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, good health security, and a National Health Insurance Scheme (NHIS) should effectively support this. No previous study on NHIS in Nigeria has considered private school workers who are a significant category of the health insurance system's beneficiary population. This research in Felele, Oluyole, and Bodija included six hundred questionnaires in sixty private schools alongside focused group discussions in six schools to elicit private school workers' perception of the Nigerian NHIS. Theoretically anchored on the health belief model (HBM) and protection motivation theory (PMT), it 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 deficient enrolment level (7.8%). Also, it portrayed that the lack of NHIS law enforcement, poverty, inequality, unfavorable registration process, and lack of interest hinder enrolment. Nigeria needs to develop a workable system of combating healthcare issues through targeted subsidies, involving potential beneficiaries in reviewing the NHIS's policies and re-strategizing information dissemination on the programme, and removing obstacles that prevent potential enrollees from registering.

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 positions. It is reasonable to expect that the National Health Insurance Scheme (NHIS) should effectively support this. The World Health Organization (WHO) posits that proper attention to workers' health and safety has extensive benefits as healthy workers are productive and raise healthy families. Adequate health insurance is a crucial component to achieving organizational goals, which maintains educators' health to expand and sustain Nigeria's education sector. (1) 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, unlike when they are unwell and cannot work beyond the basic requirements. When organizations are attentive to workers' health, employees tend to focus more on achieving set deliverables, resulting in higher productivity for both organizations and employees. Well-integrated health enhancement initiatives, including enrolment for health insurance, can improve health status and productivity in the workplace. Educators are direct role models, and their sustainable health would immensely affect the generations to come.

Health insurance literacy is simply knowing and interpreting health plans to suit one's needs. (2) Understanding health insurance is essential to affording and accessing health care in any nation (3). While health literacy has been generally studied and measured, health insurance literacy has not (3). For instance, in the United States of America (USA), the success of federal insurance schemes is partly hinged on consumers' ability to understand health insurance and make informed decisions. Therefore, health insurance literacy is one factor that may determine whether consumers select a suitable health

plan and use it to their advantage in all human ecosystems, including Nigeria. There is an urgency to develop better health and health insurance literacy in Nigeria.

The World Health Organization (4) 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 globally, accounting for 19% of global maternal deaths, with an estimated infant mortality rate at 19 deaths per 1000 births and mortality among children under five at 128 per 1000 (5). Communicable and infectious diseases are the major health problems in Nigeria (6) (7) (8) (9). As the general population in Nigeria, teachers are primarily exposed to malaria, respiratory infections, high blood pressure, typhoid, and diarrheal diseases. This is aside from the Coronavirus (COVID-19), which is still infecting thousands of Nigerians, with many deaths already recorded. WHO (10) further indicates that high reliance on out-of-pocket health expenditures has persisted despite consensus moves towards universal health coverage (UHC). Improvement of Nigeria's healthcare system is hindered by insufficient public funding, a high infectious disease burden, increased communicable and non-communicable diseases, and high infant and maternal mortality rates. Therefore, an efficient national health insurance model is required in Nigeria to attain UHC to ensure total access to quality healthcare without the risk of impoverishment. Projections by Azuogu et al. (11) highlight that about a hundred million people globally are pushed into poverty due to out-of-pocket expenditures for healthcare services, causing millions of people not to seek healthcare in hospitals since they cannot afford it. Makinde et al. (12) claim that limited funding, lack of leadership support, inadequate capacity-building opportunities and equipment are the major problems in Nigeria's health system.

Sanusi and Awe (13) contend that 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. Aregbesola (14) relays that since Nigeria's independence in 1960, there has been minimal social protection coverage, with over 90% of the population existing without health insurance. Hence, Nigeria launched the National Health Insurance Scheme (NHIS) in June 2005 to solve inequality in healthcare services and increase healthcare access. The Nigerian medical system has evolved over the years through 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 (14). Therefore, families and individuals are left to bear the burden of a flawed 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. (15) submit that catastrophic health expenditure (CHE) is widespread in Nigeria despite the implementation of the NHIS. Hence, universal health insurance coverage in Nigeria should be fast-tracked to give the expected financial risk protection and decreased CHE incidence. Asakitikpi (16) reveals that healthcare reforms have succeeded in providing medical services for the upper and middle classes and have marginalized the lower level, which constitutes over 75% of the approximately 200 million citizens. The programs that focus on re-equipping government hospitals, ensuring constant power supply, providing foreign drugs and other consumables have mainly

benefitted the upper and middle classes because reformation and commercialization of the health facilities result in higher costs of accessing them. Also, the NHIS is predominantly focused on those who work in public and organized private sectors, with the government subsidizing 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 due to poor financial support, inability to meet beneficiaries' needs, unclear legislative frameworks as well as unrealistic enrolment requirements. Odeyemi (17) contends that Nigeria can address the disappointing uptake of CBHI elements by integrating informal and formal programs alongside increased beneficiaries' involvement through improved communication and education and targeted financial assistance.

