

**SOCIAL  
INNOVATION  
IN HEALTH  
INITIATIVE**



# UKANA WEST 2 COMMUNITY-BASED HEALTH INITIATIVE

**CONTINENT**

Africa

**COUNTRY**

Nigeria

**HEALTH FOCUS**

Primary Healthcare

**AREAS OF INTEREST**

Community Health Insurance, Community Engagement, Access to Healthcare, Quality Healthcare, Affordability

**HEALTH SYSTEM FOCUS**

Service Delivery, Health Financing

# UKANA WEST 2 COMMUNITY-BASED HEALTH INITIATIVE

A pilot community-based health initiative based in a rural area in South-South Nigeria, currently involved in ensuring the provision of equitable and accessible healthcare services through community participation.

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# ABBREVIATIONS

<b>AKSPHCDA</b>	Akwa Ibom State Primary Health Care Development Agency
<b>ARFH</b>	Association for Reproductive Family Health
<b>BoT</b>	Board of Trustees
<b>CBHI</b>	Community-Based Health Initiative
<b>CCCR</b>	Centre for Clinical Care and Clinical Research
<b>LGC</b>	Local Government Council
<b>MoH</b>	Ministry of Health
<b>MSH</b>	Management Science for Health
<b>NGO</b>	Non-Governmental Organisation
<b>NHIS</b>	National Health Insurance Scheme
<b>NYSC</b>	National Youth Service Corps
<b>OOP</b>	Out-of-Pocket Payment
<b>USAID</b>	United States Agency for International Development

# CASE INTRODUCTION

In Nigeria, 40% of its population lives below the poverty line of NGN 145,446.75 (USD 381.75) a year. More than 77.2% of health expenditure is out-of-pocket payment (OOP), which further impoverishes the people. This creates gaps in equitable access to quality and affordable healthcare services. Earlier, in a bid to address the inequitable access to quality healthcare services, the primary health care approach was adopted in 1978 by previous governments.

In Akwa Ibom, a state located in the South-South Region of Nigeria, there was a need to address poor service uptake associated with primary health facilities and poor health service delivery. In August 2014, a pilot community-based health initiative (CBHI) was established in the primary health centre at Ukana West 2 Ward, Ikot Ideh Town, Essien Udim Local Government Area.

Currently, the Ukana West 2 CBHI operates as a model where financially able people pay a premium of NGN 10,000 (USD 26.25) per head. Some of the most economically disadvantaged from the catchment area are paid for through resource mobilisation from local and international partners. Pregnant women and children under five are covered by the National Health Insurance Scheme (NHIS) to avail primary healthcare services at health facilities and secondary referral services at Cottage Hospital in Ukana throughout the year. Community ownership and involvement in the CBHI help improve healthcare, service delivery, and service uptake among community members.

The CBHI aims to ensure that health services are affordable and accessible for all and eliminate barriers at the point of care through resource pooling. Through the full participation of the community in the CBHI, healthcare service delivery and uptake are improved at the health facility. The program also ensures that the community is part of financing the health facility, while some of the most economically disadvantaged are granted equitable access to healthcare services

through resource mobilisation from partners who sponsor their enrollment into the scheme.

CBHI members first visit the primary healthcare facility for primary care treatment, while secondary referral services are available at Cottage Hospital-Ukana, specifically from a medical doctor from the community health unit of the University of Uyo Teaching Hospital.

The community democratically elects members to form part of the Board of Trustees (BoTs) with other major stakeholders such as the National Health Insurance Scheme (NHIS), Local Government Council (LGC), and Ministry of Health (MoH). The CBHI secretariat comprises staff working in the NHIS and is supervised by the BoTs.

The CBHI is still a pilot program in Akwa Ibom State that has been in existence since August 2014. The partners involved in the creation of the program were the host communities, NHIS, MoH, Community Health Unit of the University of Uyo Teaching Hospital, and the United States Agency for International Development (USAID)-sponsored Management Science for Health (MSH).

After the expiration of the MSH technical partnership in 2016, the host community decided to fully own and manage the program for sustainability. Currently, the CBHI partners with MoH, NHIS, the Akwa Ibom State Primary Health Care Development Agency (AKSPHCDA) for supervision, and the Community Health Department of the University of Uyo Teaching Hospital for weekly medical doctor consultation services at the facility. The MoH supports the facility with the provision of malaria, HIV drugs, and test kits. The NHIS pays for pregnant women and children under five, while the local government deploys health workers to the facility and oversees its maintenance. More recently, the Centre for Clinical Care and Clinical Research (CCCR) has initiated a partnership with CHBI, where an initial number of 138 vulnerable community members will be enrolled in the scheme.

# 1. INNOVATION PROFILE AT A GLANCE

## Organisation details

Organisation name	Ukana West 2 Community-Based Health Initiative
Founding year	2014
Founder name	Chief Michael Akpabio
Implementer	BoT and representatives from the local government, MoH, and NHIS
Founder nationality	Nigerian
Current head of organisation	Chief Micheal Akpabio (Chairman, BoT)
Organisational structure	Nongovernment organisation
Main value proposition	The CBHI scheme was initiated to improve equitable access to quality and affordable healthcare services, especially in rural communities through an all-inclusive health insurance scheme.

