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BRIDGING THE INFORMATION GAP TO KEEP EDUCATORS HEALTHY: HEALTH INSURANCE AWARENESS AND ACTIONS BY PRIVATE SCHOOL EMPLOYEES IN NIGERIA

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Abstract

A nation relies on its educators to provide skills for upcoming learners and workers. To do this, they need to have good health security in their qualified position and the National Health Insurance Scheme (NHIS) should effectively support this. Researchers have carried out studies on NHIS in Nigeria but none have considered private school employees who are thought leaders and a significant category of the beneficiary population in the health insurance system. This research in Felele, Oluyole, and Bodija included six hundred questionnaires in sixty private schools in three selected localities alongside focused group discussions (FGDs) in six schools to elicit private school workers' perception of the Nigerian NHIS scheme. Theoretically anchored in Health Belief Model (HBM) and Protection Motivation Theory (PMT), this study assessed the awareness, perception and enrolment levels of private school workers towards NHIS to bridge the information gap and improve their contributions and health of targeted workers. Results revealed a high level of awareness (81.7%) but a very low enrolment level (7.8%) of private school workers in the NHIS. As well, it was found that the lack of NHIS law enforcement, poverty, inequality, unfavourable registration process and lack of interest hinder enrolment. Based on this data; the authors claim it is important to raise awareness, perception and enrolment levels of private school employees. The conclusion reached is that, relevant authorities in Nigeria need to develop a workable system of combating healthcare issues in the country by considering targeted subsidies, involving potential beneficiaries in reviewing the NHIS's policies and re-strategizing information flow or dissemination on the programme as well as removing obstacles that are preventing potential enrolees from registering.

Keywords: healthcare awareness, information gap, Ibadan, NHIS, private school workers, development communication, Nigeria, health insurance literacy, information dissemination, UHC, CBHI

Introduction

A nation relies on its educators to provide skills for upcoming learners and workers. To do this they need to have good health security in their qualified position and the National Health Insurance Scheme (NHIS) should effectively support this. World Health Organization (WHO) posits that proper attention to workers' health and safety has extensive benefits; healthy workers are productive and raise healthy families. They are a key component of the panoply of strategies to achieving organisational goals, which in the context of this study is to maintain the health of educators to expand and sustain the education sector in Nigeria. Burton et al. (2006) submit that workers with reduced health risks generally have improved productivity whereas those with increased health risks experience decreased productivity. When workers are healthy, they tend to work best. If they are unwell, they tend to complete only the basic work required rather than go the extra mile. When organizations are attentive to the health of workers, employees tend to focus more on achieving set deliverables. This results in higher productivity; not only added benefit for the company, but the employees too. Well-integrated and supported health enhancement initiatives including enrolment for health insurance can help to improve

health status and productivity in the workplace. Educators are direct role models and the effect of a sustainable health among this group would immensely rub off on the generations to come.

Health insurance literacy is "the degree to which individuals have the knowledge, ability, and confidence to find and evaluate information about health plans, select the best plan for their own (or their family's) financial and health circumstances, and use the plan once enrolled'' (Consumers Union, University of Maryland College Park, and American Institutes for Research, 2012). Understanding health insurance is essential to affording and accessing healthcare in any nation (Paez et al., 2014), but studies of consumers and health insurance have lacked a clear definition of health insurance literacy. While health literacy has been generally studied and measured, health insurance literacy has barely been interrogated (Paez et al., 2014). In the United States of America (USA), for instance, the success of federal insurance schemes is partly hinged on consumers' ability to understand health insurance and make informed decisions. It follows, therefore, that health insurance literacy is one factor that may determine whether consumers select a suitable health plan and use health insurance to their best advantage in all human ecosystems, including Nigeria.

World Health Organization (2016) estimates the average male and female life expectancy of Nigerians to be 53.7 and 55.4 years respectively. Maternal mortality in Nigeria is among the highest in the world accounting for 19% of global maternal deaths, with estimated infant mortality rate at 19 deaths per 1000 births and mortality among children under 5 at 128 per 1000 (Omoera, 2010). Communicable and infectious diseases are the major health problems in Nigeria (Muhammad et al., 2017; WHO, 2015). Teachers, like the general population in Nigeria are largely exposed to malaria, respiratory infections, high blood pressure, typhoid and diarrheal diseases. Malaria remains the primary killer disease in the country, resulting in over 25% of under 5 mortality, 30% childhood mortality and 11% maternal mortality. There is also the second highest HIV burden in the world of about 3.4 million (WHO, 2015).

