Community Based Health Insurance Scheme in Anambra State, Nigeria: an analysis of policy development, implementation and equity effects

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TABLE OF CONTENTS

LIST OF ACRONYMNS

Anambra state Health system Development project-II	AHSDP-II
Community-based Health Insurance	CBHI
Community Health Committee	CHC
Community Health Extension Worker	CHEW
Community Health Financing	CHF
Community Health Management Organisation	CHMO
Focus Group Discussions	FGD
Health Worker	HW
In-depth Interview	IDI
Local Government Areas	LGA
Primary Health Care	PHC
Primary Health Care Coordinator	PHCC
Principal Components Analysis	PCA
Revenue Mobilisation Allocation and Fiscal Commission	RMAFC
Socio-economic status	SES
Stake Holder Analysis	SHA
Town Union	TU
World Health Organisation	WHO

1. INTRODUCTION

1.1. Background Information

Community-based Health Insurance (CBHI) is a not-for-profit type of health insurance that has been used by poor people to protect themselves against the financial risk of illness. In CBHI schemes, members regularly pay small premiums into a collective fund, which is then used to pay for health costs if they require services. Based on the concepts of mutual aid and social solidarity, many CBHI schemes are designed for people that live and work in the rural and informal sectors who are unable to get adequate public, private, or employer-sponsored health insurance (Bennett et al. 2004).

CBHI was initiated in 2003 in Anambra state, Nigeria, with the overarching goal of increasing the provision and utilisation of health services. Before this, there had been declining levels of health care delivery, partly due to budget constraints, industrial action and the ensuing closure of all public health facilities (Uzochukwu and Onwujekwe 2005); and utilization of public health facilities and immunization coverage was also low (Uzochukwu et al 2004, State Ministry of Health 2005a).

However, some studies from other countries in sub-Saharan Africa and Asia suggest that CBHI operations have only had limited successes in ensuring affordable, participatory, and sustainable access to health care (Bennett et al. 2004). Furthermore, the benefits of policies that are intended to benefit poor people are often inappropriately (and sometimes disproportionately) captured by more wealthy and powerful groups (Victora et al., 2002; Goudge et al., 2003; Bitran and Gideon, 2003; Palmer et al., 2004). There is also some evidence that policies intended to promote equity can have unexpected negative impacts, such as reduced quality of services (Uzochukwu and Onwujekwe, 2005).

Despite wider recognition of the need for policy change (Grindle and Thomas, 1991; Hill and Hupe, 2002), there has been only limited consideration of how the forces underlying the processes of designing, implementing and managing CBHI policies can influence their success or otherwise. Moreover, where such processes have been considered, the conclusions have been quite narrowly focussed – concentrating, for example, on the need for better policy design that takes greater account of the needs of poor people, or implementation processes that just allow for experimentation and adaptation in response to experience (Gwatkin et al., 2005). Although both issues are important, they do not address the fact that these processes always involve contestation, bargaining and negotiation among a range of actors who, either deliberately or by chance, make decisions that shape policy, including how it is experienced by those it is intended to benefit (Walt and Gilson, 1994).

Some studies highlight such influences over equity-promoting health policy implementation. They show, for example, that:

- weak management of critical interest groups during policy development may shape the design of new policies in ways that limit their equity-promoting potential (McIntyre et al., 2003; Thomas and Gilson, 2004);
- limited efforts to engage with local level managers and providers about new policies may mean that they do not fully understand policy intentions and so implement guidelines and procedures incorrectly, or even avoid implementing new procedures. (Kamuzora, 2005);
- poor coordination among implementing actors can undermine or pervert effective implementation (Blaauw et al., 2003);
- the failure to take account of existing power structures within local settings, when designing and implementing new policies, may lead to unrealistic expectations about the role of community members, particularly marginalized community members, in local decision-making structures that intend to promote local influence over health care (Gilson et al., 2001; Ngulube, 2005).

Although rarely examined, past studies of CBHI have provided some indications of the way implementation processes influence experience. For example, a study of the Community Health Financing (CHF) scheme in Tanzania has shown that managerial practices and behaviour, in partial response to a top down imposition of policy, can undermine effective implementation (Kamuzora, 2005). This study also highlights the importance of managerial trust to CBHI implementation experience.

More effective implementation of policies that are intended to promote equity will therefore require more than improved design of policies or further monitoring and evaluation. It must also include active engagement with, and management of, the range of relevant actors, based on better understanding of the factors influencing their responses to new policies. For instance, in Nigeria, it is not known whether policy makers and health care providers took the community views into consideration when fixing the premium and deciding the benefit packages, and whether the community have been properly sensitized and mobilized for the scheme.

This study explores the CBHI policy development and implementation process and the factors that have constrained or enhanced its implementations.

1.2. Research Questions

2. What incentives (political, financial, moral, external factors etc) have influenced the planning and implementation of CBHI among policy makers?
3. What are the key determinants of relationships among actors and how they influence implementation process?
4. Do difficulties in communication between administrative layers (state and Local Government Areas (LGA)) within health systems undermine CBHI implementation?
5. What roles do health workers, facility heads and program managers play in translating/distorting policy in practice and how does managerial trustworthiness influence CBHI policy implementation? Does CBHI threaten implementers or require them to work in new ways?
6. What are the community's perceptions and acceptance of CBHI; what are the factors influencing community enrolment into the CBHI?

2. METHODS

2.1. Study Area

The study was undertaken in Anambra state, southeast Nigeria. Anambra state has a total land area of 4,416 sq. km and is situated on a generally low elevation on the eastern side of the River Niger. It is bounded in the Northeast by Enugu state by Engu and Abia states in the East, by Delta in the West, and, in the South and Northwest, by Imo and Kogi states respectively. The total population according to the 2006 census was 4,453,964

The state comprises of 21 LGAs, 235 districts, 328 political wards and 177 communities, with the capital at Awka. The CBHI scheme has been established in 10 communities namely: Ifite Ogwari, Ugbene and Achala in Anambra north senatorial zone; Abagana, Alor, Neni and Awka in Anambra central senatorial zone; and Igbokwu, Okija and Mbosi in Anambra south senatorial zone. Apart from Awka, the other communities are rural communities. Each community has a health centre which serves as the base focal health centre for the scheme, serving the 4-7 villages in each community.

2.2. Study design

Undertaken in Anambra State, the study involved an initial set of data collection activities at the state level, followed by data collection in two local level case study sites selected from the initial 10 pilot CBHI sites (9 rural and 1 urban).

State level data collection activities:

Initial state level activities included obtaining support for the study from Ministry of Health officials, and the collation of data on CBHI initiation and development.

Case study selection and data collection activities:

Two communities from two rural LGAs were selected for inclusion in this study, reflecting the fact that most LGAs where the scheme has been initiated are rural areas.

One more (Community A) and one less (Community B) successful CBHI site was chosen, with scheme success judged by State level CBHI task team members. These task team members were asked to indicate the communities where the scheme has been more successful and those that have been less successful. One community was consistently voted to be the most successful by all the members while three communities were voted to be less successful. When asked how they made their judgment, the task team members said that judgement was based on the level of community involvement in providing financial and material support in the early part of the scheme, and the level of enrolment in the scheme, as evidenced in their monitoring data. In each community, the Health Centre with which the CBHI is linked was then identified as the focal point for data collection activities.

The use of the case study approach allowed a detailed examination of the decision-making processes of the CBHI implementation, influences over these processes, and the potential success of CBHI in benefiting the poor. A case study design is particularly appropriate for a study of this type, which is seeking to understand why policy change succeeded or failed. The inclusion of both potentially more and less successful experiences of policy impacts was to avoid the common criticism that implementation research focuses only on the negative (Hill and Hupe, 2002), as well as facilitating the identification of practical policy and management recommendations.

2.3. Stages of work

The stages of the work were:

Phase 1:

1. Advocacy to the state Ministry of Health and training workshop for the researchers on data collection approaches and tools.

Phase 2:

2. Document review and state level policy maker interviews to: map out the different stages of implementation and obtain a sense of general experiences of CBHI scheme development processes; determine policy intentions; and identify factors, expected by these actors, to facilitate and constrain implementation and their planned implementation strategies, as well as their roles in implementation and influences over their decision-making.
3. Use of enrolment data and interviews with knowledgeable state and local level managers to assess overall policy achievements, as well as gain insight to assist in the final selection of case study sites.

Phase 3:

4. Case study investigation of the two sites, using a range of qualitative and quantitative data collection approaches, to explore the roles of policy makers, healthcare providers and community members in

implementation, the factors influencing their roles and decision-making, and the range of other influences over implementation experience.