## Project Stage

Size	One health center. Staff engaged on the scheme include a Project Consultant, Project Manager, Finance Officer, M&E Officer, Desk Officer, ICT Officer, Community Mobilisation Officer, and one volunteer. These are all supervised by a 7-member BoT, who were democratically elected from the community, and three stakeholders, with one representative each from the LGC, MoH, and NHIS. The scheme is supported at the current facility by a total of eight health center staff who are government employees, and has a total of 6,800 community members enrolled in the scheme.
Main income streams	Annual premium paid by members; Grants
Annual income from CBHI for 2019	NGN 14,000,000 (USD 36,842.11)

## Operational Details

Country of operation	Nigeria
Type of beneficiaries	Everyone can be a beneficiary, but mostly elderly persons, women, and children who are low-income earners and who reside in the host rural communities.
Number of beneficiaries (annually)	6,800
Average cost per client	NGN 10,000 (USD 26.25) per client per annum
Local engagement	The scheme is fully implemented and operated by the project staff and health center staff, under the governance and supervision of the BoTs and representatives from the LGC, NHIS, and MoH.

## Scale and Transferability

Innovative Elements	<ul style="list-style-type: none"> <li>Community-owned and managed health insurance scheme</li> </ul>
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	<ul style="list-style-type: none"> <li>• Resource mobilisation and establishment of a community health trust fund to pay the premium of the most economically disadvantaged members of the community</li> <li>• Positive health-belief and health-seeking behavior changes in the catchment area due to improved awareness of the benefits of CBHI.</li> <li>• Multi-faceted collaboration between the community, partners, and stakeholders to achieve the objectives of CBHI.</li> </ul>
Scalability	<p>This model would be scalable under the following conditions:</p> <ul style="list-style-type: none"> <li>• A community with functional democratic governance structure</li> <li>• Opportunity to train elected community members on the CBHI model</li> <li>• Take-off grant, technical support/partnerships and collaboration with relevant government agencies, non-governmental organisations (NGOs), and individuals.</li> <li>• Health center staff willing to oversee the implementation</li> </ul>
Sustainability	<p>The following are essential to sustaining the CBHI once in place:</p> <ul style="list-style-type: none"> <li>• Annual payment of premium by enrollees. Continuous expansion of the scheme through the enrollment of new members.</li> <li>• Accessing grants, resource mobilisation, and establishment of a community health trust fund to pay the premium of the most economically disadvantaged members of the community and maintain the scheme.</li> <li>• The willingness by community leaders, members, and healthcare facility staff to volunteer their time to own and implement the scheme.</li> <li>• Supporting income-generating activities in the catchment area so that more people can afford to self-enroll on the scheme.</li> </ul> <p>Support by traditional and religious leaders in the community.</p>
Key Lessons	<ul style="list-style-type: none"> <li>• The community requires initial and continuous intense sensitisation to understand, adopt, and own the scheme.</li> <li>• Practical demonstration of the benefits of the scheme and testimonies of beneficiaries has a “snowball effect” on self-enrollment.</li> </ul> <p>Health system lessons:</p> <ul style="list-style-type: none"> <li>• Due to the high poverty rate, the scheme cannot self-sustain on premium alone. Additional funding is required through grants and resource mobilisation.</li> <li>• Most political actors who decide what happens in the health system have a poor understanding of the CBHI. They require more enlightenment to understand, support, and sustain the scheme.</li> <li>• By owning the scheme, the local community can introduce new ideas in line with local peculiarities to make the scheme more inclusive.</li> </ul>

## 2. CHALLENGES

Nigeria is regularly referred to as the "Giant of Africa," owing to its large population and economy (Peter, 1987). With approximately 182 million inhabitants, Nigeria is the most populous country in Africa and the seventh most populous country in the world, having one of the largest youth populations. Health problems in Nigeria are challenging. The insufficient programs designed to address the numerous health problems in the country have led to little improvement in health status. Overall life expectancy at birth is 54 years; the infant mortality rate is 86 per 1,000 live births while the maternal mortality ratio is 840 per 100,000 live births.

The first World Health Organization (WHO) Global Status Report on Non-communicable Diseases listed Nigeria among other developing countries as the worst hit with deaths from these diseases (Bolaji, 2016). Though there are programs designed to address some of the health issues, there is a need to solve many other health problems. It has been estimated that there are only 27 physicians per 100,000 people in Nigeria. These multifaceted challenges are compounded by poor economic policies and socio-political factors in a country with a history of limited institutional capacity to provide efficient responses at a population level.

According to the United Nations Development Programme (UNDP) 2004 report, both public and private expenditures as a percentage of GDP are 0.8% and 2.6%, respectively. Successive governments have on many occasions set out their commitment to the health sector, but unfortunately, this rhetoric is not met with tangible and enduring actions, particularly in the area of health system financing. There is a window of opportunity available for initiatives aimed at enhancing the emergence of an integrative approach to public health

problems in Nigeria, taking into account the social, cultural, and economic determinants of health and also structuring the health system as an efficient channel for health services delivery.

