KNOWLEDGE, PERCEPTION AND UTILISATION OF OYO STATE HEALTH INSURANCE AGENCY AMONG CIVIL SERVANTS IN IBADAN SOUTH-WEST LOCAL GOVERNMENTAREA OF OYO STATE

BY

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DEDICATION

This research work is dedicated to the Almighty Who gave me life and Who is the source of all wisdom.

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ABSTRACT

Health insurance Scheme is a programme that shares the expenses associated with healthcare of individuals. The mode of operation of the formal sector of health insurance to which Oyo State Health insurance Agency (OYSHIA) belongs is such that the health services of the employees are addressed from funds pooled by the employer and the employees. This study investigated the knowledge, perception and utilisation of OYSHIA by Civil Servants in Ibadan South West Local Government Area (IBSWLGA) of Oyo state, Nigeria.

A descriptive cross-sectional study was conducted. The total population of the permanent staff working in Ibadan south west Local Government Area was 235 and of this, only 217 gave to participate in the study. A self-administered questionnaire was used to collect data from the respondents. Knowledge was measured on an eleven point scale; scores less than 5.5 were classified as poor and scores of 5.5 and above were classified as good. Perception was measured on an eight point scale, scores lesser than 4 were classified as poor, while scores of 4 and above were classified as good. Data was analysed using descriptive statistics and chi-square test at $p < 0.05$.

The mean age of the respondents was 44±9.3years, while 64.0% of them were females, 83.0% of the respondents had a good knowledge of OYSHIA and the services it covers, seventy-seven percent showed a positive perception towards OYSHIA, 86.0% were registered members under the OYSHIA. Fifty-nine percent of the respondents, irrespective of whether they were registered members or not, indicated they had preference for healthcare services being offered by OYSHIA; twenty-two percent indicated they preferred to use healthcare service from another source; and about nineteen percent were indecisive. Forty-five percent of the respondents who had accessed the OYSHIA healthcare services confirmed availability of drugs and services demanded during usage. Association between respondents' knowledge on OYSHIA and their utilization of the healthcare services under the OYSHIA revealed that having a good or bad knowledge did not significantly affect the level of usage of the OYSHIA services ($p = 0.541$). Also the level of usage of the OYSHIA services was not significantly associated with their perception level ($p = 0.543$).

Low level of utilisation of the services of OYSHIA by the scheme members was observed from this study. Non-availability of drugs was cited for the low utilization. There is a need for adequate provision of necessary drugs and healthcare services, so as to encourage utilization. Seminars, workshops and other for a where civil servants can express the their mind barriers to utilisation of the services of OYSHIA should be organized by the stake holders so as to deliberate on and take necessary actions needed to sort out these issues.

Keywords: OYSHIA, knowledge, utilization, perception, civil servant.
Word count: 442

CERTIFICATION

I certify that this study was carried out by Adenike Olubusola ODUOLA under my supervision at the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

LIST OF FIGURES

LIST OF ACRONYMS

W.H.O	-	World Health Organization
NHIS	-	National Health Insurance Scheme
HMOs	-	Health Maintenance Organizations
OYSHIA	-	Oyo State Health Insurance Agency
LGA	-	Local Government Area
UHC	-	Universal Health Coverage
SDGs	-	Sustainable Development Goals
PHC	-	Primary Health Care
SHI	-	Social Health Insurance
CBHI	-	Community-Based Health Insurance
OYSHIA	-	Oyo State Health Insurance Agency
PCV	-	Packed Cell Volume
FBC	-	Full Blood Count
HB	-	Haemoglobin
BCG	-	Bacili Calmette Guerrin
DPT	-	Dipteria Petusis Tetanus
HIV	-	Human Immune--Deficiency Virus
NPI	-	National Program on Immunisation
HMO	-	Health Maintainance Organisation
IVF	-	In Vitro Fertilization
GIFT	-	Gamete Intra-Fallopian Tube Transfer
ZIFT	-	Zygote Intra Fallopian Transfer
ARC	-	AIDS Related Complex

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Health, according to W.H.O., is a state of complete physical and mental wellbeing of an individual and not merely the absence of a disease or infirmity (W.H.O.2008). A healthy nation/state is a wealthy one because of the absence of debilitating diseases and epidemics in such a country, which, along with hunger and squalor, impoverishes the citizenry (Nwatu, 2004). A state that has a poor health system and policies is bound to experience poor economic growth, as productivity of citizens might be greatly affected when they fall sick or die from curable diseases. (Mugo and Nzuki 2014). The start of the social health insurance in Nigeria dates back to 1962 when the need for health insurance in the provision health care to Nigerians was first recognized.

According to W.H.O data that was published in 2018, Nigeria was given third lowest, and a world life expectancy ranking of 178, life expectancy was put at 55.7 years for females and 54.7 years for males with a total life expectancy of 55.2 years. Also, in order to meet up the target of reducing maternal mortality rate and that of under five children by two thirds (which is part of targets of the Millennium Development Goals for year 2015) and to increase the life expectancy by improving access to quality health care services and health status of the citizens, a social health insurance , the National Health Insurance Scheme (NHIS) was established in Nigeria in 1995 even though it became operational in 2005. The NHIS is a public-private-partnership between the NHIS, the Health Maintenance Organizations (HMOs), and other health care providers (private and public). The overall objective is to secure universal health coverage and access to adequate and affordable health care, with the aim of improving the health status of the citizens of Nigeria. While the NHIS shapes the health insurance policy by licensing the HMOs that operates the health insurance business, it also accredits health care facilities to provide the benefit packages to registered enrollees. The rising cost of health care services, as well as

the inability of the government health facilities to cope with the people's demand also necessitated the establishment of the Social Health Insurance Scheme.

Prior to the establishment of the NHIS, several systems, ranging from free health care purchase, out-of-pocket purchase, retainer ship, in-built health facilities within corporate organizations to health indemnity insurance have been in vogue. However while the NHIS operates at the Federal level, many states in Nigeria, including Oyo state have also established their own state insurance scheme, following successes documented in improved healthcare by most countries of the world.

The Oyo State Health Insurance Agency (OYSHIA) is a form of health care management system and a healthcare scheme established by the government of Oyo state of Nigeria. It is designed to provide comprehensive health care delivery at affordable costs, covering employees of the formal sector, self-employed, as well as rural communities, the poor and the vulnerable groups. It is a government organization established as a conscious effort of the State government to ensure access to qualitative health at an affordable cost through various prepayment systems which was flagged off on the 25th of May 2017. The OYSHIA is a mandatory, but affordable health insurance scheme that pools regular financial contributions of members and pays a network of providers of health care for defined specific set of health care services, which in turn are accountable for cost containment and improving health outcomes.

1.2 Statement of the Problem

In Nigeria, various studies show that the knowledge and utilization of social health insurance is still very low (NHIS, 2012). Coverage of social health insurance among local government workers is low (Adewole, 2015). There is poor knowledge of the components and mechanism of operation of social health insurance among government workers (Olugbenga –Bello and Adebimpe, 2010).

Problems associated with the use of social health insurance in Nigeria is that the health benefits package are considered inadequate, as it excludes some life-threatening health challenges such as those related to kidney, heart and liver (Nigerian Institute of Social and Economic Research, 2012).

Health insurance drug list which enrollees stated excludes some essential prescription drugs due to cost considerations. Health facilities at some lower level hospitals have been reported inadequate in spite of the capitation funds paid to health care providers for improvement (Nigerian Institute of Social and Economic Research, 2012).

There is a low level of trust in government programs such as social health insurance, payment of premium in social health insurance has been perceived by some government workers to be as good as inviting sickness (Adewole et al, 2015).

There is much to be done by the regulatory bodies of social health insurance to ensure that all employees in the formal sector are adequately informed about it so that they can be motivated to enroll and utilise it (Ilochonwu and Adedigba, 2017).

1.3 Justification for the Study

There is a dearth of literature on Oyo State Health Insurance Agency, much is not yet known about it although it is a form of social health insurance. This study will be useful in exploring the knowledge level, perception, and utilization of civil servants in Ibadan Southwest LGA about Oyo State Health Insurance Agency.

This study if published, will serve as a form of enlightenment to the public and to all other civil servants on Oyo State Health Insurance Agency.

The study will add to existing literatures on social health insurance and serve as a reference material to other students who may want to carry out related studies in future.

1.4 Research Questions

The research work answered the following questions:

1. What is the level of the knowledge of respondents about OYSHIA?
2. How is OYSHIA perceived by the respondents?
3. What is the level of utilization of OYSHIA by the respondents?

1.5 Objectives of Study

Broad objective

The broad objective of this study was to investigate the knowledge, perception, and utilization of OYSHIA by civil servants in Ibadan South West Local Government Area of Oyo state.

Specific objectives

The specific objectives of the study were to:

1. Assess the knowledge level of the respondents on OYSHIA
2. Determine the perception of the respondents about important aspects of OYSHIA
3. Ascertain the level of utilization of OYSHIA by the respondents.

1.6 Hypotheses

The following hypotheses were tested for:

Ho_1: There is no significant association between knowledge level and utilisation of OYSHIA among civil servants in Ibadan South west local LGA.

Ho_2: There is no significant association between the perception and utilisation of OYSHIA among civil servants in Ibadan South west local LGA.

CHAPTER TWO

LITERATURE REVIEW

2.1 An overview of Healthcare Services Delivery in Nigeria

An important factor that determines the overall healthcare service delivery in Nigeria has been the health condition of the Nigerian populace; the number of physicians or hospital beds as well as availability of drugs and other related factors. According to Soyinka (2000), ‘’good health is one of the most important basic needs of mankind and is indispensable in social and economic development of a nation’’. A study on healthcare service in Nigeria for the periods 1960 - 1980 and 1981 - 2000 showed that there were fewer number of medical and health personnel, hospital and other health facilities in the country in 1960 - 1980 period i.e. fewer number of doctors, nurses, hospitals, clinics and community health centers.

Dimeji (2000) remarked that despite the high doctor - patient and nurse - patient ratios, health services were more than what obtained in the period 1980 - 2000. Although there was a rapid expansion of health facilities in the second half of the 1970s due to oil boom that saw budgetary allocation which expanded the health sectors. This finding was corroborated by that of the World Health Organization report (2001,) RansomeKuti (1992) posits that it was this discouraging healthcare condition that informed the launching of the Primary Healthcare Services Scheme in 1990. Under this scheme, there was proliferation of public and private health institutions and facilities throughout the country.

Since then there is at least one private health institution in every town and one public health institution in each local government throughout the country (Mba, 2002). The rapid expansion of private health care institutions since the mid - 1980s represents a milestone in the quest for improved healthcare services delivery in the country. This then called for effective integration of the private health institutions into the National Health Policy so as to ensure effective provision of healthcare service throughout the country.

2.2 The goals of National Health Policy

The National Health Policy represents the collective will of the governments and people of the country to provide a comprehensive health care system that is based on primary health care. It describes the goals, structure, strategy, and policy direction of the health care delivery system in Nigeria. The main goal of the Nigerian Government has been to pursue a national policy on health which is aimed at ensuring adequate, efficient and effective healthcare services delivery since the 1960s. In June 2016, the National Health Policy in Nigeria was revised for the attainment of Universal Health Coverage (UHC) and other health-related Sustainable Development Goals (SDGs) to accommodate emerging trends. The overall policy objective is to strengthen the national health system such that it will provide effective, efficient quality accessible and affordable health services that can improve the health status of Nigerians.

The 2016 National Health Policy also aimed at promoting the health of Nigerians to accelerate socio-economic development in the country, the policy is the third health policy in the history of Nigeria. The first national health policy was in 1988, while the second policy was produced in 2004. "This new policy also provides directions necessary to support the achievements of significant progress in terms of improving the performance of the national health system. "It also lays emphasis on primary healthcare as the bedrock of our national health system in addition to the provision of financial risk protection to all Nigerians particularly the poor and vulnerable population. The policy captures the essentials of ensuring the reduction of maternal and child mortality, wider immunization coverage and better control and prevention of public health emergencies.

2.3 Benefits of improved Healthcare Services Development

First, good and effective healthcare services promote a healthy nation, healthy in the sense that it reduces incidence of diseases and ill - health. According to Abdukadri (1998) a healthy nation is one that has a very low mortality (infant, maternal and adult) rate and also has high life expectancy. Thus, adequate and effective healthcare system promotes long life span of its people.

Secondly, it ensures higher productivity in the national economy. Abdukadri (1998) states that another potentially significant case for improved healthcare services is the reduction in productivity loses caused by debility of substantial portion of the labour forces; besides, it prolongs productive years of the labour force. Accordingly, increases in the life expectancy of adults would add years to the working lives (rather than retirement years) of most adults. All things being equal, a lengthening of working life reduces the country's dependency ratio. Lower dependency ratios, increase per capital income and potentially, per capital savings, as family incomes are required to support fewer numbers.

Thirdly, good health care services promote the populates standard of living. Ugbaja (2003) posits that a nation with healthy population is always productive with the individuals meaningfully earning their living. With increasing income at their disposal, they can improve their standard of living by satisfying most of their basic needs. Grange (2007) opined that efforts to improve the nation's health care service are predicated on the imperatives of effective and adequate healthcare system.