5. Further interviews with CBHI managers to explore their views on the influences over implementation and the influences over their decision-making.

Phase 4:

6. Preliminary analysis of all collected data, involving comparison of policy intentions and plans with implementation practice experience across case study sites to identify the key factors influencing level of policy achievement.

2.4. Data collection*:*

I. Document review:

Documents reviewed included CBHI policy documents, the Anambra state health summit document, grey literature and existing evaluations of it. Documents were reviewed using a standard review template to determine policy intentions, planned implementation strategies and any identified influences over implementation experience.

2. *In-depth interviews:*

Using an in-depth interview guide, the policy makers and managers were interviewed. The sociologist conducted the interviews, assisted by the social science research assistants and the community physician, who took notes and tape-recorded the interviews. The policy makers interviewed included 1 senior politician, 8 state policy makers involved in the scheme, and 5 LGA officials Information was collected on: what motivated them to conceptualize the CBHI; how they managed the process of moving from policy development to implementation; which forms of engagement and communication with program managers, health workers and the community were used; what preparation were made; why the strategies they selected were used; and, what they think are the consequences in implementation of those strategies.

In-depth interviews (IDI) were also conducted with 4 health workers per site in the focal health facilities to identify: their views of policy achievements and failures; their own roles in implementation, the factors influencing them, and the range of other influences over implementation experience; and, perceptions of possible influences over implementation. The interviews also sought to ask health workers whether CBHI threatened them or required them to work in new ways; who gained or lost as a result of the introduction of the scheme; and, what, if any, was the form of coordination between the health workers and the CBHI managers and Community Health Committee members.

Two members of the Community Health Management Organization (Managers of the scheme) were also interviewed in each site to ascertain: whether they received any information, communication, and/or engagement about policy from higher levels before, and during, implementation; and, whether there were any forms of coordination between managers and the policy makers, and between managers and the community committees. In addition, the interview sought to explore whether any parallel initiatives existed and, if so, how these multiple strands are managed; personal levels of 'motivation' in relation to work; whether the resources required for management tasks linked to CBHI implementation were available, or how they could be obtained; and, whether any form of training was provided before the commencement of the scheme, and if so, which areas this covered.

Focus Group Discussions (FGD) were held with both members and non-members of the CBHI scheme in all catchments villages within the communities. In total, 8 FGDs were conducted in each catchment area, lasting between 60 and 75 minutes, and with 9-10 members in each FGD. The participants were stratified by sex and membership of the scheme, and were purposively selected with the help of the village heads. A discussion guide

was used to direct the discussions during the FGDs, which were moderated by a social scientist. An FGD guide was used to explore participants' perceptions, acceptability and enrolment into the CBHI, as well as their own roles in implementation and the factors influencing them. Issues covered included: participants' knowledge, or otherwise, of the scheme; reasons for enrolling or not enrolling in the scheme; perceptions of the quality of services provided; the affordability of the scheme; attitudes towards insurance; and levels of trust in CBHI managers and health workers and the community health committee members

All the 16 members of the community health committees in the 2 sites were interviewed to identify their views of policy achievements and failures and their own roles in implementation, as well as the factors influencing them, other key actors in implementation and the factors influencing them, and the range of other influences over implementation experience. The questions included: what information/communication/engagement occurred before and during the implementation? Were they involved in setting the premium and determining the package for the scheme? What trust do they have in the CBHI managers? What are their perceptions of quality and affordability? What are their attitudes towards insurance against health care risks?

For the household survey, data was collected using a pre-tested interviewer-administered questionnaire which was administered to 1000 respondents (500 from each community), selected by simple random sampling from a sample frame of primary health care house numbering system. Adequate sample size was determined, using a power of 80%, 95% confidence level and utilization rate of public health facilities of 20%. The heads of households or their representatives (if the household head was not available) were interviewed, and the sample size was 400 per community; however, 500 interviews were taken from each community in order to control for refusals and incomplete questionnaires. Data collected included socio-economic and demographic characteristics, as well as willingness to renew registration and to pay for others.

2.5. Data analysis

2.5.1. Qualitative data

All interviews were taped, and notes were taken during the interview. Tapes and notes were transcribed/reviewed as soon as field workers returned from the field.

State and case study data were analysed independently of each other as each set of data reflected different experiences. In addition, data from each case study was analysed separately, and then case study experiences compared and contrasted. Within each set of data, there was triangulation across interviews, and then, as relevant, between interview data, document reviews and household survey data. This approach allowed identification of both similarities and differences in views and experiences, and supported investigation of explanations for key differences.

The initial analysis steps included using data collected to conduct forcefield and Stake Holder Analysis (SHA). In conducting the SHA, we focused on two key elements: actors are analyzed in terms of: a) the interest they take in CBHI and, b) the quantity and types of resources they can mobilize to affect outcomes regarding CBHI. Information collected from the IDIs with the politician and state policy makers, as well as document reviews, were used to conduct SHA for policy development; and, in each study site, we used information from IDIs and FGD.

This process identified the requirements placed on stake holders in order for CBHI to be effectively implemented. These needs are framed in terms of types of resources the stakeholder possesses that could impact on the decision making or implementation of CBHI e.g., financing, physical inputs, political support, approvals, policy support, technical assistance, and so on. Stakeholders were then classified according to the resources they control and their level of power, their interests in CBHI activities and outputs, and the important resources they

can bring to CBHI. In addition, the level of interest in CBHI is indicated, and whether the stakeholder is for or against the policy. These classifications determined stakeholder's policy position, ranging from strongly positive to strongly negative (+3 to -3) or whether they are not mobilized at all; and stakeholder's power level, ranging from very high to very low (+3 to -3) and no source of power. The sources of power, some of which are more important than others, help to explain this judgment, and all are presented in a matrix.

2.5.2. Quantitative data:

A socio-economic status (SES) index was used to examine, both within and between the two sites, whether there were systematic differences in enrolment into the scheme, willingness to renew registration, and willingness of registered respondents to pay for others. Principal Components Analysis (PCA) in STATA was used to develop the index, and the input to the PCA consisted of information on ownership of radio, bicycle, motorcycle, refrigerator, television, fan and motorcar, together with the per capita weekly cost of food. Households could then be classified into four quartiles - least poor, poor, very poor and most poor -with quartile 1 (Q1) being worst-off and termed most poor, and Q4 least poor. The measure of inequity was the ratio of the mean of the poorest SES group (1st quartile) over that of the least poor SES group (4th quartile) (top/bottom quartile ratio) (Wagstaff et al., 1989, 1991). The top/bottom (Q1/Q4) quartile ratio shows the level of gap that has to be bridged in order to ensure equity and improve the condition of the poorest households, and a score of 1 signifies perfect equity (Onwujekwe, 2005).

3. FINDINGS

3.1. Study Context

3.1.1. Federal:

The population of Nigeria is currently put at 140 million (NPC 2006). Nigeria is a federation which gained independence on October 1 1960 and became a republic on October 1 1963, and has, since then, gone through both civilian and military leadership, as well as a civil war in the late 60s. There are three tiers of government - federal, state and local – and a complementary relationship exists among all the tiers of government.. The constitution of the Federal Republic of Nigeria (1999) establishes judicial, legislative and executive branches for the federal government and for each state of the federation. The National Assembly comprises the Senate and the House of Representatives whose members are elected from state senatorial districts and constituencies respectively. At the time of this study, and to date, the political party in power is the Peoples Democratic Party (PDP), and. there are 5 other major political parties, as well as about 46 minor political parties.

The health priorities include reducing the morbidity and mortality rates due to communicable diseases to the barest minimum; reversing the increasing prevalence of non-communicable diseases; meeting the global targets on the elimination and eradication of diseases; and significantly increasing the life expectancy and quality of life of Nigerians (Federal Ministry of Health 2004).

In the 1999 Nigerian constitution, health is on the concurrent list; thus, the federal government, states and LGAs have similar responsibilities for the provision of services such as health. In the present era of democracy, these bodies also have substantial autonomy and exercise considerable authority over the allocation and utilization of their resources. According to the National Health Policy, the federal government is responsible for policy formulation, strategic guidance, coordination, supervision, monitoring and evaluation at all levels. It also has operational responsibility for disease surveillance, essential drugs supply and vaccine management, as well as

for providing specialized health care services at tertiary health institutions (university teaching hospitals and federal medical centres).