The Nigerian Economic Recovery & Growth Plan 2017-2020 discloses that in Nigeria, the average life expectancy of 52 years is lower than that of Ghana (61 years) and South Africa (57 years). Furthermore, the occurrence of infectious diseases remains high and the country ranks poorly on the prevalence of tuberculosis (128 out of 138 countries) and HIV (123 out of 138 countries) (WHO, 2015). This is aside from the coronavirus (Covid-19) that has dealt and still dealing a great blow on thousands of Nigerians, with many deaths already recorded. WHO (2013) further indicates that high reliance on out-of-pocket health expenditures has persisted despite consensus moves towards universal health coverage (UHC). Improvement of the healthcare system in Nigeria has been hindered by insufficient public funding, a high infectious diseases burden, increasing occurrence of communicable and non-communicable diseases and high rates of infant and maternal mortality. This speaks to why an efficient national health insurance model is required in Nigeria to attain universal health coverage to ensure total access to quality healthcare without the risk of getting impoverished. Projections by Azuogu et al. (2016) highlight that about a hundred million people globally are pushed into poverty due to out-of-pocket expenditures for healthcare services, and millions of people do not seek healthcare in hospitals because they cannot afford healthcare services. Makinde et al. (2012) claim that limited funding, lack of support from some local government leaders, inadequate capacity-building opportunities, and lack of equipment are the major problems faced by Nigeria's health system. They also advocate that policymakers improve funding for health activities in the state and involve community stakeholders in the entire development process.

Many citizens in developing countries, such as Nigeria, lack access to universal health coverage. Sanusi and Awe (2009) contend that over the years, consumers' inability to pay for health services and inequitable healthcare provision are among the factors responsible for the lack of access to healthcare in Nigeria. Since Nigeria's independence in 1960, there has been very limited coverage for social protection with over 90% of the population existing without health insurance coverage. Hence, Nigeria launched the National Health Insurance Scheme (NHIS) in June 2005, to solve the problem of inequality in healthcare services and promote increased access to healthcare. The Nigerian medical system has evolved over the years through healthcare policies such as the National Health Insurance Scheme (NHIS), National Immunization Coverage Scheme (NICS), Midwives Service Scheme (MSS) and Nigerian Pay for Performance Scheme (P4P), all aimed to address public health challenges. Despite government efforts, political instability, corruption, limited institutional capacity and an unstable economy are major factors responsible for the poor development of health services in Nigeria (Adebisi et al., 2019).

Families and individuals are left to bear the burden of a defective and unbalanced health system, leading to delays, not seeking healthcare and having to pay out-of-pocket for medical services that are not affordable. Ilesanmi et al. (2014) submit that catastrophic health expenditure (CHE) is widespread in Nigeria despite the take-off of the NHIS. Hence, universal coverage of health insurance in Nigeria should be fast-tracked to give the expected financial risk protection and decreased incidence of CHE. Adewole et al. (2017), however, reveal that healthcare reforms have succeeded in providing medical services both for the upper and middle class, and have marginalised the lower class, which constitute over 75% of the approximately 200 million citizens. The programmes that focus on re-equipping government hospitals, ensuring constant power supply, providing drugs and other consumables have mainly benefitted the upper and middle class, because reformation and commercialisation of the health facilities result in higher costs of accessing them, which the lower class cannot afford. Also, the NHIS is predominantly focused on those who work in the public and organised private sectors, with government subsidising health insurance for employees. Although Community Based Health Insurance (CBHI) schemes through NHIS and state-run health insurance agencies have been introduced in Nigeria, they have generally not succeeded owing to poor financial support, inability to meet the realistic needs of beneficiaries, lack of clear legislative and regulatory frameworks and unrealistic enrolment requirements. Odeyemi (2014) contends that the disappointing uptake of CBHI-type NHIS elements in Nigeria can be addressed through closer integration of informal and formal programmes alongside increased involvement of beneficiaries by way of improved communication and education, and targeted financial assistance.

There are many factors that impede the uptake of health insurance in the informal sectors in Nigeria. Many studies conducted on the NHIS record a low level of awareness, unfavourable perception and minimal enrolment level (Sanusi & Awe, 2009; Adewole et al., 2017). Azuogu et al. (2016) attribute the low participation of individuals in the informal sector to the low and irregular streams of income and insecure employment status. Paez et al. (2014) further surmise that consumers fail to understand the underlying purpose of health insurance as a hedge against major medical costs. They are unaware of their personal liability should they become seriously ill. Although Adewole et al. (2017) agree that implementing and expanding health insurance in the informal sector, particularly in developing countries such as Nigeria is a challenge, they suggest that innovative models are needed to enable potential enrolees to better understand and consent to the concept of prepayment methods for funding personal healthcare. Furthermore, Okaro et al. (2010) argue that the problems with implementing NHIS are hinged on both the awareness and perception of sustaining the programme in line with the objectives of its creation. This, in a way, explains why Adebisi et al. (2019) conclude that NHIS has not fully achieved its objectives. In fact, health insurance resources delivered via communication channels that are not utilized by the target population will likely fail to reach the population they intend to serve (Furtado et al., 2016).

