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Assessment Of The Role Of Local Government Health Authority On Health Insurance Enrolment Towards Achieving The Universal Health Coverage In Kaduna State, Nigeria

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Abstract
The Local Government Health Authority (LGHA) plays a crucial role in overcoming barriers and enhancing the effective implementation of health programs by providing a local context and empowering communities within the framework of primary health care and universal health coverage (UHC). This study examines roles of LGHA in the implementation of health insurance schemes in Kaduna State, utilizes a qualitative method approach and data from 14 focus group discussion with thematic content analysis to explore contextual drivers, implementation challenges, and the roles of LGHA. Statistical analysis (chi-square tests and z-test of proportions) using Stata 16.0 revealed a significant majority (85.7%) reported a reduction in out-of-pocket (OOP) health expenses, and health insurance schemes by Kaduna State Health Management Authority (KADCHMA) significantly increased UHC. All (100%) respondents confirmed improved access and availability of essential services under the schemes. Despite the successes recorded, persistent stockout of drugs and low capitation per life are identified as a major challenge. These barriers contribute to financial burden to access and OOP procurement of drugs. Addressing them requires investment in sustainable drug supply systems, review capitation and benefit packages under the schemes, engagement with relevant stakeholders on policy intent and implementation reality.

Keywords: *Local Government Health Authority, Universal Health Coverage, Out of Pocket expenditure, Primary Healthcare and Essential services.*

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I. Introduction

Health insurance is an essential public health intervention aimed at eliminating out-of-pocket expenses and easing the financial burden on vulnerable populations, particularly pregnant women and children under five (1). Despite its proven effectiveness, the success of health insurance programs in various regions of Nigeria, including Kaduna State, is significantly undermined by inadequate involvement of relevant stakeholders in promoting health insurance.

In Nigeria, reforms in governance of the health insurance ecosystem have led to the establishment of Health Insurance Under One Roof (HIUOR). This initiative aims to reduce bottlenecks and ensure that health insurance operates within a unified decentralized system, including at the sub-national levels (2).

The implementation of Basic Health Care Provision Fund (BHCPF) at the Local Government Area (LGA) level focuses on primary health care (PHC) facilities and the community, managed by the Local Government Health Authority (LGHA). This process is supported by the LGA PHC Advisory Committee, which is responsible for advocacy, resource mobilization, and providing supportive supervision (3).

Programme managers at the local government level play a crucial role in the success of health insurance programs. They mobilize communities for enrolment, build trust between those communities and health systems, implement health policies, and share health information to encourage people to utilize services and adopt better health-seeking behaviours. Their involvement fosters a sense of community ownership, ensures that interventions are relevant to local contexts, and supports the achievement of Universal Health Coverage (UHC) by aligning local needs with broader health initiatives (4).

II. Research Methodology

Research Design and Site

The study utilized a qualitative approach to gain an in-depth understanding of the research topic. Qualitative data were collected in real-time from the Local Government Area Health Authority team, which included community representatives as part of the PHC Advisory Committee, through focus group discussions. This method enabled an exploration of individual perspectives, community dynamics, and contextual factors that affect the implementation of health insurance schemes. The

data were collected from six Local Government Areas (LGAs) in Kaduna State, with two LGAs selected from each of the 3 senatorial zones: Lere, Makarfi, Chikun, Jaba, Jema'a, and Kaduna North

Method of Data Collection

A focus group discussion (FGD) guide was utilized to gather data in support of the research hypothesis. The open-ended questions were designed to encourage informal discussions, allowing respondents to share their views, opinions, and observations (5). Each FGD was facilitated by a knowledgeable moderator, accompanied by a notetaker familiar with the local dialect. Each session lasted approximately 30 to 40 minutes and involved a minimum of eight participants. The qualitative data collected were then quantified using appropriate statistical tools to analyse complex issues and triangulate findings from multiple sources. Primary data obtained from this questionnaire were used to test the research hypothesis and address the research questions (6).

Population of the Study

The targeted population for this study included staff from the Local Government Health Authority, comprising both males and females. This group consisted of health managers, representatives from community leadership, faith-based organizations, and civil society organizations. Participants were selected based on their understanding of the local context and their involvement in the implementation of state health insurance schemes. The study specifically included six LGA Health Authority Advisory Committees, which encompassed Health Secretaries, Monitoring and Evaluation personnel, Program Managers, and community representatives who possess a thorough understanding of the local context. Informed ethical consent was obtained, and gender considerations were considered throughout the study.

Sampling Procedure and Sample Size

The study employed a random sampling technique to select six Local Government Areas (LGAs), with two LGAs chosen from each senatorial zone to ensure comprehensive coverage of the state. This approach aimed to represent the diverse demographics, socioeconomic backgrounds, religious beliefs, cultures, and population sizes of the area. The focus group discussion (FGD) participants were selected purposively, specifically targeting the LGA Primary Health Care (PHC) Advisory team. The team comprised, and was not limited to, the Health Secretary, Community Leader, Religious Leader, HMIS officer, Essential Drug Officer, LIO, M&E, Reproductive Health, and SMO.

