterdedicated to the summary, conclusion, and recommendation of the study. The chapter finally discusses the contribution to the body of knowledge and suggest few recommendations for further research.

6.1 Summary

The thesis seeks to answer the following research questions as formulated below:

1. In what ways are the policy process impacts the provision of health care services?

2. Of what value are the impacts of the economic growth in the provision of health care services?

3. Does scheme design have any impacts on the delivery of health care services?

4. Does mobilization of the rural community have impacts on the provision of health care services?

Healthcare services refer to the act of taking preventive or necessary medical procedures to improve a person's well-being. It's could be done with surgery, the administering of medicine, or other alterations in an individual's way of life. These services are characteristically accessible through a health care system made by hospitals and physician. It refers to the work done in providing primary care, secondary care, and tertiary care, as well as in public health.

Access to health care varies across country groups, and persons, mostly influenced by social and economic circumstances as well as the health policies in place. States and authorities have different policies and plans about the individual and population-based health care goals within their societies. Health care systems are organizations recognized to meet the health needs of target populations. Theirs exert shape varies between national and subnational units. In individual countries and jurisdictions, health care planning is spread among market members, whereas, in others, planning happens more centrally among governments or other coordinating bodies. In all cases, according to World Health Organization(WHO), a well – functioning health care system requires a robust financing mechanism; well-trained and adequately paid workforce; reliable information on which to base decisions and policies; and well-maintained health facilities and logistics to deliver quality medicines and technologies (WHO, 2013).

While the definition of the various types of health care services varies contingent on the different cultural, political, organizational and disciplinary viewpoints. There seems to be some agreement that primary care constitutes the first element of a continuing health care process; that may include the provision of secondary and

tertiary levels of care (MacLean, 2014). Primary careoften used as the term for the health care services that play a part in the local community. It can be delivered in different settings, such as health post, urgent care centers, etc., which provides services to patients the same day with an appointment or walk-in basis.

While, community-based health insurance scheme (CBHIS) is a plan, managed and run by a community-based association. Sooner than a private for-profit organization, which provides risk-pooling to cover the cost (or some aspect because of that) of health care service provision. Enrollees are associated or involved in the disposal of the community-based health system, at slightest in the option of the health care services it addresses. Hence, it's voluntary in nature formed by an ethnic of mutual assistance and included a mixture of benefits packages. CBHIS can be owned by health facilities, craft unions, NGOs, local management, local residential areas or cooperatives and can be possessed and run with any of the associations.

Consequently, they may be established with geographic boundaries (cities, villages), skilled organizations (i.e. Trade unions or cooperatives) or around health care facilities. They learn to be pro-poor since they sustain the need for healthcare in the poor rural countries and enable low-income communities to eloquent their health maintenance demands. Several community finance schemes have evolved in the backdrop of severe economic constraints, lack of sound self-confidence and political unsteadiness. Furthermore, the government taxation capacity is weak, formal mechanisms of social security for susceptible populations absent and the government misunderstanding of the informal health sector lacking. In such a complicated situation, community participation in funding healthcare provides a decisive first

place for enhanced access to health care by the poor rural dwellers and social security against the cost of illness.

This research studies the impact of the policy process, economic growth, scheme design and mobilization on healthcare services on rural dwellers of Sokoto state, Nigeria. A model research construct is intended to study the relationship and correlation between policy process, economic growth, scheme design and mobilization with the impact on healthcare services in the midst of the rural inhabitants of Sokoto state, Nigeria. Therefrom, multiple regression analysis is used to evaluate the variables in the study.

Four variables are identified in the study to establish the relationship between the policy process, the economic growth, scheme design and mobilization with the impact of on health services to the rural dwellers of Sokoto state, Nigeria. And they are treated as independent variables in the study while health care servicesregarded as a dependent variable in the study.

The study developed four research objectives, which borders on the policy process, economic growth, scheme design and mobilization. These objectives are investigated through the use of quantitative analysis. The findings of the study revealed that the objectives are achievable, and discussion of the findings was discussed in the previous chapter.

The conclusion of the study discovered that there is a positive relationship between the impact of healthcare services on the policy process, economic growth, scheme design and mobilization among the rural dwellers of Sokoto state, Nigeria. Also, the

results of the study revealed that the four independent variables play a unique significant contributory role in the provision of health care services among the rural dwellers of Sokoto state, Nigeria. Thus, the four independent variables are useful predictors of health care services. Four hypotheses formulated for the research study, and the findings of the four hypotheses one, two, three and four show positive relationship and correlations. Although the variable mobilization highly correlated correspondingly, then policy process, economic growth, scheme design respectively. The four variables are interrelated, and they contributed significantly to the impact of health care services among the rural dwellers of Sokoto state, Nigeria. The four hypotheses are tested using quantitative analysis.

The correlation coefficient of the policy processgiven as 0. 421 meaning that the relationship between policy process and health care servicesaveragely correlated. Meaning to say relationship does exist between policy process and provision of health services among the rural dwellers of Sokoto state, Nigeria.

The correlation coefficient of an effect of economic growth is given as 0. 465 meaning to say that there a relationship between economic growth and healthcare services the relationship is also averagely correlated. Meaning to say that there exists a relationship between economic growth and health care services of the rural dwellers of Sokoto state, Nigeria.

The correlation coefficient of the scheme design is given as .501 meaning to say that the relationship between scheme design and health care services strongly correlated. Meaning to say that scheme design is an important component of a fruitful and sustainable CBHIS. CBHIS depends on good scheme design in place to succeed.

The correlation coefficient of the mobilization .389 meaning to say that the relationship between mobilization and health care servicesaveragely correlated. The implication of this is that the role play by mobilization is essential in creating the much-needed awareness of the rural dwellers on the various advantages they stand to gain been members of CBHIS. Such implies that more sensitization is needed since the concept of CBHIS is a new one; people need to be educated about the scheme.

This study contributes to the body of knowledge by constructing a research model that could be used to develop a key performance indicator (KPI) that will serve as a guide to the implementations of CBHIS in all the states in the northern parts of Nigeria. Rather than seeing non-deliverance of social and welfare services to the rural dwellers from the view – lens of corruption, bad governance, insufficient funding, lack of political will, insecurity and political instability. And the study investigated the contribution of CBHIS analytically in the provision of health services amongst the rural dwellers of Sokoto state, Nigeria. Besides, researchers can identify other problems peculiar to their localities, and use the research model to establish the relationship between the defined variables.

Many researchers in the past focused on the impact of CBHIS on health care programs alone, which the researcher feels cannot function in isolation, the impact of CBHIS on the people, as it affects their lives, is also important. So, the research model in the study can, therefore, be used to establish CBHIS in the various rural dwellers so that the much-needed access to health care services can be achieved.

Also, the researcher contributed to the knowledge by using in –depth quantitative analysis in arriving at the findings of the study. A thorough analysis conducted on the

four variables under consideration. Research needed to be done through quantitative analysis, at least, two or three analysis to arrive at the findings of the study. In this research study, correlation, multiple regression analysis, and multicollinearity are used to come to the results of this study. And the three analyzes confirm same results about the variables of the study.

6.2 Conclusion

The concluding part of this study is going to be divided into three parts, namely: findings from the analysis of the study, results from the discussion of the research and possible suggestions. This study uses the quantitative methods of analysis.

The decision about the methodto use depends on an individual understanding and clarity of the research problem. Exploratory research is conducted to enable the understanding of a new occurrence, which further studies will be carried out to gain certification and convincing proof (Zikmund, Babin, Carr, & Griffin, 2009). The descriptive designconducted in particular situations where there is just a little knowledge of the nature of a problem. It is conducted, therefore, to provide a more precise description of a problem (Zikmund, 2000; & Sekaran, 2003). While the explanatory design is performed to provide further specific knowledge and description of the nature of relationships among the variables being investigated (Zikmund, 2000; &Sekaran, 2003). This studyconsidered explanatory because it is required to explain the relationships between policy process, an effect of economic growth, scheme design and mobilization on the impact of CBHIS on health services. The data analysis uses SPSS version 18, the data were coded, missing data was removed and the assessment of outliers and treatment done.Consequently, all the

two; univariate and multivariate outliers were checked in this study. Univariate outliers were checked using SPSS by detecting cases with large z-score values. Hence, a case with standardized z-score values of more than 3.29 is measured to be possible univariate outliers (Tabacnic, & Fiddle, 2007). Moreover, on the suggestion of Tabachnic, and Fiddle (2007) Mahanalobis Distance (D) was carried to determine and a pact with multivariate outlying cases (Hair et al., 2010).

The technique is to run Mahalanobis in the SPSS and then evaluated alongside the values with that of the Chi-square table (Tabachnick, & Fidell, 2007).Standard that 49 items were adapted, on behalf of the degree of freedom in the X2 table with P<0.001, so the normal is 85.35 (Tabachnick & Fidell, 2007 Gorondutse, & Hilman, 2014). It means that any figure with a Mahalanobis Distance of 85.35 and above is consequently multivariate outliers and are removed from contention in the analysis. Therefore, a total of 46 univariate outliers was removed while 63 multivariate outliers were also removed respectively.

Normality is the most significant postulation in multivariate analysis (Tabachnic, & Fidell, 2007; Hair et al., 2010). It treats with the character of data flow for an individual frequently construct and its relationship with the normal distribution (Tabachnic, & Fidell, 2007). Furthermore, when the final aim of the research is making an inference, then screening for normality is a significant step in approximately all multivariate analysis (Hair et al., 2010; Tabachnic, & Fidell, 2007). Consequently, all the two; the univariate and multivariate normality were examined.

The preliminary test of normality reveals that there was a sign of non –normality, which was shown by calculating the Z-score values for each item. As a few cases had a Z-value of more than +2_ and broadened above the variables. Successively, after the transformation, the Skewness and Kurtosis of all the items are within the acceptable range of < 2 and < 7 correspondingly. For example, skewness standards are less than 2; similarly, the kurtosis values, are less than 7. Conceivably this is in line with the examination of Tabachnick, and Fidell, (2007) that data alteration recover outcome, and that normality should be re-checked after normalization.

Knowing that homoscedasticity test is related to the assumption of normality, if the data are relatively valid, then the relationships between the variables are assumed to be homoscedastic and. Thus, heteroscedasticity is lacking (Tabachnick, &Fidell, 2007). The detail that, both the multivariate and univariate normalityconfirmed in this study, it could be concluded that the assumptions of homoscedasticity and the absence of heteroscedasticityachieved.

The findings from the regression analysis, the result found that the policy process is positively related to health care services (β= 0.251, P= 0.000). Though, no previous studies were conducted to test the relationship between Policy Process and Healthcare Services amongst the rural dwellers of Sokoto state, Nigeria. Policy formulation is a necessary tool for making rural dwellers havean awareness of health insurance and promoting the concept of CBHIS to potential beneficiaries goes to increase the provision of health care services at a rural community level.