Many factors impede the uptake of health insurance in the informal sectors in Nigeria. Previous studies on the NHIS record a low level of awareness, unfavorable perception, and minimal enrollment level (18) (19) (20). Azuogu et al. (11) attribute the low participation of individuals in the informal sector to the limited and irregular income and uncertain employment status. Paez et al. (3) further surmise that many people fail to realize the underlying reason that health insurance serves as a hedge against high medical costs. They are unaware of their liability should they become seriously ill. Although Adewole et al. (21) agree that implementing and expanding health insurance in the informal sector is challenging, they suggest that innovative models are needed to enable potential enrollees to better understand and consent to the concept of prepayment methods for private funding of healthcare. Furthermore, Okaro et al. (22) argue that implementing NHIS is hinged on both the awareness and perception of sustaining the program in line with its creation objectives. This partially explains why Adebisi et al. (23) conclude that NHIS has not fully achieved its goals because health insurance resources delivered via unutilized communication channels that by the target population will likely fail to reach the people they intend to serve (Tichenor et al. 1970, cited in (24).

Hitherto, studies have assessed awareness levels, enrollment, and perception of the NHIS in Nigeria among healthcare providers and consumers. However, no research has included private school workers who should form a significant health insurance system population. Investigation reveals that educators are opinion leaders and have a high level of influence in their various communities. Consequently, this study assesses the awareness, perception, and enrolment levels of private school workers in Ibadan, Oyo State, Southwest, Nigeria regarding the National Health Insurance Scheme (NHIS). It aims to bridge the information gap and contribute strategies towards achieving the NHIS objectives.

Theoretical Underpinning

To theoretically anchor this study, we use the Health Belief Model (HBM) and Protection Motivation Theory (PMT) to highlight the fine points that are critical to bridging the information gap in the awareness, perception, and enrollment levels of private school workers towards improving their contributions to the NHIS in Nigeria. The HBM and PMT have received scholarly attention over time, with the latter coming more under severe criticism, reinterpretation, and revision (25). *However, we find an alignment between the two theories that are profitable in studying the Nigerian situation. This is*

ostensible because they both emphasize the importance of people's attitude and behavioral 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.

Health Belief Model

Health Belief Model (HBM) tries to predict human health behaviors. Carpenter (25); Montanaro and Bryan (26) explain that the HBM was initially 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 behaviors is primarily due to four factors.

1. Perceived Susceptibility: except where there is an imminent risk, one is unlikely to alter one's health behaviors (27). For example, more married women of childbearing age are likely to enroll in health insurance than unmarried ones because of the need for antenatal healthcare.

2. Perceived Severity: Janz and Becker (28) claim that the likelihood of whether or not a person will alter their health patterns to avoid a consequence is hinged on how grave they perceive the implication to be. For instance, 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.

3. Perceived Benefits: persuading people to change behavior can be difficult, especially if they do not see immediate benefits. Humans are reluctant to give up what they enjoy if there is no replacement for it (26). For example, a person will probably not buy health insurance if they are not often sick compared to a frequently ill person. On the other hand, if the less sickly person is promised a rollover or cash return, they would probably enroll for health insurance because there is nothing to lose.

4. Perceived Barriers: one main reason people are reluctant to alter their health patterns is that they think it will be impossible or difficult. Changing health behaviors can be exerting financially and socially (27) (28). For instance, 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 basic needs.

Health Belief Model realistically helps to frame people's behaviors, acknowledging that, at times, just wanting to change one's pattern of payment for healthcare is not enough to make one do so essentially. Furtado et al. (24) reveal that illness may lead the uninsured to seek 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 takes to move an individual to action. They are Cues-to-Action and Self-Efficacy. Firstly, Carpenter (25) posits that cues-to-action are both internal and external events that prompt a desire to make a health change. This helps to move someone from wanting to make a health change to making the change. For example, getting a call from a friend who requests to borrow money to offset hospital bills can convince someone who is aware of health insurance but hasn't enrolled to do so. Also, having

high blood pressure symptoms such as heart palpitations or getting involved in a car accident can convince a person to take a health insurance plan.

On the other hand, self-efficacy analyses a person's conviction in their potential to make health-related adjustments. The belief in one's ability to execute a task can significantly impact one's actual capacity to perform the task (29). Believing that one can save up or take a loan to get health insurance despite one's low-income level can ultimately lead one to get health insurance. It is similar to self-concept or self-perception, where one behaves according to how one perceives themselves. Awosola et al. (30) describe Self-efficacy as part of an individual's ability to negotiate health adjustments in lifestyle successfully.