3.1.2. State:

Political context and structure

Anambra state is one of the 36 states of the federation. It has an executive governor, elected by the people, who is the chief executive of the state; an executive council appointed by the executive governor but approved by the legislators; and a House of Assembly, made up of elected legislators with powers to make laws, approve appointments and state budgets. The legislators and governor were elected into office in May 2003 and, at the time of the study, the majority of the legislators belonged to the same party (PDP) as the executive governor, with two other parties also represented. The executive council, who meet once a week to deliberate on issues affecting the state, is made up of 10 Commissioners (who each head a different ministry), 4 special assistants to the governor, the secretary to the government and the governor. The appointment of these commissioners and special assistants is based on party affiliation, interest groups and geographical considerations. Each commissioner is assisted administratively by a permanent secretary who is also appointed by the governor, based on party affiliation, interest groups, geographical considerations and experience in civil service. The permanent secretaries act as the administrative heads of each ministry.

Politically, the state is divided into three senatorial districts, namely, Anambra north, Anambra south and Anambra central. Each senatorial zone is made up of 7 LGAs. At the time of this study, the three leading politicians of the state, namely, the governor, the deputy governor and the speaker of the house of assembly, were each from a different one of these zones.

There are 21 LGAs in Anambra state, with each administered by an elected executive chairman who works with elected legislative council members from electoral wards. Each LGA also has a health department which is headed by a medical doctor as the Primary Health Care Coordinator (PHCC) or, in his/her absence, by the most senior health worker, as explained further below.

Nigerian Health system overview

The organization of health services in Nigeria is pluralistic and complex. It includes a wide range of providers in both the public and private sectors: private for profit providers, NGOs, community-based organizations, religious and traditional care providers. At the lower level, the states and LGAs share responsibility for health care. States largely operate secondary health facilities (general hospitals and comprehensive health centres), providing mostly secondary care and serving as referral level for the LGAs which provide the essential elements of primary health care (PHC).

Operationally, the decentralized health structures of the federal government are in the states, while those of states are in the LGAs. Some states build and operate tertiary facilities or specialist hospitals. While the federal government is responsible for the management of teaching hospitals and medical schools for the training of doctors, the states are responsible for training nurses, midwives and Community Health Extension Workers (CHEWs). The LGAs provide basic health services and manage the PHC facilities (health centres and health posts) which are normally the first contact with the health system.

The health system is generally funded from federal allocation to the states and LGAs, both of which also generate about 20% internal revenue from taxes, rates and levies.. The allocation of federal revenues is fixed by the Revenue Mobilisation Allocation and Fiscal Commission (RMAFC) and approved by the National Assembly for five years. The allocation formula assigns 48.5 percent to the federal government, 24 percent to the states and 20 percent to local government, with 7.5 percent retained for ‘special’ federally determined projects. Once set, the

revenue sharing formula provides limited room for maneuvers on fiscal policy (World Bank, 2003*).* The horizontal distribution formula is constitutionally fixed and allocates 40 percent to each state in equal amounts and 60 percent based on six variables. The variables are population (30 percent), land mass (10 percent), internal revenue generation efforts (10 percent), secondary school enrolment (4 percent), number of hospital beds (3 percent), and rainfall (3 percent). The revenue shares depend positively on the first three variables and negatively on the last three (Heymans & Pycroft 2003).

Nigeria's overall health system performance was ranked 187th position among the 191 Member States of the World Health Organization in 2000 (WHO 2002). Health status indicators are worse than the average for sub-Saharan Africa, for example, in 2004 Nigeria had infant mortality rate of 115/1,000; under-5 mortality rate of 205/1,000; and maternal mortality ratio of 948/100,000 (range 339/100,000 to 1,716/100,000), one of the highest in the world (Federal Ministry of Health, 2004). The poor indicators are a result of the near collapse of the health care system in Nigeria during the military era, a situation attributable to several factors, including poor funding, poor management capacity and poor infrastructure. This situation has led to a very difficult setting for achieving public health goals, as Anambra state demonstrates.

At the inception of the administration of the Anambra state government in May 2003, the health system and health care delivery in the state were significantly damaged. Health facilities were in a dilapidated state, hospital equipment was either totally lacking or in a state of disrepair, and health personnel were highly demotivated as a result of several months of non-payment of salaries and allowances. The public health facilities were consequently unattractive to patients and clients and had, therefore, been abandoned by them, with facility surroundings being covered with overgrown weeds and grasses (State Ministry of Health 2005b).

To reverse this trend in health care delivery in the state, the new government initiated a range of policies and projects. This included infrastructural repairs, provision of new equipments, and servicing of old ones, recruitment of several cadres of health workers and capacity building of health personnel. New training institutions were established while the existing ones were re-energized and empowered to become more active. Specifically, 250 staff nurses, 38 medical Doctors, 800 health assistants and some Pharmacists and laboratory technologists were recruited and posted to various hospitals and LGA. Each LGA now has a Medical Officer of health posted by the state government and, in the LGAs where the CBHI is operating, these doctors are expected to oversee the clinical aspects of the health facilities linked to CBHI (State Ministry of Health, 2005b).

The CBHI scheme

Membership of CBHI comprises of individuals and households in a community, with a minimum of 500 persons required to form a user group (State Ministry of Health, 2004). The individuals pay a flat rate monthly, yearly or in convenient instalments; and a participant who defaults in payment of monthly contributions must pay all outstanding contributions before being allowed to re-access services. The CBHI model demonstrated by Anambra state shows that the government refurbished and equipped the health facilities involved in the scheme. The households enrolled in the scheme pay premiums into the CBHI fund, the scheme pays the government for the use of the facilities, and the healthcare providers offer health care services to the scheme members. In addition, the government makes matching contributions to the premiums paid by the households to the scheme, as well as providing subsidy to health care providers in form of salaries. Non members of the scheme also have access to the health facilities but pay some user fees directly to the health care providers to access care.

The scheme is managed by a Community Health Management Organisation (CHMO) which is made up of 3 people employed by the Community Health Committee (CHC). The CHC is made up of the traditional ruler, the town union President, the town woman leader, a representative of the Ministry of Health, a representative of the LGA, and one male and one female from each village.

3.1.3. Site/Local

The two study sites are of the same socio economic status but from two different rural LGAs and located in different senatorial zones of the state. They are called towns or communities, and each town is made up of several villages, administered by a town union made up of the town union chairman and his executive members who are elected by the community members. Each town also has a traditional/cultural leader called the "Igwe". The Igwe, assisted by members of his cabinet drawn from the different villages in the community, is the custodian of the people's culture and heritage, and is either elected or ascends the throne by inheritance. For any meaningful development and peace to exist in the communities, the town union and the Igwe must have a cordial relationship. Overall, the Igwe is expected to be the father of the community and therefore accorded such respect; however, there are occasions when the Igwes and the town unions are at logger heads on matters of constitution and project implementation (Nwosu 2008).

3.2. Policy Development

Table 1 shows the timeline, in chronological order, for the policy development from its conceptualization stage to the time the case study was conducted. It also shows the important events that occurred in the process of CBHI development.

Table 1: Timeline Narrative (Political & Policy)

Year	Event	Political context
June 2003	Conceptualization of CBHI. Commissioner sold the idea to the governor.	Governor elected into a 4 year term in May 2003; but position never fully secure.
2nd to 3rd December 2003	Advocacy workshop for traditional leaders, town union presidents, civil society organization etc.	
24th January 2004	Inauguration of state task force.	
22nd April 2004	Inauguration of zonal task force for CBHI only.	
27th June to 10th July 2004	Training workshop for the state and zonal task force members.	
28th October 2004	Training of stake holders in the pilot communities.	
November 2004	10 Pilot communities commence implementation of CBHI.	
December 2005 – March 2006	Implementation stalled.	Executive Governor removed from office by a court order in March 2006.
December 2006 to February 2007	Case study took place.	

In May 2003, a new government was elected in Anambra state for a four year term of office but the position of the governor was never secured. A month after, a prominent Lady from the state, residing in the United States of America, sold the idea of a community health insurance to the Commissioner for Health. This was enabled by the a number of factors: the friendly disposition of the Commissioner allowed the Lady to secure an audience with him; the Commissioner's background as a gynaecologist had led to his concern about the high rate of maternal mortality in the state and the inability of the people of Anambra state to access good quality health care on account of poverty; and, the need to devise a method of health care financing that would be accessible and affordable. This quote embodies these key ideas.