NHIS coverage needs to be expanded across various sectors through education, improved access to facilities and work in partnership with relevant stakeholders to ensure high quality and affordable healthcare services in Nigeria. Christina et al. (2014) explain that the sustainability and viability of a country's economic and social growth depend largely on a vibrant healthcare sector. O'Donnell (2007) proposes that only through experimentation and evaluation will the poor in the developing world learn what works in raising healthcare utilisation. This utilisation can be improved with targeted programmes that are informed by research. For example, knowing where the uninsured gather information about health insurance can be used to inform targeted approaches for health insurance communication. Furtado et al. (2016) suggest that healthcare providers were universally well used and trusted across all subpopulations and may be promising partners for delivering quality health insurance information. Conversely, investing in education efforts through employers as sources of health insurance information could be strategically rewarding (Long et al., 2014). The internet, television, family and friends, and healthcare providers are among the most popular sources of health insurance information, and participants in Furtado et al.'s (2016) study reported higher trust in interpersonal sources of information, precisely in healthcare providers compared to television and the internet. This is consistent with Johnson and Meishcke (1992); Rains (2007) research that revealed that individuals generally trust people more than the media. Furtado et al. (2016) recommend reaching uninsured individuals through healthcare providers who could make referrals to community liaisons or trained lay health advisors to deliver information on health insurance.

Previously noted studies have been carried out to assess the level of awareness, enrolment and perception of the NHIS in Nigeria among the healthcare providers and consumers. However, none of these studies have included private school workers who are a significant category of the population who would benefit the society by using the health insurance system. Investigation reveals that educators are opinion leaders and have a high level of influence in their various communities. Consequently, this study is carried out to assess the awareness, perception and enrolment levels of private school workers in Ibadan, Oyo State, Southwest, Nigeria in relation to the National Health Insurance Scheme (NHIS). It aims to bridge the information gap and contribute strategies towards achieving the NHIS set goals.

Theoretical Underpinning

To theoretically anchor this study, we use the Health Belief Model (HBM) and Protection Motivation Theory (PMT) as notional development communication scaffoldings to highlight the fine points that are critical to bridging the information gap in the awareness, perception and enrolment levels of private school workers towards improving their contributions to the NHIS in Nigeria. The HBM and PMT have received scholarly attention across time, with the latter coming more under severe criticism, reinterpretation and revision (Carpenter, 2010, p.661). However, we find an alignment between the two theories that could be very profitable in studying the Nigerian situation. This is ostensibly because they both emphasise the importance of people's attitude and behavioural change in such issues as health insurance literacy and wellness matters in the context of a developing society such as Nigeria. Keeping educators healthy in such an ecosystem with all its challenges could be very complex. Hence, this study used the HBM and PMT to foreground the discussion of issues such as health insurance literacy awareness and actions as they pertain to private school workers in Nigeria. Drawing from the work of Zhiying, Wang and Singhal (2019), the study further used elements of both theories to tie the health insurance issue in Nigeria to other development scenarios and discussed their possible global implications for development communication.

Health Belief Model

The Health Belief Model (HBM) tries to predict human health behaviours. Janz and Becker (1984); Carpenter (2010); Montanaro and Bryan (2014) explain that the HBM was originally developed by four American scientists in the 1950s, and updated in the 1980s. The model is based on the theory that a person's willingness to change their health behaviours is primarily due to the following four factors:

1. Perceived Susceptibility. Except where there is an imminent risk, one is unlikely to alter one's health behaviours (Janz & Becker, 1984). For example, more married women of child bearing age are likely to enrol for health insurance than unmarried ones because of the need for antenatal healthcare. Young people who do not have pre-existing illnesses or have a known poor family health history are less likely to purchase health insurance compared to their counterparts with no family health issues or much older people who are prone to age related illnesses.
2. Perceived Severity. Janz and Becker (1984) claim that the likelihood whether or not a person will alter their health patterns to avoid a consequence is hinged on how grave they perceive the consequence to be. For example, the breadwinner of a family or someone with higher financial responsibilities is more likely to think of registering for health insurance compared to the person who has fewer responsibilities. A family with a medically challenged child is more likely to purchase health insurance compared to the one without a health challenge.
3. Perceived Benefits. Persuading people to change behaviour can be difficult, especially if they do not see immediate benefits. People are reluctant to give up what they enjoy if there is no replacement for it (Montanaro & Bryan, 2014*)*. For example, a person will probably not buy health insurance if they are not sickly compared to a person who falls sick often. On the other hand, if the less sickly person is promised a rollover or cash return, they would probably enrol for health insurance because there is nothing to lose.
4. Perceived Barriers: one main reason people are reluctant to alter their health patterns is because they think it will be difficult or impossible. This difficulty can be physical, emotional or social. Altering health behaviours can be exerting financially and socially (Janz & Becker, 1984). For

example, low-income earners are less likely to purchase health insurance (though they may need it more) because they believe that if they take out from their limited resources to buy health insurance, it will affect their ability to provide for their basic needs.