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 (31) formally coined this model to help explain fear appeals. The PMT suggests that people safeguard themselves based on four factors;

(1) The perceived severity of a threatening event;

(2) The perceived probability of the occurrence or vulnerability;

(3) The efficacy of the recommended preventive behavior;

(4) 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. The coping appraisal constitutes 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 achieve suggested goals (31) effectively. Westcott et al. (32) relay that the diversification of PMT over four decades has been used to explain individual human conduct, families, parent-child interaction, and emergency-relief situations worldwide. Its approach is that prevention is always 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 an investigation, and expanding the outcomes to form hands-on strategies beneficial to the population, could help narrow the awareness-enrollment gap and produce other research possibilities. Maddux and Rogers (33) demonstrate that self-efficacy is "the most powerful predictor of behavioral intentions" preceding actual behavior. Both BHM and PMT's objective is to identify and evaluate the threat and counter this assessment with effective alleviation options. This makes PMT and, by extension, HBM germane to investigating social issues,

including awareness, perception, and enrollment levels of private school workers towards health insurance.

Material And Methods

The Study Site

This study sought to ascertain the level of awareness, enrollment, 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. 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 enrollment levels of private school workers towards the National Health Insurance Scheme (NHIS) in three LGAs in metropolitan Ibadan in Nigeria.

Participants: Six hundred respondents participated in this study, investigating the awareness, perception, and enrollment levels of private school workers concerning NHIS.

Instruments: The researchers designed a questionnaire consisting of two sections. Section A drew information on the respondents' demographic variables, while section B comprised items that measured the awareness, perception, and enrollment levels of private school workers towards the NHIS. The 16-item questionnaire carried a 3-point response format, ranging from "Yes" to "Not Sure." There were no total scores for respondents but total item scores. To complement the result obtained through the questionnaire, the researchers conducted focus group discussions (FGDs) among the staff in six of the sampled 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 staff members, was purposefully selected. The essence of this was to probe further how the workers perceive the NHIS.

Procedure: Six hundred copies of the questionnaire were distributed in the three LGAs that make metropolitan Ibadan in Oyo State, Nigeria. Purposive sampling method was adopted because each of the LGA has a large number of private primary and secondary schools. The criterion for selecting the participating schools was based on each school having at least ten full-time staff members. Hence, twenty schools with at least ten staff (teaching and non-teaching) were purposefully selected in each of the LGA to administer two hundred copies of the questionnaire 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 they were short and straightforward, and respondents filled them on the spot. The researchers organized focus group discussions (FGDs) 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 analyzed using descriptive statistics such as simple percentages, tables, and graphs.

Results

This study was conducted to ascertain the level of awareness, enrollment, and perception of the NHIS among private school workers in Ibadan, Oyo State, Nigeria.

Demographic results in Table 1 indicate 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 was divorced (0.9%) or separated (0.9%). A majority of the respondents have a First university degree (69.6%), others have a Master's degree (9.5%), Diploma/OND (13%), and O' Level certificate (7.8%). The ratio of teaching to non-teaching staff is at 84.3–15.7%, 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 = $43.91-$60.99, N26000-N35000 = $63.43-$85.39, N36000-N45000 = $87.83-$109.78, N46000 =$112.22)

By and large, the private school workers have an understanding of what insurance is. Less than half of them know the various types of insurance that exist in the country (Fig. 4); vehicle/car (49.6%), property (42.6%), life (42.6%), health (49.6%), and education (25.2%). Regarding their awareness of the National Health Insurance Scheme, indicated in Fig. 2, a majority is aware (81.7%) and got information about the scheme from social media (30.4%), radio (17.3%), friends (17.3%). At the same time, the remaining do not recollect where they got the information. Despite this high level of awareness (Fig. 1), virtually all of them (92.2%) are not enrolled under the scheme; only 7.8% of the sampled population is registered under NHIS. Although a majority are knowledgeable about NHIS (Fig. 3), most of them (72.8%) still desire more information about the scheme (Fig. 5) 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 added information about NHIS, and this partly led to conducting the FGD for the study.

Discussion

The implication of the above is that most private school workers in metropolitan Ibadan are aware of NHIS yet are not enrolled. Enrolling under NHIS is more affordable than private HMO insurance and more convenient than individual out-of-pocket spending in any standard medical facility. So, one would wonder the reason for the low level of enrollment. Fifteen years after the introduction of NHIS, the government has successfully advertised the scheme, 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 it, or the process of registering is not conducive like some other studies (18) (19) (20) have shown?

Outcomes of Focused Group Discussions

The researchers gleaned the following comments from the focus group discussions (FGDs):

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 schools accessed in this research have a minimum of ten staff members, yet there is no form of contribution towards health insurance, and many of the workers are not aware of this law. One of the schools' principals (an employee, but a management staff) revealed that "employers are unwilling to co-contribute because they are not financially up to the task and that there is a high staff turnover making it difficult for them to get into such commitment." That particular school was the only school with 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: Many respondents relayed that they earn barely enough to survive. They claim that the remainder is not enough for decent accommodation, after transportation and feeding, let alone health insurance. Most of them suggested that the government extend health insurance subsidies to private school workers for public school workers. This measure would encourage them to enroll because they do not earn as much as public school workers. One of the respondents said, "My sister pays only five hundred naira (less than $1) 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 want the government to do the same for us, at least to encourage us."