The achievement of the millennium development goals (MDGs) to which Nigeria, like other countries, committed to achieve by 2015, remains to be seen. The issue of equity, accessibility, affordability, quality, effectiveness, and efficiency—which are the overall objectives of the revised national health policy—are still persistent. The primary health care on which the Nigerian health care system is based has not helped in effectively solving the numerous health problems in the country. Cost-effective interventions for priority public health issues such as non-communicable diseases, injuries, maternal and child health, etc., are hardly being used. Intersectoral cooperation and collaboration between the different health-related ministries remain a major issue. Each day, there are about 1,000 new infections of HIV in Nigeria. The World Health Statistics of 2011 also showed that the number of reported cases of malaria increased from 2,834,174 in 2008 to 4,295,689 in 2009 (WHO, 2011). National health systems remain weak while their management is ineffective and inefficient. There is no equitable distribution of human resources between urban and rural areas. Over 70% of doctors are in urban areas, where only 48% of the population live, leaving the other 52%, who live in rural areas, at the mercy of inadequate health personnel (Muhammed, et al., 2017).

In Akwa Ibom State where this solution is domiciled, health financing is a challenge. For instance in 2012, only 3.1% of the state budget was allocated to health. Composition of health providers is also very heterogeneous and includes unregistered and registered providers, ranging from traditional birth attendants and individual medicine sellers to modern

hospitals. Akwa Ibom State also had only 193 doctors working across the 411 health facilities in the state. The health indicators also revealed that only 21% of children and 13% of pregnant women can access malaria treatment with any anti-malarial drug. Similarly, the infant mortality rate stood at 84/1,000 live births, while the maternal mortality rate stood at 545/100,000 live births (Akwa Ibom State Community Based Health Insurance Programme Handbook, 2013).

Furthermore, as of 2013, the NHIS had only succeeded in providing coverage for less than 3% of Nigerians. In Akwa Ibom State, about 70% live in rural areas, 74% live below the poverty line. About 76% of the poor in the state live in rural areas (Akwa Ibom State Community-Based Health Insurance Programme Handbook, 2013). An employee of CBHI Ukana West 2 reported as follows.

*“Low service uptake at the health facility, dysfunctional facility, high mortality/morbidity rate, inability by the majority to afford medical fees was the prevailing situation before the introduction of CBHI .”* (Employee)

## 3. INNOVATION IN INTERVENTION

### 3.1 TAKE-OFF AND STRUCTURAL CONCEPT OF THE PROGRAMME

Guided by the blueprint provided in the Akwa Ibom State Community-Based Health Insurance Programme (CBHIP), CBHI was born out of concern for the increasingly poor and inequitable access to quality and affordable healthcare, all of which correlate with short life expectancy, high morbidity, and mortality in the catchment area. In August 2014, Ukana West 2 CBHI, a nonprofit community-based organisation was established by Management Science for Health (MSH) sponsored by the United States Agency

for International Development (USAID) to address the issue of ailing health facilities, poor service delivery and uptake, and inequitable access to quality healthcare services so that Akwa Ibom State can attain the UHC 2030. To ensure that registered members enjoy quality healthcare services, CBHI partnered with the Community Health Department of the University of Uyo Teaching Hospital (UUTH) for weekly doctor consultation services at the facility. CBHI also has medical doctors, pharmacists, and laboratory scientists temporarily posted to the facility through the National Youth Service Corps (NYSC).

### 3.2 GOAL

The goal of CBHI is to become a vibrant voice for the voiceless by soliciting, linking, and facilitating needed resources to strengthen the ailing healthcare system and the impact on vulnerable persons and communities. CBHI also identifies the most economically disadvantaged in communities and solicits funds to ensure that they are not left out of healthcare services.

### 3.3 VISION

The vision of CBHI is to have a society where the people’s right to quality and affordable healthcare services is met and guaranteed through the effective collaboration of all stakeholders.

### 3.4 MISSION

The mission of CBHI is to work with relevant partners and communities to reduce out-of-pocket expenses at the point of healthcare needs and improve access to and the use of good quality health services highlighted in the scheme’s benefits package through advocacy, service provision, public education, collaboration, policy lobbying, and capacity building. This ensures that the cost of obtaining the needed

healthcare services does not pose a barrier to beneficiaries when they need medical attention at the CBHI facility. The CBHI scheme was designed to cover services provided by the public health centre, Ukana Ikot Ideh Primary Healthcare Centre (PHC), and the referral hospital (RH), Cottage Hospital Ukana.

### 3.5 PREMIUM

Financial members of the community/catchment area pay a premium of N10,000 (\$26.32) to benefit from CBHI services for a year at the health facility, Ikot Ideh. To ensure that no one is left behind, CBHI identifies the most economically disadvantaged in the communities and solicits for funds to ensure that this group also benefits.