According to Defourny and Failon, (2008) they posited that creating awareness is very imperative from the perspective of developing a sense of ownership, thereby

engaging the rural communities in the collection of premium, resource mobilization, scheme administration, and supervision activities by the healthcare policy makers.

Also, it's the responsibility of the state government to provide an enabling legal framework that will serve as a guideline to the setting up of the CBHIS. And also, for the state government to provide policies on subsidies to the vulnerable groups in the various communities to boost membership so that there will be extensive pooling of resources that will make the CBHIS provide the most needed health care services. Therefore, from the result of this study, the policy process is positively related to the health care services. Policy plays a significant role in the sustainability and growth of any CBHIS and the provision of health care service facilities in the rural communities.

While, the findings from the regression analysis also revealed that the economic growth is significantly related to health care services (β= 0.166,P= 0.000).This result is consistent with (Sauerborn et al. 1996; OECD/WHO 2003; Scheil-Adlung et al. 2006; Asfaw and Jutting, 2007; Considering the fact that people in sub-Saharan African rural areas rely mainly on their labour productivity and assets as livestock for income generation, a severe fall in income can be prevented through community-established health insurance system.

Previous studies have shown that demand for health care at the community level of wellness care is influenced by the power of the rural individuals to pay (Gertler & Van der Gaag, 1990). In line with the above, Tallinn (2006) uses prime death rate, potency rate, and life expectancy to examine the economic costs of ill health along with benefits from improving it for Estonia. The study finds that fertility rate and

adult mortality rate have a significant and negative impact on both OLS and Fixed effect model specification.

Furthermore, by using survey data, the study also concludes that ill health has a statistically healthy and adverse impact on labor supply and productivity at the individual level. Hence, being healthy is crucial for the rural dwellers as that would make them boost their labor productivities thereby increasing their economic activities. Thus, on that point is a substantial relationship between the economic growth and healthcare services among the rural dwellers of Sokoto state Nigeria. Therefore, economic growth is significantly related to healthcare services.

The findings on regression analysis reveal that scheme design is positively related to health care services (β= 0.260, P= 0.000). Community-based health insurance in some form has been identified to play a significant role in rural communities' access to health care and turns the unexpected health expenditures into expected payments in the form of insurance. That, in turn, encourage rural dwellers to invest further in their well-being (Asgary et al. 2004; OECD/WHO, 2003). The appropriateness of a CBHIS partially depends on outside determinants that can hardlyinfluence by the scheme such as a country's legal and policy framework (Criel,1998b). However, the function of the organization and its functioning, as well as community support, are vital factors of sustainability.

The best size of a system to ensure sustainability and adequate risk pooling and possible verge levels of membership needed to realize substantial savings on a scale are not yet known (Debaig, & CIDR 1999). Therefore, the way CBHIS is designed will determine its success and design people oriented CBHIS will lead to its success

and more people will enroll thereby pooling more resources to reduce out-of–pocket expenses whenever accessing health care by the rural dwellers of Sokoto state Nigeria. Therefore, scheme design is positively related to health care services.

The findings from the multiple regression analysis show that there is a positive relationship between mobilization and health care services (β= 0.119, P= 0.002).According to Delgado-Gaitan, Concha (2001), community call-up is a procedure that is called forth by a community itself, or by others. That is planned, ran out, and measured by the community's individuals, groups, and systems on a participatory and sustained basis to improve the healthcare services, cleanliness and learning the degree to intensify the overall standard of livelihood in the rural residential districts.

Establishing CBHIS through mobilizations of the rural dwellers is unyielding. Community readiness for help often regarded as spontaneous developments began from the people, which describe the type of personality improvement with little scale ventures (Prusad, 2003).Therefore, Community mobilization is all about the way in which the rural people can be mobilized to join the CBHIS to experience relief of difficulties families face whenever illness attack the member of a family in the rural residential districts. Therefore, the findings from this study reveal that mobilization is positively related to healthcare services.

6.2.1 The Research Contribution

The research contributes to both theory and practice to Public Administration as shown from the analysis of data collected. The theoretical and methodological contributions of this research are as follows: -

6.2.2 Theoretical Contributions

Empirically, the study contributes to the better understanding of the impact of CBHIS on the provision of healthcare services using the twenty-three local government areas of Sokoto State.The researcher used questionnaires in the process of data gathering. In this study,the contingent valuation method was adopted as health care in not a good traded on the market. As a result, determining the worth of health care can be difficult. To resolve this difficulty, economists have developed the contingent valuation method (CVM), which mostly entails of approximating the value a person places on a good, more often than not one that is not sold in the market. The hypothesis of contingent valuation are most regularly utilized to measure the capability of family units and people to pay for the community health insurance. And this is in line with the work of Dong et al. (2003a, 2003b, 2004a, 2004b, & 2005).

CBHIS tend to be small. Theoretically, no general rules on the minimum size of a CBHIS can be given because its size depends on the nature of the insured risks. However, experience suggests that subtle schemes are difficult to sustain. Unlike larger insurance pools, the small membership pool of many CBHIS limits scopes for risk diversification. As a consequence, there is a threat that a small policy base will

be unacceptable volatile. Small risk pools make it prohibitively expensive to cover rare, but high health hazards (Tabor, 2005, 30).

Another contribution is that more than the past ten years, scholars have recognized a move in the character of policy and policy-making, which points to the innovation of a great deal bigger array of stakeholders in policy making procedure. So, it's very significant when making policy about health care service delivery the views and aspiration of the rural dwellers should be brought into account.

Also, part of theoretical contribution health is a significant form of social capital, and there exists a substantial conformity in the literature on the relationship between health and economic growth. Through a relationship between capability and need, and this is in line with the work of Fogel, (1994). Moreover, the spirit of CBHIS voluntarism contributes to social solidarity and inclusiveness. Therefore, the rural dwellers are moving to come together through joint efforts to provide them with health care services to ease their suffering.

Another contribution of this research is that health acknowledged as a substantial portion of the country's socioeconomic growth of good health does not just contribute to better quality of life. But is also essential for an active labor force for the foundation and maintenance of the nation's wealth, and this is in line with the work of Eshiobo et al. (2007).

Another contribution of this research is that it shows the importance of having a healthy population cannot be toyed with because without health there is no any

human activity that will be possible. Without having a vibrant and healthy population, this is in line with the work of Asefzade, (2008).

The social capital in the community can be an asset for a breakthrough of CBHIS, thus contributing to the demand for CBHIS at the community level. Furthermore, as outlined by BIT, (2002), one of the fundamental principles of a healthy functioning of CBHIS is the solidarity and trust between members. This solidarity and trust stir up members who are susceptible to risk to put together their resources for everyday use. As a substance of fact, social capital in a community is vital for the sustainability and successful performance of CBHIS (Zhang, Wang, Wang, Hsio, (2006); &Donfouet, Essombe, Mahieu, Malin, (2011).

Furthermore, Coleman (1990), Putnam et al. (1993), and Wikinson (1996) recognize that social capital in a community acts positively on the significance people attach to their health. Thus, a community with a high level of social capital will be more inclined to go through change.

Additionally, previous studies that have investigated the impact of health care services through CBHISrelied mainly on qualitative methods of investigations.Most scholarsexamined the impact of the health care scheme or to a large extent on the health care providers ignoring the implications for the rural dwellers. In the Sub-Saharan Africa, the literature on the provision of health care services through CBHIS are conquered mainly by donor agencies or consultancy reports. They are purposely concerned with the financial and managerial capacity of the existing CBHIS rather than thoroughly exploring the impact on the rural dwellers. Further studies to consider using a theory of social change because CBHIS as a strategy to provide the

rural dwellers health care services is about bringing change into the society as far as how to access health care services are concerned. Therefore, this study agrees with the theory of the contingent valuation method (CVM) as the right theory for this research because health as a public good cannot be price anyhow. Since the rural dwellers would have to make some contribution in the form of premium for them to enjoy this provision of health care services through health insurance program.

6.2.3 Methodological Contribution

The methodological contributions of this study are that the researcher used a quantitative method to investigate the impact of the policy process, economic growth, scheme design and mobilization on health care services among the rural dwellers of Sokoto state using the individual rural dwellers as the unit of analysis. The data were collected using different sources, such as secondary data and primary data through questionnaires. With asample of 593 respondents; most previous studies used a qualitative method. Hence, the researcher embarked on a purely quantitative approach to bridge the gap.

This study chooses a quantitative method because it's a study referring to as an investigation into a collective or personal difficulty based on an examining theory comprises of constructs, determine with numbers and analyzed by the statistical method. To determine whether the forecast generalizations of the theory hold true (Creswell, 1994).

Correspondingly, Fowler, (1988) posited that a survey design can also provide a quantitative or a mathematical explanation of some portion of the populace (sample)

through the process of data collection or of asking the inquiry of people. This process of data collection, in goes round, to make the researcher take a broad view the result from an illustration of responses to a populace. Based on these suggestions the survey methods were in use in this research. Also, the research work is cross-sectional because data collected from the respondents within certain periods of time to meet the research objectives (Sekaran, & Bougie, 2010), not like a longitudinal study in which data collected for a longer period.

Quantitative analysis is used to describe the descriptive statistics of the variables in the study. In this research study, the variables under consideration are four, namely: impact of healthcare services as the dependent variable. And policy process, economic growth, scheme design and mobilization as independent variables. Multivariate analysis, such as correlation and regression analysis are used to draw inference on the four variables of the study. The frequency distribution is used for demographic data while correlation and regression analysis are used to test the four hypotheses of the study.

Ormrod and Leedy,(2005) posited that to answer questions associated with relationships among specific variables, the quantitative technique is employed because it has the ability in explaining, predicting and controlling phenomena. Therefore, based on Leedy and Ormrod, (2005) explanation, the quantitative method is used in this study to answer the research questions. Cresswell, (2003) also posited that quantitative approach is better and the most suitable method due to its fast turnaround in data collection.

Hence, there was a need to cross-validated the measurement scale to confirm its validity and reliability. To this end, Cronbach's Alpha reliability, face validity, content validity and construct validity were all calculated and found to be above the minimum threshold in all cases.

While qualitative research particular strength lies in its capacity to provide a broad analysis of phenomena, while can focus on the operation of social processes in greater depth. Furthermore, qualitative research allows for in-depth analysis, it can apparently deal with contradictory data, and provide insights into respondent's perspectives, which may be rendered invisible by quantitative methods. Also, the qualitative method has an increased degree of flexibility in the research design; the ability to avoid reliance on the researcher's pre-determined assumptions; and the ability to focus on the meanings of key issues for participants, especially any contradictions or inconsistencies in their perspectives.

Despite these laudable advantages of qualitative research among its limitations are subjectivity that can lead to procedural problems, applicability is tough, research bias is built-in and unavoidable, qualitative research is labor intensive and expensive, etc. Therefore, the selection of the appropriate method should always be dictated by the research question (s) under investigation.

6.2.4 Implication for Future Research

The findings of this thesis could be used to address the problems facing the provision of health care services to the rural dwellers of Sokoto state and Nigeria, in general, using the contingent valuation method. The study will be useful for healthcare policy

makers and public sector in general on how to enhance the provision of healthcare services among the rural dwellers of Sokoto State.

