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**AN APPRAISAL OF THE KATSINA STATE CONTRIBUTORY  
HEALTH CARE SCHEME AS MEANS TO ACHIEVING UNIVERSAL  
HEALTH COVERAGE (UHC) IN KATSINA FEDERAL  
CONSTITUENCY**

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## **ABSTRACT**

*Dating back to the Alma Ata Declaration of 1978; Achieving Health for All by the Year 2000 through the era of Millennium Development Goals (MDGs) up to the present, closing decade of the Sustainable Development Goals (SDGs), the International Community had repeatedly emphasized the significance of health in socio-economic development of the World. Health is one of the 17 SDGs which represent the global call to action for a prosperous and peaceful world. Health is SDG 3: Ensure healthy lives and promote well-being for all at all ages. Universal Health Coverage (UHC) is one of the targets of SDG-3, it is intended to ensure all people have access to quality health services – prevention, treatment, rehabilitation and palliative care whenever and wherever they need them without suffering financial hardship. UHC pillars include (i) population coverage (ii) facilities coverage (iii) and financial protection. The third pillar is ensured by Health Insurance Scheme which has variants, one of which is the contributory health care scheme adopted by various states. The study is therefore aimed at appraising the Katsina State Contributory Health Care Scheme as Means to Achieving (UHC) in Katsina Federal Constituency. A structured questionnaire was designed and data obtained from 200 eligible enrollees of the scheme. The study has the following as its findings high awareness, high registration rate, positive perception of benefits, however, the study recommends that the following challenges should be addressed:-*

*drugs shortages, drug quality concerns, waiting time issues and health worker shortage, effectiveness and efficiency.*

**KEYWORDS:** Millennium Development Goals (MDGs), Sustainable Development Goals (SDGs), Universal Health Coverage (UHC), Katsina Federal Constituency.

## **INTRODUCTION**

Universal Health Coverage (UHC): is a global health drive towards affording full access to the range of quality health services to the people when and where they need them without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life course (www.WHO.int.). UHC is a critical component of the SDGs which include a specific health goal:

To ensure healthy lives and promote wellbeing for all at all ages” (SDG3) within this, health goal target 3.8 is specifically to achieve UHC, including financial risk protection, access to quality essential risk care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

While UHC is the target of SDG 3.8 it brings together all the health issues: disease and population specific health targets in an integrated approach to strengthen health systems and provide comprehensive health care without financial hardship. It is therefore presented as an umbrella for SDG 3. The global movement for UHC is supported by a wide range of international and domestic actors including multi-lateral organizations, bi-lateral organizations, national governments non-state networks and actors. (UHC 2030).

SDG indicator 3.8.1 which is the UHC service coverage and SDG indicator 3.8.2 which is the proportion of the population facing financial hardship in health (www.WHO.int.) have been on the decline as attested to by the Director General UN General Assembly stating that despite improvement until 2015, progress in coverage of essential health services, sustainable development goal indicator 3.8.1 decelerated and stagnated between 2019 and 2021, while catastrophic health spending 3.8.2 worsened continuously between 2000 and 2019.

**The Health care system in Nigeria:** this reflects the following structure. The tertiary level which includes the University Teaching Hospitals and the federal medical centers, the State maintains (secondary health care) which is the General Hospitals and the Primary Health care which includes the dispensaries are maintained by the Local Government Authorities. The private health services are there as a result of the inadequacies of the public health providers.

**Health Financing:** this is a core function of health systems that enable progress towards UHC by improving effective service coverage and financial protection. –today millions of people do not access the services due to the cost; many others receive poor quality of service even when they pay out of pocket. Sufficient and timely disbursement to providers can help to ensure adequate staffing and medicines to treat patients.

**WHO's approach to health financing focuses on the under-listed core functions:**

- Revenue sourcing (sources of funds including Government budgets, compulsory or voluntary prepaid insurance schemes e.g. KATCHIMA, direct out of pocket payment by users and external aid.
- Pooling of funds (the accumulation of prepaid funds on behalf of some or all of the population.
- Purchase of services (the payment or allocation of resources to health service providers (www.WHO.int.)

**Financial protection:** This is at the core of the UHC and is one of the final coverage goals of health financing policies. It is achieved when direct payments made to obtain health services do not expose people to financial hardship and do not threaten living standards. The key to protecting people is to ensure prepayment and pooling of resources for health rather than relying on people paying for health services out of pocket at the time of use.

