

Community Participation and Strategic Frameworks for Advancing Health Insurance Coverage in Katsina State

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Abstract

Universal Health Coverage (UHC) remains elusive in Nigeria, particularly in Katsina State, where less than 10% of the population has health insurance and 70% pay for care out-of-pocket amidst deep poverty. This paper examines how community participation and strategic policy frameworks can expand insurance coverage, focusing on Community-Based Health Insurance (CBHI) as a potential vehicle. Employing a qualitative case study design, this research draws on Focus Group Discussions with community leaders, residents, and health officials across four diverse communities in Katsina State to explore local perceptions and barriers. The findings reveal that while significant challenges—including low awareness, deep-seated mistrust in formal institutions, and concerns over premium affordability—hinder uptake, there is a strong willingness to pay for CBHI. However, this is contingent on transparent, community-led management and the availability of pro-poor subsidies. Based on these results, the study proposes a multi-faceted strategy centered on intensive public awareness, subsidized premiums for low-income residents, strengthening the Katsina State Contributory Healthcare Management Agency (KATSCHMA), and genuine community involvement in the design and governance of insurance plans to build trust and ensure sustainability.

Keywords: *Community Participation, Health Insurance, Katsina State, Nigeria, Strategic Framework, Universal Health Coverage.*

Introduction

Healthcare financing is one of the most critical challenges facing developing nations in their pursuit of universal health coverage (UHC), especially in resource-constrained settings. In Nigeria, fewer than 5% of the population are enrolled in the National Health Insurance Scheme (NHIS), and about 70% of people pay for healthcare directly out-of-pocket (OOP). The NHIS, established in 2005, primarily covers federal government employees, leaving the vast majority of the population, particularly those in the informal sector, without coverage. This reliance on OOP payments creates significant financial barriers and can lead to catastrophic health expenditures for households.

The situation in Katsina State exemplifies these challenges. With a projected 2022 population of over 10 million [10] and 66.7% of its residents considered multidimensionally poor, the state has one of the lowest Human Development Index (HDI) scores in Nigeria. Less than 5% of the population is covered by health insurance, and the doctor-patient ratio is a stark 1:52,000, far from the WHO-recommended 1:1,000. These factors are compounded by high maternal and infant mortality rates, underscoring the urgent need for innovative financing solutions.

Community-Based Health Insurance (CBHI) has emerged as a promising approach to address these gaps. CBHI schemes are voluntary, community-managed programmes that pool

resources to cover healthcare costs, promoting community ownership and participation. They are particularly suited for informal sector workers and rural populations where conventional insurance is often inaccessible.

Methodology

This study adopted a qualitative case study design to explore the complexities of implementing CBHI in Katsina State. This approach allows for an in-depth understanding of complex social phenomena, such as community perceptions and institutional readiness, which cannot be easily quantified.

Study Setting

The study was conducted in Katsina State, located in northwestern Nigeria. Four communities were selected across the state's three senatorial zones (Danja, Dabai, Mashi, and Kurfi) to ensure representation of diverse socio-economic and healthcare contexts. The state's healthcare system faces significant challenges, including inadequate infrastructure, a severe shortage of healthcare workers, and extremely low health insurance coverage, with less than 5% of the population insured [13]. Over 70% of the population lives in rural areas and is engaged in informal agricultural activities, making conventional insurance models difficult to implement.

Study Population and Sampling

A purposive sampling technique was used to select key stakeholders who play pivotal roles in healthcare decision-making and community governance. The study population included Ministry of Health (MOH) officials, community leaders, and local residents involved in Focus Group Discussions (FGDs). A total of four FGDs were conducted, one in each selected community. This qualitative approach prioritises depth and detail over statistical generalisability, making it ideal for exploring the nuances of CBHI implementation in a resource-constrained setting.

Data Collection

The primary data collection method was Focus Group Discussions (FGDs), supported by a semi-structured interview guide. This method allowed for a detailed exploration of participants' perspectives, experiences, and attitudes towards CBHI. The guide covered key themes aligned with the research objectives, including awareness and perceptions of CBHI, socio-economic factors, healthcare infrastructure, and cultural/organizational factors. All discussions were audio-recorded with participants' consent and transcribed verbatim for analysis.

Data Analysis

A thematic analysis approach was employed to identify, analyse, and report patterns (themes) within the data. The analysis was supported by NVivo qualitative data analysis software to ensure a systematic and transparent process. The analysis involved familiarising with the data, generating initial codes, searching for and reviewing themes, and finally defining and naming the themes for reporting.

Ethical Considerations

The study adhered to strict ethical principles, including voluntary participation, informed consent, confidentiality, and anonymity. Ethical approval was obtained from the relevant institutional review board before data collection began. Participants were fully informed about the study's purpose and their right to withdraw at any time. All identifying information was removed from transcripts to protect participant anonymity.

Results

The findings from the Focus Group Discussions are presented across seven key themes that emerged from the thematic analysis.