In this section, recommendations are proposed in the light of the conclusions specific to the Sokoto state in the scheme design, mobilization, policy process, the economic growth of the rural dwellers on the provision of health care services and management of CBHIS.Policy recommendations unique to the Sokoto state context are proposed.

This work investigates the impact of healthcare services on the policy process, economic growth in health, on scheme design andmobilization in therural communities of Sokoto state, Nigeria, and the fiscal burden of medical expenses among the rural poor. The findings have significant implications for health care policy makers as far as the provision of health care is concerned.

Nigeria, health care expenditure related to hospitalization has been often terrible for many rural dwellers among the wretched. The survey indicates that using CBHIS strategy can adequately protect the rural inhabitants from the unsure risk of health care payment. Therefore, CBHIS can be applied in rural areas where the institutional ability is also weak to arrange the compulsory NHIS for the nationwide risk pooling, to provide healthcare services to the rural dwellers.

The survey identifies the contributions of the policy process, economic growth and the mobilization of the rural dwellers that have led to the accomplishment of goals such as increasing access to healthcare utilization, risk sharing, financial security and the scheme's financial sustainability throughCBHIS.

The study has shown that CBHIS can help provide the much-needed provision of the healthcare services that are lacking before CBHIS. Principal components that facilitate inclusion of the rural dwellers include affordable premiums and positioning the scheme within the larger rural communities to address other needs of the rural residential districts. For example, the Sokoto state government should provide more subsidies to the vulnerable groups to cover more vulnerable rural dwellers that are so poor to pay the premium, and also, the NGOs should also be invited by the rural communities to assist in some area of intervention as far as health care services are concerned.

Furthermore, for not charging co-payment, it removes one of the barriers to access to health care, especially among the rural dwellers. In general, with CBHIS in operation, it has mitigated the financial burden of healthcare services expenditures of the rural households. Among the main factors that determine rural dwellers enrollment in any CBHIS are the problems with the affordability of the premiums, and the attractiveness of the benefits package and the quality of care that is offered by the CBHIS facility. CBHIS has a clear and uncomplicated procedure for accessing health care in the various clinics and health post services in the rural areas of Sokoto State.

The take-up of CBHIS benefit was high, and this could be attributed to the way the rural dwellers were mobilized and the friendly operational procedures that must comply with to access the inpatient and outpatient healthcare services using the CBHIS benefit. CBHIS can be used as larger pooling arrangements, which could constitute contributions from rural households, but also from other sources (State

government, NGOs, and Donor funding). This work has shown that CBHIS under certain situations can well be an attractive strategy to improve the rural dwellers right to use health care services and security from catastrophic health care related expenses. All the same, to pursue the policy, an explicit policy of expansion of such CBHIS is required.

The access to inpatient and outpatient care emphasized the problem of physical access to healthcare provision. The relatively soaring expenditure of obtaining hospital/clinic care among rural dwellers can be catastrophic. Hence, an approach that the health care scheme may be able to employ to facilitate the approach to well-being and protection from catastrophic expenditure caused by non-medical cost is to assure the accessibility of physical access to health care facilities at the minimal distance.

Consequently, for CBHIS to be successful in improving the general access to health care of the rural dwellers of Sokoto State. There is the need for the Sokoto state government to provide an enabling law that will serve as a guide to the various local governments to actively participate in CBHIS and to assist in providing awareness about the different advantages of delivering health care services through CBHIS. And to provide subsidies to the vulnerable groups who are so poor to afford the payment of premium will go a long way in enrolling a large number of the rural dwellers. Also, the state government should build more health care facilities and equipped them and provide health care personnel as this are the prerequisite for providing equitable access to health care to the rural dwellers of Sokoto State.

In designing the CBHIS both inpatient and outpatient healthcare services should be included in the CBHIS benefits package so that the rural dwellers should feel that they are going to be covered.A scheme for monitoring and assessing the performance of CBHIS is vital. To produce adjustments in the design of CBHIS, it needs detailed data on who is enrolled and why, rates and causes of hospitalization, expenses on hospital admissions, and barriers that prevent enrollment in the CBHIS by the insured. Conversely, that every change that the CBHIS administrators make to the system, whether in extent or quantity of the benefits package or interventions to recover the charge, etc. Therefore, well-organized management of a CBHIS can control and manage the financial risk of the scheme.

The Sokoto state government can contribute to the effectiveness and sustainability of CBHIS for the rural dwellers in the informal sector in general through providing key policies such as providing well- targeted subsidies boosting the CBHIS contributions of low-income rural dwellers. Reinsurance for enlarging the effective size of small risk pools and cover the catastrophic health expenses. Providing technical support to strengthen the management capacity of local CBHIS in the rural dweller communities.Management techniques to boundary spending fluctuations; and the organization and reinforcement of links with conventional financing and provider schemes will get a long way in helping and providing organizational support to these emerging CBHIS in the rural regions.

Small-scale health insurance like CBHIS can supplement other sources of finance in low-income countries rather than being a replacement for them. Therefore, this fact calls for partnerships between public institutions, the private sector, and the new

system of non- profit health insurance. The dynamic organization depends primarily on a legal framework guaranteeing a transparent and honest relationship between the different actors, the negotiating capacity of the government vis-à-vis the dominant interest groups as well as the incentives provided for the private sector to build such cooperation.

6.2.5 Areas for further research

This survey tested the impact of the policy process, economic growth, scheme design and mobilization on health care services among the rural dwellers of Sokoto state in improving access to wellness care and their financial security. For the rural dwellers from catastrophic health expenses with the primary focus on providing an enabling policy process by the Sokoto state government. Through boosting the rural dwellers economic activities, through designing a people oriented CBHIS and efficient mobilization and enlightenment of the rural dwellers on using the CBHIS strategy with the sole aim of reducing the inequalities of providing health care services in the rural communities.

This study examined the process of policy making and find out that there is no available policy framework establish to guide the rural dwellers on how to formCBHIS the policy backing is lacking and thus give the rural dwellers doubt on the acceptance and sustainability of the CBHIS. Further studies should be carried out looking at a particular way that the Sokoto state government will provide the enabling legal framework to use CBHIS as a strategy in providing health care services to the rural the rural communities who lack these services.

Further research should be conducted to evaluate the role of enhancing the economic activities of the rural dwellers of Sokoto State. Most especially on the new and improve ways of farming activities as farming is the main occupation of the rural dwellers so that the rural dwellers can be able to afford the payment of agreed premiums without much burden. Also, this will make the policy makers to have a precise estimate of the general expenses and benefits of introducing CBHIS for the rural dwellers as well on an apprehension of what influence enrollment, community mobilization among the rural inhabitants. Furthermore, further research should address the question of how to provide subsidies to the poorest in the rural communities so that through CBHIS strategy the poor can be able to access healthcare services.

Also, more research is needed on other promising measures to fight the social exclusion of the rural dwellers in access to social protection in low and middle-income countries. Although, this study found out that not much is made by the Sokoto state government to create awareness by enlightening the rural dwellers on benefits of CBHIS and on practical measures of alleviating poverty among the rural communities on a regular basis.

Also, this study found out that, non-medical expenses did not play a significant role in contributing to catastrophic health care expenditure, on the other hand, insufficient details of such costs made it difficult to propose suitable policy options to tackle this face-up. Looking at on expenses caused by non-medical items are needed to obtain an in-depth understanding of the problem, also to the potential effects of

interventions in reducing the cost of obtaining health care services by the rural dwellers.

Open inquiry for additional studies is what type of social capital to develop is a priority. Equally inter and other community social capitals have pros and cons, and it is uncertain which one should be reinforced. One necessary policy implication is to strengthen social ties at the community level.

Implementation of CBHIS-type programs within the NHIS of Nigeria has been disappointing to date, but experience elsewhere suggests that uptake and sustainability could be improved. Through policies that include closer integration of the informal and formal sectors under the existing NHIS umbrella with increasing involvement of beneficiaries in scheme design and management, improvement in mobilization and education, higher public and private healthcare funding, and targeted financial assistance.

These findings are likely to be instructive for healthcare policy makers in Sokoto state, the federal government of Nigeria and in Sub- Saharan Africa generally in achieving UHC goals and improving healthcare outcomes among the rural dwellers

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APPENDIX A: CONFERENCE AND JOURNALPUBLICATIONS FROM THE THESIS

1. Investigating the Impact of the Community-Based Health Insurance Scheme Among the Rural Dwellers of Sokoto State, Nigeria, **Mediterranean Journal of Social Sciences** 6 (1), 145-155, January 2015 (Indexed by SCOPUS).

2. Community-Based Health Insurance Scheme as a Way Forward in Health Financing in Nigerian Rural Areas of Sokoto State. ***Journal of Nursing and Health*** *Sciences*,3 (4) VER III15-18(Jul – Aug. 2014) (Indexed by Scirus/ Q.Sensei/ Copernicus).

3. Investigating the Impact of the Community-Based Health Insurance Scheme Among the Rural Dwellers of Sokoto Atate, Nigeria: A Pilot Study, ***European Journal of Business and Management,*** 6 (22) 84-88 41(4),2014. (Indexed by EBECOhost/Cross ref/ WorldCat/Copernicus).

4. The Way Forward for Community-Based Health Insurance Scheme in Funding HealthCare Among the Rural Communities of Sokoto State, Nigeria. **Journal of Research on Humanities and Social Sciences.** Accepted for publication on April 30, 2015. (Indexed by EBECOhost /Cross ref/ WorldCat/Copernicus).

5. The Relationship of Economic Growth on the Impact of Community-Based Health Insurance Scheme Among the Rural Dwellers of Sokoto State, Nigeria.Presented at 3rd International Conference on Social Sciences Research(ICSSR 2015) this took place on June 08-09, 2015 at MELIA Kuala

Lumpur, Organized by World Conferences.net@KOKISDAR, Koperasi Kolej University Islam Antarabanga Selangor, Malaysia.

APPENDIX B: RESEARCH QUESSIONNAIR

Ghazali Shafie Graduate School of Government
College of Law, Government and International Studies (COLGIS)
Universiti Utara Malaysia

Dear respondent,

I am a Ph.D. candidate at the Northern Universiti of Malaysia. I am carrying out a research project on **"the impact of policy process, economic growth,scheme design and mobilization on health care services among the rural dwellers of Sokoto state, Nigeria."** This research is a prerequisite for the award of Doctor of Philosophy in Public Administration. The researcher, therefore, wishes to seek for your response on health care habits and other health related issues. The researcher equally welcomes your suggestions on how to improve community health insurance programs in order to reduce health related problems among rural dwellers in Sokoto State, Nigeria.

Be assured that your identity will be kept confidential during the research process. Although your participation is voluntary, but you should know that your contribution will assist in establishing a formidable community-based health insurance scheme in Sokoto State.