"Actually, the community health care financing scheme was one of the major policy initiatives I was able to put in place as the commissioner for health. The reason why I had to just do that was my knowledge of wastage or death of women as evidenced from the high rate maternal mortality ratio in Nigeria. We knew that one of the fundamental problems or reasons why people die is because they don't access quality health care… because of poverty…if we had to make very important head way in the health sector, we must devise a method of health care financing that would be accessible and affordable to the people." (IDI with Policy maker)

The Commissioner then took the idea to the Governor, where his personal connections supported his ability to influence the governor. As a member of the same college of medicine alumini association (an association that is closely knit and highly respected by members) and of the governor's kitchen cabinet (a small group of people that are very close to the governor who take decisions on very confidential and sensitive matters before presenting it to the executive council), the Commissioner was able to convince the Governor of the need to have CBHI. The scheme was then discussed during the executive meeting and approval was given.

The scheme was therefore introduced in the state during a 2 day advocacy workshop from 2nd to 3rd December 2003, organized by the Ministry of Health in collaboration with the World Bank assisted Anambra state Health system Development project-II (AHSDP-II). The workshop was attended by traditional leaders, town union chairmen, the Nigerian medical association, the Nursing and Midwifery Council of Nigeria and other stakeholders from all over the state. In his opening address, the Governor stated:

"it is interesting to know that this workshop is designed not only to sensitize the people and creat awareness of the new concept, but also to provide a forum for discussions and exchange of ideas and knowledge concerning health problems in Anambra state. I hope that after dissecting the theme, you will come out with action plans that will help address the many problems bedeviling, the design, planning, delivering, utilization and financing of healthcare in Anambra state"

During the workshop, papers were presented by the Project Manager AHSDP, World Health Organization Anambra Field Officer, the permanent secretary, the directors of medical services, Planning Research and Statistics and Primary health care and disease control, a micro insurance consultant, a non-governmental organization (Youth, Health and social reform) and an academic from Imo state University. The issues covered included: an overview of the financing scheme; the strategy and core concepts of the proposed scheme; community mobilization strategies in community health financing scheme; capacity building and manpower needs for the scheme; the role of the community in the sustainability of the scheme; administrative responsibilities in the scheme; the role of community health maintenance organization, ethics and discipline in the sustainability of the scheme' and record keeping, monitoring and evaluation of the scheme.

The input from this workshop was taken away by the task force team and used to refine the contents of the scheme, which aimed to foster community-government partnership in healthcare delivery with the objective of making healthcare accessible and affordable to all the citizens of the state, whether rich or poor.

On the 29th January 2004, the CBHI task force team was inaugurated by the Commissioner for Health. The team consisted of the Project Manager, Project Secretary, Project Communication Officer, Project Monitoring and Evaluation Officer, Project Mobilization Officer and Project Logistic Officer. These members were drawn from the state Ministry of Health, and had other primary assignments in the state Ministry of Health, as well as different health training backgrounds, for example, while the Project Manager is a medical doctor with post graduate training in public health, the Secretary is an administrator; the Project Communication Officer and the Mobilization Officers are health educators; and the M&E Officer and the Logistic Officer are environmental health officers. There was no health economist, nor anyone with specific, relevant technical knowledge, in the team.

A vehicle, a coloured television and four hand megaphones were released to the Task Force for sensitization of the communities and for supervision of the scheme. The Ministry of Health divided the state into five health zones for effective coverage of the state and easier implementation of the scheme' however, the criteria for this division are not quite known as it did not match the senatorial division of the state. Subsequently, the zonal project team was inaugurated by the commissioner on 22nd April 2004.

A two week training workshop, organized by the Ministry of Health, in conjunction with World Bank Assisted AHSDP-II, and facilitated by a non-governmental organization, was held between 27th June and 10th July 2004, for members of the project team. The workshop equipped the members with the knowledge they needed for the efficient and effective implementation of the scheme. On the 28th October, the Ministry organised another one-day workshop for the stakeholders in the pilot communities, which created an opportunity for the pilot LGA head of health department and heads of pilot health facilities, town union presidents and chairmen of community health committees to learn about the scheme.

Ten pilot communities were subsequently selected by the state government, following application to the state government by writing through their town union president, for the initial commencement of the scheme. One or more of the 10 communities came from each of the five zones created for the purpose of CBHI implementation; however, and interesting, the towns chosen as pilot communities were largely home areas of major actors in the scheme.

Each community was expected to form a CHC or board consisting of:

- The traditional ruler or his representative;
- The town union president;
- The town woman leader;
- A representative of the Ministry of Health;
- A representative of the LGA; and
- Two persons (male and female) to represent each of the villages in the town.

Their functions were to be the following

1. Educate and mobilize members of the community to participate in the scheme.
2. Determine the amount of premium payable per person or household per month, and the appropriate banking and disbursement of the money.
3. Oversee the account of the scheme (payment and withdrawal).
4. Monitor the utilization of such money for the purpose of servicing the health care of the members of the community in the designated health institution.
5. Monitor attendance to work by medical personnel and ensure that standards are maintained in health care delivery.
6. Evaluate periodically the community health services scheme and modify as the need arises.

In addition, each health facility used for the scheme had a CHMO consisting of three persons, employed by the CHC and paid from the scheme's capitation funds. One of the members was appointed by the CHC as the Coordinator or the Local CBHI Manager. Their duties were essentially to be administrative and overseeing the day-to-day functioning of the health facilities

At the same time, the 10 pilot health facilities were refurbished. They also received extra staff as one Doctor and 2-4 nurses were posted to the health facilities participating in the scheme, and drugs and equipment were procured by the state government and delivered to the communities. Registration forms, membership cards, letter headed papers, file jackets and complementary cards, and information education and communication materials

were printed by the state and also supplied to the pilot communities. Following these activities, registration of clients and clinical services commenced.

In the scheme, medical treatment is restricted to those obtainable at primary healthcare facilities, for example, the treatment of ailments like malaria, diarrhea diseases and upper respiratory tract infections, antenatal care and delivery. Treatment is sealed at a cost of 5,000 Naira per month, above which the patient is expected to pay additional money.

CBHI benefited from the usual Ministry of Health funds that came from their budgets and, whilst there were actually no specific funds allocated to CBHI, the World Bank Assisted AHSDP-II project, which had the restructuring of the state health systems as their mandate, provided support for the trainings and workshops.

The Governor was removed in March 2006 as a result of political tensions in the state, and the Commissioner left with him. Following his removal, state interest in and support for CBHI dwindled, and there has been no subsequent expansion of the scheme.

3.3. Implementation Experiences

3.3.1. Case study A: Community A

Enrollment level and Socio-economic variation

From the survey data shown in table 1, 48.4% of the respondents registered for CBHI in the community A, thus making it more 'successful' than community B, as identified previously. Most respondents who registered did so because they perceived that the scheme offered financial risk protection. Availability of good quality treatment was the next most common reason for registering and the most common reason for not registering was unavailability of funds (not shown in the table). 82.4% of registered respondents indicated willingness to renew registration for themselves and other members of their households. Also 77.9% of the registered respondents were willing to pay for others.

As shown in table 2 below, there were no significant SES difference in registration, and willingness to renew registration, for the respondent as well as for other household members. In addition, the number of registered respondents indicating increase in facility utilization did not differ significantly across SES groups.

Table 2: SES differences in experiences of respondents in Community A (N = 455)

	n(%)
Registered for CBHI	199 (43.7)
SES differences among respondents registered for CBHI (n=199)	
Q1 (%): Most poor	50(25.1)
Q2 (%): Very poor	51(25.6)
Q3 (%): Poor	48(24.1)
Q4 (%): Least poor	50(25.1)
Chi square (p value)	0.53(0.91)
Poor rich ratio Q1:Q4	1.0
Willingness to renew registration (164)	
Q1 (%): Most poor	41(25.0)
Q2 (%): Very poor	43(26.2)
Q3 (%): Poor	39(23.8)
Q4 (%): Least poor	41(25.0)
Chi square (p value)	0.61(0.89)
Poor rich ratio Q1:Q4	1.0
Willingness of registered respondents to pay for others (155)	
Q1 (%): Most poor	40(25.8)
Q2 (%): Very poor	39(25.2)
Q3 (%): Poor	37(23.9)
Q4 (%): Least poor	39(25.2)
Chi square (p value)	0.28(0.97)
Poor rich ratio Q1:Q4	1.03

Community Participation (Health committee and role of Igwe and relationship with the facility workers)

For the scheme to succeed and be sustained, a high level of community effort and ownership is required, as stressed by the Commissioner during the flag off of clinical services in community A. In his remark during this occasion, the Igwe of the community, a medical doctor by training, pledged his community's preparedness to ensure the success of the scheme, provided the government maintained the required seriousness. To this end, various philanthropists in the community made many contribution to the scheme, for example, three individuals donated three giant generating plants, one made a donation of drugs worth 100,000 naira, another donated an ambulance while one donated hospital beds. Whilst the town union and another member assisted in the renovation of the infrastructure, some individuals paid the premium for other members of the community, a fact supported by the survey data shown in table 2, where about 77.9% (155/199) of those registered showed the willingness to register for other members. The CHC members were also involved in sensitizing the community members on the need to register, and there seemed to have been a well coordinated CHC under the leadership of the Igwe.