This depends on the ability of the government to embark on effective health planning and formulation of effective health policy that will benefit the populace, especially rural dwellers who have continually been neglected by past health policies.

2.4 Financing of Healthcare Service in Nigeria

Health care in Nigeria is financed by a combination of tax revenue, out-of-pocket payments, donor funding, and health insurance (social and community). Achieving a successful health care financing system continues to be a challenge in Nigeria. Limited institutional capacity, corruption, unstable economic, and political context have been identified as factors why some mechanisms of financing healthcare have not worked effectively.

Tax Revenue

Health financing systems where government revenues are the main source of health care expenditure are referred to as tax-based systems. Funds are usually generated through taxation or other government revenues. Although the Nigerian government generates

revenue through taxation, the bulk of the revenue is derived from the sale of oil and gas. Revenues are raised at the federal, state, or local government levels. However, the federally generated revenue which is shared according to a formula forms the majority of the funds for the other tiers of government. The states and local governments being closer to PHC are expected to provide adequate funding for PHC, but owing to their low internal revenue generation capacities, most of them still largely depend on the allocation from the federal government. The federal allocations to the states and local governments are not earmarked neither are the states and local governments required to provide budget and expenditure reports to the federal government. By implication, the federal government does not have a substantial control on funds allocated for both secondary and primary health services accounting for a reason why health care has been at the peril of underfunding by the Nigerian government.

Out-of-Pocket Payments

This involves payment for health care at the point of service. The charges levied for health care services are referred to as user fees. The scope of user fees is quite variable and can include any combination of drug costs, medical material costs, entrance fees, and consultation fees. Out-of-pockets account for the highest proportion of health expenditure in Nigeria. Households bear the highest burden of health expenditure in Nigeria.

User fee was introduced by the Nigerian government in 1998 under the Bamako Initiative which advocated for cost sharing and community participation to increase the sustainability and quality of health care. It was proposed that user fee will increase the resources available for health care and improve efficiency as well as equity to health care.

James *et al*. concluded that abolishing user fees may not be appropriate in all contexts, nonetheless, in settings where it has been shown to have had limited benefits, removal should undoubtedly be a favorable policy options. User fees have been removed by the federal government and some states for the treatment of malaria in the under-5s and pregnant women.

Social Health Insurance

Social Health Insurance (SHI) is a system of financing health care through contributions to an insurance fund that operates within a tight framework of government regulations. It is a form of mandatory insurance scheme). It provides a pool of funds to cover the cost of health care and it also has a social equity function which eliminates barriers to obtaining health care services at the time of need especially for the vulnerable groups. In SHI, every citizen is required to make contributions. Governments may contribute on behalf of the poorest and the unemployed; employers also usually contribute on behalf of their employees. The Nigerian government established a social health insurance (NHIS) under Act 35 of 1999 with the aim of improving access to health care and reducing the financial burden of out-of-pocket payment for health care services. The formal sector SHIP is presently extending to states and local government employees with OYSHIA operating in Oyo state as a form of social health insurance programme.

Community-Based Health Insurance

Community-Based Health Insurance (CBHI) is a form of private health insurance whereby individuals, families, or community groups finance or co-finance costs of health services. Other forms of private health insurance include non-profit and for-profit plans. Usually, private health insurance is voluntary compared with SHI schemes which tend to be mandatory. CBHI is designed for people living in the rural area and people in the informal sector who cannot get adequate public, private, or employer-sponsored insurance. It usually involves some form of community involvement in their management. The effects of CBHI on equity, the quality, and efficiency health services are still confusing. It has been shown that even when charges are small, the very poor are unable to enroll. Thus, the existing inequalities may be worsened, since the less poor people are more likely to enroll and have improved access to care and financial protection. Designing, implementing, managing, and especially sustaining CBHI are complex. It requires a strong intuitional capacity, technical expertise, and management skills.

This refers to financial assistance given to developing countries to support socioeconomic and health development. The major challenges in Nigeria with donor funding are effective coordination of the funds and tracking donor resource flow. The National Planning Commission coordinates the use of financial assistance to Nigeria. At the state and local government levels, the State Planning Commission or State Ministry of Finance coordinates the use of financial assistance and provides a link between the LGAs and the federal government. The states vary in their capacities to effectively coordinate development aid. Other challenges with donor funding in Nigeria include the following: high cost of technical assistance, donor-driven approach to aid delivery, proliferation of aid agencies, uneven spread of donors' activities, institutional weaknesses, and problem of counterpart funding.

2.5 Global Perspective of Social Health Insurance

This definition of health by World Health Organization looks like an aberration in Nigeria and if we go strictly by it, no Nigerian can be said to be a healthy client for the insurance industry. Every country strives to provide for its citizens affordable and accessible healthcare. In South Africa for instance, there is no nationally operated public health insurance scheme. Yet, they can boast of better health indices than Nigeria. They have private health insurance schemes that are affordable, well developed and functioning effectively and efficiently (Gana, 2010). A look at the healthcare systems of some key countries can only enlighten us more. In the United Kingdom (UK), there is the National Health Scheme (NHS) which is a publicly funded healthcare system for all residents of the UK. No premiums are collected, costs are not charged at the patient level and costs are not prepaid from a pool. It is actually not an insurance system but it does achieve the main aim of insurance which is to spread financial risk arising from ill health directly from general taxation. The United States health care system on the other hand relies heavily on private health insurance, which is the main source of coverage for most Americans. In Canada, public and private schemes exist; most health insurance schemes in Canada are administered at the level of provinces under the Canadian Health Act, which requires all people to have free access to healthcare. About 65% of Canadians have some form of supplementary private health insurance; many of them receive it through their employers.

(Gana, 2010) France operates a solidarity system; it has both public and private schemes. The peculiarity of the French system is that; the more ill a person becomes, the less the person pays. This means that for people with serious or chronic illness, the insurance system reimburses them 100% of expenses, and waives co-payment charges. Complementary private health insurance is also available (Gana, 2010).

In Australia functional public health insurance exists alongside private schemes. The public health system (Medicare) ensures free universal access to hospital treatment and subsidized out-of-hospital medical treatment. Medicare is funded by 1% levy on all taxpayers, an extra 1% levy on high income earners as well as general government revenue. Some private health insurers are for profit while some nonprofit health insurance organizations are also operational. The sickness fund of Germany is a health insurance scheme paid for by employers and employees and managed by non -profit organizations. It is characterized by private provider base, efficient management, adequate investment and effective control of provider and purchaser behavior. In Chile, public and private schemes exist, but like in most countries of Latin America, patients are migrating from public to private schemes (Korte, 1992). The Nigerian System allows private healthcare providers as major stakeholders despite the establishment of the NHIS. The extent of coverage of the NHIS is such that artisans, farmers, sole proprietors of businesses, street vendors, traders and the unemployed are not yet accounted for. Even within the formal sector, not all government and corporate organisation employees are enrolled within the scheme. Our public and private hospitals therefore are still operating on a fee for service basis for the majority of its clients (Gana, 2010).

2.6 Knowledge, perception and utilisation of social health insurance (SHI)

Bello and Adebimpe (2010) in their study in Osun state, observed that majority of the civil servant had a low knowledge of the objectives of social health insurance, its components, objectives, and who ideally should benefit from it. The study further stated that most of the respondents believed that there is need to properly fund SHI, because it does not cover all their health needs and care for every member of their family. A study on Knowledge, Attitude, Perception and Clients' Satisfaction with Health Insurance

Scheme Services at the General Hospital Minna, Niger State-Nigeria by Ibrahim et al, (2012) revealed that though all the study participants were aware of health insurance, knowledge on services was below average while the level of satisfaction was also low.

Agba (2010) examined employees' access to health care services in Cross River State, and noted the existence of discrepancies among employees in their access to health insurance as Federal civil servants had more access to the scheme in Cross River State than those of the State government and Local Government staff. The study emphasized on the impact of social health insurance on each categories of urban and rural workers access to health care. In addition, Osuchukwu and Ushie (2011) carried out a study on factors affecting the utilization of social health insurance in Asaba , Delta state, Nigeria. Their study revealed that the utilisation of social health insurance is still low in Nigeria. The underutilization of this service varies from region to region and from state to state. A cross-sectional study identified (72.2%) of respondents utilize social health insurance, while people in the urban areas utilize the service than those in rural areas, the focus of this study was directed on factors affecting the utilisation of SHI services in Delta state. Studies such as those of Tanimole (2011), Adekunle and Oluwole (2012) among others, examined the effects of social health insurance utilisation at University of Ilorin Teaching Hospital Staff Clinic.

The result showed that health insurance led to increase in the utilization of health services in Kwara State. Jibo (2011) in his study with respondents drawn from the public sector to examine the awareness and utilisation of social health insurance among public servants in Kano showed that more than half of the respondents were males, married and had tertiary education also that awareness was high among male compared to females; Jibo further noted that there are obvious reasons for low awareness of the scheme in some rural areas because of low educational level, access to good health care and lack of information on the scheme. Ndie (2013) assessed the awareness of social health insurance among civil servants in Enugu and Abakaliki. He concluded that the civil servants working with Ebonyi and Enugu state governments do not know much about the social health insurance .Mensah (2010) examined the impact of social health insurance on pregnant women in

Oporoma, Bayelsa State. The study found out that pregnant women who participated in the scheme enjoyed reduced incidents of birth complications as they are more likely to receive pre-natal care, deliver at a hospital and are attended to by a trained health professional during birth. Andersen (1995) says that the utilization of social health Insurance Scheme services varies across different cultures for a variety of reasons but it appears to Nora (2005) that the determining factors are universal. Nora noted that utilisation of social Health Insurance Scheme services is determined not only by its availability but by a number of other factors, some of which are highlighted as follows:

Factors that determine utilisation of social health insurance

Location/Distance to Facilities

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

Accessibility to Health care services

In the explanations of Fiedler (2003), access to health care services is considered as the link between the health care system and the population it serves; the volume and type of services, whether or not the service can be reached, the client's perceptions of the relative worth of the service and acceptability of services provided, all influence access and the utilization of services. In line with the postulates of the central place theory, health care facilities in Nigeria constitute a hierarchical system which is reflected in space by the geographical arrangements of service outlets in which a particular area tends to have numerous primary health facilities, much fewer secondary facilities and very few tertiary facilities, if at all. The need for health care varies in space and so the organization of provision necessarily has a spatial component. Neither population totals nor population characteristics such as age, sex, occupation is uniform in space. In a like manner, the physical environment varies in characteristics from place to place and this invariably has implication for the pattern of demand for health care. The spatial dimension is also

important in utilization behavior since accessibility is a major determinant of the use of health care service (Okafor, 2007). The spatial pattern of utilization of service of the various categories of health establishments by the beneficiaries show marked differences between local governments where tertiary and secondary health establishments are accessible and those where such facilities are not accessible. As reported by Okafor (2007), factors such as the level of formal education, facilities available in the health establishments, availability of alternative medical attention in the locality, perception of the attention received in the health care centre and the distance to the centres in terms of travel cost and time of reaching the health centre influence the pattern of utilization of health care services among its beneficiaries .

Client's Perception of Services

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

Self-Rated Health Status of participant

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

Level of Education

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

Gender

According to Charles (2001), sex is one of the most influential variables affecting the use of the National Health Insurance Scheme services. Sex has influence on utilisation of the health care services through its association with other predictors of utilisation such as tendency to use services anxiety and skepticism. Charles noted that levels of personal distress are an important trigger in the use of health care services; since women have higher levels of distress, they make more use of the health care services. Charles (2001) further stated that another possible explanation for the higher rate of utilization among women is that they are more dependent and affiliated and thus seek interpersonal solutions to feelings of distress more than the men.

Culture

According to Henry (2002), the health status of members of a society is positively correlated to their cultural practices. Culture determines what symptoms or signs are recognized as illness, the cause to be associated with them, who has authority to assess and diagnose them and most importantly who should be consulted for treatment. Mohammed (2008) reported that cultural perception of ill health has been identified as a hindrance to health insurance utilisation. Cultural problems evolve with the belief of illness and risk which may be affiliated to religion or traditional norms. When illnesses are perceived ethnically or religiously by the society as punishment for certain misdeeds,

it affects the rate of enrollment in health insurance; in the end, acceptance and utilization of health insurance is threatened.

According to Windsor (2004), culture plays a very big role in the life of man specifically with regards to his medical life. Most often emphasis is placed on socio-economic conditions as the main determinants of people's willingness to enroll in a health insurance scheme, neglecting culture which also has much impact. Helman (2001) further reported that it is of paramount importance to note that illness and choice of health care services is shaped by cultural factors governing perception in the sense that how we perceive and cope with disease is based on our explanations of sickness, explanation specific to the systems of meaning we employ. It is not surprising then that there can be marked cross-cultural variation in how diseases are defined and coped with in our societies. Helman (2001) concluded by saying that it is obvious that culture and ethnicity are influential social determinants of willingness to enroll or use a health insurance scheme.

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

Social Factor in Health Insurance

The ethnic cultural and religious diversity of societies or people within a society reduce solidarity and people's willingness to enroll or pay premium. This is due to lack of

homogeneity and close link to assemble mutual trust (Doherty, Mclyntyre & Gilson, 200).