Health Belief Model realistically helps to frame people's behaviours, acknowledging that at times, just wanting to change one's pattern of payment for healthcare is not enough to essentially make someone do so. Furtado et al. (2016) reveal that illness may lead the uninsured to seek out health information but it might not prompt them to search for insurance information.

Two additional elements are incorporated into the HBM to approximate what it really takes to move an individual to action. They are Cues-to-Action and Self-Efficacy. First, Carpenter (2010) posits that cues-to-action are both internal and external events that prompt a desire to make a health change. A cue-to-action is something that helps to move someone from wanting to make a health change to actually making the change. For example, getting a call from a friend who request to borrow money to offset hospital bills can convince someone who is aware of a health insurance but hasn't enrolled to do so. Also, having symptoms of high blood pressure such as palpitations or getting involved in a car accident can convince a person to take a health insurance plan. Self-efficacy may determine whether someone takes advantage of opportunities to purchase health insurance or seeks out needed health care services with confidence about their coverage, though personal characteristics and extent of health care utilization may play a role in how confident a person feels with selecting and using health insurance (Paez et al, 2014). Second, self-efficacy analyses a person's conviction in their potential to make health-related adjustments. It has been shown that belief in one's ability to execute a task can have enormous impact on one's real capacity to perform the task (Rosenstock, Strecher, & Becker, 1988). Believing that one can save up or take a loan to get health insurance despite one's low level of income can ultimately lead one to getting health insurance. It is similar to self-concept or self-perception where one behaves according to how they perceive themselves. Thinking that it is an impossible feat will most certainly make it impossible. Self-efficacy in the words of Awosola, Omotajo, and Aigbena (2017) can be said to be one of the important factors in an individual's ability to successfully negotiate health adjustments or changes in lifestyle.

Protection Motivation Theory (PMT)

Protection Motivation Theory extends the concepts and links to some of the elements of HBM. PMT establishes how people are inspired to react in a self-protective way towards apparent health related threats similar to postulations by the HBM. Rogers (1983) formally coined this model to help explain fear appeals. The PMT suggests that people safeguard themselves based on four factors:

a. the perceived severity of a threatening event,
b. the perceived probability of the occurrence or vulnerability,
c. the efficacy of the recommended preventive behaviour, and
d. the perceived self-efficacy.

Protection motivation branches from both the threat appraisal and the coping appraisal. While threat appraisal measures the seriousness of the circumstances, coping appraisal refers to how a person responds to it. Coping appraisal is made up of both efficacy and self-efficacy. Efficacy is the anticipation that a person can accomplish a recommendation to remove a threat, whereas self-efficacy is the conviction in oneself to effectively accomplish suggested goals (Rogers, 1983). Westcott et al. (2017) relay that the diversification of PMT over four decades has been used to explain individual human conduct, families, parent-child interaction as well as emergency-relief situations across the globe. Its approach is that prevention is always cheaper and better than cure.

The ability to transform people's awareness of health insurance into effective preparedness by buying into the NHIS scheme ahead of the pressures of an imminent health risk, the narrower the gap between threat awareness and survival will be. Dynamically applying theory to investigation, and expending the outcomes to form hands-on strategies beneficial to the population, could help narrow the awareness-enrolment gap and produce other research possibilities. Maddux and Rogers (1983) demonstrate that self-efficacy is "the most powerful predictor of behavioural intentions" that precedes actual behaviour. The objective of both HBM and PMT is to identify and evaluate the threat, and then counter this assessment with effective alleviation options. This makes HBM and PMT, as viable

intellectual resources in development communication, germane to investigating social issues, including awareness, perception and enrolment levels of private school workers towards health insurance.

Material and Methods

The Study Site

This study was conducted to ascertain the level of awareness, enrolment and perception of the National Health Insurance Scheme (NHIS) among private school workers in Felele, Ibadan Southeast Local Government Area (LGA), Oluyole, Ibadan Southwest LGA and Bodija, Ibadan North LGA of Oyo State, in Southwest Nigeria. Felele is a bustling urban community with a large number of private primary and secondary schools. Bodija is a district in Oyo State's biggest LGA. It is the residential hub of many academics from the University of Ibadan and has a large number of schools, both private and public. Oluyole is an industrial hub situated in the most populous LGA in Oyo State, with many private primary and secondary schools. These localities within the metropolitan Ibadan were chosen for the study because of the high population of private school workers, owing to the large number of private primary and secondary schools situated in them.

Design

The study employed an exploratory survey design to investigate the awareness, perception and enrolment levels of private school workers towards the National Health Insurance Scheme (NHIS) in three LGAs in metropolitan Ibadan in Nigeria.

Participants

A total number of 600 respondents participated in this study that investigated the awareness, perception and enrolment levels of private school workers concerning NHIS.