Unfavorable Registration Process: Many of the respondents do not know where and how to register under the scheme. This implies a severe information gap in the system. Even those who claim to know contended that the process is very cumbersome and discouraging. Apart from the only registration center being far, they maintained that one would have to go back and forth before registration. Some claimed that it takes about two to three months to get registered after payment and that based on the system's configuration, it could take longer if an intending married enrollee does not enroll their spouse. Sometimes after making payment, the NHIS system could be down. This implies that one would have to keep checking to determine when one can go back for registration. Also, NHIS conducts registration only one or two days a week.

In this regard, one respondent said, "When I heard about NHIS, I searched for their address, their security said they had moved to Ikolaba, opposite the Federal Secretariat. When I finally located the place, I was asked to go to any UBA bank to pay and photocopy 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 realize that they had moved.

They told us to first make payment at any UBA bank at the new address before bringing the teller back to the NHIS office. When I got to the bank, there were so many people in the queue for deposits. I had to postpone making the payment and return to work. The next time after leaving the account section, the person to register told us that they only register people on Tuesdays and Thursdays. 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. Eventually, my sister's name came out after two months" A third respondent said, "I couldn't go through the long process, so my husband and I registered with a private HMO. Instead of paying fifteen thousand naira ($36.60), we paid forty thousand naira ($97.59) per person; how many people can afford that?"

Lack of Interest Due to Alternative Medicine and Superstitious beliefs: Both the Health Belief Model and Protection Motivation Theory suggest that the perceived self-efficacy and the perceived severity of a threatening event influence people's approach to making health decisions. Here, some of the respondents claimed that they do not fall sick often. When they do, they seek the help of herbal/traditional healers or alternative medicine, which they believe is natural and has fewer side effects than orthodox medicine. They do not regard health insurance information seriously because they do not have severe illnesses and can effectively remove the threat without health insurance. They also perceive an individual's purchasing of health insurance is synonymous with attracting sicknesses 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 mixture), at worst I go to the chemist, get drugs and that's it. Maybe I'll 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 from his office and he's the only one who falls sick. My children and I don't fall sick; for almost five years now, I've not been to any hospital; maybe the day I register for NHIS, I'll start falling sick."

There is an obvious need for increased enlightenment regarding health insurance among the populations. They fail to realize that the underlying purpose of health insurance is to cushion the effect of high medical costs. The preceding explains why we used HBM and PMT to fortify this study. Both stress the value of people's attitude and behavioral change in such matters as health insurance literacy and actions in the context of a developing society such as Nigeria. They constitute a critical theoretical template for identifying and evaluating social issues, including awareness, perception, and enrollment levels of private school workers towards health insurance. The Educators we researched seem to be unaware of their liability should they become seriously ill. NHIS coverage in Nigeria needs to be expanded across various sectors through education, improved access to facilities, and partnership with relevant stakeholders to ensure high quality and affordable healthcare services in Nigeria.

Indeed, Christina et al. (34) explain that the sustainability and viability of a country's economic and social growth depend primarily on a vibrant healthcare sector. O'Donnell (35) proposes that only through experimentation and evaluation will the poor in the developing world learn what works in raising healthcare utilization. Hence, investing in education efforts through employers and healthcare providers

as sources of health insurance information could be strategically rewarding (36) (24) as individuals generally trust people more than the media. (37) (38)

Conclusion

This study corroborates Adewole et al.'s (39) submission that poor engagement in partnerships with the beneficial populations results in a low level of awareness and knowledge of the government schemes on health insurance and its benefits which hinders enrollment. Several issues to address among potential enrollees include non-adaptive behavior such as positive predispositions or postponing a decision to act later to "wait and see." Belief in myth and superstitions, for instance, purchasing health insurance, is equivalent to attracting sickness to oneself. Self-responsibility and self-sufficiency, such as depending on uncontrolled herbal mixtures to stay healthy and prevent the body from coming down with diseases. Policy regulations that help improve perception and enrolment of health insurance in the country, such as health insurance subsidy extended to private workers who are also taxpayers.

Declarations

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Conflict of interest

We hereby state that there is no conflict of interest in this study

Ethical Approval

Not applicable

Consent to participate

Not applicable

Consent for publication

Not applicable

Availability of data and material

Not applicable

Code availability

Not applicable

Authors' Contributions

Both authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by Adegoriola Adeyinka M. The first draft of the manuscript was written by both authors, who commented on previous versions of the manuscript. Both authors read and approved the final manuscript.