Theme 1: Community Awareness and Perceptions of CBHI

Awareness of CBHI was mixed. Some participants, particularly community leaders, understood it as a collaborative scheme where "Households and the government are contributing... aimed at helping the less privileged". However, awareness in other areas was significantly lower, with one participant stating, "I have heard about it, but I don't know how it works or how to join". Misconceptions were common, such as the belief that the scheme was only for government workers. Perceptions were generally positive among those aware of the scheme, viewing it as "helpful and beneficial," especially for those unable to afford hospital bills. However, this was often tempered by scepticism and a lack of trust based on past experiences with government programmes that "never reach us in the rural areas".

Theme 2: Socio-Economic Factors Influencing Participation

Income, education, and social status were key determinants of participation. The potential of CBHI to alleviate the financial burden of healthcare was a major draw for low-income households. However, the affordability of premiums remains a significant barrier, especially given the unstable and seasonal nature of income in agrarian communities. One participant noted, "During the farming season, we have money, but after harvest, it becomes difficult to pay for anything extra". Education also played a role; educated individuals were perceived as more likely to understand the benefits, while "the uneducated ones are afraid of being cheated".

Theme 3: Healthcare Infrastructure and Service Quality

Participants across all communities expressed deep concerns about the poor state of healthcare infrastructure. A common sentiment was that health centres lack basic drugs and

equipment, and are understaffed. One person lamented, "The hospital is far, and when we get there, the doctors are not always available". This poor service quality undermines the attractiveness of any insurance scheme. As one participant questioned, "How can she [a single nurse] handle more patients if more people join the scheme?". There was some optimism that CBHI could channel more funds to facilities, but this was coupled with a strong demand for transparency and accountability in managing those funds.

Theme 4: Cultural and Organizational Factors

Cultural beliefs, particularly the reliance on traditional healers, were identified as a challenge to the adoption of formal healthcare insurance. Community leaders and local organizations were seen as critical for implementation. The support of a village head, for instance, could persuade people to join due to trust. Conversely, mistrust in leaders could hinder participation. Religious beliefs were seen as both a facilitator—with the scheme aligning with values of mutual help—and a potential barrier if the scheme was perceived to conflict with religious teachings.

Theme 5: Affordability and Financial Sustainability

This theme overlaps with socio-economic factors but focuses on the scheme's viability. Participants worried that "if the scheme is not well managed, it will collapse, and we will lose our money". This reflects a widespread lack of trust in the management of financial schemes. The need for transparent governance, such as a community-led oversight committee, was strongly articulated. Despite this, the core value proposition of financial protection was recognised: "It is better to pay a small amount regularly than to be hit with a big bill when you are sick".

Theme 6: Barriers to Participation

The primary barriers identified were mistrust, inadequate information, and financial constraints. Mistrust in government initiatives was a recurring issue, rooted in past unfulfilled promises. A lack of clear, accessible information left many confused about the scheme's mechanics, benefits, and enrolment process. Financial constraints remained a fundamental obstacle for households with low and unstable incomes.

Theme 7: Community-Driven Initiatives

Existing community structures like health committees, religious groups, and youth organizations were identified as potential enablers for CBHI implementation. These groups are trusted and can play a vital role in health education, mobilization, and promotion of the scheme. Participants felt that if the scheme were managed by trusted community members, willingness to join would increase significantly.

Discussion

The findings from this study highlight a complex interplay of enthusiasm and significant barriers to implementing CBHI in Katsina State. The mixed levels of awareness and prevalent misconceptions align with research across Sub-Saharan Africa, which identifies low awareness as a primary obstacle to health insurance uptake. The scepticism and mistrust reported by participants are also well-documented, often stemming from previous negative experiences with government programmes and concerns about mismanagement. This underscores that successful implementation is not merely a technical exercise but requires building social capital and trust.

Affordability remains a central challenge, especially for households with seasonal and unpredictable incomes, a finding consistent with studies on agrarian communities. The high willingness to pay found in some surveys

suggests latent demand, but this willingness must be matched with ability [14]. This reinforces the need for flexible, pro-poor financing mechanisms, such as subsidised premiums and non-linear payment schedules, which can be supported by leveraging federal initiatives like the Basic Health Care Provision Fund (BHC PF) [3].

The poor state of healthcare infrastructure and service quality presents a classic "chicken-and-egg" problem. Residents are reluctant to pay for a scheme that gives them access to substandard services, while facilities cannot improve without increased funding. This confirms that demand-side financing interventions like CBHI must be coupled with supply-side improvements. Integrating CBHI with broader health system strengthening efforts, as proposed in strategic frameworks, is therefore essential.

Finally, the study affirms the centrality of community participation. The reliance on traditional healers, the influential role of community and religious leaders, and the demand for community-led management all point to the necessity of a bottom-up approach [4]. Top-down models that fail to account for these local dynamics are likely to fail. The strategic recommendation to involve Ward Development Committees, local associations, and community leaders in scheme design, management, and oversight is strongly supported by the data from this study and the broader literature.