### 3.6 INNOVATIVENESS IN RESOURCE MOBILISATION

The CBHI, from its inception, prioritised resource mobilisation to ensure inclusiveness of vulnerable lives. As a result of such efforts, in September 2016, the former Secretary to the State Government, Sir Etekamba Umoren, paid the premium for 900 economically disadvantaged persons in the catchment area to access services at the health facility and also receive secondary referral services at Cottage Hospital-Ukana. In May 2018, the World Bank State Save One Million Lives (SOML) Project paid the premium for 804 identified vulnerable lives in the catchment area and, in August 2018, the Association for Reproductive Family Health (ARFH) Akwa Ibom State LOPIN 1 Project paid the premium for 500 vulnerable lives in Essien Udim Local Government Area (LGA). In December 2018 and 2019, CBHI was selected and supported financially by the Civil Society Engagement Mechanism Stakeholders (CSEM) to mark universal health coverage day in Nigeria.

### 3.7 RECOGNITIONS

In 2019, CBHI received an award from the National Institute for Policy and Strategic Studies, Kuru, Nigeria, who were in Akwa Ibom State to assess the healthcare system. CBHI received an award as the only outstanding organisation in the state providing quality and affordable healthcare to people.

## 4. IMPLEMENTATION

### 4.1 INNOVATION IN IMPLEMENTATION

As an innovation, CBHI is different from other interventions, as it seeks to ensure equitable access to quality and affordable healthcare services for all, through community participation in health service delivery and resource mobilisation. Primary health care as the first point of contact for any healthcare need is often neglected and, at most times, dysfunctional. This is indeed the very reason CBHI exists as a social innovation in healthcare. It is therefore imperative at this juncture to provide the full operational details of Ukana West 2 CBHI scheme.

#### CBHI Operations: Ukana West 2 CBHI Scheme Functional Parameters

The functional parameters for the Ukana West 2 CBHI scheme were informed by a combination of the results of the NHIS-supported feasibility study in Essien Udim LGA, and various discussions with the Ukana Ward Development and Village Development Committees.

**Table 1. Snapshot of the Ukana West 2 CBHI Scheme**

1.	<b>Introduction</b>	The Ukana West 2 Community-Based Health Initiative is a registered health insurance scheme piloted by the Akwa Ibom State Government in collaboration with USAID-Management Sciences for Health (MSH) and the National Health Insurance Scheme (NHIS).
2.	<b>Applied concept of health insurance</b>	Health insurance is a prepaid mechanism where funds are pooled to limit risk of incurring medical expenses among individuals. It is a type of insurance that covers medical expenses incurred by the insured so that the individual can access treatment without payment at the point of treatment. Here it is community-based because it is owned and managed entirely by the community members with minimal regulation by the government.
3.	<b>Eligibility</b>	<p>Anyone that registers and subscribes by paying the required premium is eligible. Registration can be done in different categories:</p> <ul style="list-style-type: none"> <li>● As a family unit of six (6) made up of a father, mother, and four children;</li> <li>● Each child must be less than 21 years old for him/her to be included in the family unit;</li> <li>● Additional member in a family unit of more than six (6) or; as an individual.</li> </ul>
4.	<b>Cost of Registration (Premium) in the Scheme</b>	<p>Units of Enrollment: This is based on two units of enrollment, family and individual.</p> <p>Family: A family of six made up of a father, mother, and four children of less than 21 years of age pay NGN 60,000 (NGN 10,000 each) per annum to be enrolled into the scheme.</p> <p>Additional Family Members: Additional members of the family pay NGN 7,000 (a 30% discount) per person, per annum. To be recognised as an additional family member, the person must be certified as such by the Chairman of the beneficiary's Village Development Committee (VDC).</p> <p>Individual: An individual pays the sum of NGN 10,000 per annum.</p>
5.	<b>Registration Point</b>	Registration for the scheme takes place at the Primary Health Centre, Ukana Ikot Ide, where the Secretariat of the scheme is located. Registration can also be done during CBHI community outreaches and roadshows.
6.	<b>Registration Process</b>	Enrollees are required to pay at the bank designated by the Scheme or at the Primary Health Centre, Ukana Ikot Ide. A payment teller must be present for biometric data capturing. The enrollee then receives a health insurance card with a unique registration number once registration is complete.
7.	<b>Discount or incentive for certain categories of</b>	The National Health Insurance Scheme (NHIS) is subsidising pregnant women and children under the age of five