The level of community participation in the scheme was captured by these various quotes from CHC members:

"At its inception, I was satisfied with the progress and response of people. Some philanthropists in our community paid for hundred persons to benefit from the scheme. The town also rendered all the necessary support." (IDI Community Health Committee member)

"We went to many places to inform people, to village meetings, to churches, so many of us like myself, I went to churches around my own quarter to inform people and enlighten them on the importance of going to the hospital." (IDI, Community Health Committee member)

"There was maximum support in diverse ways from the community. Even one person donated ambulance for the program, some donated drugs, and some doctors provided part time services even without remuneration all in the bid to see that the program succeeded." (IDI community Health committee member)

In addition, the Igwe played a prominent role in the management of the scheme: he took over much of the management as the drugs, kept other unused equipment were kept in his house, and organized most of the sensitization activities. It was possible for the Igwe to undertake these activities for a number of reasons: he had cordial relationship with the town union; was able to mobilize the influential people in the community to donate to the scheme; was highly respected by the community and the state government; and is also well educated. Although opposed by the health workers, these actions seemed to have contributed to the success of the scheme in community A.

Community views and issue of trust

Although the scheme appears to have been doing well in community A, the community members do not trust the health workers, and this may have also been one of the reasons for the Igwe keeping custody of the drugs and other equipment. In contrast, the majority of the participants trust the CBHI managers and the community members to manage CBHI funds, a fact that may have contributed to the higher enrollment a shown in the survey data in table 1, where 43.7% of the respondents registered for CBHI and 82.4% of these were willing to renew their registration.

The various comments by community members reflect the level of trustworthiness of the operators of the scheme and their perceptions of them:

"They perform their duties so we don't bother if they are trusted or not; nothing more important than getting what one want for at the end of the day. It is the same with everyone." (FGD women registered with CBHI)

"Yes we have trust in them. For example, her Royal Highness had managed a hospital before and knows anything about hospital. She is not a politician and puts in her own personal efforts. And those that are helping her are also reliable and trust worthy people that like the progress of their brothers. This is because we see the kind of suffering they undergo. At times, they use their car to go around and at times they cook begging people to come. So we have faith in them" (FGD participant, Men registered with CBHI)

However there are still few discerning voices from those not registered with the scheme, as shown by the quote:

"I would not say I have faith in them. If they are accountable then there will not be lack of drugs." (FGD women not registered with CBHI)

In the community's view, the nurses who were there before CBHI was introduced were not comfortable with the program and would not want it to succeed. Additionally, community members reported that the nurses complained that they were not informed about the program by their boss (the local government), and that their term of reference is the health centre and not the CBHI scheme. According to the community members, these factors led to the nurses moving away from the laid down guidelines in relation to the implementation of the scheme. For example, two sets of drugs are held within each health centre, one for the CBHI and the other, some of which are brought by the nurses, for non CBHI members. Some members of the community reported that there are occasions when the health workers will want to convince the patients to opt for the non CBHI drugs which they have to pay for, especially when the CBHI drugs get stock out. This was seen by the community committee members as undermining the success of CBHI and some of these concerns were captured by the community members in the following quotes:

"They specifically said that the CBHI program did not involve them. On the other hand it could be that the success of the program will hinder them from getting some personal benefits." (IDI Community health committee member)

"Initially the nurses were not happy because they are not well paid and probably due to the fact that the scheme would make them lose income from sale of private drugs." (IDI Community health committee member)

"The nurses, initially were not happy, because it was a way of trying to slow them in their on income method. There are certain drugs they used to buy on their own and then sell it to the patients. So this made it difficult for them to engage in private practice. So that made the nurse not to be giving attention to them. Even at a time the nurses started having problem with the committee members. They said that they would no long come to collect drugs unless they are brought to them… So all these where causing problem." (FGD men)

"It seems they have their own format different from CBHI. At time they feel that we are obstructing them from making some little personal gains. It is better having nurses specifically for the scheme to avoid conflict or a case of serving two masters." (IDI Community health committee member)

"The nurses are not complying. They tell you they don't know about it. That is one. Another thingy, these nurses actually were seeing the health centres as gold mine before now. They were using it sometimes to make money. We didn't quite know it. And when the state started, they saw it as a threat. Now the community members are going to be seeing the things that they do. They were really pegged. So they see to it that it doesn't work. You can imagine how that thing can go." (IDI health committee member)

Health worker response

In both sites, the health workers themselves also expressed reservation about the scheme, although they dwelt more on loss of incentives. They complained that, whilst learning about the scheme from the state task force team during the initial period of sensitization and community mobilization, they did not receive any form of training on the scheme before, or during, the implementation. There was also little or no supervision from the doctor in charge of the facilities. This made implementation difficult for the health workers; however, this was more keenly expressed in community B than in community A. Some of these views are captured in the quote below:

"I have not gained anything. Instead I am loosing. At the time we were practicing it, the organizers made promise to give us something because we suffer. But till now they have not given us anything, even pure water. The only thing they know is that you should keep your record properly, but there will be not even a pen for you. So there is nothing I gained from the scheme." (IDI health worker)

This opinion confirms the views expressed by many of the community members:

"We don't have faith in the nurses. That is because; they are interested in their own only. They do not want this scheme to progress. They don't even want the registered members to be coming to take drugs instead they want the unregistered member so that they do their business." (FGD participant, men registered with CBHI)

3.3.2. Case study B: Community B

Enrollment level and SE variation

From the survey data shown in table 3, 14.9% of the respondents registered for CBHI in Community B, significantly less than community A, where 43.7% registered. This made it less successful than community A, as initially identified. Again, most respondents who registered did so because they perceived that the scheme offered financial risk protection. Availability of good quality treatment was the next most common reason for registering and the most common reason for not registering was unavailability of funds. More people from this community did not register because of a lack of trust in those managing the CBHI funds (not shown in the table). 54.5% of registered respondents indicated willingness to renew registration for self and other members of their households, as opposed to 82.4% in community Also only 40.3% of the registered respondents were willing to pay for others as opposed to 77.9% in community A

As shown in table 3 below, there were, again, no significant SES difference in registration and willingness to renew registration for the respondent as well as for other household members.

Table 3: SES differences in experiences of respondents in Community B (**N=516**)

	n(%)
Registered with CBHI	**77 (14.9)**
SES differences among respondents registered for CBHI (n=77)	
Q1 (%): Most poor	15(19.5)
Q2 (%): Very poor	16(20.8)
Q3 (%): Poor	20(26.0)
Q4 (%): Least poor	26(33.8)
Chi square (p value)	1.05(0.79)
Poor rich ratio Q1:Q4	0.58
Willingness to renew registration (n=42)	
Q1 (%): Most poor	8(19.0)
Q2 (%): Very poor	8(19.0)
Q3 (%): Poor	9(21.4)
Q4 (%): Least poor	17(40.5)
Chi square (p value)	1.08(0.80)
Poor rich ratio Q1:Q4	0.47
Willingness of registered respondents to pay for others (n=31)	
Q1 (%): Most poor	3(9.7)
Q2 (%): Very poor	6(19.4)
Q3 (%): Poor	8(25.8)
Q4 (%): Least poor	14(45.2)
Chi square (p value)	5.57(0.14)
Poor rich ratio Q1:Q4	0.21

Community Participation (Health committee and role of Igwe and relationship with the facility workers)

Community participation was very poor in community B. This was as a result of lack of proper mobilization of the community by the managers and health workers, for example, according to some respondents, some people who could have registered with the scheme did not do so because of lack of information. Moreover, according to the CHC members, influential and wealthy people in the community lacked interest in the scheme:

"we met many well- to- do people in our area. We talked to them about the program and they promised a lot of things to help in terms of vehicle, drugs and every other thing but they never did…….. at a stage you know how government is this thing picked up and at the peak of it there was another change over of government. The whole thing collapsed. Now it is at standstill and nothing is working again."