If you have any inquiries regarding this survey, please do not hesitate to contact me or my supervisor, Prof. Madya Dr. Azhar bin Harun @ +60173135086, +6049286493 or @ h.azhar@uum.edu.my

Thanks in anticipation of your cooperation.
Yours Faithfully,

Garba, Ibrahim Tanko
Ph.D. Candidate,
COLGIS, Universiti Utara Malaysia,
06010, Sintok,
Kedah, Darul Aman.
Email: s94132@studen..uum.edu.my
H/Phone: +6019400620
+2348062245789

SECTION A: POLICY PROCESS

This part of the questionnaire is used to key out your perception of policy process on healthcare services. Please answer all items and **circle** the number that best suits your response between 1 and 5.

1=Strongly Disagree	2= Disagree	3= Not Applicable	4= Agree	5= Strongly Agree

S/N	ITEMS					
1	Government policy on healthcare is adequate	1	2	3	4	5
2	Government policy making on healthcare is not adequate.	1	2	3	4	5
3	Policy on healthcare services is not all encompassing	1	2	3	4	5
4	In my opinion government is doing its best to provide healthcare services	1	2	3	4	5
5	You are familiar with government policy on healthcare	1	2	3	4	5
6	Policy on healthcare services are not people oriented	1	2	3	4	5
7	Policies on healthcare services are not implemented	1	2	3	4	5
8	Government policies on health insurance to provide healthcare services are adequate	1	2	3	4	5
9	Do you consider policies on health insurance to improve healthcare services.	1	2	3	4	5
10	Policies on improving healthcare services is welcome	1	2	3	4	5
11	Involving people in policy making make them to accept the policy.	1	2	3	4	5
12	In my opinion policy is necessary for achieving success in the provision of healthcare services.	1	2	3	4	5
13	Through government policy on healthcare, people are encouraged to live healthy.	1	2	3	4	5
14	Living healthy requires a good policy on healthcare services.	1	2	3	4	5
15	Policy on the provision of healthcare services through health insurance is acceptable to rural dwellers	1	2	3	4	5
16	Policy on health insurance now provides healthcare services in my community.	1	2	3	4	5
17	In my opinion rural dwellers are happy with government health insurance policy on healthcare services	1	2	3	4	5

SECTION B: Economic Growth

The following section attempts to collect information on the economic growth on healthcare services. Please answer all points and circulate a number that best suits

1=Strongly Disagree	2= Disagree	3= Not Applicable	4= Agree	5= Strongly Agree

S/N	ITEMS					
1	In my view, my income can pay for my healthcare needs.	1	2	3	4	5
2	My means of livelihood is not adequate to pay for my healthcare services.	1	2	3	4	5
3	I spend less money when accessing healthcare services in my community.	1	2	3	4	5
4	In my opinion the premium payment is affordable for accessing healthcare services in my community	1	2	3	4	5
5	I don't have to borrow money to access healthcare services in my community	1	2	3	4	5

SECTION C: Scheme Design

This section seeks to provide information on scheme design on the impact on healthcare services. Please answer all items and circle a number that best suits your response between 1 and 5.

1=Strongly Disagree	2= Disagree	3= Not Applicable	4= Agree	5= Strongly Agree

S/N	ITEMS					
1	In my opinion, scheme design should be people centered	1	2	3	4	5
2	In my opinion, a good scheme design can provide better health care services.	1	2	3	4	5
3	In my opinion, scheme design incorporates the status of health care services in the community.	1	2	3	4	5
4	In my opinion a good scheme design encouraged rural dwellers to use healthcare services in my community	1	2	3	4	5
5	In my opinion, having good scheme design checks on moral hazards on the utilization of healthcare services.	1	2	3	4	5
6	In my opinion, having a good scheme design checks on the abuse usage of healthcare services.	1	2	3	4	5

SECTION D: Mobilization

This section seeks to obtain information on the role of mobilization on healthcare services. Please answer all points and circulate a number that best suits your response between 1 and 5.

1=Strongly Disagree 2= Disagree 3= Not Applicable 4= Agree 5= Strongly Agree

S/N	ITEMS					
1	In my opinion, people are aware of Community-based health insurance scheme to provide healthcare services.	1	2	3	4	5
2	In my opinion, people are often mobilizing to use health care services in my community.	1	2	3	4	5
3	In my opinion, mobilizing rural people to use healthcare services is inadequate.	1	2	3	4	5
4	In my opinion, the government is not much interested in mobilizing people to use healthcare services in their communities.	1	2	3	4	5
5	I know I can make a difference in my community about healthcare service utilization.	1	2	3	4	5
6	People in my community often join to work on problems on healthcare services.	1	2	3	4	5
7	In my opinion, mobilizing the rural people to access healthcare services is adequate.	1	2	3	4	5
8	Community mobilization policies support community improvement efforts on healthcare provision in my community.	1	2	3	4	5
9	In my opinion rural people have mobilized to participate in healthcare services.	1	2	3	4	5
10	I know how to work with others to solve problems on healthcare needs of my people.	1	2	3	4	5
11	I can influence community members to take action on important issues like healthcare services.	1	2	3	4	5

SECTION E: IMPACTS OF HEALTHCARE SERVICES

This part of the questionnaire is used to describe your perception of the impacts of healthcare services in the residential district Please answer all points and circulate a number that best suits your response between 1 and 5.

1=Strongly Disagree 2= Disagree 3= Not Applicable 4= Agree 5= Strongly Agree

S/N	ITEMS					
1	Do you agree that Policy of providing the rural people with much-needed health care services are adequate?	1	2	3	4	5

2	Do you agree that the policy process (policy makers) is significantly related to the impact of healthcare services on the rural dwellers?	1	2	3	4	5
3	Participation in CBHIS will raise additional funding for the provision of health services.	1	2	3	4	5
4	Do you agree that the economic growth of the rural dwellers is concerned with the impact of healthcare services?	1	2	3	4	5
5	Do you agree that the Improvement of rural dweller's income will enhance healthcare service utilization?	1	2	3	4	5
6	Do you agree that the scheme design is significantly related to the impact of the provision of healthcare services to the rural dwellers?	1	2	3	4	5
7	Do you agree that	1	2	3	4	5
8	Do you agree that mobilization of rural dwellers is significantly related to the provision of health care services?	1	2	3	4	5

SECTION F: DEMOGRAPHIC DATA

INSTRUCTION Pleases tick in the appropriate that best represents your response.

1. What is your status in your household?
   1 = female heads of household ☐
   2 = male head household ☐
   3 =wives ☐
   4 = grandmother ☐
   5= Representative of household ☐

2. Are you the principal income earner in your family? 1 = yes
   2= no

3. How many people live in your household?
   1. 1 - 5 ☐
   2. 6 - 15 ☐
   3. 16 - 25 ☐
   4. 26 -35 ☐
   5. 35 – above ☐

4. How old are you?
   1. 0 - 18 ☐
   2. 19 – 25 ☐
   3. 25 – 35 ☐
   4. 35 – above ☐

5. Sex? 1 = male ☐ 2 = females ☐

6. What is your highest education status?

☐ 1. Never attend school 2. Primary school ☐
☐ 2. Secondary 4. Vocational college ☐
☐ 5. University or higher

7. What occupation is your major source of income?

☐ 1. Famer 5. Unemployed ☐
☐ 2. Petty trading 6. Big business ☐
☐ 3. 6. Government worker 7. Self-employed professional ☐
☐ 4. Employed in private sector 8. Others ☐
If others, please specify

THANK YOU

APPENDIX C: DISCRIPTIVE STATISTICS

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
SMEAN(PPROCESS1)	593	1.0	5.0	3.640	1.0497	-.769	.100	.065	.200
SMEAN(PPROCESS2)	593	1.0	5.0	3.785	.9724	-.886	.100	.547	.200
SMEAN(PPROCESS3)	593	1.0	5.0	4.177	.9625	-1.239	.100	1.186	.200
SMEAN(PPROCESS4)	593	1.0	5.0	3.941	.9417	-1.147	.100	1.458	.200
SMEAN(PPROCESS5)	593	1.0	5.0	3.420	1.0873	-.410	.100	-.520	.200
SMEAN(PPROCESS6)	593	1.0	5.0	3.319	.9967	-.191	.100	-.391	.200
SMEAN(PPROCESS7)	593	1.0	5.0	3.671	.9131	-.500	.100	.002	.200
SMEAN(PPROCESS8)	593	1.0	5.0	3.792	1.0246	-.719	.100	-.046	.200
SMEAN(PPROCESS9)	593	1.0	5.0	3.162	1.1304	-.061	.100	-.906	.200
SMEAN(PPROCESS10)	593	1.0	5.0	3.497	1.0559	-.561	.100	-.325	.200
SMEAN(PPROCESS11)	593	1.0	5.0	2.904	1.2368	.125	.100	-1.027	.200
SMEAN(PPROCESS12)	593	1.0	5.0	3.405	1.1321	-.416	.100	-.637	.200
SMEAN(PPROCESS13)	593	1.0	5.0	3.221	1.1883	-.247	.100	-.894	.200
SMEAN(PPROCESS14)	593	1.0	5.0	3.241	1.1643	-.369	.100	-.710	.200
SMEAN(PPROCESS15)	593	1.0	5.0	3.010	1.2108	-.025	.100	-.983	.200

SMEAN(PPROCESS16)	593	1.0	5.0	3.057	1.1698	-.207	.100	-.926	.200
SMEAN(PPROCESS17)	593	1.0	5.0	3.624	.9472	-.563	.100	.147	.200
SMEAN(EEGROWTH1)	593	1.0	5.0	3.669	1.0631	-.857	.100	.219	.200
SMEAN(EEGROWTH2)	593	1.0	5.0	3.000	1.0982	-.084	.100	-.812	.200
SMEAN(EEGROWTH3)	593	1.0	5.0	3.110	1.0810	.038	.100	-.571	.200
SMEAN(EEGROWTH4)	593	1.0	5.0	3.305	1.1535	-.310	.100	-.775	.200
SMEAN(EEGROWTH5)	593	1.0	5.0	3.632	1.0428	-.797	.100	.142	.200
SMEAN(SD1)	593	1.0	5.0	3.572	1.0128	-.612	.100	-.003	.200
SMEAN(SD2)	593	1.0	5.0	3.627	.9029	-.646	.100	.273	.200
SMEAN(SD3)	593	1.0	5.0	3.487	1.0797	-.424	.100	-.354	.200
SMEAN(SD4)	593	1.0	5.0	3.115	1.0798	-.076	.100	-.684	.200
SMEAN(SD5)	593	1.0	5.0	3.386	1.0288	-.350	.100	-.424	.200
SMEAN(SD6)	593	1.0	5.0	3.491	.9883	-.443	.100	-.142	.200
SMEAN(MOBILIZA1)	593	1.0	5.0	3.211	1.1916	-.269	.100	-.961	.200
SMEAN(MOBILIZA2)	593	1.0	5.0	3.324	1.0826	-.358	.100	-.630	.200
SMEAN(MOBILIZA3)	593	1.0	5.0	3.535	1.0929	-.572	.100	-.368	.200
SMEAN(MOBILIZA4)	593	1.0	5.0	3.366	1.1752	-.390	.100	-.775	.200
SMEAN(MOBILIZA5)	593	1.0	5.0	3.957	.9829	-1.199	.100	1.498	.200
SMEAN(MOBILIZA6)	593	1.0	5.0	3.776	.9537	-.734	.100	.195	.200
SMEAN(MOBILIZA7)	593	1.0	5.0	3.109	1.2433	-.128	.100	-1.030	.200
SMEAN(MOBILIZA8)	593	1.0	5.0	3.594	.9999	-.661	.100	.025	.200
SMEAN(MOBILIZA9)	593	1.0	5.0	3.654	1.0185	-.740	.100	.019	.200
SMEAN(MOBILIZA10)	593	1.0	5.0	3.922	.9139	-.911	.100	.724	.200
SMEAN(MOBILIZA11)	593	1.0	5.0	3.974	.8686	-.881	.100	.949	.200