Moral Hazard

This is a tendency of the entitlement to the benefits of health insurance to act as a strong incentive for people to consume more and "better" health care and a weak incentive for them to maintain a healthy lifestyle (Atim, 2001). It also occurs on the side of the provider and vice versa. Moral hazard entails overuse of the insurance services provided which is caused by both demand and supply sides (patients and health care providers). It occurs in all types of insurance, be it public or private (compulsory or voluntary), it always deters the purchase of very generous coverage against relatively high probability, low-cost form of treatment. Reports from several case studies in different African countries such as Cameroon and Ghana by Atim (2001) on Mutual Health Organizations (MHOs) showed that moral hazard can be controlled by imposing co-payments or deductibles.

Fraud

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

Adverse Selection

This is also known as biased selection. It is the likelihood that a person with a high risk of illness and a greater need for frequent health care would enroll in health insurance scheme than a person with a low risk of illness and less need for frequent health care use. This is common when enrollment of individuals into health insurance scheme is voluntary (Dorfman, 2000). Adverse selection occurs as a result of information asymmetry that arises when insurance subscribers have better information about their individual risks than the insurer. Higher risk individuals pay an average premium that is well below what an actuarially appropriate rate for their risk group should be. This

destabilizes voluntary insurance markets since healthier individuals eventually drop out as premiums rise. One prominent way of eliminating adverse selection is through compulsory membership of the target population (Dorfman, 2000; Atim, 2001).

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

Provider-Related Factors

Just as certain users-related factors influence the utilisation of Social Health Insurance Scheme services, certain provider-related factors also play an important part. According to Jerome (2004), once the need for a certain type of health care service has been identified, the degree to which it is met may depend on the health care provider's desire to meet that particular need. It is obvious that health care providers cannot offer a health service unless the necessary personnel, equipment and facilities, are available. Jerome (2004) further noted that the fact that the resources and ability to offer certain health care services are available at an accredited health care centre does not necessarily mean that the services will be offered in the optimal fashion by any mean. The manner and attitude with which those services are offered may seriously affect the utilization of those

services. Similarly, the success of services offered depend on the degree to which it fits the lifestyle and needs of the users. Jerome (2004) recommended that the health care services should as much as possible be offered at a time and in a place that is compatible with the way users actually live. In the opinion of Johnson (2002), the entire atmosphere of the health care services should not be greatly at variance with the prevailing culture, lifestyle, language, or beliefs of the users. According to Johnson (2002), this provider-related factor that influences the utilization of health Insurance Scheme services is the provider's set of values, the reasons why the provider is offering the services in the first place. This is central because the reasons why a health care provider wants to offer a particular health care service may well decide how it is offered.

According to Hamza (2006), beneficiaries feel entitled to the best services available but are easily upset if treated rudely. There are certain factors in the users, the providers of the health care services, and in society in general that directly affect the utilization of services once they exist.

2.7 Oyo State Health Insurance Agency (OYSHIA)

Oyo State Health Insurance Agency has developed different healthcare plans to cover all categories of residents of the state in order to ensure that they have access to good healthcare services. Data collected from Oyo state Health Insurance Policy showed that OYSHIA has the following health plans:

A. Standard Plan

This is a plan designed with the aim of achieving universal health coverage. It is designed for the following segments of the society:

- Formal sector
- Informal sector
- Vulnerable group i.e. pregnant women, Children under five, Prison inmates, Retirees & Aged.
- Communities & Rural dwellers.

B. **Top-up Plans**

These come in two different categories of Standard plus & Standard peak. These plans are to provide alternatives for the Formal sector segment of the populace & to generate subsidy for the vulnerable group.

C. **Students & Tertiary Institutions Plan**

This is the plan for Ages 5-18 and segments of the populace in tertiary institutions. It offers the benefits that come with the standard plan.

2.8 Benefits of OYSHIA

The following constitute the benefit packages of each of OYSHIA plan.

2.8.1. Standard Plan

A. Primary Healthcare

Registration

- GP Consultations throughout the year of cover.
- Treatment of common ailments and conditions e.g. uncomplicated malaria, gastroenteritis, respiratory tract infections, etc.
- Provision of prescribed drugs (basic).
- Hospitalization/ Accommodation in a general ward for the first seven days (cumulative).
- Valid secondary investigations for primary and secondary care (which include Malaria Parasite, Blood film, Widal's test, Fasting & Random Blood sugar, Hb/PCV, FBC, HB genotype, Urinalysis, Stool microscopy, Urine pregnancy test).
- Professional fees.
- HIV Counseling and Education.
- Family planning education.
- Routine physical examinations.
- Minor surgeries which include suturing of lacerations, drainage of superficial Abscesses, and minor wound dressing.
- Perinatal events limited to spontaneous deliveries (excluding caesarian sections).

B. Secondary Healthcare

The following Services are Secondary Healthcare to be covered under Fee for Service payable to the provider by the HMO and covered by the premium paid by the enrollees:

- Intermediate Surgical procedures like herniorrhaphy, appendectomies, laparotomies, myomectomies etc.
- Perinatal events including assisted deliveries and caesarian.
- Primary dental care (simple extractions, amalgam fillings and dental examination) excluding cosmetic treatment, surgical extractions and prostheses.
- Optometric care restricted to eye examinations and provision of plain lenses (excluding the cost of frames). Limit of ₦1,500pa.
- Medical ophthalmic examination and treatment excluding provision of glasses.
- Out of Station emergency: This is a situation in which an enrollee registered under the scheme with another provider presents at a different facility with a condition requiring urgent medical care or as an outright emergency. The enrollee is treated after proper identification as a scheme member or electronic/telephonic confirmation by HMO and after authorization by the HMO and verification by the Consultant.
- Psychiatric assessment and treatment of the acute phase of illness for a period not more than two weeks.
- Hospitalization in General Ward up to a maximum of 14 (28 for orthopedic cases) cumulative days (excluding first seven days) during the year of cover HMO to notify Beneficiary & Provider in writing once limit is reached.
- Ailments and conditions proven to require tertiary care within the limit specified in the policy.
- Specialist referrals within the limits specified in the policy.
- Further investigations (i.e. those not included under capitation cover).

C: Exclusions

The following services are excluded:

- Services that are not medically necessary.
- Services performed or prescribed under the direction of a person who is not a certified and registered healthcare practitioner.

- Services that are beyond the scope of practice of the healthcare practitioner performing the service.
- Services rendered before the coverage commencement date.
- Services rendered after the plan coverage (including any extension of benefits) has terminated.
- Experimental services.
- Medical or surgical treatment for infertility, including investigations, In Vitro Fertilization (IVF), Ovum transplants and Gamete Intra-Fallopian Tube Transfer (GIFT), Zygote Intra Fallopian Transfer (ZIFT), or cryogenic or other preservation techniques used in these or similar procedures.
- Surgical operations of the cranial cavity, brain, spine, spinal cord, heart and chest cavity.
- Surgeries relating to malignant conditions (cancers).
- All kinds of transplants and any surgical procedures requiring implants.
- The First 25% of the tariff cost of the treatment of pre-existing conditions noted on the registration form and notified by the HMO to the Provider.
- Medical or surgical treatment for obesity.
- Medical or surgical treatment or regimen for reducing or controlling weight.
- Cosmetic treatments and surgeries.
- Prostheses
- Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma etc.
- Any condition, which in the opinion of the provider's Chief Medical Officer is directly related to the Human Immune Deficiency Virus (HIV) including Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Complex (ARC).
- Injuries and conditions arising from domestic violence.
- Injuries arising from extreme and combat sports.
- Drug abuse and addiction, self-inflicted injuries.
- Family planning devices.
- Advanced investigations like CT scan, MRI etc.
- Management of renal failure including dialysis.
- Chemotherapy and Radiotherapy.

- Maternity care, antenatal care, normal and assisted delivery and caesarian above a total cost of ₦100, 000.
- Accidents and emergencies above a total cost of ₦100, 000.
- All treatments above benefit limit of ₦275, 000pa. HMO to notify beneficiary & provider in writing once limit is reached.
- Hospitalization exceeding 14 (28 for orthopedic) cumulative days during year of cover. HMO to notify beneficiary & provider in writing once limit is reached.

The premium for the Standard plan is ₦7, 800 + a ₦200 service charge per annum.

2.8.2 Standard Plus Plan

A. **Primary Healthcare**

The primary care capitated services covered under this plan include:

- All capitated services listed for the Standard plan.
- Routine Medical Examination for enrollees who did not access care during period of cover. This service is available ONLY within 21days of the expiry of the cover and limited to Physical Exam, BP, BMI, FBS/RBS, and Urinalysis and to a limit of ₦1, 000.

B. Secondary Healthcare

The secondary care services covered under this policy include:

- All secondary care services covered under the standard plan.
- Dental scaling and polishing.
- Provision of frames not costing more than ₦2,500 for lenses once every two years.
- Cancer diagnosis and treatment to a limit of ₦50, 000pa.
- Advanced investigations including CT and MRI to a limit of ₦35, 000pa.
- Hospitalization in semi-private ward where available or general ward in lieu up to a maximum of 21 (35 for orthopedic) cumulative days (excluding first seven days) during year of cover. HMO to notify beneficiary & provider in writing once limit is reached.

C: Exclusions

The services excluded are the same as for standard package except that:

- Limit on accident emergencies is ₦150, 000 i.e. total costs of treatment above this limit is excluded.

- Limit on total cost of maternity care, antenatal care, normal and assisted delivery and caesarian is ₦150,000 i.e. total costs of treatment above this limit is excluded.
- Hospitalization exceeding 21 (35 for orthopedic) cumulative days (excluding first seven days) during year of cover. HMO to notify beneficiary & provider in writing once the limit is reached.

The premium for the Standard plus plan is ₦13, 200 per annum.

3. **Standard Peak Plan**

A. **Primary Healthcare**

The following constitute the capitated services to be provided:

- Registration
- GP Consultations throughout the year of cover.
- Treatment of common ailments and conditions e.g. uncomplicated malaria, gastroenteritis, respiratory tract infections, etc.
- Provision of prescribed drugs (**branded).**
- Hospitalization/ Accommodation and meals in air-conditioned **Private ward** for the first 96 hours.
- Pertinent ancillary investigations for primary and secondary care (which include Malaria Parasite, Blood film, Widal's test, Fasting & Random Blood sugar, Hb/PCV, FBC, HB genotype, Urinalysis, Stool microscopy, Urine pregnancy test).
- Routine NPI Immunizations (BCG, DPT, HPV, Oral Polio).
- Professional fees.
- HIV Counseling and Education.
- Family planning education.
- Routine physical examinations.
- Annual (one per year) Medical check-up covering BP, BMI, FBS/RBS, Urinalysis, ECG, Routine Chest X-ray, Urea & Creatinine, Urine Microscopy, Lipid Profile. Additionally for men over 45 Differentiating PSA study (ratio of free to total PSA or total PSA to prostatic volume). For women, breast examination, mammography once every 2years and if in the range of 40-55 years PAP smear.
- Minor surgeries which include suturing of lacerations, drainage of superficial abscesses, and minor wound dressing.

- Perinatal Events limited to spontaneous and assisted deliveries (excluding caesarian sections).

B. Secondary Healthcare

The following Services are Secondary Healthcare to be covered under Fee For Service payable to the provider by the HMO and covered by the premium paid by the enrollees:

- Intermediate Surgical procedures like herniorraphy, appendectomies, laparotomies, myomectomies etc.).
- Major surgeries including cranial cavity, brain, spine, spinal cord, heart and chest cavity up to a limit of N750,000.
- Medical Tourism for approved treatment abroad up to indicated limit for medical tourism and within total policy limit of ₦2, 500,000. The tertiary provider chosen by the enrollee must indicate non-availability of the service at its facility. The HMO may refer to other accredited tertiary provider where such a necessary treatment is available as an alternative to medical tourism.
- Perinatal Events assisted deliveries and caesarian.
- All Dental care including dental examination, simple extractions, amalgam fillings, scaling and polishing (once during year of cover), root canal treatment, prostheses etc. up to limit of ₦75,000pa but excluding cosmetic treatment.
- Optometric care unrestricted including provision of plain lenses and frames (once every 2years) up to a limit of ₦10, 000pa.
- Medical ophthalmic examination and treatment up to a limit of ₦100,000pa.
- Advanced investigations, including USS, CT, MRI, mammography to a limit of ₦100, 000.
- Annual (once in year of cover) medical check-up investigations PSA (men over 50), cervical cancer screening, breast cancer screening and other investigations which in the opinion of the Consultant physician of the provider is indicated by the preliminary findings to a total Limit ₦ 25, 800pa.
- Cancer diagnosis and treatment to a limit of ₦350, 000pa.
- Out of Station emergency: This is a situation in which an enrollee registered under the scheme with another provider presents at a different facility with a condition requiring

urgent medical care or as an outright emergency. The enrollee is treated after proper identification as a scheme member or electronic/telephonic confirmation by HMO and after authorization by the HMO and verification by the Consultant.