	<b>persons enrolled in the scheme</b>	enrolled in the family units of the CBHI scheme. What this means is that for every family that has a pregnant woman and/or children under five, NHIS pays the sum of NGN 5,000 (a 50% discount) for each pregnant woman and NGN 7,000 (a 70% discount) for each child under the age of five.
8.	<b>Part payment during registration</b>	There is a three-month period within which payment of the premium can be made. However, health services can only be accessed after full payment of the premium.
9.	<b>Access to health services by new enrollees</b>	Enrollees do not immediately access the health services as soon as they complete the payment of the premium, rather they are expected to wait for four weeks before accessing the services. This is called the waiting period.
10.	<b>Where can beneficiaries access health services under the scheme?</b>	Under the CBHI scheme, basic health services have been provided only at the PHC, Ukana Ikot Ide, while secondary health services were accessed at Cottage Hospital-Ukana, upon referral. Both facilities are located in the Essien Udim Local Government Area of Akwa Ibom State.
11.	<b>Any provision for roll-over of payment if services are not utilised by the beneficiary for the year premium was paid for?</b>	There is no provision for a roll-over of premium paid for a particular year. The premium lasts for only a year, i.e., 12 calendar months. Enrollees can benefit from any of the scheme's services such as routine medical check-up such as blood pressure checks, blood sugar tests, medical and health counseling, etc., even when not ill. However, plans are ongoing to put a mechanism in place to reward those who register but do not utilise services for the period of their registration.
12.	<b>Services covered under the scheme</b>	The services covered under the scheme form the benefits package; they include treatment of uncomplicated malaria in under five children, pregnant women, and the general population; immunisation services and family planning services; treatment of common and minor ailments, laboratory tests, general consultation, and curative care, including screening for chronic diseases such as hypertension and diabetes, treatment for uncomplicated hypertension including counselling lifestyle changes, maternal and child health care, including antenatal care, normal deliveries and postnatal care; dental care with pain relief and treatment; free prescription drugs and ambulance services for emergency cases.
13.	<b>Provision for referral services</b>	Enrollment into the scheme entitles beneficiaries to referral services in the following areas: <ul style="list-style-type: none"> <li>● Treatment of severe malaria, including essential drugs for treatment of complicated malaria in children under five, pregnant women, and the general population;</li> <li>● Minor surgeries such as appendectomy and herniorrhaphy, including post operation care;</li> <li>● Maternal care, including ultrasound and relevant laboratory investigations, caesarean section,</li> </ul>

		<p>management of eclampsia, puerperal sepsis, and post-partum hemorrhage, as well as</p> <ul style="list-style-type: none"> <li>● Ambulance services.</li> </ul>
14.	Services excluded from the scheme	<p>Presently, the scheme does not cater the following services:</p> <ul style="list-style-type: none"> <li>● Medicals: Treatment of complicated hypertension cases, tuberculosis, cancer, diabetes, major accident cases, contact lenses, renal and liver failures, stroke.</li> <li>● Surgical Cases: Orthopedics, gynecological surgeries e.g., mastectomy, hysterectomy, etc., chronic and major surgeries, dental procedures and surgeries, neuro surgeries, cosmetic surgeries, prostatectomy, cardio thoracic surgeries, all transplants.</li> <li>● Communicable Diseases: HIV/AIDS services, including drugs and PMTCT services; tuberculosis and leprosy services.</li> </ul>

Source: Ukana West 2 CBHI Scheme Flyer, 2014.

The response of this beneficiary sheds more light on how impactful the Ukana West 2 CBHI scheme has been.

*“I thank God, the programme did so wonderful to me and my family. In the case of finances they stood by me. Right from when my mother, my wife was undergoing the treatment. They assisted me seriously. It is a very nice programme indeed.”* (Beneficiary 1)

In the words of the founder:

*“There is distrust between the healthcare service providers and the host community. CBHI brings the host community in working in partnership with the community health workers to improve healthcare service delivery and service uptake at the facility. Moreover, the scheme ensures that indigent persons are not left out of healthcare services. CHBI has the potential of ensuring that secondary and tertiary healthcare facilities in Nigeria are no longer overburdened because the number of people visiting the Primary Health Care facilities will increase. This health innovation is changing the ideology and attitude of both the demand and supply side on healthcare services. The healthcare workers’ capacity in technology will also be developed for record-keeping and*

*centralised patient history databases.”*  
(Founder, CBHI)

At present, a major problem confronting the scheme is that the support of major technical partners like MSH, sponsored by USAID, has ended, leaving the scheme to survive mainly on premiums, which, by itself, cannot ensure its sustainability. The implications of funding shortages go far beyond the availability and quality of human resources operating the scheme. It may impugn on the very core of the scheme itself, which is the ability to sustain the confidence and trust of beneficiaries/enrollees on the service delivery quality of its healthcare services across the board. Confidence and trust in the scheme are directly linked to its sustainability and scalability. Furthermore, other impediments to providing quality healthcare services include factors influencing the health-seeking behaviour of community members, such as cultural barriers, belief system, and ignorance, all of which may constitute part of the barriers to the health-seeking behaviour of enrollees and would-be enrollees alike. In the community, some members believe in traditional medicine for treatment, or

rather patronise quacks or prayer houses more for their medical needs.

## 4.2 ORGANISATIONAL STRUCTURE

The Community-Based Health Initiative (CBHI) is supervised by seven democratically elected community members who constitute the Board of Trustees (BoT), with three other stakeholders who are representatives from the local government, the National Health Insurance Scheme (NHIS), and the State Ministry of Health. The BoT is the highest decision-making body of the organization. The CBHI is managed by the staff made up of the Project Consultant, Project Manager, Finance Officer, M&E Officer, Desk Officer, Community Mobilisation Officer, and Volunteers.