SMEAN(DMO1)	593	1.0	5.0	2.691	1.4787	.589	.100	-1.101	.200
SMEAN(DMO2)	593	1.0	2.0	1.663	.4732	-.690	.100	-1.529	.200
SMEAN(DMO3)	593	1.0	5.0	1.904	.9386	1.299	.100	1.887	.200
SMEAN(DMO4)	593	1.0	4.0	2.420	.7334	.550	.100	-.062	.200
SMEAN(DMO5)	593	1.0	3.0	1.476	.5024	.139	.100	-1.879	.200
SMEAN(DMO6)	593	1.0	5.0	4.384	1.2332	-1.663	.100	1.027	.200
SMEAN(DMO7)	593	1.0	8.0	4.459	2.0637	.179	.100	-.949	.200
SMEAN(IMPACTCHIBSHEALTH1)	593	1.0	8.0	3.290	1.1770	-.223	.100	-.461	.200
SMEAN(HEALTHS2)	593	1.0	5.0	3.467	1.0214	-.507	.100	-.322	.200
SMEAN(HEALTHS3)	593	1.0	35.0	3.709	1.6296	11.791	.100	229.459	.200
SMEAN(HEALTHS4)	593	1.0	5.0	3.332	1.0263	-.389	.100	-.304	.200
SMEAN(HEALTHS5)	593	1.0	5.0	3.488	.8966	-.472	.100	.299	.200
SMEAN(HEALTHS6)	593	1.0	5.0	3.273	.9827	-.162	.100	-.381	.200
SMEAN(HEALTHS7)	593	1.0	5.0	3.543	.9684	-.603	.100	.017	.200
SMEAN(HEALTHS8)	593	1.0	5.0	3.722	.9992	-.735	.100	.328	.200
Valid N (listwise)	593								

APPENDIX D: FACTOR ANALYSIS POLICY PROCESS

Correlation Matrix[a]

		SMEAN(PPROCESS1)	SMEAN(PPROCESS2)	SMEAN(PPROCESS3)	SMEAN(PPROCESS7)	SMEAN(PPROCESS12)	SMEAN(PPROCESS13)	SMEAN(PPROCESS14)
Correlation	SMEAN(PPROCESS1)	1.000	.303	.194	.183	.204	.176	.213
	SMEAN(PPROCESS2)	.303	1.000	.237	.192	.126	.151	.138
	SMEAN(PPROCESS3)	.194	.237	1.000	.175	.149	.120	.009
	SMEAN(PPROCESS7)	.183	.192	.175	1.000	.154	.160	.154
	SMEAN(PPROCESS12)	.204	.126	.149	.154	1.000	.543	.399
	SMEAN(PPROCESS13)	.176	.151	.120	.160	.543	1.000	.560
	SMEAN(PPROCESS14)	.213	.138	.009	.154	.399	.560	1.000
Sig. (1-tailed)	SMEAN(PPROCESS1)		.000	.000	.000	.000	.000	.000
	SMEAN(PPROCESS2)	.000		.000	.000	.001	.000	.000
	SMEAN(PPROCESS3)	.000	.000		.000	.000	.002	.418
	SMEAN(PPROCESS7)	.000	.000	.000		.000	.000	.000

SMEAN(PPROCESS12)	.000	.001	.000	.000		.000	.000
SMEAN(PPROCESS13)	.000	.000	.002	.000	.000		.000
SMEAN(PPROCESS14)	.000	.000	.418	.000	.000	.000	

a. Determinant = .331

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.705
Bartlett's Test of Sphericity	Approx. Chi-Square	651.348
	df	21
	Sig.	.000

Rotated Component Matrix[a]

	Component	
	1	2
SMEAN(PPROCESS1)		.622
SMEAN(PPROCESS2)		.710
SMEAN(PPROCESS3)		.666
SMEAN(PPROCESS7)		.525
SMEAN(PPROCESS12)	.757	
SMEAN(PPROCESS13)	.853	
SMEAN(PPROCESS14)	.807	

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

Rotated Component Matrix[a]

	Component	
	1	2
SMEAN(PPROCESS1)		.622
SMEAN(PPROCESS2)		.710
SMEAN(PPROCESS3)		.666
SMEAN(PPROCESS7)		.525
SMEAN(PPROCESS12)	.757	
SMEAN(PPROCESS13)	.853	
SMEAN(PPROCESS14)	.807	

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 3 iterations.

Communalities

	Initial	Extraction
SMEAN(PPROCESS1)	1.000	.384
SMEAN(PPROCESS3)	1.000	.506
SMEAN(PPROCESS5)	1.000	.274
SMEAN(PPROCESS7)	1.000	.375
SMEAN(PPROCESS12)	1.000	.589
SMEAN(PPROCESS14)	1.000	.666
SMEAN(PPROCESS13)	1.000	.739

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %

dimension 0	1	2.371	33.869	33.869	2.371	33.869	33.869	2.020	28.860	28.860
	2	1.302	18.597	52.467	1.302	18.597	52.467	1.652	23.607	52.467
	3	.848	12.113	64.580						
	4	.834	11.918	76.498						
	5	.692	9.890	86.388						
	6	.566	8.092	94.480						
	7	.386	5.520	100.000						

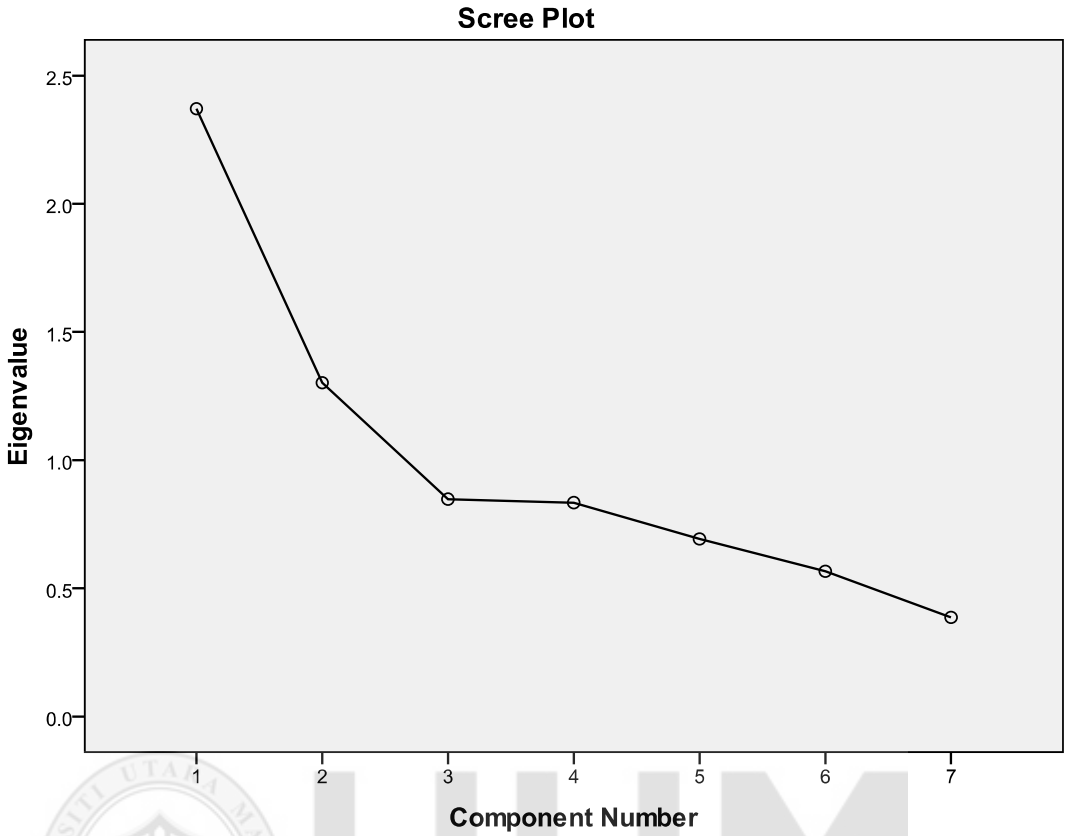
Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component	
	1	2
SMEAN(PPROCESS1)	.522	
SMEAN(PPROCESS2)	.457	.547
SMEAN(PPROCESS3)		.564
SMEAN(PPROCESS7)	.427	
SMEAN(PPROCESS12)	.713	
SMEAN(PPROCESS13)	.766	
SMEAN(PPROCESS14)	.698	-.410

Extraction Method: Principal Component Analysis.

a. 2 components extracted.