Instruments

The instrument to elicit responses from the participants was a questionnaire designed by the researchers. It consists of two sections. Section A drew information on the respondents' demographic variables while section B comprised items that measured the awareness, perception and enrolment levels of private school workers towards the NHIS. The 16 items on this section of the questionnaire carried 3-point response format, ranging from "Yes" to "Not Sure." The responses were simply counted for all respondents. That is, there were no total scores for respondents, but total item scores. In order to complement the result obtained through the questionnaire, focus group discussions (FGDs) were conducted among the staff in six of the sampled private primary and secondary schools (one primary and secondary from each LGA) who had filled the questionnaire. One school each from primary and secondary levels with the highest population of members of staff was purposefully selected. The essence of this was to further probe how the workers perceive the NHIS.

Procedure

A total number of 600 copies of questionnaire were distributed in the three LGAs that make metropolitan Ibadan in Oyo State, Nigeria. The sampling method adopted was purposive sampling. The reason for this is that each of the LGA has a large number of private primary and secondary schools. Hence, twenty (20) schools that had at least ten (10) staff (both teaching and non-teaching) were purposefully selected in each of the LGA for the administration of 200 copies of the questionnaire. The criterion for selecting the participating schools was based on each of them having at least ten (10) fulltime members of teaching and nonteaching staff. Therefore, sixty (60) schools were decisively selected in the three LGAs where 600 copies of questionnaire were administered. This was done within the school premises in the LGAs. To make the process of administering the questionnaire easy, the

researchers employed the services of research assistants. All copies of the questionnaire were retrieved from the field because the questions were simple and short and respondents filled them on the spot. Besides, focus group discussions (FGDs) were organized for selected workers who filled the questionnaire in the LGAs. The aim was to generate additional information for the research.

Analysis

The data collated were analysed using descriptive statistics such as simple percentages, tables and graphs.

Results

Table 1: Demographic Characteristics of Respondents

Gender	Male 50.4%	Female 49.6%		
Position	Teaching 84.3%	Non-teaching 15.7%		
Marital status	Married 58.2%	Single 40%	Divorced 0.9%	Separated 0.9%
Age	18-25 years 16.5%	26-32 years 33%	33-39 years 27.9%	40Years-Above 22.6%
Educational qualification	First Degree 69.6%	Masters 9.5%	Dip/OND 13%	O' Level 7.8%
Salary range (NGN/USD)	1800-25000/ 46.57-64.68 43.5%	26000-35000/ 67.27-90.55 32%	36000-45000/ 93.14-116.43 17.3%	46000-Above/ 119.01-Above 6.9%

1 USD = 386.54 NGN1-0
(N1800-N25000 = $46.57-$64.68, N26000-N35000 = $67.27-$90.55, N36000-N45000 = $93.14-$116.43, N46000 =$119.01)

This study was conducted to ascertain the level of awareness, enrolment and perception of the National Health Insurance Scheme among private school workers in Ibadan, Oyo State, Nigeria. A total of six hundred copies of questionnaire were distributed to respondents who are workers in private schools located in Felele, Ibadan south-east, Oluyole, Ibadan South-west and Bodija, Ibadan North local government areas (LGAs) in Oyo State. Twenty schools were selected in each of the LGA chosen based on each school having at least ten fulltime members of staff (teaching and non-teaching) employed. All copies of the questionnaire were retrieved, analysed and presented using simple percentages and pie charts. Demographic result (in Table 1) indicates that there is almost an equivalent number of male (50.4%) and female (49.6%) staff in the fifteen schools sampled. Their age range is 18-25 years (16.5%), 26-32years (33%), 33-39 years (27.9%) and 40 years above (22.6%). More of the teachers were married (58.2%) than single (40%) and only a fraction of them were divorced (0.9%) or separated (0.9%). A majority of the respondents have a first university degree (69.6%), others have Master's degree (9.5%), Diploma/OND (13%) and O' Level certificate (7.8%). The ratio of teaching to non-teaching staff is at 84.3% to 15.7% respectively. In terms of salary range in Naira, they earn; between 18,000-25,000 (43.5%), 26,000-35,000 (32%), 36,000-45,000 (17.3%) and 46,000 above (6.9%). *(N1800-N25000 = $46.57-$64.68, N26000-N35000 = $67.27-$90.55, N36000-N45000 = $93.14-$116.43, N46000 =$119.01)*

Discussion

By and large, the private school workers or employees have an understanding of what insurance is. Less than half of them know the various types of insurance that exist in the country; vehicle/car (49.6%),

property (42.6%), life (42.6%), health (49.6%) and education (25.2%) as illustrated in Figure 1. Regarding their awareness of the National Health Insurance Scheme, a majority is aware (81.7%) and got information about the scheme from social media (30.4%), radio (17.3%), friends (17.3%), while the remaining do not recollect where they got the information as shown in Figure 2. In spite of this high level of awareness, Figure 3 indicates that virtually all of them (92.2%) are not enrolled under the scheme. Only 7.8% of the sampled population is registered under NHIS. Although in Figure 4 a majority of them are knowledgeable about NHIS, Figure 5 shows that most of them (72.8%) still want to have more information about the scheme via SMS (16.5%), WhatsApp (29.5%), Email (13%), Facebook and face-to-face contact at 6.9% respectively. Only 27.2% of them declined extra information about NHIS and this partly led to conducting the FGD for the study.