Instruments for Data Collection

Before data collection began ethical clearance was obtained from the Kaduna State Health Research Ethics Committee. Participants were provided with ethical clearance and consent obtained from them before the interviews commenced. Qualitative data were gathered using a focus group discussion (FGD) guide that was administered to the local Government Health Authority team, as well as to representatives from the community and religious leaders.

Statistical Analyses

Measurement of Variables

The study employed a rigorous approach to measure key constructs related to Universal Health Coverage (UHC) across the qualitative data stream. Measured qualitatively through Focused Group Discussions (FGDs) to determine defined roles and strategies for UHC promotion and implementation.

Validation of Instrument

The data collection instrument for the FGDs was reviewed and validated by five subject matter experts. This panel included public health officials, academic researchers with experience in healthcare financing, and executives from the health sector, ensuring the content aligned with established health system and policy constructs.

Ethical Considerations

Ethical approval for this study was obtained from the State Ministry of Health, as required before starting any health-related research in the state. This approval ensured strict adherence to ethical procedures and standards, as outlined by the State Health Research Ethical Committee guidelines. Informed consent was obtained from participants, with assurances of privacy and confidentiality. The rights of participants to withdraw from the study and their autonomy were prioritized throughout the research.

Method of Data Analysis

The qualitative analysis involved thematic coding of interview transcripts, focus group discussions, and field notes, identifying themes and patterns through iterative coding. Transcribed interview notes (FGDs) were entered into the software. Analysis involved developing a coding dictionary (validated with facilitators), coding the full dataset, and extracting broad themes, relationships, and notable outliers to provide contextual explanations for the quantitative findings.

Rule Decision (Statistical Decision Rule)

All statistical inferences derived from the quantitative analysis were anchored to a pre-determined criterion, ensuring consistency and rigor in hypothesis testing:

Level of Significance (α): The study established 5% types-I error limit (α=0.05).
The decision rule applied to the null hypotheses was as follows:

1. If the calculated p-value is less than or equal to the significance level ($p \leq 0.05$):
a) The Null Hypothesis is REJECTED.
b) Interpretation: The observed difference or association is considered statistically significant and unlikely to have occurred by chance.
2. If the calculated p-value is greater than the significance level ($p > 0.05$):
a) The Null Hypothesis is NOT REJECTED (Fail to Reject).
b) Interpretation: The observed difference or association is considered statistically insignificant.

III. Results And Discussion

Table 1.0: Socio Demographic Information

		Frequency (n=84)	Percentage
Age (years)	< 30	12	14.3
	40 - 49	30	35.7
	50 - 59	42	50.0
Sex	Female	24	28.6
	Male	60	71.4
Role in the organization	Community Leader	12	14.3
	DHIS2 Officer	6	7.14
	Essential Drug Officer	6	7.14
	Health Secretary	18	21.4
	HMIS Officer	6	7.14
	LIO	12	14.32
	M&E	6	7.14
	Reproductive Health	6	7.14
	Secretary	6	7.14
	SMO	6	7.14

Table 1.0: Presents the socio-demographic characteristics of 84 respondents, showing a balanced gender distribution with 71.4% males and 28.6% females. The largest age group is 50-59 years (50.0%), followed by 40-49 years (35.7%), while the smallest group is <30 years (14.3%). These individuals, holding roles such as Health Secretary, Local Immunization Officer (LIO), and Community Leader, represent the institutional voice closest to the grassroots service delivery points. Their collective assessment is authoritative concerning the operational status and community perception of the schemes.

Table 2.0: Coverage and contribution to health insurance scheme

	No F (%)		Yes F (%)	
Access to affordable healthcare.	0	(0.0)	14	(100.0)
Availability of BHCPF in rural communities	0	(0.0)	14	(100.0)
Coverage of essential health services.	0	(0.0)	14	(100.0)
Reduced out-of-pocket health expenses	2	(14.3)	12	(85.7)
Availability of policy strategy to promote UHC	5	(35.7)	9	(64.3)

The quantitative findings provide strong evidence of the success of the KADCHMA and BHCPF schemes. Every health community leader surveyed (100%) affirmed that KADCHMA has improved access to affordable healthcare, that BHCPF has increased healthcare availability in rural areas, and that the scheme covers essential health services. Additionally, there is financial risk protection, as a significant majority (85.7%) reported a reduction in out-of-pocket (OOP) health expenses due to KADCHMA.

To evaluate the significance of the Health Insurance scheme and BHCPF operated by the Kaduna State Contributory Health Management Authority (KADCHMA) in relation to universal health coverage (UHC) in Kaduna State, we tested the null hypothesis using the chi-square test at a 5% level of significance.