Factor Analysis ECONOMIC GROWTH

Correlation Matrix[a]

		SMEAN(EEGROWTH1)	SMEAN(EEGROWTH2)	SMEAN(EEGROWTH3)	SMEAN(EEGROWTH5)
Correlation	SMEAN(EGROWTH1)	1.000	.248	.193	.312
	SMEAN(EGROWTH2)	.248	1.000	.401	.243
	SMEAN(EGROWTH3)	.193	.401	1.000	.222
	SMEAN(EGROWTH5)	.312	.243	.222	1.000
Sig. (1-tailed)	SMEAN(EGROWTH1)		.000	.000	.000
	SMEAN(EGROWTH2)	.000		.000	.000
	SMEAN(EGROWTH3)	.000	.000		.000
	SMEAN(EGROWTH5)	.000	.000	.000	

a. Determinant = .671

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.654
Bartlett's Test of Sphericity	Approx. Chi-Square	235.151
	df	6
	Sig.	.000

Communalities

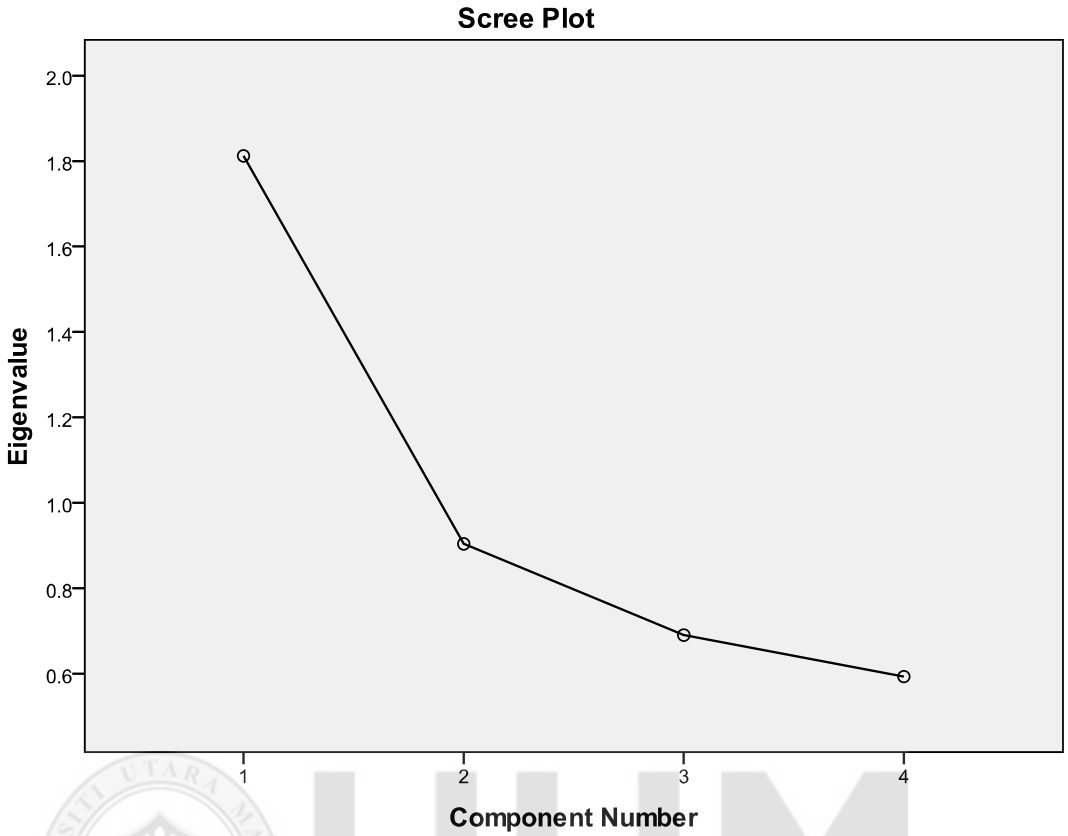
	Initial	Extraction
SMEAN(EGROWTH1)	1.000	.675
SMEAN(EGROWTH2)	1.000	.675
SMEAN(EGROWTH3)	1.000	.732
SMEAN(EGROWTH5)	1.000	.634

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	1.812	45.303	45.303	1.812	45.303	45.303	1.397	34.919	34.919
2	.904	22.599	67.902	.904	22.599	67.902	1.319	32.983	67.902
3	.691	17.264	85.166						
4	.593	14.834	100.000						

Extraction Method: Principal Component Analysis.



Component Matrix[a]

	Component	
	1	2
SMEAN(EGROWTH1)	.632	.525
SMEAN(EGROWTH2)	.724	
SMEAN(EGROWTH3)	.685	-.513
SMEAN(EGROWTH5)	.647	.464

Extraction Method: Principal Component Analysis.

a. 2 components extracted.

Rotated Component Matrix[a]

	Component	
	1	2
SMEAN(EGROWTH1)		.814
SMEAN(EGROWTH2)	.796	
SMEAN(EGROWTH3)	.851	
SMEAN(EGROWTH5)		.779

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 3 iterations.

Factor Analysis SCHEME DESIGN

Correlation Matrix[a]

		SMEAN(SD1)	SMEAN(SD2)	SMEAN(SD3)	SMEAN(SD4)	SMEAN(SD5)	SMEAN(SD6)
Correlation	SMEAN(SD1)	1.000	.407	.199	.135	.170	.138
	SMEAN(SD2)	.407	1.000	.277	.216	.148	.256
	SMEAN(SD3)	.199	.277	1.000	.262	.391	.190
	SMEAN(SD4)	.135	.216	.262	1.000	.305	.312
	SMEAN(SD5)	.170	.148	.391	.305	1.000	.264
	SMEAN(SD6)	.138	.256	.190	.312	.264	1.000

Sig. (1-tailed)	SMEAN(SD1)		.000	.000	.000	.000	.000
	SMEAN(SD2)	.000		.000	.000	.000	.000
	SMEAN(SD3)	.000	.000		.000	.000	.000
	SMEAN(SD4)	.000	.000	.000		.000	.000
	SMEAN(SD5)	.000	.000	.000	.000		.000
	SMEAN(SD6)	.000	.000	.000	.000	.000	

a. Determinant = .463

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.700
Bartlett's Test of Sphericity	Approx. Chi-Square	453.389
	df	15
	Sig.	.000

Communalities

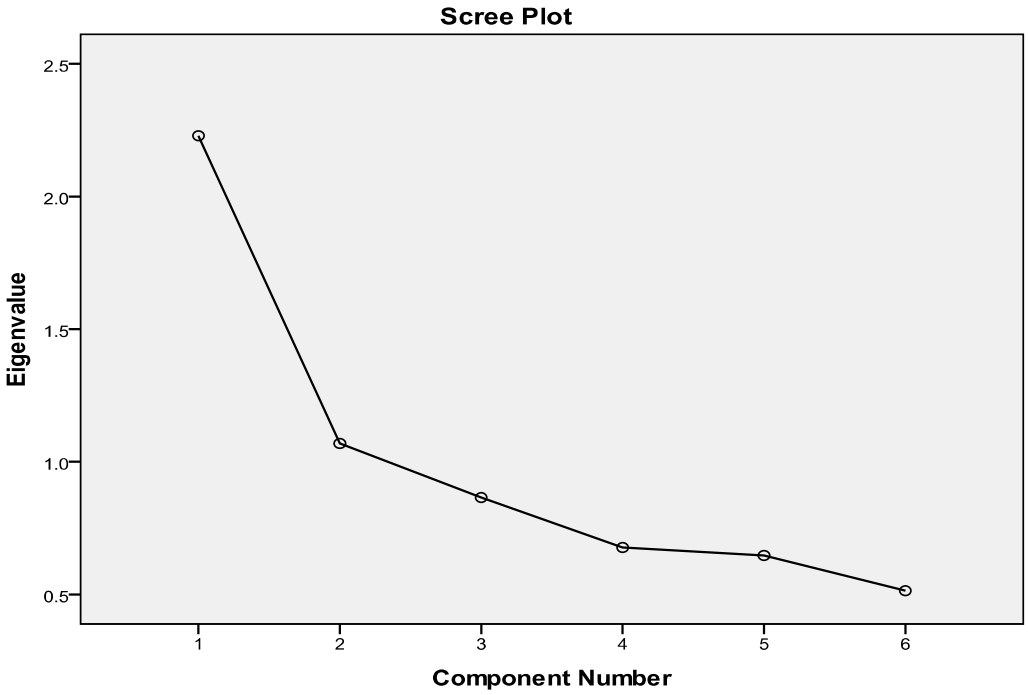
	Initial	Extraction
SMEAN(SD1)	1.000	.715
SMEAN(SD2)	1.000	.687
SMEAN(SD3)	1.000	.447
SMEAN(SD4)	1.000	.497
SMEAN(SD5)	1.000	.568
SMEAN(SD6)	1.000	.385

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component		Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
		Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
dimension 0	1	2.229	37.153	37.153	2.229	37.153	37.153	1.853	30.890	30.890
	2	1.069	17.812	54.966	1.069	17.812	54.966	1.445	24.076	54.966
	3	.865	14.419	69.384						
	4	.677	11.278	80.662						
	5	.647	10.776	91.439						
	6	.514	8.561	100.000						

Extraction Method: Principal Component Analysis.



Factor Analysis MOBILIZATION

Correlation Matrix[a]

		SMEAN (MOBILIZA1)	SMEAN(MOBILIZA2)	SMEAN(MOBILIZA3)	SMEAN(MOBILIZA10)	SMEAN(MOBILIZA11)
Correlation	SMEAN(MOBILIZA1)	1.000	.561	-.041	.097	.100
	SMEAN(MOBILIZA2)	.561	1.000	.013	.111	.120
	SMEAN(MOBILIZA3)	-.041	.013	1.000	.132	.147
	SMEAN(MOBILIZA10)	.097	.111	.132	1.000	.387
	SMEAN(MOBILIZA11)	.100	.120	.147	.387	1.000
Sig. (1-tailed)	SMEAN(MOBILIZA1)		.000	.162	.009	.008
	SMEAN(MOBILIZA2)	.000		.373	.003	.002
	SMEAN(MOBILIZA3)	.162	.373		.001	.000
	SMEAN(MOBILIZA10)	.009	.003	.001		.000
	SMEAN(MOBILIZA11)	.008	.002	.000	.000	

a. Determinant = .551

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.539
Bartlett's Test of Sphericity	Approx. Chi-Square	351.203
	df	10
	Sig.	.000

Communalities

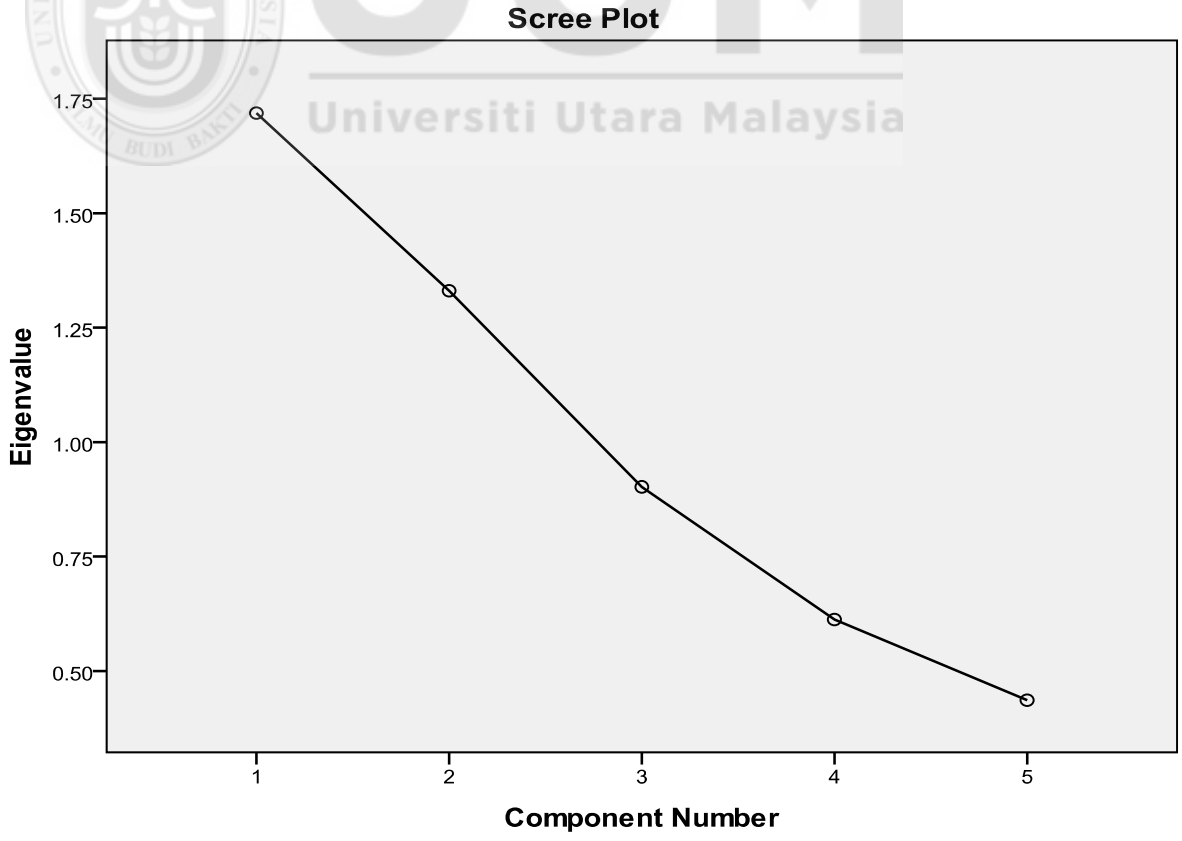
	Initial	Extraction
SMEAN(MOBILIZA1)	1.000	.777
SMEAN(MOBILIZA2)	1.000	.760
SMEAN(MOBILIZA3)	1.000	.295
SMEAN(MOBILIZA10)	1.000	.601
SMEAN(MOBILIZA11)	1.000	.616