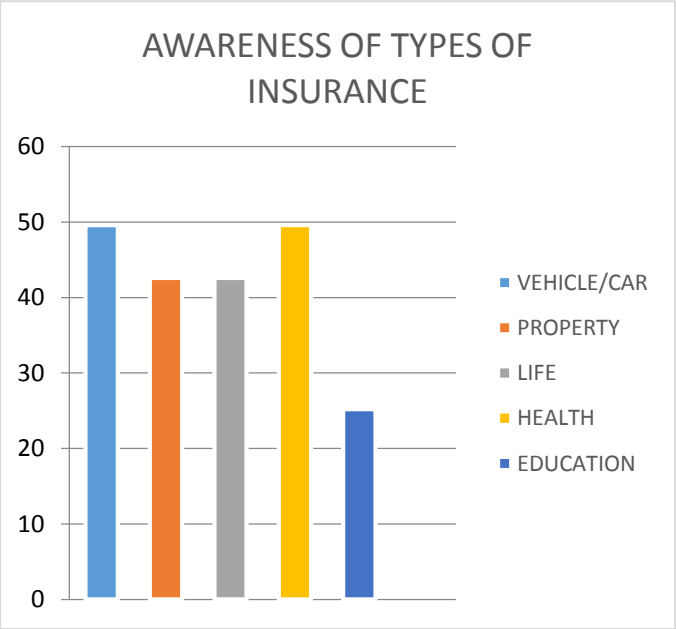

Figure 1: Awareness of Types of Insurance

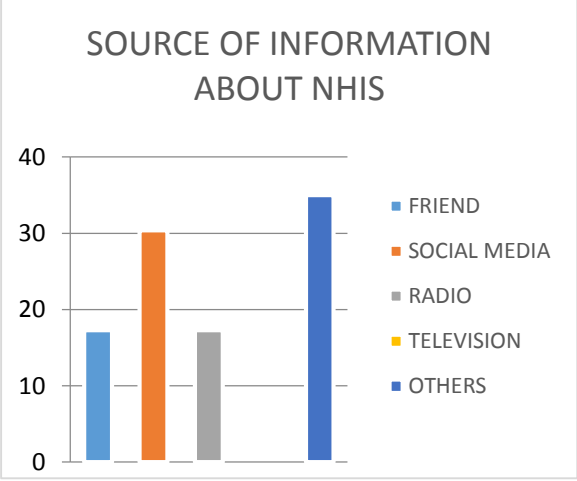

Figure 2: Source of Information About NHS

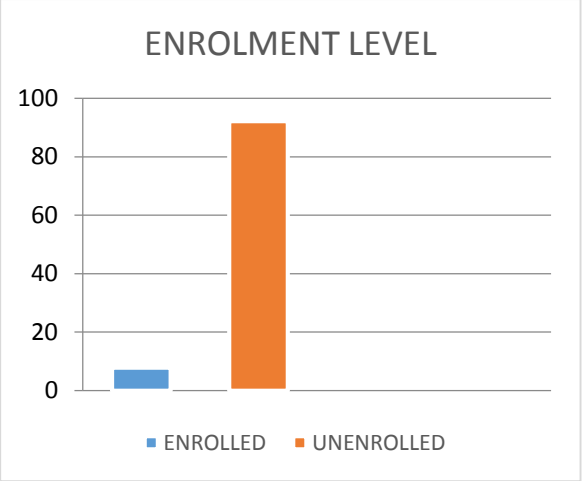

Figure 3: Enrolment Level

Figure 4: Available for More Information on NHIS

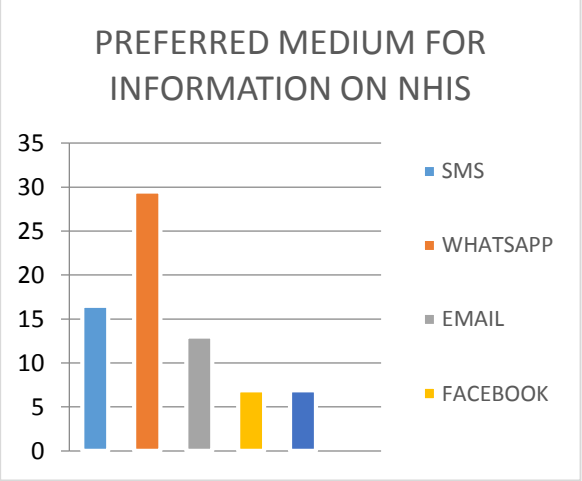

Figure 5: Preferred Medium for NHS Information

The implication of the above is that most private school workers in metropolitan Ibadan are aware of NHIS yet are not enrolled. As a federal government organised scheme in Nigeria; NHIS is more affordable than private health maintenance organization (HMO) insurance and should be more convenient than individual out-of-pocket spending in any standard medical facility. So, one would wonder about the reason for the low level of enrolment as seen in Figure 3. A look at other health insurance scheme jurisdictions shows that there are a lot of questions bordering on trust in the Nigerian situation as represented by the data got from Ibadan. In the United State of America (USA), for instance, healthcare providers are universally well used and well trusted across all subpopulations and may be promising partners for delivering quality health insurance information (Furtado et al., 2016). As well, the researchers found several trends in the ways in which the uninsured pursue information about health insurance, including many ways in which those behaviours differ from health information-seeking behaviours more generally (Furtado et al., 2016). The present study points at a similar scenario as indicated in Figure 2. A majority of the respondents get information about health insurance from friends. This chimes in with the previous position of Furtado et al. (2016), which holds that interpersonal sources of information were trusted more than other media sources such as the internet, newspapers, and magazines. As well, understanding health insurance has been found to be central to affording and accessing healthcare in places like the United States of America (Paez et al., 2014). Hence, such effort needs to be deepened in Nigeria to obtain optimal results in its health insurance scheme.

Furthermore, Zhiying, Wang and Singhal (2019) employed elements of HBM and PMT to carry out a systematic three-part mixed-methods evaluation of *Don't Respond to Strangers (DRTS,* a popular television drama in China that was intentionally produced to raise public consciousness about the insidious nature of domestic violence, to contribute to its elimination, and to protect and uphold the rights of women. In the end of the study, their triangulated results suggested that, overall, *DRTS* was highly effective in using fear appeals to get the public's attention on domestic violence, spur public discussions on the topic, and foster a favourable policy climate—one that culminated in 2015 in the passage of anti-domestic violence legislation (Zhiying, Wang & Singhal, 2019). Such a study with practical development communication agenda has implications for healthcare insurance communication in developing societies such as Nigeria with regard to persuading Nigerians, particularly private school workers to make necessary attitudinal or behavioural change. This is in view of the fact that although the government has successfully advertised the scheme fifteen years after the introduction of NHIS, yet beneficiaries are not taking advantage of the opportunity. The big question is: why are citizens not registering for health insurance in Nigeria? Could it be that the scheme is not quite affordable for the beneficiaries, or they lack confidence in the scheme, or the process of registering is not conducive like some other studies (Sanusi & Awe, 2009; Adewole et al., 2017) have shown?