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References

1. Burton, W. N., Chen, C., Conti, D. J., Schultz, A. B., Edington, D. W. (2006). The Association Between Health Risk Change and Presenteeism Change, Journal of Occupational and Environmental Medicine: March 2006 - Volume 48 - Issue 3 - p 252-263 doi: 10.1097/01.jom.0000201563.18108.af | PubMed| CrossRef
2. Quincy, L. (2012). Measuring health insurance literacy: A call to action. Retrieved from http://consumersunion.org/research/measuring/Health-Insurance-Literacy-a-call-to-action [Google Scholar] Accessed 20 August, 2020.
3. Paez, K., Mallery, C., Noel, H., Pugliese, C., Mcsorley, V., Lucado, J., Ganachari, D. (2014). Development of the Health Insurance Literacy Measure (HILM): Conceptualizing and Measuring Consumer Ability to Choose and Use Private Health Insurance. Journal of health communication. 19 Suppl 2. 225-39. 10.1080/10810730.2014.936568.
4. World Health Organization (2016). *World Health Statistics 2016*. Geneva: World Health Organization.
5. Omoera, O.S. (2010). Broadcast Media in Family Planning in Rural Nigeria: The Ebelle Scenario. *Journal of Communication, 1*(2), 77-85. DOI: 10.1080/0976691X.2010.11884773
6. Muhammad, F., Abdulkareem, J.H., & Chowdhury, A.A. (2017). Public Health Problems in Nigeria. *South East Asia Journal of Public Health, 7*(1), 6-11.
7. World Health Organization (1994). Global strategy objectives and actions for occupational health for all. http://www.who.int/occupational_health/publications/globstrategy/en/index6.html. Accessed 23 August 2020.
8. World Health Organization (2009). *Global Tuberculosis Report-2009*. Geneva: World Health Organization.
9. World Health Organization (2015). Water, Sanitation and Hygiene in Health Care Facilities Status in Low- and Middle-Income Countries and Way Forward.

http://apps.who.int/iris/bitstream/10665/154588/1/9789241508476_eng.pdf. Accessed 26 January, 2020.

10. World Health Organization (2013). *Research for Universal Health Coverage: World Health Report*. Geneva: World Health Organization
11. Azuogu, B. N., Madubueze, U. C., Alo, C., Ogbonnaya, L. U., & Ajayi, N. A. (2016). Level of Awareness, and Factors Associated with Willingness to Participate in the National Health Insurance Scheme among Traders in Abakaliki Main Market, Ebonyi State, Nigeria. *Afr J Med Health Sci*, *15*, 18-23.
12. Makinde, A., Olusesan, A., Samson, B., Adeleke, O., Ohadi, E. M., Dieng, A. D. & Osika, J. S. (2012). *Assessment of the Routine Health Management Information System in Taraba State, Federal Republic of Nigeria*. Bethesda, MD: Abt Associates, Inc.
13. Sanusi, R. A. & Awe, A. T. (2009). An Assessment of Awareness Level of National Health Insurance Scheme (NHIS) among Healthcare Consumers in Oyo State, Nigeria. *Pakistan Journal of Social Sciences*, *4*(2), 143 – 148.
14. Aregbeshola, B. S. Enhancing Political Will for Universal Health Coverage in Nigeria. MEDICC Rev. 2017 Jan;19(1):42-46. PMID: 28225545.
15. Ilesanmi, O. S., Adebiyi, A. O. & Fatiregun, A. A. (2014). National Health Insurance Scheme: How Protected are Households in Oyo State, Nigeria, from Catastrophic Health Expenditure? *International Journal of Health Policy and Management*, *2*(4), 175–180.
16. Asakitikpi, A. (2019). Healthcare Coverage and Affordability in Nigeria: An Alternative Model to Equitable Healthcare Delivery. 10.5772/intechopen.85978.
17. Odeyemi, I. A. (2014). Community-Based Health Insurance Programmes and the National Health Insurance Scheme of Nigeria: Challenges to Uptake and Integration. *International Journal for Equity in Health*, *13*-20. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3941795/Accessed 20 January, 2020.
18. Ukpong, U. (2009). Poor coverage by NHIS worries senate. *Daily Sun* (Newspaper), March 7, 2009.
19. Sanusi, R. A & Awe, A. (2009).“Perception of National Health Insurance Scheme (NHIS) by Healthcare Consumers in Oyo State, Nigeria. *Pakistan Journal of Social Sciences*, 6(1): 48 – 53.
20. Adewole, D. A., Adebayo, A. M. & Osungbade, K. O. (2017a). A Qualitative Survey of Pre-Payment Scheme for Healthcare Services in a Rural Nigerian Community. *Afr J Biomed Res*, *20*, 17-24.
21. Adewole, D. A., Akanbi, S. A., Osungbade, K. O. & Bello, S. (2017b). Expanding Health Insurance Scheme in the Informal Sector in Nigeria: Awareness as a Potential Demand-Side Tool. *Pan African Medical Journal*, 27-52. https://www.panafrican-med-journal.com/content/article/27/52/full. Accessed February 10 2020.
22. Okaro, A. O., Ohagwu, C. C., & Njoku, J. (2010). Awareness and Perception of National Health Insurance Scheme (NHIS) among Radiographers in South East Nigeria. *Am J Sci Res.*, 8(1), 18–25.
23. Adebisi, S.A., Odiachi, J.M., & Chikere, N.A. (2019). The National Health Insurance Scheme (NHIS) in Nigeria: Has the Policy Achieved its Intended Objectives?*Academic Journal of Economic Studies,* 5(3), 97-104.