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component		Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
		Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
dimension0	1	1.719	34.372	34.372	1.719	34.372	34.372	1.589	31.774	31.774
	2	1.331	26.613	60.985	1.331	26.613	60.985	1.461	29.211	60.985
	3	.902	18.043	79.027						
	4	.612	12.247	91.275						
	5	.436	8.725	100.000						

Extraction Method: Principal Component Analysis.



Rotated Component Matrix[a]

	Component	
	1	2
SMEAN(MOBILIZA1)	.882	
SMEAN(MOBILIZA2)	.870	
SMEAN(MOBILIZA3)		.524
SMEAN(MOBILIZA10)		.765
SMEAN(MOBILIZA11)		.773

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 3 iterations.

Factor Analysis of HEALTHCARE SERVICES

Correlation Matrix[a]

		SMEAN(HEALTHS3)	SMEAN(HEALTHS4)	SMEAN(HEALTHS5)	SMEAN(HEALTHS6)	SMEAN(HEALTHS7)	SMEAN(HEALTHS8)
Correlation	SMEAN(HEALTHS3)	1.000	.106	.124	.102	.168	.128
	SMEAN(HEALTHS4)	.106	1.000	.359	.250	.314	.311
	SMEAN(HEALTHS5)	.124	.359	1.000	.222	.313	.300
	SMEAN(HEALTHS6)	.102	.250	.222	1.000	.383	.250
	SMEAN(HEALTHS7)	.168	.314	.313	.383	1.000	.497
	SMEAN(HEALTHS8)	.128	.311	.300	.250	.497	1.000

Sig. (1-tailed)	SMEAN(HEALTHS3)		.005	.001	.006	.000	.001
	SMEAN(HEALTHS4)	.005		.000	.000	.000	.000
	SMEAN(HEALTHS5)	.001	.000		.000	.000	.000
	SMEAN(HEALTHS6)	.006	.000	.000		.000	.000
	SMEAN(HEALTHS7)	.000	.000	.000	.000		.000
	SMEAN(HEALTHS8)	.001	.000	.000	.000	.000	

a. Determinant = .425

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.756
Bartlett's Test of Sphericity	Approx. Chi-Square	504.667
	Df	15
	Sig.	.000

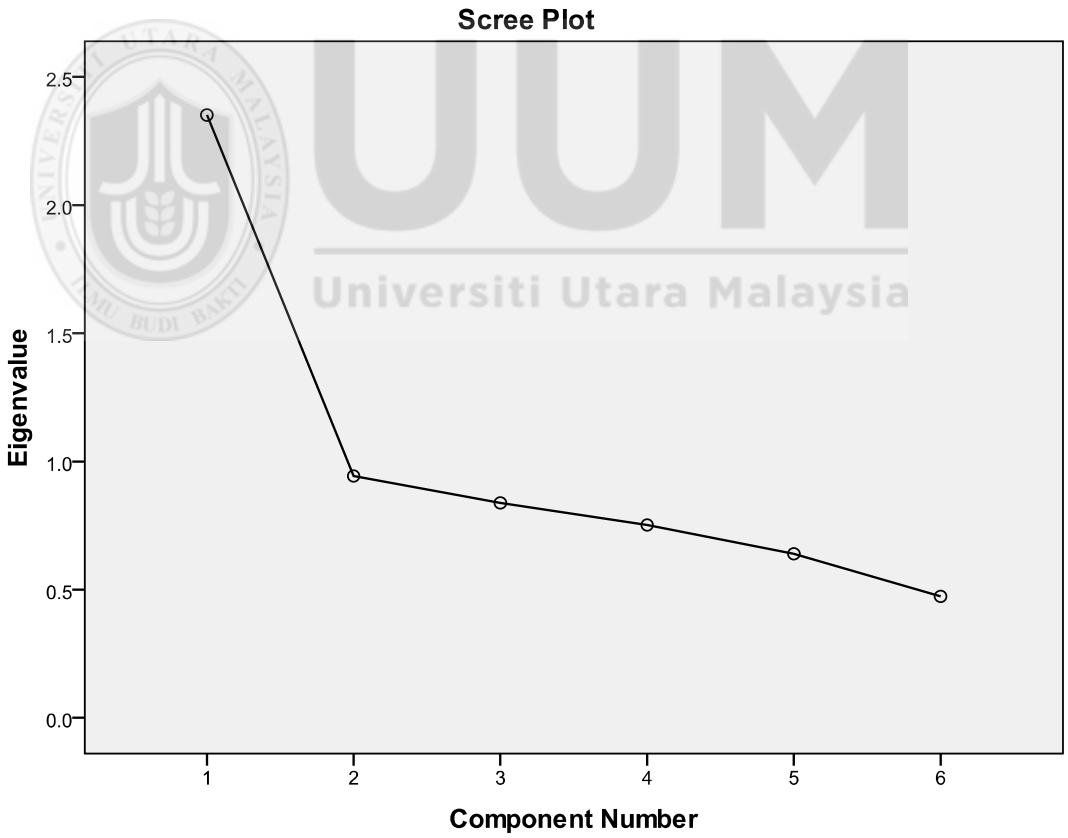
Communalities

	Initial	Extraction
SMEAN(HEALTHS3)	1.000	.991
SMEAN(HEALTHS4)	1.000	.441
SMEAN(HEALTHS5)	1.000	.408
SMEAN(HEALTHS6)	1.000	.363
SMEAN(HEALTHS7)	1.000	.585
SMEAN(HEALTHS8)	1.000	.508

Extraction Method: Principal Component Analysis.

Component		Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
		Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
dimension 0	1	2.351	39.192	39.192	2.351	39.192	39.192	2.275	37.919	37.919
	2	.944	15.726	54.917	.944	15.726	54.917	1.020	16.999	54.917
	3	.839	13.980	68.897						
	4	.752	12.541	81.438						
	5	.640	10.663	92.101						
	6	.474	7.899	100.000						

Extraction Method: Principal Component Analysis.



Rotated Component Matrix[a]

	Component	
	1	2
SMEAN(HEALTHS3)		.992
SMEAN(HEALTHS4)	.664	
SMEAN(HEALTHS5)	.636	
SMEAN(HEALTHS6)	.601	
SMEAN(HEALTHS7)	.749	
SMEAN(HEALTHS8)	.707	

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 3 iterations.

APPENDIX E:REGRESSION

Descriptive Statistics

	Mean	Std. Deviation	N
Healthcare	3.5113	.65590	593
Policy	3.5916	.61229	593
Economic	3.3526	.72091	593
Scheme	3.4463	.61849	593
Mobilization	3.5931	.59227	593

Correlations

		Healthcare	Policy process	Economic	Scheme	Mobilization
Pearson Correlation	Healthcare	1.000	.421	.465	.501	.389
	Policy	.421	1.000	.511	.456	.434
	Economic	.465	.511	1.000	.578	.411

	Scheme	.501	.456	.578	1.000	.482
	Mobilization	.389	.434	.411	.482	1.000
Sig. (1-tailed)	Healthcare	.	.000	.000	.000	.000
	Policy	.000	.	.000	.000	.000
	Economic	.000	.000	.	.000	.000
	Scheme	.000	.000	.000	.	.000
	Mobilization	.000	.000	.000	.000	.
N	Healthcare	593	593	593	593	593
	Policy	593	593	593	593	593
	Economic	593	593	593	593	593
	Scheme	593	593	593	593	593
	Mobilization	593	593	593	593	593

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	Mobilization, Economic, Policy, Scheme[a]	.	Enter

a. All requested variables entered.

b. Dependent Variable: Health care services

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
dimension0 1	.575[a]	.330	.326	.53864	.330	72.445	4	588	.000	1.887

a. Predictors: (Constant), mobilization, Economic, policy, scheme

b. Dependent Variable: Healthcare services

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	84.077	4	21.019	72.445	.000[a]
	Residual	170.601	588	.290		
	Total	254.678	592			

a. Predictors: (Constant), mobilization, Economic, policy, scheme

b. Dependent Variable: Health care services

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Correlations			Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	.911	.164		5.561	.000					
	Policyprocess	.165	.044	.154	3.727	.000	.421	.152	.126	.663	1.507
	Economic	.166	.040	.182	4.122	.000	.465	.168	.139	.583	1.716
	Scheme	.285	.047	.268	6.057	.000	.501	.242	.204	.581	1.722
	mobilization	.131	.045	.118	2.932	.004	.389	.120	.099	.702	1.424

a. Dependent Variable: Health care services

Collinearity Diagnostics[a]