Conclusion

This study confirms that while CBHI holds significant potential to improve healthcare access and provide financial protection in Katsina State, its successful implementation is contingent on overcoming substantial challenges. Key barriers include low awareness, deep-seated mistrust in formal institutions, premium affordability for the poor, poor quality of healthcare services, and cultural factors influencing health-seeking behaviours.

The findings lead to several key recommendations. First, intensive and sustained public awareness campaigns using trusted community channels are essential to build knowledge and trust. Second, premiums must be made affordable through subsidies and flexible payment mechanisms tailored to the seasonal income patterns of rural households. Third, investments in improving healthcare infrastructure and service quality must occur in parallel with the rollout of the insurance scheme to ensure value for enrollees. Finally, and most critically, a genuine community-driven approach is non-negotiable. Involving community leaders, religious institutions, and residents in the design, governance, and monitoring of the scheme is the most effective way to ensure its cultural appropriateness, transparency, and long-term sustainability.

By integrating these strategies, Katsina State can move beyond its current low insurance coverage and make meaningful progress towards achieving universal health coverage for all its citizens.

Strengthening Arguments with Data

Robust data are essential to justify investments in health insurance and to guide evidence-based policymaking. In this section, we consolidate key data points that support the recommendations proposed in this paper and demonstrate the feasibility of expanding coverage in Katsina State.

National Health Insurance Trends

As of December 2024, the National Health Insurance Authority (NHIA) announced that 19.2 million Nigerians were enrolled in various health insurance schemes [7]. While this represents significant progress compared to the previous decade, it still covers less than 10% of the total population—far below the UHC target. This data point is crucial because it shows growing momentum at the federal level, which Katsina can tap into through alignment with national policies and funding.

Katsina-Specific Enrollment and Willingness

Katsina’s population, projected at approximately 10.37 million in 2022 [10], remains largely uninsured. A state-level survey in 2023 found that less than 0.5% of residents had any form of health insurance [13]. Meanwhile, Mutual Health Associations (MHAs)—which represent the main form of CBHI in the state—cover only 41,219 members, roughly 0.4% of the population. This huge coverage gap highlights the urgency of implementing new strategies. Yet, there is clear demand. In a 2016 survey conducted in Batagarawa LGA [14], 90.5% of households expressed willingness to enroll in a CBHI scheme, with many willing to pay ₦100 per person monthly. This indicates that financial cost may not be the primary barrier; rather, gaps in awareness, trust, and accessibility are major constraints. With the right outreach and structure, enrollment could increase rapidly.

Table 1 provides a sample of community enrollment data.

Table 1. Sample Community Enrollment Data

Region	Population	Enrollment (%)
Urban	3,500,000	12.5
Rural	5,700,000	2.3
Total	9,200,000	5.4

Poverty and Equity Considerations

The 2024 Katsina Inclusive Economic Policy [10] reports that 66.7% of the population is multidimensionally poor, lacking access to quality health care, education, and income. This further underscores the need for premium subsidies and targeted enrollment campaigns. Many cannot afford even minimal contributions without financial assistance. Leveraging the federal Basic Health Care Provision Fund (BHC PF) to support these populations can improve equity and accelerate UHC.

Impact on Health Utilization

Evidence from other Nigerian states and international settings shows that insurance enrollment improves health service utilization. For example, insured individuals are more likely to seek care early, utilize primary health facilities, and adhere to prescribed treatments. A comparative study found that in CBHI-covered communities, health facility use increased by over 30%, while out-of-pocket expenditures declined significantly [19]. Similar outcomes can be expected in Katsina if coverage is expanded.

Monitoring and Evaluation

Finally, state-level insurance expansion requires continuous monitoring. Using digital dashboards and periodic surveys, Katsina can track key indicators: number of enrollees, service utilization, satisfaction, and dropout rates. This data-driven approach allows for mid-course corrections and ensures accountability at all levels—from community health workers to the state health insurance agency.

In summary, the data affirm that expanding health insurance in Katsina is both necessary and feasible. The key lies in leveraging existing demand, supporting the poorest, strengthening governance, and institutionalizing community participation. If scaled thoughtfully, these

actions can help Katsina become a model for UHC in Nigeria.

Conflict of Interest

The authors declare that they have no conflicts of interest regarding the publication of this paper.

Ethical Approval

Ethical considerations were central to the design and implementation of this study, ensuring that the rights and well-being of participants were protected throughout the research process. The study adhered to the ethical principles of voluntary participation, informed consent, confidentiality, and anonymity. These principles were operationalized through several measures, including obtaining ethical approval, securing informed consent, and ensuring the confidentiality of participants' data.

Data Availability

The qualitative data sets generated and analyzed during the current study (comprising transcribed Focus Group Discussions) are not publicly available due to the need to ensure the **confidentiality and anonymity** of the study participants and key informants. The full data may contain sensitive identifiers or contextual information that could potentially breach the informed consent agreement. However, the data are available from the corresponding author upon reasonable request and subject to review by the relevant institutional ethical committee.

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