- Psychiatric assessment and treatment of the acute phase of illness for a period not more than 6weeks.
- Hospitalization in **Air-conditioned Private Ward** up to a maximum of 42 cumulative days (60 days for orthopedic cases) during year of cover HMO to notify Beneficiary & Provider in writing once limit is reached.
- Ailments and conditions proven to require tertiary care within the limit specified in the policy.
- Specialist referrals within the limits specified in the policy.
- Further investigations (i.e. those not included under capitation cover).

C: Exclusions

Services that are not medically necessary.

- Services performed or prescribed under the direction of a person who is not a certified and registered healthcare practitioner.
- Services that are beyond the scope of practice of the healthcare practitioner performing the service.
- Services rendered before the coverage commencement date.
- Services rendered after the plan coverage (including any extension of benefits) has terminated.
- Experimental services.
- Medical or surgical treatment for infertility, including investigations, In Vitro Fertilization (IVF), Ovum transplants and Gamete Intra-Fallopian Tube Transfer (GIFT), Zygote Intra Fallopian Transfer (ZIFT), or cryogenic or other preservation techniques used in these or similar procedures.
- Surgical operations of the cranial cavity, brain, spine, spinal cord, heart and chest cavity exceeding N750, 000 in Nigerian facilities and indicated medical tourism limit for approved treatment abroad.

- First USD$5,000 of treatment costs for approved treatment abroad and medical tourism for treatment available in accredited Nigerian tertiary institution.
- Investigations and treatment for malignant conditions (cancers) in excess of ₦350,000pa.
- All kinds of transplants and any surgical procedures requiring implants.
- Treatment of pre-existing conditions.
- Medical or surgical treatment for obesity.
- Medical or surgical treatment or regimen for reducing or controlling weight.
- Cosmetic treatments and surgeries.
- Prostheses
- Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma etc.
- Any condition, which in the opinion of the provider's Chief Medical Officer is directly related to the Human Immune Deficiency Virus (HIV) including Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Complex (ARC).
  Injuries and conditions arising from domestic violence.
- Injuries arising from extreme and combat sports.
- Drug abuse and addiction, self-inflicted injury.
- Family planning devices.
- Advanced investigations like CT scan, MRI etc.
- Management of renal failure including dialysis.
- Chemotherapy and Radiotherapy.
- Maternity care, antenatal care, normal and assisted delivery and caesarian above a total cost of ₦250,000.00
- Accidents and emergencies above a total cost of ₦500, 000.
- All treatments above benefit limit of ₦2,500,000pa. HMO to notify beneficiary & provider in writing once limit is reached.
- Hospitalization exceeding 42 (60 for orthopedic cases) cumulative days during year of cover. HMO to notify beneficiary & provider in writing once limit is reached.
  The premium for the Standard peak plan is ₦108, 000 per annum.

4. **Students & Tertiary Institutions Plan**

A. **Primary Healthcare**

Registration

- GP Consultations throughout the year of cover.
- Treatment of common ailments and conditions e.g. uncomplicated malaria, gastroenteritis, respiratory tract infections, etc.
- Provision of prescribed drugs (generic).
- Hospitalization/ Accommodation in a general ward for the first seven days (cumulative).
- Pertinent ancillary investigations for primary and secondary care (which include Malaria Parasite, Blood film, Widal's test, Fasting & Random Blood sugar, Hb/PCV, FBC, HB genotype, Urinalysis, Stool microscopy, Urine pregnancy test).
- Routine NPI Immunizations (BCG, DPT, HPV, Oral Polio).
- Professional fees.
- HIV Counseling and Education.
- Family planning education.
- Routine physical examinations.
- Minor surgeries which include suturing of lacerations, drainage of superficial Abscesses, and minor wound dressing.
- Perinatal events limited to spontaneous deliveries (excluding caesarian sections).

B. Secondary Healthcare

The following Services are Secondary Healthcare to be covered under Fee for Service payable to the provider by the HMO and covered by the premium paid by the enrollees:

- Intermediate Surgical procedures like herniorrhaphy, appendectomies, laparotomies, myomectomies etc.
- Perinatal events including assisted deliveries and caesarian.
- Primary dental care (simple extractions, amalgam fillings and dental examination) **excluding** cosmetic treatment, surgical extractions and prostheses.
- Optometric care restricted to eye examinations and provision of plain lenses (**excluding** the cost of frames). Limit of ₦1,500pa.
- Medical ophthalmic examination and treatment excluding provision of glasses.

- Out of Station emergency: This is a situation in which an enrollee registered under the scheme with **another provider** presents at a different facility with a condition requiring urgent medical care or as an outright emergency. The enrollee is treated after proper identification as a scheme member or electronic/telephonic confirmation by HMO and after authorization by the HMO and verification by the Consultant.
- Psychiatric assessment and treatment of the acute phase of illness for a period not more than two weeks.
- Hospitalization in General Ward up to a maximum of 14 (28 for orthopedic cases) cumulative days (excluding first seven days) during the year of cover HMO to notify Beneficiary & Provider in writing once limit is reached.
- Ailments and conditions proven to require tertiary care within the limit specified in the policy.
- Specialist referrals within the limits specified in the policy.
- Further investigations (i.e. those not included under capitation cover).

C: Exclusions

The following services are excluded:

- Services that are not medically necessary.
- Services performed or prescribed under the direction of a person who is not a certified and registered healthcare practitioner.
- Services that are beyond the scope of practice of the healthcare practitioner performing the service.
- Services rendered before the coverage commencement date.
- Services rendered after the plan coverage (including any extension of benefits) has terminated.
- Experimental services.
- Medical or surgical treatment for infertility, including investigations, In Vitro Fertilization (IVF), Ovum transplants and Gamete Intra-Fallopian Tube Transfer (GIFT), Zygote Intra Fallopian Transfer (ZIFT), or cryogenic or other preservation techniques used in these or similar procedures.
- Surgical operations of the cranial cavity, brain, spine, spinal cord, heart and chest cavity.

- Surgeries relating to malignant conditions (cancers).
- All kinds of transplants and any surgical procedures requiring implants.
- The First 25% of the tariff cost of the treatment of pre-existing conditions noted on the registration form and notified by the HMO to the Provider.
- Medical or surgical treatment for obesity.
- Medical or surgical treatment or regimen for reducing or controlling weight.
- Cosmetic treatments and surgeries.
- Prostheses
- Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma etc.
- Any condition, which in the opinion of the provider's Chief Medical Officer is directly related to the Human Immune Deficiency Virus (HIV) including Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Complex (ARC).
- Injuries and conditions arising from domestic violence.
- Injuries arising from extreme and combat sports.
- Drug abuse and addiction, self-inflicted injuries.
- Family planning devices.
- Advanced investigations like CT scan, MRI etc.
- Management of renal failure including dialysis.
- Chemotherapy and Radiotherapy.
- Maternity care, antenatal care, normal and assisted delivery and caesarian above a total cost of ₦100, 000.
- Accidents and emergencies above a total cost of ₦100, 000.
- All treatments above benefit limit of ₦275,000pa. HMO to notify beneficiary & provider in writing once limit is reached.
- Hospitalization exceeding 14 (28 for orthopedic) cumulative days during year of cover. HMO to notify beneficiary & provider in writing once limit is reached.

The premium for the Students & Tertiary Institutions plan is ₦2,600 + a ₦200 service charge per annum.

Health Maintenance Organisations (HMOS)

These are individual organisations empowered by the NHIS Act to play the role of a contractor under the scheme by lessoning between the National health insurance scheme council and the health services providers. They directly coordinate and oversee the activities of the HSPs with respect to provision of the service under the scheme. The NHIS Act empowers the HMOs to carry out the following functions under the scheme;

i. Open account for the Health Service Providers registered with (each of) them,
ii. Receive the contributions by the government and workers via the National Health Insurance Scheme Council.
iii. Make payment to health services providers for medical services provided for public servants registered with them.
iv. Oversee the activities of Health Service Providers.

Health Services Providers (HSPs)

These are the healthcare institutions registered by the National Health Insurance Scheme Council to provide health services to the people under the scheme. These institutions are classified into the following;

i. Primary Healthcare Providers:-These include community health centers, private clinics, hospital and maternity.
ii. Secondary Healthcare Providers: - These include state government general hospital and big private hospitals.
iii. Tertiary Health Providers: - These include specialist and teaching Hospitals which serves essentially the scheme.

2.9 Theoretical Framework

Theory of Reasoned Action (TRA)

The Theory of Reasoned Action as described by Fisbein & Ajzen (1975) was used as the theoretical base for this study The most proximal cause of behaviour is behavioural intention (what one intends to do or not to do). Behavioural intention, in turn, is determined by attitude (one's evaluation of the behavior) and subjective norm (one's evaluation of what important others think one should do), either of which might be the most important determinant of any particular behaviour. Usually, this is revealed empirically by the beta weights obtained from multiple regression analyses, where behavioral intention is regressed on to attitude and subjective norm. If the result is a larger attitude than subjective norm beta weight, the behaviour is deemed to be more under attitudinal than normative control, but if the reverse is true, then the behaviour is deemed to be more under normative than attitudinal control. In either case, then, it is desirable to know what determines attitude or subjective norm, respectively, if a behaviour is to be influenced. Attitude is determined by behavioural beliefs (beliefs about the likelihood of various consequences) and evaluations of how good or bad it would be if those consequences happened. Subjective norm is determined by beliefs about what specific important others think one should do and how much one is motivated to comply with those important others. Both attitude and subjective norms are assumed to be determined by summative processes. Thus, to form an attitude, people are assumed to sum behavioral belief-evaluation products whereas to form a subjective norm, people are assumed to sum normative belief-motivation to comply products.

TRA suggests that a person's behaviour is determined by his intention to perform the behaviour and that this intention, is in turn, a function of their attitude towards the behavior and the subjective norms (Fishbein & Ajzen 1975) An intention is a plan or likelihood that someone or a population will behave in a particular way in a specific situation, by focusing on attitudes and norms, TRA could provide a framework for understanding the knowledge ,perception and utilization of OYSHIA public servants in Ibadan South West L.G.A. It looks at the population's attitudes (positive or negative) towards the use of OYSHIA as well as the norms that they perceive from influential

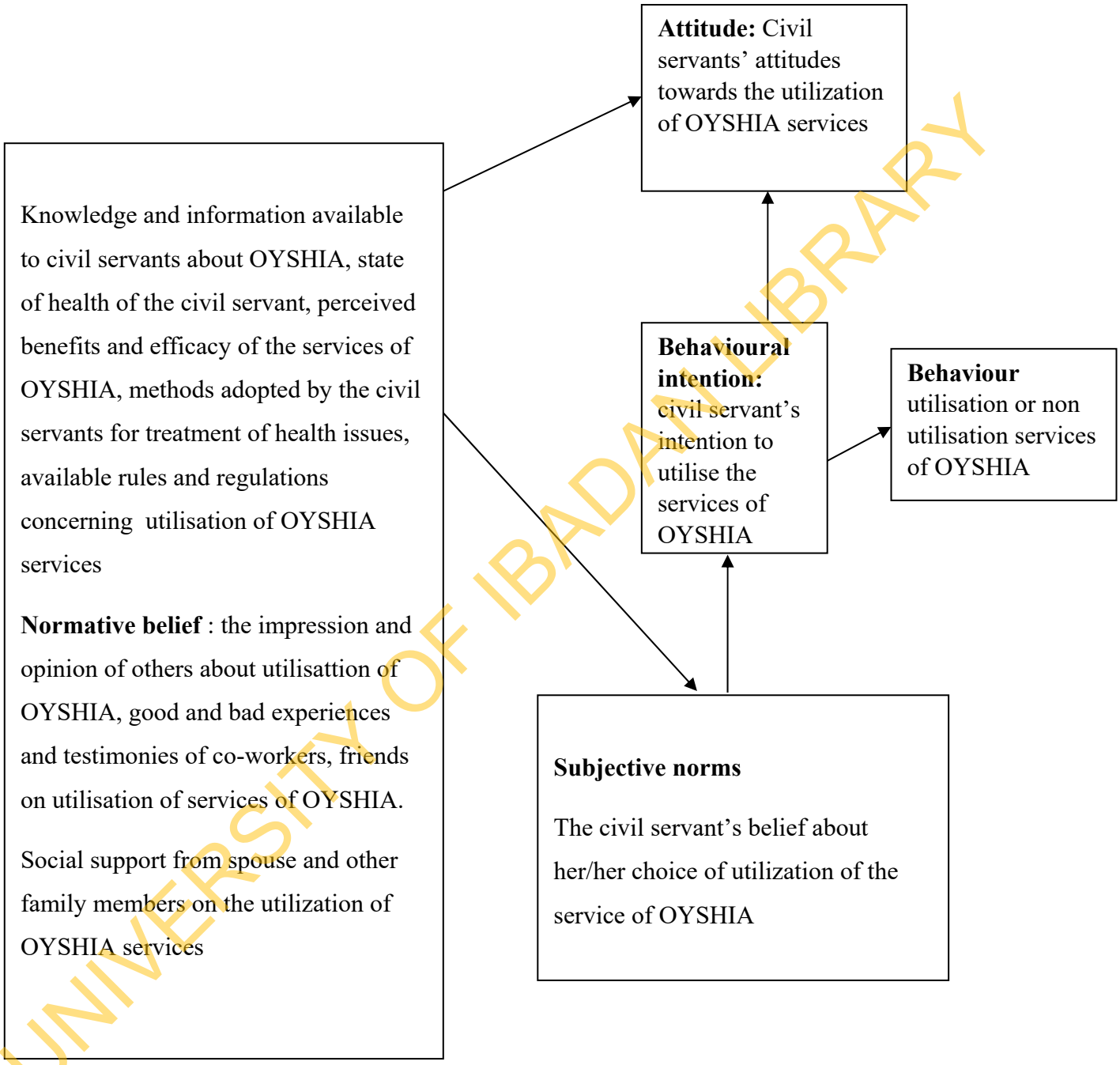
people and groups around them and how it could influence the intention to use the services of OYSHIA, which in turn is the main motivator of the behaviour.