The CBHI board of trustees comprise the apex of the organisational structure. They are primarily the governing body of the Ukana West 2 CBHI scheme. The BoT is registered with the Corporate Affairs Commission (CAC) and has non-governmental organisation (NGO) status. The purpose of the BoT is to ensure management and sustainability of the CBHI scheme towards the provision of equitable, accessible, affordable, quality health care services to the people of Ukana West Ward 2 in Essien Udem LGA and its environs. The BoT has a three-year tenure, where the first term is renewable by election for another three years. The BoT positions are not remunerated as community service rendered is voluntary. However, expenses incurred while carrying out CBHI duties are reimbursed.

Management of the CBHI scheme is done at the level of the secretariat. The CBHI secretariat is the administrative and management arm of the BoT, with the responsibility of carrying out administrative and program management duties. The secretariat employees are remunerated. They are recruited and supervised by the BoT, guided by the human resource policy and procedures of

the CBHI scheme, in accordance with Nigerian labor law. In line with the CBHI organisational structure, the scheme secretariat is made up of a program manager and project consultant at the second level, both of whom report directly to the BoT. On the third level are the desk officer, M&E officer, finance officer, and community mobilisation officer, who all report to the program manager. And at the last level of the organisational structure are the volunteer staff who report directly to the desk officer.

*“With the right type of funding in place, the scheme would be able to attract and retain persons skilled and knowledgeable enough to enhance the scheme even with remuneration that is just sufficient enough to keep them going, while waiting for better employment opportunities.”* (Founder, CBHI)

## 5. OUTPUTS AND OUTCOMES

### 5.1 IMPACT ON HEALTH DELIVERY

The CBHI measures the impact of its health innovation by the number of people in the community who access healthcare services at the facility as beneficiaries of the scheme. These include the number of pregnant women who receive antenatal and post-natal services, the number of babies delivered in the facility, the number of children below five years old who have been immunised, the number of complicated cases referred to Cottage Hospital-Ukana for secondary services, and the number of low-income persons who also benefit from the program. Unlike what most obtain across the Nigerian healthcare system, with the enrollment payment of NGN 10,000 (USD 26.25) as premium per head for a year, the CBHI ensures that beneficiaries need not pay any fee at all before receiving service for all levels of healthcare. This feature of the scheme is cardinal to helping reduce mortality and morbidity in the catchment area. This is because in a developing country like Nigeria, where an

overwhelming majority of the population grapple with multidimensional poverty and fall completely below the poverty line, eliminating out-of-pocket payments in accessing essential healthcare services is a major life-saving tool.

All primary healthcare services at the facility are completely free. However, for secondary healthcare services that involve referrals to Cottage Hospital-Ukana, the CBHI pays half (50%) of the fee while the beneficiary pays the other half (50%) after the health services have been rendered. Referral services within the CBHI scheme are based on fee-for-service

(pay-per-service) collated on a monthly basis. So, the provider payment system is capitation for PHC and fee-for-service at the RH level. The CBHI benefits package is based on Ministry of Health (MoH)-defined service packages at the ward and referral hospital minimum package, with some adjustments.

This initiative has ensured that up to 11,600 people in the community and its environs have accessed affordable healthcare without discrimination. Table 2 shows the service uptake by vulnerable populations in the Primary Health Centre, Ikot Ideh as a result of the CBHI.

**Table 2. Evidence of breakdown of service uptake by vulnerable populations in the Primary Health Centre, Ikot Ideh, as a result of the CBHI.**

S/N	Service Uptake	2014	2015	2016	2017	2018	2019
1	Total number of children immunised	473	1431	873	1106	1545	830
2	Total number of children under five years service utilisation (0-5 years)	168	371	544	860	991	417
3	Antenatal care	455	442	458	620	475	395
4	Total number of deliveries	29	29	43	67	47	52
5	General treatment of minor ailments and severe malaria infection	201	197	234	206	419	277
6	Curative care	8	19	17	23	23	20
7	Surgeries (herniorrhaphy, caesarian sections, and appendicitis)	0	7	21	27	34	21
8	Laboratory investigation	300	416	507	1281	1901	1661

Source: Primary Health Centre, Ikot Ideh, 2020.

Concerning surgeries (Item 7 in Table 2), it is noteworthy that 69% of them were primarily related to caesarean sections, while 18% were herniorrhaphy surgeries and 13% were appendectomies.

Furthermore, a board member of the CBHI sheds more light on specific

examples of unfettered access to quality healthcare by beneficiaries of the scheme.