Table 3.0: Test of significance of proportion for coverage of health insurance scheme

Question	No		Yes		Chi-square	p-value
Access to affordable healthcare.	0	(0.0)	14	(100.0)	15.238	.004
Availability of BHCPF in rural communities	0	(0.0)	14	(100.0)		
Coverage of essential health services.	0	(0.0)	14	(100.0)		
Reduced out-of-pocket health expenses	2	(14.3)	12	(85.7)		
Availability of policy strategy to promote UHC	5	(35.7)	9	(64.3)		

According to the chi-square results presented in Table 4.3, the p-value of the analysis is less than 0.05. Therefore, the null hypothesis is rejected. This leads to the conclusion that the Health Insurance scheme and the Basic Health Care Provision Fund (BHCPF) operated by the Kaduna State Contributory Health Management Authority (KADCHMA) have significantly improved universal health coverage in Kaduna State.

IV. Discussion Of Findings

The data strongly rejected the null hypothesis that the roles of these institutions are unclear, confirming that all key stakeholders have recognized and actively participate in promoting Universal Health Coverage (UHC). Additionally, the data highlighted improved access to health insurance schemes, particularly among the formal sector and vulnerable groups, who have enrolled under the KADCHMA and BHCPF schemes, respectively. However, it was noted that enrollment in the informal sector remains lower than expected.

The National Health Act of 2014 has made the BHCPF scheme available at the Local Government Area (LGA) level. To effectively onboard this initiative, both the state and the LGAs play crucial roles in ensuring that the state meets the outlined requirements. Findings indicate that LGAs are instrumental in the development and implementation of health facilities' quarterly business plans (BPs) and quality improvement plans (QIPs). They also provide routine supportive supervision and mentoring to these health facilities. However, inadequate counterpart funding from the LGAs has negatively impacted routine supervision, leading to poor services and lack of accountability for funds.

The KADCHMA and BHCPF schemes have developed robust benefit packages that cover essential services for beneficiaries, particularly Basic Emergency Maternal and Newborn Care (BEMoNC) and Comprehensive Emergency Maternal and Newborn Care (CEMoNC). To enhance these offerings, KADCHMA has harmonized its benefit packages to improve access and coverage towards achieving UHC. The LGAs are essential in ensuring that these benefit packages are delivered at the highest quality within health facilities.

Traditional and religious leaders, along with Ward Development Committees (WDCs) and Community-Based Organizations (CBOs), actively engage in mobilizing resources and identifying vulnerable individuals to reduce out-of-pocket (OOP) expenditures. The LGAs play a vital role in raising awareness and mobilizing key stakeholders to emphasize the importance of health insurance schemes. Communities also contribute significantly to resource mobilization through the Ethical Health Financing (EHF) Initiative, which is supported by the UK and Nigeria Partnership for Health 'Lafiya Programme.' The EHF initiative aids in community enrollment, effectively reducing OOP costs. LGAs are crucial in supporting the establishment of institutional frameworks for the EHFs.

The state has an abundance of key policies and strategies aimed at achieving universal health coverage. These documents outline the roles and expected deliverables of the LGAs. Notable initiatives include the Primary Healthcare Under One Roof (PHCOUR), National Health Insurance Under One Roof (NHIOUR), the Kaduna State Primary Healthcare Board Law (2020), the KADCHMA Law (2021), BHCPF 1.0, and the recently introduced BHCPF 2.0.

V. Conclusions

In conclusion, the LGHAs have enhanced coordination, planning, and implementation of primary healthcare services, including the KADCHMA and BHCPF schemes, all aimed at achieving Universal Health Coverage (UHC) by 2030.

The LGHAs have also demonstrated their commitment to enhancing access to services, accountability and transparency of funds, and improving community engagement and mobilization towards attainment of universal health coverage.

The LGHAs have also demonstrated their commitment to enhancing participatory budgeting in the development of facilities, business plans, and quality of services in developing health facilities quality improvement plans.

VI. Recommendations

The federal and state government policies must be translated into actionable steps at the Local Government Area (LGA) level to ensure that targeted beneficiaries receive optimal healthcare services. Additionally, LGA leadership should allocate funding to support the implementation of planned activities, coupled with a robust accountability mechanism. This will improve oversight and transparency within the LGA. Additionally, BHCPF 2.0 introduced a strong role for the LGA PHC Advisory Committee, which, when fully implemented, will result in improved quality of service delivery at the LGA level.

The State Ministry of Health plans to set up a mandatory high-level coordination platform that includes KADCHMA, the State Primary Health Care Board (SPHCB), and other relevant agencies. This initiative aims to tackle ongoing delays in funding disbursement, shortages of essential supplies, and improve coordination between the NHIA/KADCHMA and NPHCDA/SPHCB gateways.

Conflict of Interest

The authors declare that there is no conflict of interest.

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