The attitude of this public servants could be formed by whether or not they think registering and utilizing the social health insurance will be useful to them or not. For example an individual who is hypertensive and needs to visit the hospital most times would see it as a means of reducing his or her hospital bills and will embrace the idea, while the one who hardly fall ill and does not think he needs any health services provided by OYSHIA, or has alternative means of proffering solutions to his ill health may consider registration with OYSHIA a waste of money and its utilization will be unimportant to him. He may not show much interest in the services of OYSHIA .Their attitudes could also be based on past experiences on social health insurance which may include the attitude of health workers, availability of health services, drugs, and the length of waiting time it took before they were attended to.

Subjective norms will be influenced by perceptions and the beliefs of those around them (friends, colleagues, and family members), because these individuals are likely to approve or disapprove of the use of the social health insurance.

The best predictor of behaviour is intention (belief that the behaviour will lead to the intended outcome) Intention is determined by three things: the attitude towards the specific behavior, their subjective norms (expectancy of social environment) and their perceived behavioural control. The more favourable the attitude and the subjective norms and the greater the perceived control, the stronger the person's intention to perform the behavior.

If the civil servants in Ibadan south West Local Government Area evaluate their being compelled to register under OYSHIA as being advantageous to them, the utilization of the service will be enhanced, also if people around them such as their spouses, other family members and friends approve the use of the services of OYSHIA. these civil servants will consider the registration and utilization of OYSHIA important and the utilization level will be high. This may also afford them the opportunity to know and get more details about OYSHIA.



Figures 2.1 Theory of Reasoned action as applied to the study of Knowledge Perception and Utilization of OYSHIA in Ibadan South West Local Government Area of Oyo State.

CHAPTER THREE

METHODOLOGY

3.1 Study Design

A descriptive, cross sectional design was employed for this study.

3.2 Study Location

The study was carried out among civil servants in Ibadan South West Local Government Area (ISWLGA) of Oyo state, Nigeria. ISWLGA was created on the 27th of August, 1991, it is one of the local governments that were carved out of defunct Ibadan Municipal Government following the nationwide broadcast of 3rd May 1989, when the then President and Commander in Chief of Armed forces, Gen. Ibrahim Babangida announced the creation of additional one hundred and fifty nine Local Governments all over the country. It has its headquarters at Aleshinloye area of Ibadan town of Oyo state, ISWLGA consists of popular areas like Ring Road, Molete, Oke Ado, Oke Bola, Awodife, Foko, Isaleosi, Kososi, Odo-ona and Aleshinloye. It covers a landmass of 133,500 square kilometers, It is bounded by Ibadan North LGA to the North, Oluyole LGA to the South, the Ibadan South East and Ibadan North East LGAs to the East, with Ido and Ibadan North West LGAs bounding it to the West. (Source: Oyo state Local Government Service Commission).

ISWLGA is a home for small, medium and large scale industries such as SUMAL foods, 7up bottling company, vital foods Nigeria limited and others. Some tourist attractions centres are also situated within the LGA. It is divided into 11 political wards for easy administration.

This local government gets its income and revenue majorly from drilling services, commercial activities, issuing of certificate of local government identification, tax/fine from industries within its jurisdiction, hiring of plants and equipment among others for the development of the entire districts and communities under its jurisdiction. (Source: Oyo State Local Government Service Commission.)

3.3 Study Population

The study was a total population study

3.4 Sample size Calculation

Total population study was done whereby all the 235 permanent staff of the Local Government Area were recruited for the study.

3.5 Inclusion Criteria

Staffs of IBSWLGA who were present in the secretariat at the time of carrying out the study and willing to give an informed consent were included in the study.

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3.6 Instrument for Data Collection

The instrument for data collection was a self-administered questionnaire. The questionnaire was developed using information obtained from literature on knowledge, perception and utilization of social health insurance. Based on the specific objectives, the instrument had four (4) sections as follows.

Section 1: Demography.

Section 2: The level of knowledge of the respondents on OYSHIA.

Section 3: The level of perception of respondents about OYSHIA.

Section 4: The pattern of utilization of OYSHIA among the respondent.

3.7 Validity of the Instrument

The researcher ensured validity of the instrument by reviewing relevant literatures. The instrument was scrutinized by experts in health promotion and education to validate it and the supervisor was also consulted. The researcher edited the instrument before it was administered.

3.8 Reliability and Pre-testing of Instrument

The reliability of the instrument was ensured by conducting a pretest among 10% of the total sample population among civil servants in Ibadan North-East Local Government which has similar characteristics with the study site. Reliability analysis for the

questionnaire was done by using Cronbach Alpha statistical test with a reliability coefficient of 0.798. A revision was made on the questionnaire based on the analysis of the result of the pretest.

3.9 Data Collection Procedure

Three research assistants, who were literate, mature and undergraduates of various tertiary institutions with previous experiences on data collection were recruited and trained for one day. The content of the training included purpose of the study, interpersonal communication and data collection procedure. Survey was self-administered, except in situations where clarifications were sought from the research assistants on any item or question.

The investigator explained the nature of research including the issue of voluntary consent and confidentiality to the potential participants, adequate information about the study was given and their permission was sought for, the staff members who gave their consent were then given the informed consent form (attached to the questionnaire) to read, comprehend and sign.

3.10 Data Management and Analysis

After the questionnaire copies had been filled, completeness and errors were checked for before leaving the field; 217 correctly filled questionnaires copies were used for the analysis, each questionnaire copy had a serial number assigned to it for identification, correct entering and analysis. Using the coding guide that was developed with the questionnaire, each question was entered into the computer for analysis. An 11 point scale was used to measure knowledge while perception was measured on an 8 point scale. Analysis was done with the use of Statistical Programme for Social Science (SPSS) version 20.The result was presented using frequency tables, charts, mean and standard deviation. The hypotheses were tested for using chi square.

3.11 Ethical Consideration

Ethical approval was sought and obtained from the Oyo State Ministry of Health Research Ethics Committee before going to the field for data collection. Also, written informed consent was attached to the questionnaire. To ensure confidentiality of research participants, identifiers such as names and other information that can reveal the identity of research participants were excluded from the research instruments. The nature of the study, benefits and objectives were explained to the respondents and they were assured that the information given would be treated with utmost confidentiality and respect. Respondents were intimated about the opportunity to withdraw their consent freely at any point during the study. Confidentiality and anonymity of each participant was maximally maintained during and after the collection of their information.

Confidentiality of data: In order to assure respondents of confidentiality of the information that were supplied, names of respondents were not required, only serial numbers were assigned to the questionnaires for proper recording.

Translation: Information was collected using semi-structured, self-administered questionnaires, written in English, was translated to Yoruba and translated back to English to preserve their original meaning.

Beneficence to participants: The outcome of the research will be of benefit not only to the participants but to other stake holders of health insurance scheme as it will provide information on the reasons for low utilization of the services of the scheme.

Non maleficence to participants: The research did not require collection of invasive materials. Hence minimal harm was done to the participants.

Voluntariness: The participants were given full details concerning the research before taking part in it so as to ensure that they fully understood and comprehend, and are willing to participate in the study.

3.12 Limitation of Study

Responses from the study cannot be generalized for knowledge, perception and utilization of Oyo State Health Insurance Agency, since only one local government area of the state was used for the study.

CHAPTER FOUR

RESULTS

The results are represented in this chapter. It consists of four sections as follows

- Socio-demographic information of respondents
- Knowledge of civil servants on OYSHIA
- Perception of respondents towards OYSHIA
- Utilisation of OYSHIA among the civil servants

4.1 Socio-Demographic Characteristics

The socio-demographic characteristics of the civil servants who participated in the study as presented on Table 1 revealed that more females (64%) participated in the study. The respondent's age ranged between 20 and 59 years, with a mean age of 44 ± 9.3 years; most of them (69.6%) fell between ages 40 and 59 years. Majority (84%) of the participants were married, while (6%) were separated, divorced or widowed. Most of the respondents (68%) indicated that they practiced Christian religion, 92% of the participants had attained tertiary level of education, 0.5% had just the primary education. 18% of the staff that participated in this study were on level 1 – 6, 52.5% on level 7 – 12, 29.5%. were on level 12 and above.

Table 4 .1: Socio-demographic characteristics of respondents (N = 217)

	Frequency	Percent (%)
Sex		
Male	78	35.9
Female	139	64.1
Age Group		
20 – 29 years	22	10.1
30 – 39 years	44	20.3
40 – 49 years	92	42.4
50 – 59 years	59	27.2
Mean age 44 ±9.3		
Marital Status		
Single	21	9.7
Married	183	84.3
Separated	2	0.9
Divorced	3	1.4
Widowed	8	3.7
Religion		
Christianity	147	67.7
Islam	65	30.0
Traditional religion	5	2.3
Level of education		
Primary	1	0.5
Secondary	16	7.4
Tertiary	200	92.1
Civil service level		
Levels 1 – 6	39	18.0
Levels 7 – 12	114	52.5
Level 12 and above	64	29.5

4.2 Knowledge on OYSHIA

Knowledge regarding the meaning of OYSHIA was generally good among the participants with 94.5% having good knowledge. Forty-nine percent rightly answered the question on plans for public servants under the OYSHIA. Evaluation of the knowledge of the civil servants on the health needs covered by the OYSHIA (Table 4.2) revealed that; ninety-four percent picked treatment of malaria, 84.0%, investigation for malaria parasite, 61.8% eye care with provision of plain glasses, 67.0%, treatment of respiratory tract infection, 64.5%, family planning education, 58.0%, tooth extraction, and fifty-seven percent, caesarean section were correctly identified as health needs the OYSHIA covered for its registered members.

The participants indicated the various sources through which they learnt about OYSHIA (Figure 4.1), some of these include colleagues (25.8%), television (twenty-five percent), and radio (nineteen percent). Assessment of the general knowledge of the participants on OYSHIA, showed that eighty-three percent had good knowledge while seventeen percent had poor knowledge as shown in Figure 4.2.

Table 4. 2: Knowledge of civil servants on OYSHIA

Knowledge Variable	Frequency	Percent (%)
Meaning of OYSHIA: Oyo State Health Insurance Agency		
Yes (Good knowledge)	205	94.5
No/Don't know (Poor knowledge)	12	5.5
There are two plans run for public servants under OYSHIA		
Yes (Good knowledge)	106	48.8
No/Don't know (Poor knowledge)	111	52.2
Health needs covered by OYSHIA		
Family planning education		
Yes (Good knowledge)	134	61.8
No/Don't know (Poor knowledge)	83	38.2
Hospitalization in the general ward for three months		
No (Good knowledge)	82	37.8
Yes/Don't know (Poor knowledge)	135	62.2
Tooth extraction		
Yes (Good knowledge)	125	57.6
No/Don't know (Poor knowledge)	92	42.4
Treatment of malaria		
Yes (Good knowledge)	204	94.0
No/Don't know (Poor knowledge)	13	6.0
Investigation for malaria parasite		
Yes (Good knowledge)	182	83.9
No/Don't know (Poor knowledge)	35	16.1
Caesarean section		
Yes (Good knowledge)	124	57.1
No/Don't know (Poor knowledge)	93	42.9

Table 4. 2 continued: Knowledge of civil servants on OYSHIA

Knowledge Variable	Frequency	Percent %
Eye care with provision of plain glasses		
Yes (Good Knowledge)	145	66.8
No/ don't know (Poor knowledge)	72	33.2
Insertion of family planning devices		
Yes (Good knowledge)	97	44.7
No/Don't know (Poor knowledge)	120	55.3
Treatment of respiratory tract infection		
Yes (Good knowledge)	140	64.5
No/Don't know (Poor knowledge)	77	35.5