*“[Beneficiary]’s wife was pregnant with twin babies but could not afford money for a caesarean section upon referral to Cottage Hospital-Ukana, on 24th December 2018. The wife was admitted by Cottage Hospital and operated upon without demanding a fee before*

*service. She delivered twin baby boys. CBHI upon referral, paid half of the caesarean section fee while her family paid the remaining half. This enabled Mrs. Happiness Peter to deliver her babies with ease at Cottage Hospital and returned home without financial complication.”* (Board Member, CBHI)

*“[Beneficiary]’s baby boy of two years old was suffering from severe pains of scrotum hernia and he had no money to pay for the operation. On April 2017, the boy was referred to Cottage Hospital-Ukana for the operation because [the beneficiary] registered his family into CBHI. Cottage Hospital admitted the baby and operated the hernia without first asking for a service fee. After the operation, the CBHI paid half of the bills and [beneficiary] paid the remaining half. After the operation, his son was discharged immediately.”* (Board Member, CBHI)

The CBHI is also involved in managing the facility in its operations, with the environment kept clean and the facility maintained through minor repairs. The CBHI also supports the facility with the provision of essential drugs and dispensaries.

It is important to note that the Ukana West 2 CBHI remains the only surviving pilot CBHI program in Nigeria. The program was initially piloted in five states: Lagos, Kwara, Adamawa, Akwa Ibom, and Borno. However, the pilot CBHI programs in the northern states could not thrive due to insecurity in the region. Meanwhile, the initiatives in Lagos and Kwara lasted only a few years before being discontinued due to a lack of sponsorship and political will.

## **5.2 FIRST POINT OF CARE: PRIMARY CARE SERVICES**

Enrollees in the Ukana West 2 CBHI scheme access primary care (first point of care) services at PHC, Ukana Ikot Ideh. The health center services fifteen villages in Ukana West 2. The facility provides

services to enrollees and non-enrollees. Services for enrollees are based on the CBHI scheme benefits package. This ensures that enrollees do not pay out-of-pocket for services received at PHC, Ukana Ikot Ideh, while non-enrollees on the other hand, pay out-of-pocket for services received.

The facility is reimbursed by the CBHI scheme through a ‘capitation’ basis per enrollee per annum. The capitation is paid into a dedicated bank account for the PHC on a quarterly basis from the CBHI premium account upon presentation of the previous quarter reports for approval and clearance by the scheme BoT and the CBHI Programme Officer. The capitation is used to purchase drugs and for facility administrative expenditure. This particular beneficiary from the Nsiak community, in the same Essien Udim LGA, recounts how his wife gave birth through the CBHI programme on 25 October 2018 in the Primary Health Centre, Ikot Ideh.

*“When we came here, we registered under the multi-purpose healthcare service, so I believe that the service we enjoyed is [the] courtesy of the people in charge [of it]. It is a sensitive programme, a programme that is working. A programme that is meant to help. We are praying to God to do his wonders to supply for the organisation. The programme is there to empower people, those who need help medically... Pray for God to supply for the CBHI programme.”* (Beneficiary 2)

## **5.3 REFERRAL SERVICES**

The Cottage Hospital-Ukana provides referral secondary services to the CBHI enrollees according to the secondary services in the referral package (a part of the benefit package for enrollees) for the scheme. The PHC-Ukana Ikot Ideh documents referrals with the use of a referral form for enrollees to the Cottage Hospital-Ukana. The Cottage Hospital authenticates referrals from the CBHI Secretariat and duly fills the referral case

claims after treatment has been given to the patient. At the Cottage Hospital-Ukana, a CBHI patient file exists to keep and record referral services and treatment.

Expenses for all referred patients are filed in the referral claims note and submitted by the Cottage Hospital-Ukana to the CBHI secretariat. The secretariat validates and approves the bill for reimbursement to the Cottage Hospital-Ukana. The CBHI programme officer collates claim sheets, invoices, and the discharge summary of the patient and enters relevant information into the database at the scheme secretariat. Reimbursement for referral services is fee-for-service (pay-per-service) collated on a monthly basis from the Cottage Hospital by the CBHI scheme and payable by cheque or direct electronic bank transfer.

To shed more light on how the Ukana West 2 CBHI has thrived and impacted lives in the community, the words of this beneficiary whose wife delivered twin baby boys by caesarean section at Cottage Hospital Ukana through the CBHI secondary services referral system is instructive.

*“God will bless the organisers of this programme and will expand their coast in Jesus’ name. Concerning the bill, it is likely going to be fifty something thousand [for] everything, summed up together. For now I have deposited NGN 10,000. By God’s special grace we see what we can add up since we know the programme will help us out.”*  
(Beneficiary 3)

## 6. SUSTAINABILITY

### 6.1 WHAT NEEDS TO BE DONE?

The CBHI depends mostly on premium, resource mobilisation, and grants for sustainability. It is non-profit and does not generate revenue. The solution is integrated into the community as they fully participate in the program. For it to

persist, the community must adopt and be part of the solution. Identified vulnerable populations must build their capacity in income-generating ventures to sustain long-term access to healthcare services. The solution must also collaborate with relevant organisations for greater and impactful projects and must also be involved in rigorous sensitisation programs and resource mobilisation.