Another issue that was constantly raised in this community is the role of the scheme coordinator or manager. The Coordinator here, who was also a member of the community, was said to have been acting as a sole administrator instead of working in harmony with the other members of CHC. It was reported that he had not been following the directives of the town union president; that he was trying to make money out of the scheme; and, at one point, was registering people on his own and printed his own cards. Although this Coordinator eventually died and was replaced, all the people that registered through him could not be accounted for, and it is not clear why the Igwe in this community was not active with respect to the CBHI.

This attitude of the Coordinator disenchanted many members of the CHC, and the community at large, and may have contributed to the poor performance of the scheme in this community: This is captured by these various quotes:

"We have confidence that they will do that job but somebody that was entrusted with the work was not telling us the truth so that made most people to develop cold feet, but we thank God that he has answered God's call. Even the health center they proposed to build around our area he obstructed it. He did not want anything to progress. Drugs brought by the health people to be given to people were also withheld… People actually did not understand what was happening. It was even after he died that people started to come out; he was not an honest person. We somewhat grateful he has answered the call of God. So if they can get someone that will tell us the truth people will be interested to belong to the scheme." (FGD participant, women not registered with CBHI)

"The reason is that the person given the mandate was not active; the coordinator was not following the directive of the town union president. In short his attitude made most people to develop cold feet. To make matters worse he died along the line. So that made the entire programme to be almost grounded." (FGD participant, men not registered)

"I would say that the person given the work was unfit for the job; the scheme suffered because it was handled by an incapable hand, who used influence of favoritism in the delegation of duties." (FGD participant, men not registered)

Community views and issue of trust

Whilst the initial distrust with the main Coordinator of the scheme effected the low number of registrations, the replacement coordinator may have accounted for the willingness of more than half (54.5%) of the respondents to re-register. Thus, the actions of the Coordinator evidently affected the acceptance of the scheme in Neni and may have inadvertently affected implementation. These are reflected in the following quote:

"They are trustworthy and live up to expectation. They also feel bad when you come and you can't find a doctor. The committee also runs around to see how that can be settled so that there will be a resident doctor." (Participant FGD men registered)

Following the replacement of the Coordinator, the majority of the participants confirmed that they started trusting the CBHI managers and the community members to manage CBHI funds.

Community members also raised the issue of nurses not being comfortable with the program, and therefore intent on making sure that it failed. They also felt that the workers were resentful because they had extra work to do without a corresponding incentive, as captured by this quote:

"When you employ some body with a bigger task; they are all government workers and you are adding more work to them without incentive. They will be bearing grudges." (IDI member of the CHC)

"They are trustworthy and live up to expectation. They also feel bad when you come and you can't find a doctor. The committee also runs around to see how that can be settled so that there will be a resident doctor." (Participant FGD men registered)

Although the community members acknowledged that services are now readily available, they regretted the limited benefit package. Not only was surgery excluded, but there is an absence of Doctors in the health centres and, when Doctors are available, they are usually Doctors on their National Youth service assignment who are from other tribes and therefore cannot speak the local language, making communication with the clients difficult. Community B complained more about the absence of Doctors compared with Community A and this may have also contributed to the poor performance in this community. Some of these issues were raised thus:

"The only thing is that the provision of the scheme is limited; we can't perform surgery with such a package and also it does not cover drugs for the treatment of hypertension, which is very expensive. For such cases they will write the prescription for you to buy." (IDI with member CHC)

Health worker response

Whilst the health workers acknowledged that the community has gained a lot in the scheme, they also expressed reservation about the scheme, the main reason being the lack of incentives from the state government driving the policy. Again, as in community A, the health workers found out about the scheme from the state task force team; however, they claimed that no detailed information was provided to them in relation to the establishment of the scheme. This could be explained by a number of reasons: it is possible that some of the health workers were not those initially posted to the health facility when the scheme took off, as some of them claimed, or they were not interested in the scheme, or they were not actually carried along. The effect was that the health workers concentrated more on the schedule of duties, as given to them by the local government that pays their salaries, that in new activities linked to the scheme. There was also little or no supervision from the doctor in-charge of the facility.

Although the health workers were not properly informed, the CHC members of the communities and policy maker accepted that proper communication and information about the scheme was provided. Seminars, church announcements, consultations with the opinion leaders by the policy makers and monitoring were part of the activities of the stakeholders in the scheme.

Implementation was also made difficult for the health workers as they did not receive any form of training on the scheme, before or during the implementation. The following quote expresses this in relation to this community:

"For me I have not received any training on this scheme except my professional course and workshops organized by the local government." (IDI Health worker)

"if there is any training for it, I will appreciate it. At least to see that the scheme progresses." (IDI Health worker)

3.4. What sustains/undermines policy development and implementation?

In trying to explain what sustained or undermined the policy development and implementation process, we will look at the various stakeholders in CBHI, their roles, as well as the powers they possessed, and how these were utilized or applied in the process.

Table 4 below shows the actors and their perceived roles, also providing a summary and reminder of the key aspects of experiences already presented.

Table 4: Actors and their perceived roles

Actors	Perceived roles
State	
Governor	Sets the overall policy trust in the state
Commissioner for health	Formulate policy, mobilize both human and financial resources
Permanent secretary of health	Formulate policy. Chief accounting officer of the ministry Directly responsible for budget preparation for the ministry and releases funds for the project
Directors of Medical services, Public health, Planning, Research and statistics, Pharmaceutical services	Involved in policy formulation and development
CBHI Task force	Responsible for the overall implementation, monitoring and supervision of the scheme.
World Bank assisted AHSD II project	Provides funds for training and workshops
LGA	
LGA chairman	Political and accounting head of the LGA. Played no role in either site
PHCC	Oversees all the health activities within the LGA. Likely to support policy.
Community	
The Igwe (Community A)	Organizes the meetings of the CHC High capacity to mobilize resources
The Igwe (Community B)	Played no role
Town union presidents	Notified the state of their intention to participate in CBHI in writing.
CHC	Employed and pays the Community Health Management Organization including the CBHI coordinator Mobilization of the community Determination of the premium Monitoring the utilization of the capitation fund Monitoring health worker attendance
Community members	Enroll and utilize health services
Facility	
CBHI Coordinator	Oversee the day-to-day administration of the health facility Liaises with the CHC and the health facility Registration of CBHI members Monitor drugs and equipment available in the facility
Health workers	Provision of health care to the community. Likely to oppose policy actions.

3.4. 1. Policy Development

Political instability of the state:

The government in power at the time of the study came into force under special circumstances: they were replacing the previous government which was said to have performed particularly poorly, but were of the same political party. As shown in table 4, the executive governor sets the overall policy thrust in the state. In this instance, the replacement Governor, concerned about the deplorable state of the health system in the state occasioned by the poor performance of the previous government, along with the need to score some political points, decided to throw his executive, political, financial and personality power behind the CBHI policy because he wanted to justify his election into office.

Two months after the Governor was elected into office, he was abducted – allegedly with police co-operation – after he lost the support of his original sponsors during the election. Although the new governor regained freedom after few days, this incident showed the instability of his position and the political uncertainty within a state wanting to develop and implement a new policy. These difficulties were compounded as, 2 years after CBHI was conceptualized and rolled out, the executive governor was removed from office by a court action instituted by one of the aggrieved political parties, spending only 2 years of his 4 year term in office,. His removal was said to have been facilitated and supported by his party as he lost the support of his original sponsors during the election; and, as a result, the little funding that the scheme had received was lost, along with the political support and sustained state support.

In trying to explain actors' interest, policy position and power to influence policy actions, we initially conducted forcefield analysis, as shown in figure 1 below. Forcefield analysis helps to clarify actors' position, as well as the comparative importance or salience of the actor on the forcefield. The stakeholder analysis in table 5 is then used to explain figure 1.

Figure 1: Anamabra State CBHI Forcefield Analysis, data (Policy design level)

	Proponents			**Opponents**	
Power of actor	**high support**	**<< <<**	**not mobilized**	**>> >>**	**high opposition**
Very High **v** **v**	Governor Commissioner		Legislators		
		Permanent Secretary World Bank-assisted AHSDP			
Medium		Director, Public health, Director Pharmaceutical services	LGAs		
		Directors Medical services Director Planning, Research and statistics,	Nigerian Medical Association Nigerian Nurses & Midwifery Association		
v **v** **Very Low**		CBHI Task Force			

Thus, as shown in figure 1 and table 5, although the executive governor welded a lot of influence and power by virtue of his position, these powers could not be translated into action because of the political instability and uncertainties of the state.

Whilst the political transition (the initial change of government) in Anambra state opened a window of opportunity for the CBHI policy, it has been noted that, in such reforms, technical concerns are likely to be of secondary importance to political imperatives (Zaharadis 1999).