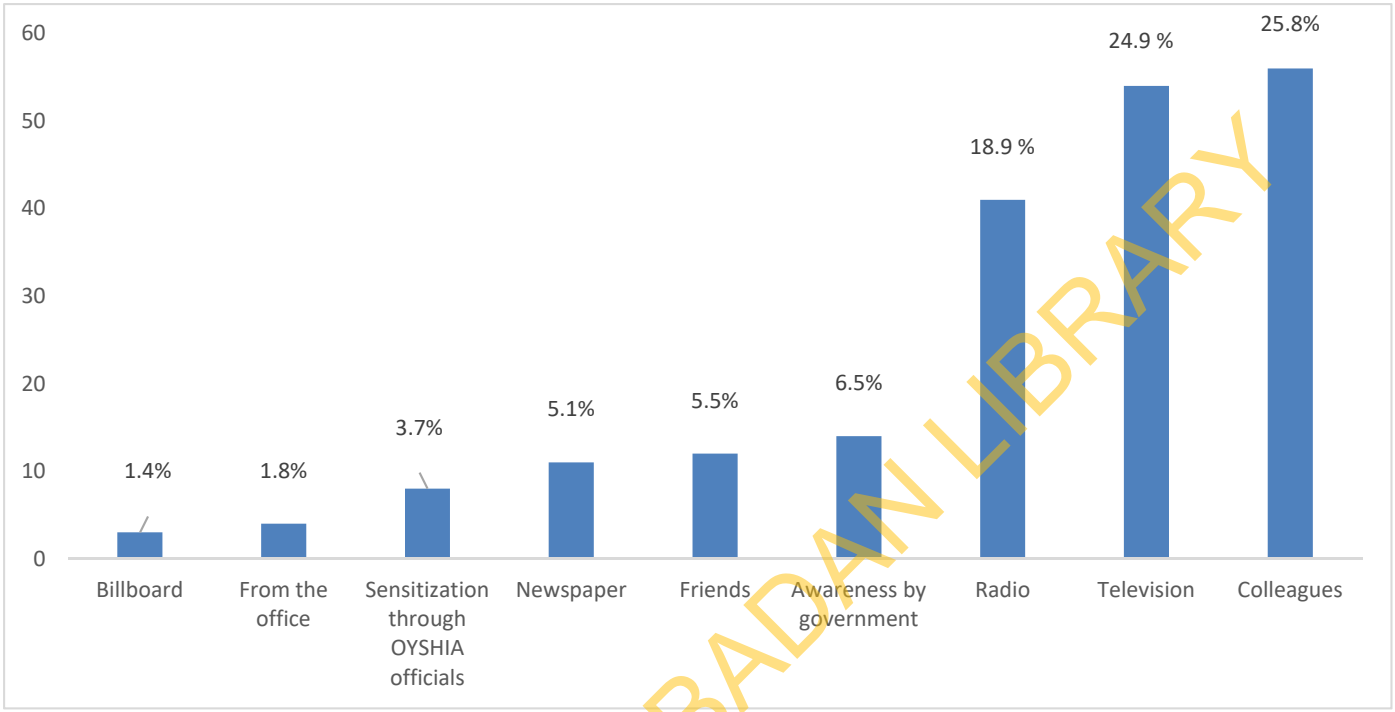

Figure 4.1.Sourcesof information leading to awareness about OYSHIA

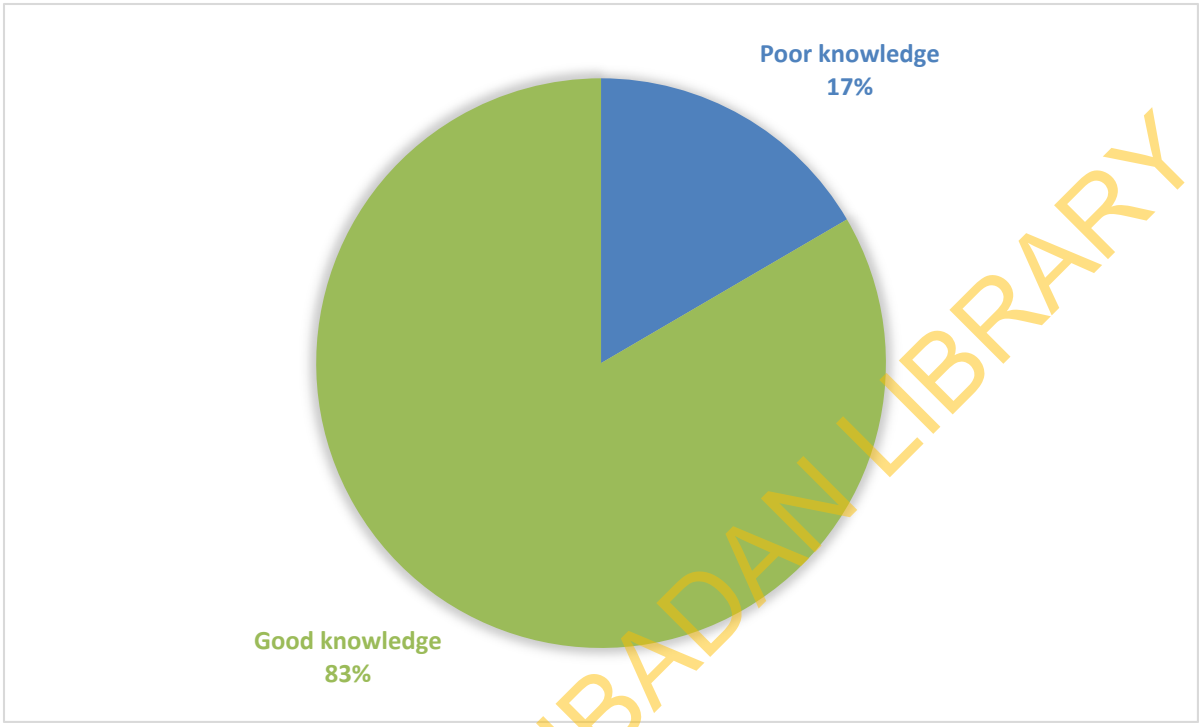

Figure 4. 2: Overall Knowledge on OYSHIA

4.3 Perception of OYSHIA

The perception of the civil servants towards OYSHIA was explored. Table 4.3 showed that 84.8% of the respondents believed that the OYSHIA improves access to quality and efficient health; 83.4% suggested that the OYSHIA is a good idea, and they will encourage others to use it; 82.9% were of strong opinion that the Oyo state government could sustain OYSHIA; 70.5% rated the performance of OYSHIA as good and satisfactory; 68.7% of the participants disagreed with the perception that out of pocket payment method was better than OYSHIA; 64.1% disapproved of the idea that monthly deduction of OYSHIA premium is either deceitful or may be a cause of illnesses (67%). 56% believe that the OYSHIA should be made compulsory for all Oyo state workers.

A general evaluation of the perception level of the civil servants (Fig 4.3) showed that 77% had shown a positive perception towards OYSHIA, while 23% had negative perception.

Data on Table 4.4 also showed that 48.5% of the respondents mentioned access to more health care options as reasons for their preference for out of pocket payment to OYSHIA, 14.7% preferred it to OYSHIA because payment is made only when one is sick and 10.3% preferred out of pocket payment because the services of OYSHIA are not available to family members.

Table 4. 3: Perception of respondents towards OYSHIA (n = 217)

	Frequency	Percent %
OYSHIA improves access to quality and efficient health		
Yes	184	84.8
No	33	15.2
OYSHIA is a good idea; I will encourage others to use it		
Yes	181	83.4
No	36	16.6
OYSHIA should be made compulsory for all Oyo State workers		
Yes	122	56.2
No	95	43.8
Out of pocket payment method is better than OYSHIA		
Yes	149	68.7
No	68	31.3
The performance of OYSHIA is good & satisfactory		
Yes	153	70.5
No	64	29.5
OYSHIA will be sustained by Oyo State government		
Yes	180	82.9
No	37	17.1
Monthly deduction of OYSHIA premium is deceitful		
No	139	64.1
Yes	78	35.9
Monthly deduction of OYSHIA premium may attract illnesses		
No	146	67.3
Yes	71	32.7

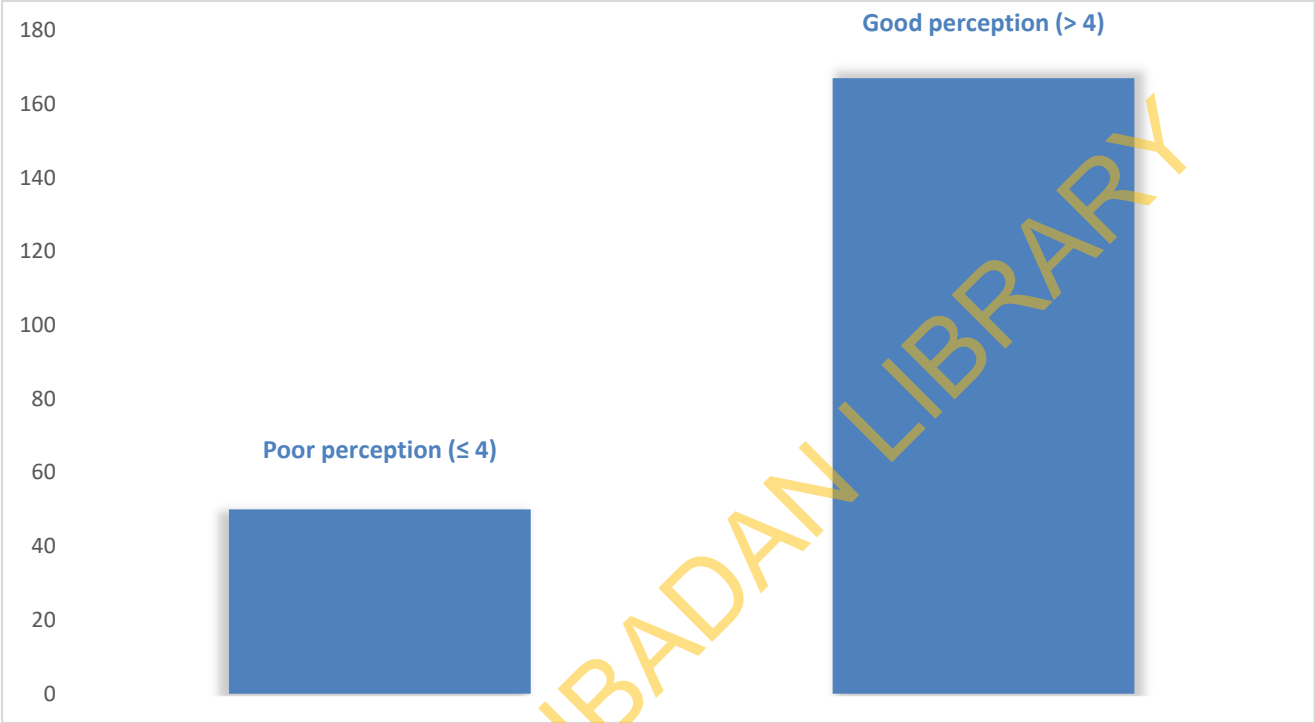

Figure 4.3: Overall Perception of OYSHIA

Table 4.4: Reasons for preference of Out of Pocket Payment over OYSHIA N=59

	Frequency	Percent %
Access to more healthcare options	33	55.9
Payment is only made when one is sick	10	16.9
OYSHIA's defectiveness (services not available to family members, treatment is not administered)	7	11.9
Self-customized healthcare services can be sought	6	10.2
Better for emergent healthcare	3	5.1

Respondents' Perception of Benefits of OYSHIA

As shown on Table 4.5 the participants mentioned several benefits of OYSHIA, which include easy access to quality healthcare services (17.9%); 8.8% said its benefit was that it provides affordable healthcare services to the civil servants. Over 7% were of the opinion that it provides good healthcare services to its members; 4.6% said it affords them the opportunity of checking their health status; 3% mentioned that it was very useful in times of emergent health needs; while 2.3% stated that they found it beneficial because it is as insurance policy that allow them to pay for health services at a time when they did not need it.

Table 4. 5: Responses on benefits of the OYSHIA (N=123)

	Frequency	Percent %
Quality healthcare services can be easily accessible	39	31.7
It provides affordable healthcare services	19	15.5
They provide good healthcare services to members	16	13.0
Encourages the members to check their health status	10	8.1
Very useful for emergent health needs	6	4.9
	5	4.1.
Don't know any benefit it has; not benefitted yet	19	15.4
OYSHIA has no genuine benefits	9	7.3

Multiple responses apply

4.4 Utilization of OYSHIA

Result from the study as shown on Table 4.6 revealed that 86.2% of the respondents under the Ibadan South West LGA were registered under the OYSHIA. Among these 187 registered members; 8% could not recall when they registered under the scheme, 3.2% in 2017, 4.3% registered in 2018, and 84.5% made their registration in 2019. Also the result showed that only 25.1% of the registered members of OYSHIA have accessed the healthcare services under OYSHIA. Over forty percent of those who had accessed healthcare under OYSHIA could not specify when they last accessed healthcare through the scheme; 19.1% had accessed healthcare service under the scheme within 30 days preceding the study, 14.9% reportedly accessed the scheme's healthcare service between 31 – 60 days preceding the study; 8.5% had last accessed the healthcare service between 61 – 90 days; and 12.8 % had last accessed healthcare service through the scheme for over 90 days prior to the study.

Over forty percent of the respondents who had accessed the OYSHIA healthcare services confirmed availability of drugs and service demanded during their usage. For those who had not used the OYSHIA services 42.9% had reportedly opted for health care services in government hospitals, 40.6% in private hospitals and 4.1% in spiritual home. Furthermore 59.4% of the respondents, whether registered members or not, indicated they had preference for healthcare services under the OYSHIA. Factors enumerated by respondents as limiting the use of OYSHIA services as shown in Figure 4.4 include non-availability of necessary drugs and services (35.9%), attitude of health workers (13.8%), shortage of staffs (11.5%), long waiting periods (11.5%), and distance to OYSHIA facilities from their residences (9.7%).