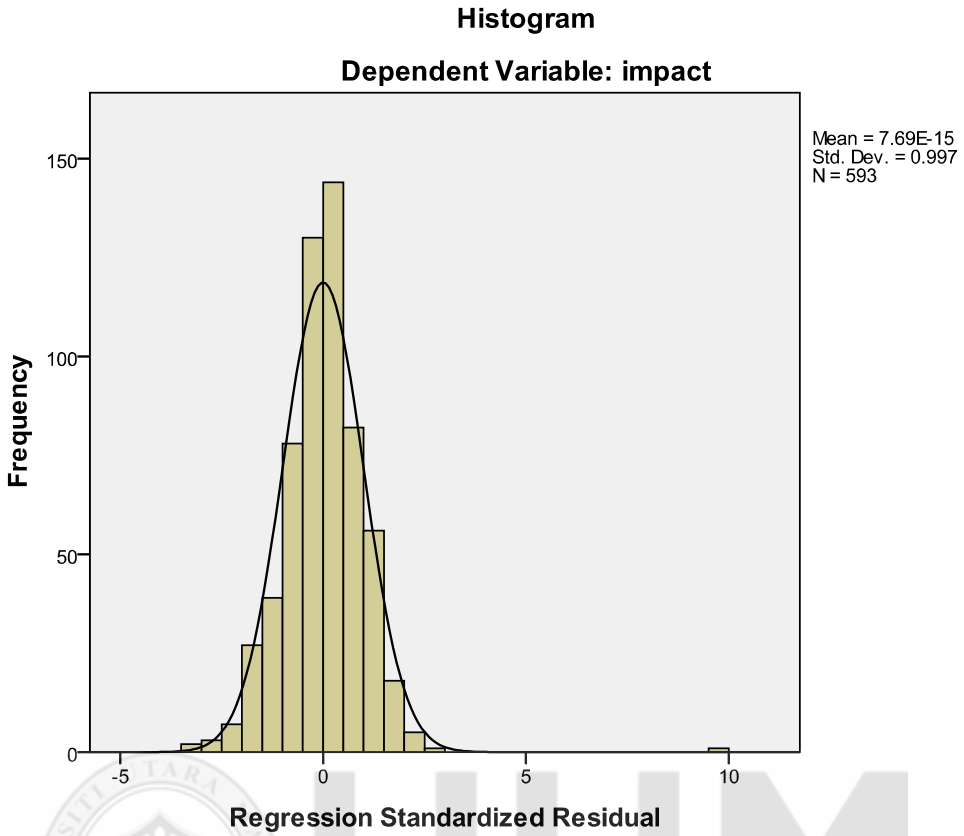
Model	Dimension		Eigenvalue	Condition Index	Variance Proportions				
					(Constant)	policy	Economic	scheme	mobilization
1	dimension0	1	4.933	1.000	.00	.00	.00	.00	.00
		2	.025	14.066	.16	.01	.64	.01	.10
		3	.016	17.405	.01	.62	.01	.37	.13
		4	.013	19.247	.09	.03	.15	.47	.69
		5	.013	19.811	.75	.34	.20	.15	.08

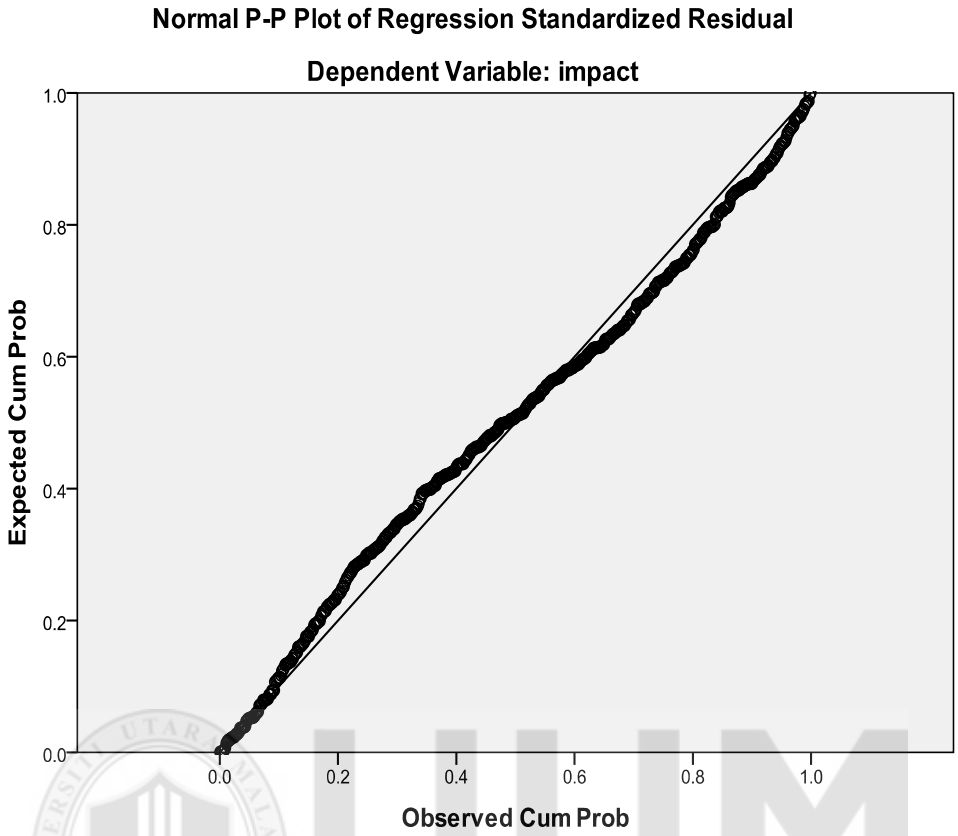
a. Dependent Variable: healthcare services

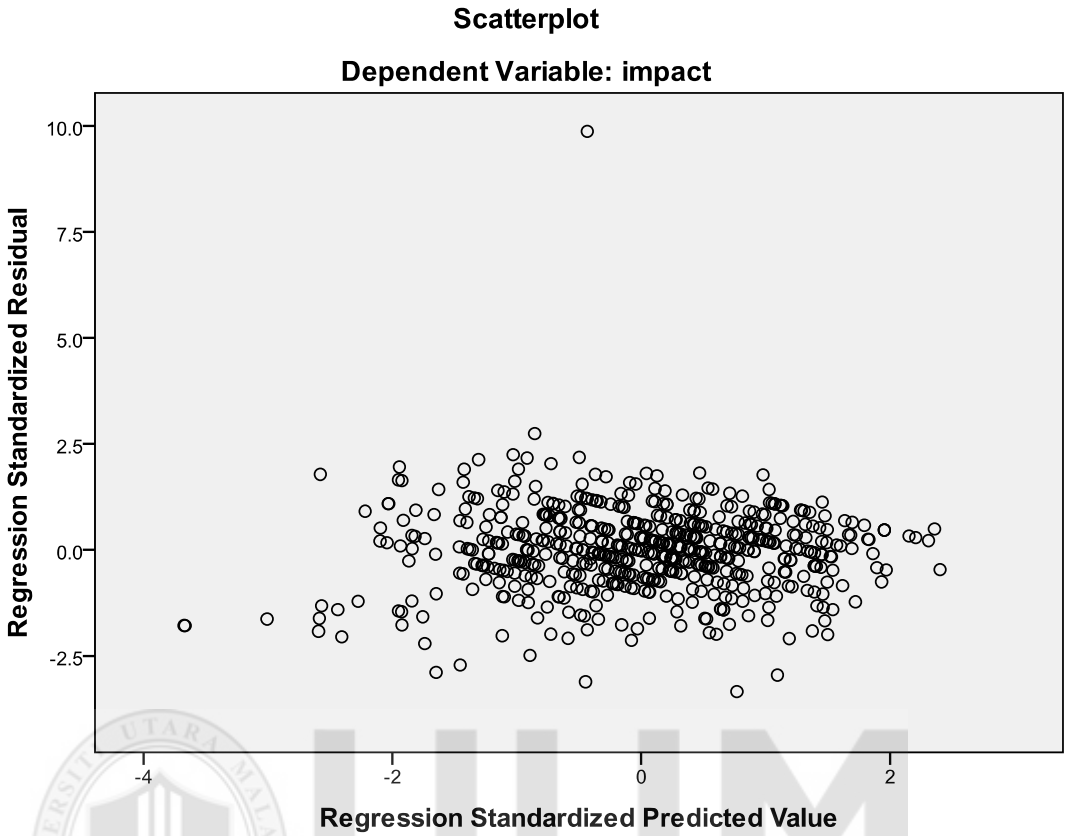
Residuals Statistics[a]

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	2.1271	4.4163	3.5113	.37686	593
Residual	-1.80101	5.31890	.00000	.53682	593
Std. Predicted Value	-3.673	2.401	.000	1.000	593
Std. Residual	-3.344	9.875	.000	.997	593

a. Dependent Variable: healthcare services







EGROWTH RELIABILITY

Reliability Statistics

Cronbach's Alpha	N of Items
.597	4

S D RELIABILITY

Reliability Statistics

Cronbach's Alpha	N of Items
.669	5

MOBILIZATION RELIABILITY

Reliability Statistics

Cronbach's Alpha	N of Items
.618	11

HEALTHCARE RELIABILITY

Reliability Statistics

Cronbach's Alpha	N of Items
.722	8

APPENDIX F: DISCRIPTIVE STATISTICS OF DEMOGRAPHIC DATA

Statistics

		DMO1	DMO2	DMO3	DMO4	DMO5	DMO6	DMO7
N	Valid	45	45	45	45	45	45	45
	Missing	0	0	0	0	0	0	0
Minimum		1	1	1	1	1	1	1
Maximum		5	2	5	4	5	8	8

DMO1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	female heads of household	154	22.0	22.1	22.1
	male head household	267	38.1	38.4	60.5
	Wife	97	13.9	13.9	74.4
	grandmother	9	1.3	1.3	75.7
	representative of household	169	24.1	24.3	100.0
	Total	696	99.4	100.0	
Missing	System	4	.6		
Total		700	100.0		

DMO2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	250	35.7	36.2	36.2
	NO	440	62.9	63.7	99.9
	4	1	.1	.1	100.0
	Total	691	98.7	100.0	
Missing	System	9	1.3		
Total		700	100.0		

DMO3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-5 PEOPLE	256	36.6	36.6	36.6
	6-15	308	44.0	44.0	80.6
	16-25	81	11.6	11.6	92.1
	26-35	29	4.1	4.1	96.3
	36 AND ABOVE	26	3.7	3.7	100.0
	Total	700	100.0	100.0	

DMO4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-18 years	45	6.4	6.5	6.5
	19-25	379	54.1	54.4	60.8
	26-35	206	29.4	29.6	90.4
	36 and above	67	9.6	9.6	100.0
	Total	697	99.6	100.0	
Missing	System	3	.4		
Total		700	100.0		

DMO5

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NEVER ATTEND SCHOOL	374	53.4	53.9	53.9
	PRIMARY SCHOOL	311	44.4	44.8	98.7
	SECONDARY	3	.4	.4	99.1
	VOCATIONAL COLLEGE	3	.4	.4	99.6
	UNIVERSITY OR HIGHER	3	.4	.4	100.0
	Total	694	99.1	100.0	
Missing	System	6	.9		
Total		700	100.0		

DMO6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	FAMER	29	4.1	4.1	4.1
	PETTY TRADING	102	14.6	14.6	18.7
	EMPLOYED IN PRIVATE SECTOR	3	.4	.4	19.1
	SELF EMPLOYED PROFESSIONAL	30	4.3	4.3	23.4
	UNEMPLOYED	536	76.6	76.6	100.0
	Total	700	100.0	100.0	

DMO7

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MALE	367	52.4	52.4	52.4
	FEMALE	333	47.6	47.6	100.0

DMO7

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MALE	367	52.4	52.4	52.4
	FEMALE	333	47.6	47.6	100.0
	Total	700	100.0	100.0	