Table 5: Stakeholder Analysis (Policy Development)

Actors	**Interest**	**Policy position (strongly positive to strongly negative: -3 to +3) or are they not mobilized/it is not clear**	**Power to influence policy action (Very high to very low: -3 to +3}**	**Source of power**
Governor	Concern about the deplorable state of the health system. Concern to score a political point.	Strongly positive: +3	Very high: +3	Executive Political Financial Personality
Commissioner	Concern about the deplorable state of the health system. Concern to score a political point. Personalized interest.	Strongly positive: +3	Very high: +3	Executive Political Financial Personality
Legislators	Law making and checking the excesses of the executive.	Not mobilized, not clear	**High: +2	Legislative
Permanent Secretary	Carry out government decision on CBHI (by preparing budget).	Positive: +2	High: +2	Political Formal role in all policy development
Directors of Medical services, Public health, Planning, Research and statistics, Pharmaceutical services	Design details and implementing the decisions of the ministry.	Positive: +2	Low: +1	Knowledge Formal role in all policy development
CBHI Task force	Be seen to follow instructions.	Positive: +2	Low: +1	Nil
World Bank assisted AHSD II project	Maintain political support for wider programme of work.	Strongly Positive: +3	Very high: +3	Financial
Nigerian medical association, Nigerian	Assist the state in delivering health	Not mobilized, not clear	Low: -1	Members

Nursing and midwifery association etc. (these are specific CSOs not rep of all!)	services. Members interested.			

** Justification for these judgments in columns is in information provided in text in earlier and these sections

Composition of the CBHI Task force

As shown in table 4, the Commissioner of Health was a key actor in the CBHI policy, along with the Executive Governor, and his main task was to formulate the policy and mobilize resources. During the period of study, the Commissioner's position was probably also relatively powerful due to his closeness to the executive governor (as already noted). Therefore, he derived strong influences from his executive, political, financial and personality powers, as shown in table 5, exhibiting these profusely and, in support of the development of the policy, positively. Sharing the Executive Governor's concern about the deplorable state of the health system, and also his desire to score a political point by leaving a legacy of being the first to initiate such a nobel idea in the country, the Commissioner personalized some of the decisions pertaining to the CBHI. For example using his executive, financial and personality powers, he was able to assemble a small group of people, constituting membership of the CBHI Task Force, to oversee the development and implementation of the scheme.

These members shared some common features: they were entirely drawn from the Ministry of Health; all had individual primary assignment in the ministry; and had not had any training in health policy or health economics. Table 4 demonstrates the group's responsibility over the overall implementation, monitoring and supervision of the scheme; however, table five shows that, as civil servants, their interest is to be seen as following instructions, a point emphasized by one of the policy makers: *"The way we work here, just direct them, tell them what they will do and they will start doing it"*. As shown in figure 1, whilst the Task Force had medium support for the policy, their influence was poor due to very low power and knowledge bases.

In relation to this issue, research has noted that such personalized decision making by key political figures is not uncommon in African countries (Porter 1995). Furthermore, it is also suggested that, under pressure to show results in short periods of time, as is characteristic of new governments, policies do not get designed properly (e.g. Gilson et al.2003).

Importantly, there was no LGA member in the Task Force despite the financial, political and human resources power wielded by this group, as shown in figure 1 and table 5. The scheme was to be implemented at the LGA level and, bearing in mind that the LGA and the state function independently of each other; one wonders how the Task Force was to make an inroad into the LGA without the full participation of LGA officials. It is worthy to note that each administrative level is autonomous in Nigeria; because of this, it is difficult for state officials to monitor, supervise and discipline health workers, who are only responsible to LGA, effectively and without encroaching on the statutory functions of the LGA officials.

Whilst state supervision was possible in relation to a few health workers on secondment to LGA facilities and therefore paid by the state government, there was, in effect, adisconnect between the state and LGA. Furthermore, because the LGA was not appropriately communicated to and mobilized, they exhibited considerable resistance as they did not want their powers eroded by the state. In our opinion, not including an LGA member in the team and limiting the design of the policy to a small group as policy champions may have worked against the success of the scheme: the Policy, in general, was not politically supported by a wider group of people as they were not involved from the beginning.

Role of World Bank assisted Anambra State Health Systems Development (AHSD II) project

There was a limited support from the World Bank assisted Anambra State Health Systems Development (AHSD II) project and their interest was to maintain political support for wider program acceptability. The World Bank assisted AHSD II project derived their power from their financial position and this greatly enhanced the planning and implementation of the policy. It should be stressed, however, that although they gave support to the policy through sponsoring workshops and providing some infrastructural renovation of the health centers, this body was not involved in the design and the policy because it was not part of their mandate; therefore, their support may not have been specifically for CBHI.

Apathy by the technical experts within the Ministry of Health

The personalized nature of decision making in the CBHI policy by the Commissioner created apathy amongst the technical people and other policy makers, for example, Directors, within the Ministry of Health. They doubted the genuine intensions of the main reformer and felt funds were disproportionately being allocated to the scheme and not properly managed, as expressed by one of the policy makers: "*The policy revolved around the commissioner"*.

As shown in figure 1 and table 5, the other actors from the Ministry of Health were there to carry out government decision on CBHI by preparing the budget, or had formal roles in all policy development and implementing the decisions of the Ministry. As such, these individuals had limited influence over the policy. For example, the Planning, Research and Statistics unit of the Ministry surprisingly had no special role in the design and implementation of the policy. They had limited influence from their formal policy position and this influence was further constrained by the overbearing influence of the commissioner, the weaknesses of their power base and the capacity constraints, namely a lack of training in health economics and health policy.

Non mobilization of the legislators:

It is our opinion that one of the most important reasons as to why the scheme was not sustained after the government change was the fact that the policy was not backed up by law and the Legislators, although possessing legislative powers, had not been mobilized to support the policy and therefore remained aloof to it. In the political system of Nigeria, and also Anambra state, legislators have the powers to make laws, approve or reject policies, or even prevent them from entering the agenda. Whilst the legislators at the time of the study belonged to the same party as the Governor and Commissioner and, as such, would have given approval to the policy and supported it; in retrospect, legal backing of the CBHI policy would, at least, have given the policy leverage as to be continued by the next administration with the government being constitutionally committed to continuing it. This would have prevented the problem of sustainability of the policy from arising when the Governor and his Government were replaced..

3.4. 2. Policy Implementation

Many factors enhanced or constrained implementation of the scheme. Issues were present in the design process, for example, which had direct bearing on implementation process. There was weak communication to nurses until the implementation period because the process was speedy and personalized. Also, some members of the Task Force were in other programs that had more funds allocated to it, and some were rightly left out for other programs when funding for CBHI from the state dwindled. This resulted in a complete lack of supervision from the state. It is also worthy to note that, at the middle of implementation, the state CBHI manager left for the technical aid corp (TAC) programme abroad and was replaced by another individual, probably entering with his own ideas and style of management.

In explaining the factors that enhanced or constrained implementation at the community level, as well as actors' interest, policy position and power to influence policy actions, we again conducted a forcefield analysis at this level, as shown in figure 2 below and the stakeholder analysis in tables 6 and 7 used to explain figure 2.

Figure 2: Forcefield Analysis (Implementation)

	Proponents			**Opponents**	
Power of actor	**high support**	**<< <<**	**not mobilised**	**>> >>**	**high opposition**
Very High **v** **v**	Igwe A TU A CHC A		LGA Officials		
	CBHI-C A Community A			Igwe B TU B CHC B	CBHI-C B Community B
Medium	HW A				HW B
v **v** **Very Low**					

CBHI-C = Community Based Health Insurance coordinator
CHC = Community Health Committee
TU = Town Union
HW = Health Worker

From the analysis, some of the factors that enhanced or constrained implementation at the community level included:

Community support

Community participation for the implementation of the scheme seemed to have been fairly strong in both sites as members were involved in the following activities: overall coordination, sensitization of the populace about the scheme, encouraging people to enroll in the scheme and advising them that they ought to go to hospital when sick, and providing infrastructure for the scheme. Figure 1 shows that community participation was stronger in community A than community B, and this may have accounted for its success in A. As shown in tables 6 and 7, the traditional leader in site A was involved in the mobilization of financial resources from his subjects for the scheme and ensuring appropriate drug use in the health centre. He brought his economic/financial, knowledge, traditional power to bear on the scheme and, as such, gave it maximum support. This was also true for the Town Union and CHCs. In site B, however, this was the opposite: the traditional leader, Town Union and CHC showed less support, despite their medium power, for reasons that are not very clear.