### 6.2 HOW IS THE CBHI KEPT AFFORDABLE?

Since most of the community members are farmers, they agreed that they would be able to afford NGN 10,000 (USD 26.25) as premium per head for a year to access quality healthcare services in the primary health facility of Ikot Ideh and secondary referral services at Cottage Hospital-Ukana.

Furthermore, the earlier mentioned innovative incentives and subsidies in the scheme, such as the discount of 30% for every verified additional family member; the NHIS subsidies of 50% for pregnant women and 70% for children under five; and the three-month extended period to accommodate enrollees who cannot pay the premium for registration at once are all strategies to ensure social sustainability and long-term membership retention. In addition to these, the CBHI follows up on members with phone calls and visits. Another innovative incentive by the CBHI scheme to ensure long-term membership retention is one-year free access after three years of consistent re-enrollment. The CBHI also collaborates with non-governmental organisations (NGOs) to empower its members and improve their wellbeing and household social status. It is also involved in resource mobilisation where they engage stakeholders in the state and community to cover the premium for the economically disadvantaged individuals so they can have equitable access to quality healthcare services. Overall, the effect of social influence cannot be overlooked,

because current beneficiaries with a favourable perception of the scheme are likely to influence other family members, friends, and members of the community into joining.

An alternative source of funding was the creation of the Essien Udim Community Health Trust Fund where major stakeholders in the communities are members.

They have to pay the premium of identified economically disadvantaged persons in the community, employ and pay staff salaries, and pay off referral bills. Unfortunately, this funding scheme is under-patronised by prominent stakeholders from the catchment area, thereby leaving serious gaps in the current capabilities of the scheme to meet its demands. The annual cost of providing the solution stands at about NGN 9,720,000 (USD 25,578.95).

## 7. SCALABILITY

The innovation is still a pilot program in the Primary Health Centre, Ikot Ideh and has not been implemented in more than one setting. Ukana West 2 CBHI is the only CBHI situated in a primary health care facility in Nigeria, against the backdrop of being the only survivor of pilot schemes that took off simultaneously in five states, namely, Lagos, Kwara, Adamawa, Akwa Ibom, and Borno. This report has highlighted the importance of sufficiently comprehending the uniqueness of the Ukana West 2 CBHI model as the only surviving ward pilot CBHI program in Nigeria. For instance, a factor discovered in operating the model which may hinder scalability is the fact that cost-for-service treatments for complicated malaria, minor ailments, curative care, and surgeries significantly depleted the financial capacity of the CBHI scheme. This limitation hindered its ability to expand and take on additional

commitments, as the programme relies solely on premium contributions from members. The situation is further exacerbated by inadequate government support and a lack of political will to sustain and scale up CBHI initiatives.

All the same, on the prospects of scalability, the aspect that can be scaled up is establishing a CBHI in every primary health care facility and having the host community own and manage the program with technical support from partners. The establishment of CBHI can be scaled up to other places to ensure maximum health coverage for all. To scale the solution, it needs technical and financial support. The solution should be replicated first across Nigeria because of its increasing population, high poverty rate, high disease burden, and the ailing health facilities.

## 8. KEY LESSONS

The Ukana West 2 CBHI is a formidable example of how community participation and community governance structure can be maximised to achieve equitable access to healthcare services, especially for vulnerable persons in underserved communities. It has demonstrated that to be effective, interventions or schemes of this nature do not need to be costly. Since its inception in 2014, the CBHI has significantly reduced mortality and morbidity in the catchment area, as healthcare services are now within the reach of the community and they need not patronise unregistered health providers. Most expectant women now opt for facility-based delivery instead of home delivery.

As expected for a pilot scheme, the innovation is still experiencing many teething problems, especially on how to improve its capital base through growing its membership base, mobilizing resources, and attracting grants. So far, much has been achieved by the scheme

through joint effort, with well-meaning partners and collaborators, but much is still begging for attention, particularly since support from such key partners have come to an end.

Any “self” or “other” investment in the CBHI is directly related to guaranteeing affordable and inclusive healthcare which all translate to one purpose: saving lives. The challenge, therefore, is for the

government, policymakers, NGOs, and other stakeholders to collaborate and invest the necessary effort to ensure that this critical social innovation in health not only survives as a healthcare model but is integrated into broader health system strategies. It must be scaled thoughtfully across the health system to bring quality and affordable healthcare closer to the people, especially to the vulnerable or economically disadvantaged populations.

## CASE INSIGHTS

1. Community-owned health insurance models like Ukana West 2 CBHI effectively eliminate out-of-pocket payments at the point of care, significantly increasing service uptake and reducing morbidity and mortality in rural, impoverished settings, demonstrating a feasible pathway to equitable access.
2. The success and sustainability of community-based health initiatives are contingent on efficient resource mobilisation beyond member premiums and strong political will from local and state governments, underscoring the need for integrated financing strategies within the broader health system.
3. By empowering local communities to own and manage primary healthcare schemes, innovations can decongest secondary and tertiary facilities and foster positive health-seeking behaviors, highlighting the transformative potential of grassroots governance in strengthening health service delivery.

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