24. Furtado et al. (2016) Furtado, Karishma & Kaphingst, Kimberly & Perkins, Hannah & Politi, Mary. (2015). Health Insurance Information-Seeking Behaviors Among the Uninsured. Journal of health communication. 21. 1-11. 10.1080/10810730.2015.1039678.
25. Carpenter, C. J. (2010). A Meta-Analysis of the Effectiveness of Health Belief Model Variables in Predicting Behaviour. *Health Communication*, 25 (8), 661–669. hhg doi :10.1080/10410236.2010.521906
26. Montanaro, E. A., & Bryan, A.D. (2014). Comparing theory-based condom interventions: health belief model versus theory of planned behavior.*Health Psychol., 33*(10), 1251-60. doi: 10.1037/a0033969
27. Rosenstock, I. M. (1974). Historical Origins of the Health Belief Model. *Health Education & Behavior, 2*(4), 328–335. doi :10.1177/109019817400200403 .
28. Janz, N. K., & Becker, M H. (1984). The Health Belief Model: A Decade Later. Health *Education & Behavior, 11*(1): 1–47.doi :10.1177/109019818401100101 .
29. Rosenstock, I. M., Strecher, V. J., Becker, M. H. (1988). Social learning theory and the health belief model. *Health Education & Behavior, 15*(2), 175–183. doi :10.1177/109019818801500203 .
30. Awosola, R.A., Omotajo, J.A., & Aigbena, J. E. (2017). Revalidating the child depression scale of the centre of epidemiology studies in Nigeria. In J. A. I. Bewaji, K. Harrow, E. Omonzejie, & C. Ukhun (Eds.).*The Humanities and the Dynamics of African Culture in the 21st Century* (pp.99-106). Newcastle upon Tyne: Cambridge Scholars Publishing
31. Rogers, R.W. (1983). Cognitive and physiological processes in fear appeals and attitude change: A Revised theory of protection motivation. In J. Cacioppo & R. Petty (Eds.), *Social Psychophysiology*. New York: Guilford Press. doi:1080/00223980.1975.9915803
32. Westcott, R., Ronan, K., Bambrick, H., & Taylor, M. (2017). Expanding protection motivation theory: Investigating an application to animal owners and emergency responders in bushfire emergencies. *BMC Psycol., 5*(1):93-114. doi:10.1186/s40359- 017-0182-3
33. Maddux, J.E., & Rogers, R. W. (1983). Protection motivation theory and self-efficacy: A revised theory of fear appeals and attitude change. *Journal of Experimental Social Psychology, 19*(5), 469–479. doi:1016/0022-1031(83)90023-9.
34. Christina, C. P., Latifat, T. T., Collins, N. F. , & Olatunbosun, A. T. (2014). National Health Insurance Scheme: How Receptive are the Private Healthcare Practitioners in a Local Government Area of Lagos State. *Nigerian Medical Journal: Journal of the Nigeria Medical Association*, *55*(6), 512–516.
35. O'Donnell, O. (2007). Access to Health Care in Developing Countries: Breaking Down Demand Side Barriers. *Cadernos de SaúdePública*, *23*(12), 2820-2834.
36. Long, S. K., Kenney, G. M., Zuckerman, S., Goin, D. E., Wissoker, D., Blavin, F., ...Hempstead, K. (2014). The health reform monitoring survey: Addressing data gaps to provide timely insights into the Affordable Care Act. Health Affairs, 33(1), 161–167. doi: 10.1377=hlthaff.2013.0934
37. Johnson, J. D., & Meishcke, H. (1992). Differences in evaluations of communication channels for cancer-related information. Journal of Behavioral Medicine, 15(5), 429–445. doi: 10.1007=bf00844940

38. Rains, S. A. (2007). Perceptions of traditional information sources and use of the World Wide Web to seek health information: Findings from the Health Information National Trends Survey. *Journal of Health Communication, 12*(7), 667–680. doi: 10.1080= 10810730701619992

39. Adewole, D. A., Adeniji, F. I., Adegbrioye, S. E., Dania, O. M., Ilori, T. (2020). Enrollees' Knowledge and Satisfaction with National Health Insurance Scheme Service Delivery in a Tertiary Hospital, South West Nigeria. *Niger Med J*, *61*, 27-31.