Another issue that was manifest in the implementation is the power dynamics between local community actors. As shown in the forcefield analysis, the Igwe in community A had a lot of influence on the scheme by virtue of his position and disposition. He controlled the CBHI drugs and ensured accountability which, in turn, resulted in greater trust on the scheme by the community members, thus increasing enrollment. On the other hand, in community B, the CBHI coordinator, prior to his death, wielded substantial power which was negatively exhibited. He was not taking instructions from the committee that employed him and completely executed his functions without recourse to the laid down standards of operations. The actions of the coordinator were captured by one of the respondents thus:

"We have confidence that they will do that job but somebody that was entrusted with the work was not telling us the truth so that made most people to develop cold feet, but we thank God that he has answered God's call. Even the health center they proposed to build around our area he obstructed it. He did not want anything to progress. Drugs brought by the health people to be given to people were also withheld… People actually did not understand

what was happening. It was even after he died that people started to come out; he was not an honest person. We are somewhat grateful he has answered the call of God. So if they can get someone that will tell us the truth people will be interested to belong to the scheme," (FGD Neni)

The effect of this was that both the community and committee members lost interest in the scheme and had no trust in the management, leading to low registration, a fact that was also buttressed by the community survey.

It is also quite obvious that the implementation of CBHI policy was constrained by policy makers' seemingly weak understanding of how policy objectives and design could provoke opposition at the local level and, hence, derail implementation. This has been noted by Grindle and Thomas (1991), in whose study the policy makers did not take into cognizance how the LGA and health workers will react to the policy, especially when they were not properly consulted. Policy makers were also naïve to the politics that go on in the communities: as noted by Nwosu (2008), the nature and magnitude of community disputes in Anambra state had devastating consequences, not only on government projects, but also on community development.

Table 6. Stakeholder Analysis (Implementation level): Site A

Actors	**Interest**	**Policy position (strongly positive to strongly negative: -3 to +3) or are they not mobilized/it is not clear**	**Power to influence policy action (Very high to very low: -3 to +3}**	**Source of power**
Officials of the LGA	Being consulted/involved in policy development.	Not mobilized Strongly negative: -3	High: +2	Financial Human resources Political
The Igwe	Mobilization of the community. Mobilization of financial resources. Limiting the excesses of the health workers.	Strongly Positive: +3	Very high: +3	Financial/Economic Knowledge Traditional Personality
Town union	Improving the health status of the community.	Strongly Positive: +3	Strongly High: +3	Political
CHC	Success of the policy Community development.	Positive: +2	High: +2	Igwe Formal implementation role
CBHI Coordinator	Overseeing the day-to-day administration of the health facility.	Positive: +2	Lower: +1	Formal implementation role
Community Members	Want good quality and affordable healthcare.		High: +3 (positive)	Members
Health workers	To maintain opportunities for extra income.	Strongly negative: -3	High: +2 (negative)	Knowledge Economic

Table 7. Stakeholder Analysis (Implementation level): Site B

Actors	Interest	Policy position (strongly positive to strongly negative: -3 to +3) or are they not mobilized/it is not clear	Power to influence policy action (Very high to very low: -3 to +3}	Source of power
Officials of the LGA	Being consulted/involved in policy development	Not mobilized Strongly negative: -3	High: +2	Financial Human resources Political
The Igwe	Not obvious	Positive: +1 ??	Low: +1 ?	Traditional
Town union	Improving the health status of the community	Positive: +1	Low: +1	Political
CHC	Success of the policy Community development	Positive: +1	Low: +1	Formal implementation role
CBHI Coordinator	Overseeing the day-to-day administration of the health facility	Positive: +2	High: +2 (negative)	Formal implementation role
Community members	Want good quality and affordable healthcare		High: +3 (negative)	Members
Health workers	To maintain opportunities for extra income	Strongly negative: -3	Strongly High: +3 (negative)	Knowledge Economic

Parallel CBHI and non-CBHI drugs

Another issue that might have derailed implementation in both sites was the issue of parallel CBHI and non CBHI drugs. In the CBHI policy, drugs are purchased and specifically used for the scheme in the health facilities; however, other drugs belonging to the LGA and health workers are kept in the same facility, and are not part of the CBHI drugs and can therefore be benefited from by non members. It is really surprising that the designers of the CBHI policy did not think of the problem this was going to create, both in terms of morals and administratively. It is an open secret that health workers stock their own drugs in the facilities which they sell as a coping mechanism to make ends meet, and these different drugs created problems as health workers contested the policy values for fear of personal loss and self interest. This resulted in health workers' reluctance to work within CBHI scheme guidelines and created a problem with scheme implementation, for example there was frequent expiration of CBHI drugs as few people were utilizing them because the health workers were not encouraging them to do so.

In our opinion, bringing together the two parallel drug schemes in one facility was a naïve policy design, and the government should have ensured that facilities offering CBHI services are different from those not offering CBHI services, instead of allowing the centres to do both services at the same time.. This example shows the different ways in which the changing context of reform, including parallel policy reforms, can constrain CBHI policy. It also demonstrates how the actors in implementation will shape how things happen; indeed, health worker actions always mediate the experience of policy implementation for beneficiaries and often, themselves, act as a constraint on achieving equity goals.

Communication Strategies

At the state level, guidelines were prepared for the pilot sites and training given to pilot site leaders by the state task team. The results showed that communication with the community was, however, weak, and this was reflected by both health workers and community members, with some people who could have registered not doing so due to lack of information. The situation was more pronounced in community B than in community A, despite the fact that the same communication strategies, in the form of advocacies and community sensitization in market places, churches and local meetings, were said to have been used in both sites. This was captured by a health worker in community B:

"*Anyway, I can say that they need more enlightenment…..to sensitize and encourage the community to patronize the centre."* (IDI health worker)

The nurses also claimed that they did not receive proper communication, despite the claim by the policy makers that they did. There was no form of training for the nurses on this and the policy guidelines were not provided for them. Furthermore, there was no form of internal monitoring, and the only monitoring and supervision carried out came from the Task Force which, as stated earlier, was irregular and unproductive as the team feared eroding the powers of the LGA. It has been noted that failing to communicate policy changes to frontline healthcare providers and the public can undermine policy implementation and, given equal access to services, fully informed individuals may make different choices in relation to the use of a particular service (Mcintyre and Mooney 2007).

Weak position of Medical Doctors at the LGA level

At the same time as CBHI was being rolled out, Medical Doctors were recruited by the state government and posted to all the LGAs as medical officers of health and PHC coordinators. They were to supervise the nurses and community health extension workers, irrespective of their salary grades and years of service. The nurses resisted this as most of the doctors were less than 5 years post graduation and were therefore junior to the nurses and other health workers, both in terms of salary and years of service. Moreover, the Doctors did not have the postgraduate training in public health that, by law, authorizes them to be medical officers of health, a law that the nurses capitalized on to make their protest to the government. Understandably, this created a lot of friction and rancor between the doctors and the nurses who were not ready to tolerate the effrontery; however, this definitely undermined the implementation of the CBHI as these doctors could not supervise the nurses who were their superiors and Doctors could not take orders from these superiors.

4. CONCLUSION

CBHI offer insights into the particular challenges of implementing health policy interventions in more disadvantaged areas of Nigeria. Over all, CBHI policy was devised during a window of political opportunity and initiated by a few members of the state policy elite. It did not have adequate backing to be fully sustained after political factors led to the removal of the state governor and the policy, in general, was not politically supported by a wider group of people as they were not involved from the beginning.

The study also provides evidence of how community level politics can influence policy implementation. Experience in Community A shows how local political leaders can support effective implementation, for example, by mobilising community support and ensuring appropriate drug use. These actions, however, also conflicted with the routine health worker practice of selling drugs and, as there was no attempt to get the health workers buy in, their lack of interest in the scheme challenged implementation. In Community B, poor CBHI scheme management was not addressed by local political leaders, deterring community support for the scheme.

In planning and implementing new policies such as CBHI, efforts should be made to have sufficiently widespread backing among groups (both within and outside the Ministry of Health) with the power to sustain implementation. There is also a need to manage the interests and values of those local actors whose direct roles in implementation mean that they can either sustain or block implementation. In designing policies that will be implemented at the local level, the power dynamics between local community actors should be taken into consideration. Sustainability can be complicated if there is inadequate range of political engagement, and there should be enough political engagement locally, as well as managerial roles for the local actors. Moreover, in order to ensure sustainability, a larger group is required for policy making, and appropriate legislative back up is crucial.

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