Outcomes of Focused Group Discussions

The following insightful comments were gleaned during the Focus Group Discussions: *Lack of Enforcement of the National Health Insurance Law*: the law states that "An employer who has a minimum of ten employees may, together with every person in his employment, pay contributions under the Scheme, at such rate and in such manner as may be determined, from time to time, by the Council." All the sixty (60) schools used in this research have a minimum of ten members of staff yet there is no form of contribution towards health insurance and many of the workers are not aware of this law. One of the principals of the schools (an employee, but a management staff) revealed that "employers are not willing to co-contribute because they are not financially up to the task and that there is a high staff turnover so this makes it difficult for them to get into such commitment. That particular school was the only school that had registered members of management staff (Principal, Vice Principal and Head Mistress) under health insurance, though not NHIS and did not co-contribute to get them enrolled.

Low Disposable Income/Unequal Subsidy

The respondents relayed that they earn barely enough to survive. They claim that after transportation and feeding, the remainder is not enough for a decent accommodation let alone health insurance. They suggested that the government should subsidise health insurance for private school workers as it has

done for those in public schools. To them, this measure would encourage them to enrol because they do not earn as much as public-school workers. One of the respondents said; "My sister pays only five hundred naira ($1.29) for NHIS because she is a government worker. Why can't the government make the subsidy go round? Our colleagues teaching in government schools pay the same yet their salary is more than ours. We would like the government to do the same for us at least to encourage us."

Unfavourable Registration Process

It was noted that many of the respondents do not have the knowledge of where and how to go about registering under the scheme. This implies a serious information gap in the system. Even those who claim to know contended that the process is very cumbersome and discouraging. Apart from the registration centre being very far, they argued that one would have to go back and forth before one can get registered. Some of them claimed that from other people's experience, it takes about two to three months to get registered after payment. Worst, some officials say that the process might take a longer time if an intending enrolee who is married does not register their spouse because the system might not recognize such registration. Sometimes after payment has been made, the NHIS system could be down. This implies that one would have to keep checking to find out when one can go back for registration. Also, registration is conducted only one or two days a week.