Table 4.6: Utilization of OYSHIA among the civil servants

	(n = 217)	Percent %
Registered with OYSHIA		
Yes	187	86.2
No	30	13.8
Duration since registered with OYSHIA (n = 187)		
2017	6	3.2
2018	8	4.3
2019	158	84.5
Can't recall	15	8.0
Accessed healthcare under OYSHIA (n = 187)		
Yes	47	25.1
No	140	74.9
Last time accessed healthcare under OYSHIA (n = 47)		
1 – 30 days ago	9	19.1
31 – 60 days ago	7	14.9
61 – 90 days ago	4	8.5
Over 90 days ago	6	12.8
Can't recall	21	44.7
Availability of drugs and services available (n = 47)		
Yes	21	44.7
No	11	23.4
Can't recall	15	31.9
Other places for assessing healthcare for non-users of OYSHIA (*Multiple responses;* n = 170)		
Spiritual home	7	4.1
Private hospitals	69	40.6
Government hospitals	73	42.9
Preference for healthcare under OYSHIA		
Yes	129	59.4
No	48	22.1
Indecisive	40	18.5

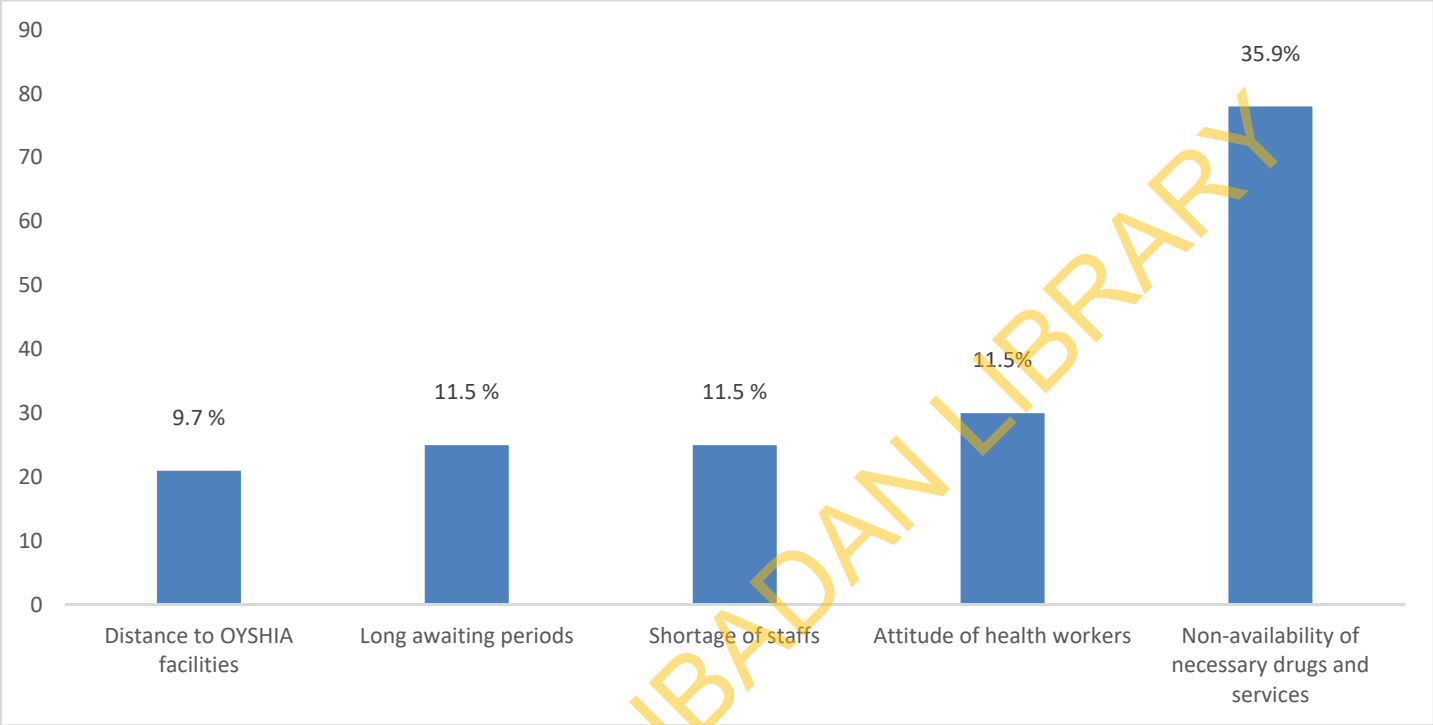

Figure 4.4: Factors limiting use of OYSHIA services

Test of Hypotheses

Table 4.7: Hypothesis 1

1. There is no significant association between respondents' knowledge on OYSHIA and their utilisation of the healthcare services under OYSHIA.

Knowledge on OYSHIA	Utilisation of OYSHIA Yes (%)	Services No (%)	Total	Chi square	P value
Poor (%)	8 (22.2)	28 (77.8)	36	0.008	0.541
Good (%)	39 (21.5)	142 (78.5)	181		
Total	47 (17.3)	170 (82.7)	217		

The result shows that there is no significant association between respondents' knowledge on OYSHIA and their utilisation of the healthcare services under OYSHIA; therefore we fail to reject the null hypothesis.

Table 4.8: Hypothesis 2

2. There is no significant association between respondents' perception on OYSHIA and their utilisation of healthcare services of the OYSHIA.

Perception	Utilisation of OYSHIA Yes (%)	Services No (%)	Total	chi square	P value
Negative (%)	11 (22.0)	39 (78.0)	50	0.04	0.543
Positive (%)	36 (21.6)	131 (78.4)	167		
Total	47 (21.7)	170 (78.3)	217		

The result shows that there is no significant association between respondents' perception on OYSHIA and their utilisation of the healthcare services of the OYSHIA; therefore we fail to reject the null hypothesis.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 DISCUSSION

The socio-demographics of the civil servants who participated in the study showed that more females (64%) participated in the study, majority of the participants were married, having more people within age 40-49 years group, mean age was 44±9.3 Many (92%) of the participants had also attained a tertiary level of education. This can be explained by the following reasons. First, increase in the number of women from 12% to 50% in the Nigerian labour force, (as recorded by the international labour organisation 2019), which is due to the fact that more women now go further into higher education due to civilization and some government policies; increase opportunities for adult education in Nigeria which has also afforded older men and women the opportunity of attaining higher educational qualifications even after child bearing. This study is similar to a study carried out on health insurance (Ilochonwu and Adedigba 2017) where age range of the participants was between 19–56 years, more females participated in the study than males, majority (65.4%) of the study participants were married and a high proportion (83.7%) of the participants also had tertiary education.

Assessment of the general knowledge of the participants on OYSHIA showed that 83% had good knowledge of health insurance while 17% had poor knowledge. The major sources of awareness as stated by the participants were through colleagues, radio and television which are effective platform for disseminating information on health programmes, having the ability to reach people in a diverse range of settings. Either a radio or television or both are available in most homes in Nigeria, messages on them are usually repetitive, educative and easy to remember. There is a radio programme that takes place every Saturday morning on Fresh 105.9 FM radio which educates on details of OYSHIA, this may have accounted for having a good knowledge of the scheme.

Also since monthly premium is deducted from their salaries most individuals would always like to know the details of what their money is being used for and share this information with their colleagues while discussing in the office.

These findings agreed with the findings of Kwa-Zulu-Natal study, (Latiff-Khamissa et al 2015) where ninety-two percent of the respondents had good or satisfactory knowledge of the scheme. On the contrary limited knowledge of health insurance was reported in a similar study carried out by (Okaro et al. 2010) where a significant number (70%) of the respondents had poor knowledge of the health insurance.

Perception of OYSHIA is in consistent with the study of Adewole et al (2015) in their study on perception of health insurance in Orire Local Government which showed that majority of the respondents perceived social health insurance as a good idea and will encourage others to do it. A general evaluation of the perception of the civil servants in Ibadan South West LGA revealed that majority showed a positive perception towards OYSHIA, the participants who had positive perception towards the scheme were of the opinion that it will afford them the opportunity of checking their health status anytime they wished without having to spend much money, this is important perhaps because checking one's health status goes a long way to help in early identification and prompt treatment of life threatening diseases like hypertension and diabetes when they are identified. People also have the opportunity of being counseled on the prevention and management of such ailment when they visit the hospital to check their health status.

They were also of the opinion that it will provide easy access to quality health care services for which they are able to pay for at a time when they are not ill. This is important because it will reduce the number of people who visit quarks for health care because of lack of money, coupled with the facts the hospitals that provide the services under OYSHIA use qualified healthcare professionals.

They were also of the opinion that the services of OYSHIA will be useful to some extent at times when emergency care is needed and salaries had not come, since it is usually said by a Yoruba adage that it is only the week that most civil servants receive their salaries that they are able to say that they have cash on them.

Those with negative perception were of the opinion that it does not have its services extended to their family members and it excludes the provision of expensive drugs and services to its enrollees. Anytime an individual is ill in a nuclear family every member of the family will have their own share, either psychologically, financially or otherwise, hence having a health insurance that is able to accommodate all members of a nuclear family is important. There is a general saying that whatever is worth doing at all is worth doing well, if a health insurance is to be adopted, it should be properly done, and make necessary provision for health care, as against the opinion of some individual that half bread is better than none.

This is consistent with the study of Olayemi (2017) who in his own study claimed that the respondents had positive and negative perception of health insurance, while majority attested that social health insurance is capable of improving healthcare delivery in Nigeria and are willing to participate in the scheme, some alluded that the range of services provided are inadequate and that it does not provide better healthcare services.
The utilisation of the health insurance scheme among the workers in Ibadan South West Local Government was not encouraging. Although the study revealed a high level of knowledge of the scheme but it was not translated into participation. This is because out of 86% of the civil servants who were registered for the health insurance scheme, only a quarter of the registered members had accessed or utilised the healthcare services under OYSHIA. Also not up to half of the respondents who had accessed the OYSHIA healthcare services confirmed availability of drugs and service demanded during their usage.

Similar to the studies of Bisallah (2002), Nora (2005), Ilochonwu and Adedigba (2017), factors which accounted for low utilisation of health insurance among these civil servants were non-availability of necessary drugs and services, attitude of health workers, shortage of staff and long waiting periods. This indicates that enrolling for health insurance does not guarantee access to adequate health services, other factors such those mentioned above should be considered.

Health insurance is meant to reduce household and individual's spending on health care, but where the above factors discourage its utilisation, it will be tantamount to double spending on health, while people will be unable to receive adequate health care services despite the monthly deducted premium; hence there is a need to for more research and studies to be done on how to tackle these problems.

Implication for Health Promotion

Findings from this study have health promotion and education implication and require a need for multiple actions so as to improve the utilisation of OYSHIA.

Sensitisation and Mobilisation: Although, the awareness and knowledge of OYSHIA is high among these civil servants, there is still a need for intensive sensitisation and mobilisation by OYSHIA officials so as to encourage its utilisation among civil servants. Strategies to target low – income groups among the civil servants should be developed, so that they can enjoy the benefits of the scheme.

Advocacy: There is a need for the officials in charge of the scheme to encourage all the local government staff who have not registered to register for the health insurance, so as to be able to utilise the services of the health insurance scheme even when they do not have money on them. Advocacy should also be made to Oyo state government by these officials for provision of more funds to cater for provision necessary drugs, personnel and services.

Policy to extend the scope of health services covered by OYSHIA: extending the scope of health services covered by OYSHIA will further encourage the utilisation of the services of OYSHIA.

The extension of OYSHIA services to the family members of its enrollees should also be advocated for by these officials so as to increase its utilisation.

5.2 Conclusion

In conclusion this study explored the knowledge, perception and utilisation of Oyo State Health Insurance Agency (OYSHIA) among the permanent staff of Ibadan South West Local Government Area, Ibadan. The study found a relatively low level of utilization of social health insurance, despite high knowledge level and good perception of the scheme.

This is due to factors such as non-availability of necessary drugs and services, negative attitude of health workers, shortage of staff, long waiting periods at the designated health facilities, and also as a result of far distance of OYSHIA facilities from the residents of the staff.

It is important that solution to these problems should sorted out so as to enable the civil servant to make maximum use of this health insurance. Good health will go a long way in enabling the workers to put in their best in the civil service.

5.3 Recommendations

In order to accomplish the aim of OYSHIA among the civil servants in Oyo state, which is to ensure access to good health services, the following recommendations are made:

i. It is recommended that seminars should be conducted regularly by OYSHIA officials in the local government secretariats, or any appropriate place so as to enlighten the staff on operations and the benefits of utilising the services of OYSHIA while local government administrators should make such seminars compulsory for all.

ii. More awareness campaign on the mass media will be beneficial in this regard as the workers will understand fully what their benefits and responsibilities are.

iii. The personnel who are in charge of OYSHIA in collaboration with the Health Maintenance Organisations should source for ways of making available the necessary drugs and services needed for the health care providers, so as to improve the services rendered by them.

iv. Donations could be sought from philanthropist, government and non-governmental organisations.

v. OYSHIA should continuously review this scheme to ensure that it operates in a manner that will ensure the justification of its implementation and achievement of its goal of providing quality health care services to the people of Oyo state. In this regard, it should ensure that factors preventing the utilisation of its services are dealt with to allow for maximum utilisation of its services.