Table

Table 1
Study Demographics

Gender	**Male**	**Female**		
	50.4%	**49.6%**		
Position	Teaching	Non-teaching		
	84.3%	15.7%		
Marital status	Married	Single	Divorced	Separated
	58.2%	40%	0.9%	0.9%
Age	18–25 years	26–32 years	33–39 years	40Years-Above
	16.5%	33%	27.9%	22.6%
Educational qualification	First Degree	Masters	Dip/OND	O' Level
	69.6%	9.5%	13%	7.8%
Salary range (NGN/USD)	1800–25000/ *$43.91-$60.99*	26000–35000/ *$63.43-$85.39*	36000–45000/ *$87.83-$109.78*	46000-Above/ *$112.22-*Above
	43.5%	32%	17.3%	6.9%

1 USD = 409.90 NGN

(N1800-N25000 = $43.91-$60.99, N26000-N35000 = $63.43-$85.39, N36000-N45000 = $87.83-$109.78, N46000 = $112.22)

Table 1. Presents a general overview of the study's demographics: population; male to female ratio, position; teaching and nonteaching, marital status, age group, educational qualification and income indicated in naira and US dollars.

Figures

Figure 1

Enrollment Level of NHIS

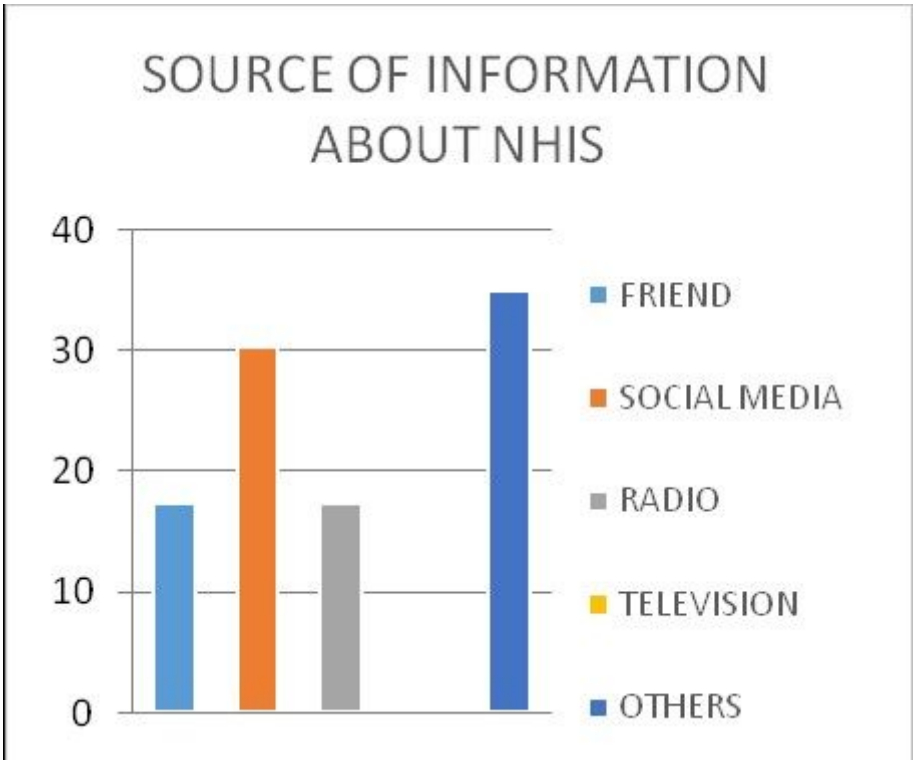

Figure 2

Information Sources about NHIS

Figure 3

Respondents available for more information on NHIS

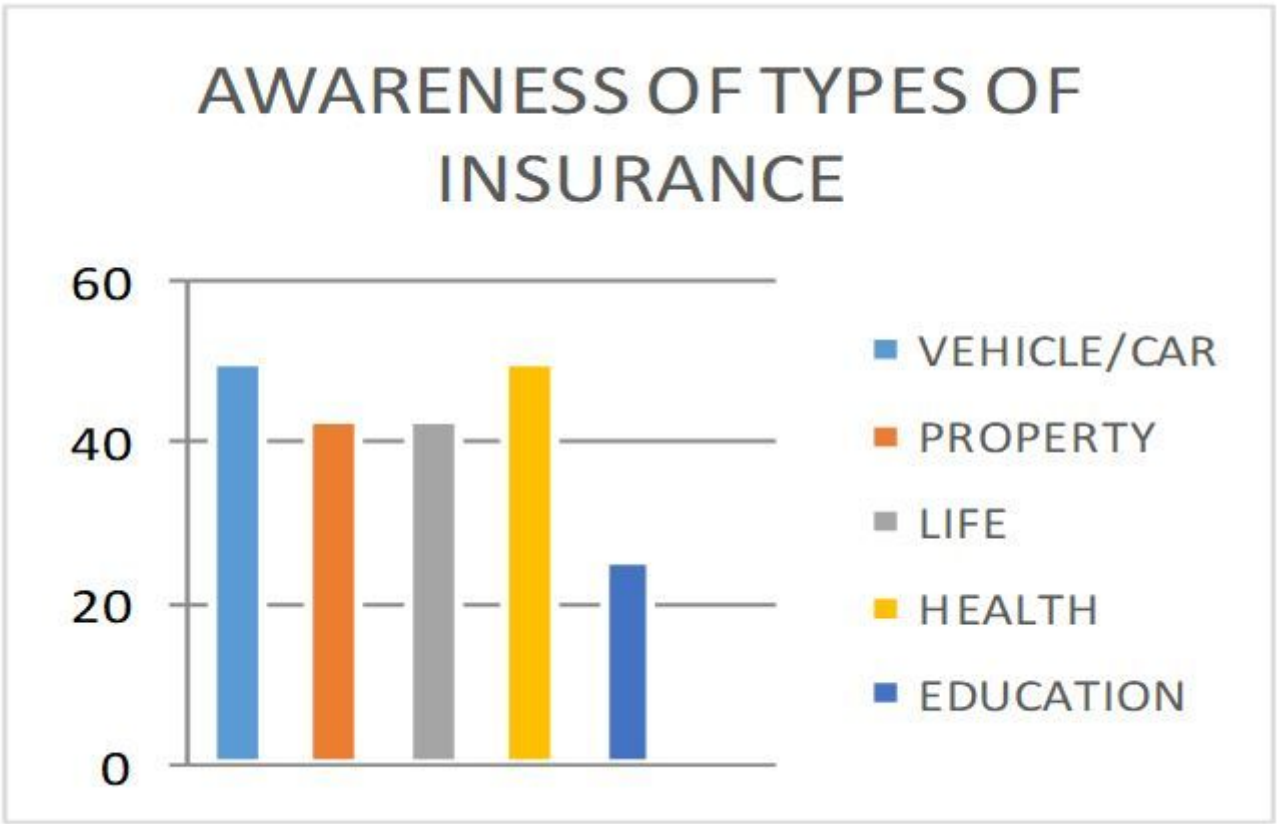

Figure 4

Respondents Knowledge of available Types of Insurance

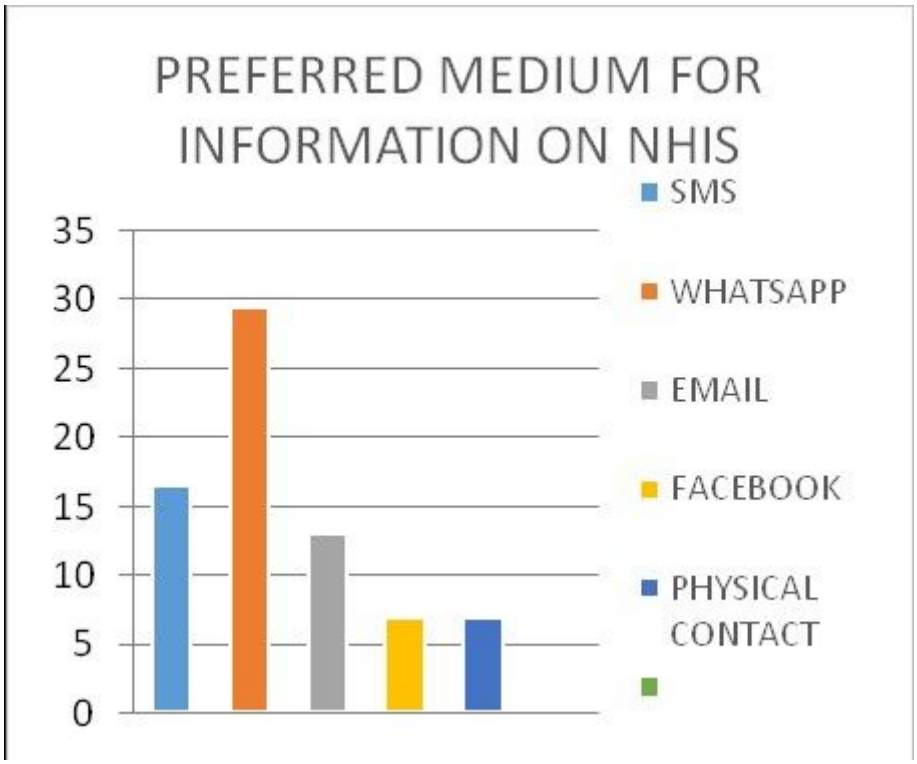

Figure 5

Respondents Prefared Medium for getting more information on NHIS