In this regard, one respondent said; "When I heard about NHIS, I searched for their address, upon getting to the place on your way to Agodi Gardens; the security told me that they had moved to Ikolaba, the street opposite the Federal Secretariat. When I finally located the place, the person who attended to me said I had to go to any UBA bank to pay and make photocopy of the teller before I could be registered.' Another noted that; 'My pregnant sister and I first went to the address we saw online only to be told that they had changed address. We took a bike to the new address and we were told to first make payment at any UBA bank before bringing the teller back to the NHIS office. When I got to the bank (I'd told my sister to wait while I go make payment) there were so many people in the banking hall and the queue for deposit was very long. Break time was almost over so had to postpone making the payment and called my sister to go back home while I returned to work. The next time we got there (NHIS Office) after paying at the bank and making photocopy of the teller, and finishing at the account section, the person to register told us that they only register people from 10am till 2pm so we couldn't register since it was already 3:30pm. The next time we got there, they said their system was down so we should check back later. I decided to get the man's number to be sure of when to return. The first time I called, on a Wednesday, he said they only register on Tuesdays and Thursdays, the following day I called again he said they were doing a system upgrade and that he would call me to inform me when to come and register. To cut the long story short, it took another one month to get my sister registered. Even at the point of registering they told us that if she didn't register her husband there was no guarantee that her name would come out, since the system was programmed that way. I asked about people who didn't have husbands and he didn't reply me. Eventually, my sister's name came out after two months. They didn't even call us; I had to go there to check since the man wasn't picking my calls at that time.' A third respondent said 'I couldn't go through the back-and-forth process so my husband and I registered with a private HMO. Instead of paying fifteen thousand naira ($38.83), we paid forty thousand naira ($103.56) per person, how many people can afford that?"

Lack of Interest Due to Alternative Medicine and Superstitious Beliefs

Both HBM and PMT suggest that the perceived self-efficacy and the perceived severity of a threatening event influences the manner in which people make decisions about their health. Here, some of the respondents claimed that they do not fall sick often and when they do, they seek the help of herbal/traditional healers or alternative medicine, which they believe is natural and has less side effects compared to orthodox medicine. They do not regard information about health insurance seriously because they do not have severe illnesses and it is not only cheaper for them not to purchase health insurance, they can also effectively remove the threat (illness) without health insurance. They also perceive an individual's purchasing of health insurance as being synonymous to attracting sicknesses and diseases to that individual. This they can do because the threat is not so grave. One of the

respondents claimed; "I don't fall ill regularly I can stay for a whole year without getting sick even if I do its minor and all I do is take agbo (local herbal concoction) and I'll be alright at worst I go to the chemist and get my drugs and that's it. Maybe I can register if they'll return my money if after one year, I don't use any hospital or they roll it over'. Another insisted that; 'Only my husband has health insurance and that's because his office provides that, and he's the only one who falls sick. My children and I don't fall sick often, for almost five years now; I've not fallen sick or been to any hospital maybe the day I register for NHIS I'll start falling sick that's why I'm not interested." There is an obvious need for increased enlightenment regarding health insurance among the populations as they fail to understand the underlying purpose of health insurance as a hedge against major medical costs. They are unaware of their personal liability should they become seriously ill.

Conclusion

This study corroborates Adewole et al.'s (2020) submission that poor engagement in partnerships with the beneficial populations result in low level of awareness and knowledge of the government schemes on health insurance and its benefits, which hinders enrolment. Hence, there are a number of issues to address among potential enrolees. These include: non-adaptive behaviour such as positive predispositions or postponing a decision to act later to "wait and see." Such spiritual beliefs that one is protected from sickness or that since one seldom falls sick or has no known family health condition, one does not need health insurance can lead to regrets in the future. Belief in myth and superstitions, such as purchasing health insurance is tantamount to attracting illness and disease to one's self or family; self-responsibility and self-sufficiency – such as depending on uncontrolled herbal mixtures to stay healthy and prevent the body from coming down with diseases or that at the worst, a chemist or pharmacy would suffice; policy regulations: there is the need to address gaps in public policy to help improve perception and enrolment of health insurance in the country such as health insurance subsidy for government workers only, leaving out private workers who are also tax payers.

Therefore, Nigeria needs to develop a workable system of combating healthcare issues in the country by considering targeted subsidies; involving potential beneficiaries in reviewing the scheme's policies and re-strategizing information flow or dissemination on the NHIS programme as well as removing obstacles that are preventing potential enrolees from registering. As Odeyemi (2014) proposed, elements of the community-based health insurance (CBHI) under NHIS in Nigeria can be propagated through suitable incorporation of both formal and informal schemes combined with increased involvement of beneficiaries through improved communication and education, among other efforts. What's more, like Furtado et al. (2016) and Long et al. (2014) suggested, healthcare providers as well as employers could be deployed to introduce health insurance to uninsured individuals by making referrals to community liaisons or trained lay health advisors to deliver further information in order to sustain the NHIS objective.

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