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APPENDICES

APPENDIX 1

INFORMED CONSENT FORM

My name is **ODUOLA ADENIKE OLUBUSOLA** from the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. I am carrying out a study on knowledge, Perception and Utilisation of Oyo state Health Insurance Agency by Civil Servants in Ibadan South-West Local Government Area of Oyo state.

The information you provide will be useful in having an understanding of the knowledge, perception and utilization of Oyo State Health Insurance Agency among Civil Servant Servants in Ibadan South-west Local Government Area of Oyo State. It is not compulsory for you to partake in this study, and if you decide to partake you may choose to stop the interview when you no longer want to be a part of the study.

Thank you for your assistance.

I understand all that has been explained above and I am willing to participate in the study.

_____ _____

Sign **Date**

SECTION A: Socio-Demographic Information

In this section, please tick (√) any of the responses that apply to you in the options provided or complete the blank spaces provided as applicable.

1. Sex: (1) Male [ ] (2) Female [ ]
2. Age as at last birthday:_____ years
3. Marital Status: (1) Single [ ] (2) Married [ ] (3) Separated [ ] (4) Divorced [ ] (5)Widowed [ ]
4. Religion: (1) Christianity [ ] (2) Islam [ ] (3) Traditional [ ] (4) Others [ ]
5. Level of education completed: (1) Primary [ ] (2) Secondary [ ] (3) Tertiary [ ]

6. Civil service level: (1) 1-6 [ ] (2) 7-12 [ ] (3) 12 and above [ ]

SECTION B: Knowledge of Respondents on OYSHIA

Please tick (√) the most appropriate answer to you

7. OYSHIA means Oyo State Health Insurance Agency? (1) Yes [ ] (2) No [ ]
(3) I don't know [ ]

8. OYSHIA has two health care plans for public servants. (1) Yes [ ] (2) No [ ]
(3) I don't know[ ]

9. How did you get to know about OYSHIA? (1) Television[ ] (2) Friends[ ]
(3) Colleagues[ ] (4) Billboard[ ] (5) Radio[ ] (6) Newspaper[ ]
(7)Others (specify)_____

Health needs covered by OYSHIA

S/N	Health needs covered by OYSHIA include	YES	NO
10	Family planning education		
11	Hospitalization in the general ward for three months		
12	Tooth extraction		
13	Treatment of malaria		
14	Investigation for malaria parasite		
15	Caesarean section		
16	Eye care with provision of plain glasses		
17	Insertion of family planning devices (Intra Uterine Contraceptive device)		
18	Treatment of respiratory tract infection		

SECTION C: Perception of OYSHIA

Please tick (√) the most appropriate answer to you or fill the blank spaces provided as applicable

19. OYSHIA improves access to quality and efficient health. (1) Yes [ ] (2) No [ ]

20. OYSHIA is a good idea; I will encourage others to use it. (1) Yes [ ] (2) No [ ]

21. OYSHIA should be made compulsory for all Oyo state workers (1) Yes [ ] (2) No [ ]

22. Out of pocket method of payment is better than OYSHIA. (1) Yes [ ] (2) No [ ]

23. If yes why? _____

24. The performance of OYSHIA is good and satisfactory. (1) Yes [ ] (2) No [ ]

25. OYSHIA will be sustained by Oyo State government. (1) Yes [ ] (2) No [ ]

26. Monthly deduction of OYSHIA premium is deceitful. (1) Yes [ ] (2) No [ ]

27.Monthly deduction of OYSHIA premium may attract illnesses. (1) Yes [ ] (2) No [ ]

28. What benefits do you think OYSHIA has? _____

SECTION D: Utilization of OYSHIA

29. Are you registered with OYSHIA? (1) Yes [ ] (2) No [ ]

30. How long have you registered with OYSHIA? (1) 2017 (2) 2018 (3) 2019

31. Have you assessed health care under OYSHIA before? (1) Yes [ ] (2) No [ ] **(if yes, skip to question 33)**

32. If you have never assessed health care under OYSHIA, where do you assess health when you are ill (1) Traditional healing home [ ] (2) Spiritual home [ ] (3) Private hospitals [ ] (4) Government hospital[ ] (4) Others (specify)_____

33. When last did you assess health care under OYSHIA? (1) 0-30 days [ ] (2)31-60days [ ] (3) 61-90 days ago[ ] (4) Over 90 days ago[ ]

34. Were all necessary drugs and services available? (1) Yes [ ] (2) No [ ]

35. Would you prefer to use your health care provider under OYSHIA any time you are ill? (1) Yes [ ] (2) No [ ]

36. What are the things that discourage you from making use of the services of OYSHIA? (1) Attitude of health workers [ ] (2) Non-availability of necessary drugs and services [ ] (3) Long waiting periods [ ] (4) Shortage of staffs [ ] (5) Distance [ ] (6) Others (specify) _____

Thank you.

APPENDIX II

YORUBA QUESTIONNAIRE

Iweifohunsokan

Oruko mi ni **ODUOLA ADENIKE OLUBUSOLA**, mo je akeko onipo giga keji ni eka ilera gbogbogbo, ni ile eko giga ti unifasiti ti ilu Ibadan. Mo fe se akojo ayewo lori imo, ero ati lilo eto adojutofo ilera(OYSHIA) ti ipile Oyo, ni awujo awon osise ijoba ibile guusu iwo oorun, Ibadan, gbogbo idahun ti e ba pese yio wulo fun nini oye nipa imo, ero ati lilo eto adujutofo ilera ((OYSHIA) laarin awon osise ijoba ibile guusu iwo oorun, Ibadan.

Kii se dandan fun yin lati kopa ninui wadi yi, bi e ba si kopa ,e le da iforowanilenuwo yi duro ni igba ti e ko ba fe kopa mo.

E se fun iranlowo yin.

Gbogbo alaye ti o wa loke yi ni o ye mi, mo si fe kopa ninu iwadi yi i.

Ami idanimo:_____

Ojo:_____

ABALA A: ItanAkoole

Ni abala yi, jowo fi amii o gbaa(√)si idahun ti o ro pe o to, tabi se akotan alafo ti a pese bi o ti to.

1.Oruko eka oro: (1) Ako [ ] (2) Abo [ ]

2.Ojo ori ni ojo ibi ti o keyin : _____ odun

3. Ipo Igbeyawo : (1) Mi o ti se gbeyayo ri [ ] (2) Mo ti se gbeyayo [ ] (3) Mo ti kuro lodo oko tabi iyawo mi [ ] (4) Mo ti se ikosile [ ] (5) opo [ ]

4.Esin:(1) elesin Kristi (2) musulumi (3) Esin Abalaye (4) esin miran

5.Eko ti e pari : (1) Iwe mefa [ ] (2) iwe mewa [ ] (3) Ile eko giga [ ]

6.Ipele ni ibi ise ijoba: (1) ookan si eefa [ ] (2) eeje si mejila [ ] (3) mejila soke [ ]

ABALA B : Imo olukopa nipa adojutofo ilera (OYSHIA)

E jowo e fi ami o gbaa((√)si idahun ti e ro pe o to

7.Itumo OYSHIA ni ile ise adojutofo ilera ti ipinle Oyo (1) Beeni [ ] (2)Beeko [ ]

8. Ipele itoju meji ni OYSHIA ni fun awon osise Ijoba (1)Beeni [ ] (2)Beeko [ ] (3) N komo [ ]

9. Bawo ni e se gbo nipa OYSHIA (1) Telifisan [ ] (2) Ore [ ] (3) Olubasisepo [ ] (4)Aworan ori patako [ ] (5)Redio [ ] (6) Iwe iroyin [ ] (7) ona miran [ ] (so pato)

	Eto ilera ti OYSHIA n se amojuto	BEENI	BEEKO
10	Eko nipa ifeto somo bibi		
11	Aye fun dida duro ni ile iwosan fun osu meta		
12	Eyin yiyo		
13	Itoju Iba		
14	Sise ayewo fun oonfa Iba		
15	Fifi abe gbebi		
16	Itoju oju ati ipese awoju ti ko gaara		
17	Sise ifeto somo bibiti o ni fifi si ile omo		
18	Sise itoju arun awon eya ara ti a fi n mi		

ABALA D: Eronipa OYSHIA

E jowo fi amin o gbaa(√) si idahun ti o ye, tabi ki e ko idahun si aye ti o sofo bi o ti ye

19 OYSHIA je ona si ilera to o dara, ti o si ye koro (1) Beeni [ ] (2) Beeko [ ]

20. OYSHIA dara, n o ro awon eniyan lati ma lo o (1) Beeni [ ] (2) Beeko [ ]

21.OYSHIA gbodo je dandan fun gbogbo osise ipinle oyo (1) Beeni [ ] (2) Beeko [ ]

22. Ona sisan owo lati apo eniyan dara ju ti OYSHIA lo (1) Beeni [ ] (2) Beeko [ ]

23. Ti o ba je beeni, ki ni idi re? _____

24.Isowo sise OYSHIA dara , o si te mi lorun (1) Beeni [ ] (2) Beeko [ ]

25. Ijoba ipinle Oyo yi o o le ma so amojuto OYSHIA lo fun igba pipe.

(1) Beeni [ ] (2) Beeko [ ]

26. Ohun etan ni yiyo owo fun OYSHIA ni ososu (1) Beeni [ ] (2) Beeko [ ]

27.Yiyo owo fun OYSHIA ni ososu le mu ki aisan ki o ma jinna si eniyan

(1) Beeni [ ] (2) Beeko [ ]

28. Awon anfaani woni o romo OYSHIA

_____

ABALA E (SISAMULO ETO OYSHIA)

Jowo fi amin o gbaa(√) si idahun ti o ye

29.N je e ti fi oruko sile pelu OYSHIA (1) Beeni [ ] (2) Beeko [ ]

30.Ni igba wo ni e fi oruko sile pelu OYSHIA (1) 2017 [ ] (2) 2018 [ ] (3) 2019 [ ]

31. N je e ti lo fun itoju nipase OYSHIA ri (1) Beeni [ ] (2) Beeko [ ]

Bi o ba je beeni e lo si ibeere ketalelogbon (33)

32. Bi e ko bati lo fun itoju nipase OYSHIA ri, nibo ni e ti ma n gba itoju ni igba ti ara yin ko ba ya.

(1) Ile iwosan abalaye [ ] (2) Ile iwosan ti ile ijosin [ ] (3) Ile iwosan ti aladani [ ] (4) Ile Iwosan ti ijoba [ ] (5)Ibomiran [ ] (e so nipato)

33. Ni igba wo ni e gba itoju gbeyin ni pase OYSHIA (1) Ogbon ojo seyin [ ] (2) ookanlelelogbon si ogota ojo [ ] (3) ookanlelogota si aadorun ojo [ ] (4) aadorun ojo soke [ ]

34. N je gbogbo ogun ati eto ti e nilo ni o wa ni ikale (1) Beeni [ ] (2) Beeko [ ]

35. N je e feran lati ma gba itoju ni pase OYSHIA ni igbakugba ti ara yin ko ba ya

(1) Beeni [ ] (2) Beeko [ ]

36. Ki ni awon nnkan ti ki je ki o wu yin, lati ma lo eto OYSHIA

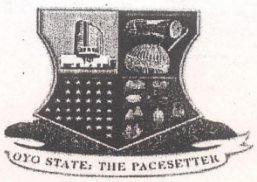
(1) Ihuwasi awon osise eleto ilera [ ] (2) A i si ogun ati eto ti o ye. [ ] (3) Diduro fun igba pipe [ ] (4) A i to awon osise [ ] (5) ona jinjin [ ] (6) Ohun miran [ ] (e so ni pato)

E se, mo dupe

APPENDIX II

ETHICAL APPROVAL LETTER

P TELEGRAMS..... TELEPHONE.....



MINISTRY OF HEALTH
DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION
PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....
All communications should be addressed to the Honorable Commissioner quoting
Our Ref. No. AD 13/479/1562

3rd December, 2019

The Principal Investigator,
Department of Health Promotion and Education,
Faculty of Public Health,
College of Medicine,
University of Ibadan,
Ibadan, Nigeria.

Attention: Oduola Adenike

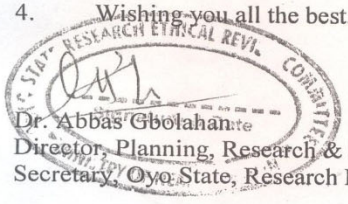
ETHICS APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE

This is to acknowledge that your Research Proposal titled: "Knowledge, Perception, and Utilization of Oyo State Health Insurance Agency (OYSHIA) by Civil Servants in Ibadan South West Local Government Area of Oyo State, Nigeria." has been reviewed by the Oyo State Ethics Review Committee.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.



Dr. Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethics Review Committee