Catastrophic out of pocket spending defined as exceeding 10% of a household budget. More than one billion people or 14% of the global population experienced such large out of pocket payment relative to their budget. But even small expenditures in absolute terms can be devastating for low income families.

**Out of Pocket Expenditure:** These are direct payments made by individuals to health care providers at the time of service, excluding insurance or government reimbursements. It covers medicines, diagnosis and consultation fees.

Nigeria's percentage of out of pocket expenditure on health is superseded only by Afghanistan, Armenia and Turkmenistan. The Out Of Pocket expenditure as a percentage of private expenditure on health is 95%. The high level of OOP health spending as a major source of health care financing limits the ability of poor households to access and utilize basic health care services. The UNDP voices its concern over out of pocket payments, catastrophic health expenditure relative to poverty. The expectation is for health insurance to

contribute its achievement of UHC because it increases access and utilization by lowering the price of health care. Individuals will have better health if they utilize preventive and curative health care when needed and in a timely manner (UNDP 2011)

**Health Workers Shortage and Distribution:** the chronic under investment in education and training of health workers in relation to health systems contribute to shortages. This is in addition to international migration of health workers which exacerbates shortfalls in low and lower middle income countries (www.WHO.int)

### **Government Health Spending and Budget Allocation**

Dehinde and Osagie listed four main sources of public funding for the public (non-federal) health sector: state Governments, LGAs, Direct allocation from the Federal Government, private individuals and organizations NGOs and International donors. The Federal and some State Governments have increased funding for (primary health care) with a dramatic increase from 2005 to 2007 (Dehinde and Osagie, 2019).

Nigeria spends 5.3% of its GDP or \$139 per capita on healthcare compared to Burkinafaso 6.7% and Democratic Republic of Congo 7.9% which have considerable lower GDP per capita (Dehinde and Osagie, 2019).

One of the main issues facing Nigeria is balancing oil sector revenue and government spending. Over the last few years the accrued oil revenues have not led to improvements on the welfare of most of the population (Dulta & Hongoro 2011). Nigeria rank 156<sup>th</sup> of 173 countries with data on the human development index (HDI) (Okolo et al 2019).

### **Quality of Care and Health Service Delivery Efficiency**

Nigeria is placed at 142 out of 195 countries according to Lancet's report's ranking of health systems performance using healthcare access and quality as its criteria. It also ranks poorly based on the World Bank's UHC service coverage. Although access to healthcare for all Nigerians through the basic minimum package of health service is backed by the National health act, the package has faced huge challenges in dissemination and implementation. Several State Governments are lagging in operationalizing it at ward levels

### **Progress of Achievement towards UHC in Nigeria**

Between 2000 to 2022 impoverishing out of pocket health spending declined mainly because fewer people were further impoverished by health payments from (26.6% to 18.6%) while the share pushed into poverty remained unchanged at (1.9% to 2.8%) however poverty reduction

occurred faster than reduction in impoverishing out of pocket spending resulting in a growing concentration of people pushed into or further into poverty by health costs among those already poor

In a report by Michael (2025) We are proud to enter into partnership with the Katsina State Government to build a more inclusive and resilient health care system. via Bus-der-EHA clinics through this collaboration will not only digitize care processes but also use advanced data analytics and AI to improve health outcomes, reduce costs, and bring life-saving services closer to the people who need them most, aligning with His Excellency's vision. This initiative includes patients' feedback tools.

The Katsina State Government will provide infrastructural support through its ongoing rehabilitation project, ensure registration, oversight and lead communication based enrollment and outreach efforts via the Katsina State Government Contributory Health Care Management Agency (KATCHIMA).

In spite of the above the NASS Committee on Health probes Health Care challenges in Katsina.

Chaired by Amos Gwamna Magaji a National Assembly Committee visited Katsina over the implementation of basic health care services. Magaji expressed concern over the state's high registration rate and zero dose immunization in some LGAs (Mani, Kankara, Safana, Rrimi, Funtua, Baure, Batagarawa and Katsina). He queried the State health care delivery despite Katsina being one of the most educated states. He also queried the oversight of funds approved by NASS. "So we want to know why we are still having constraints, what are the problems? And why we are having challenges in the health care system. The Healthcare indicators are bad" says the committee chairman.

### **State of Health in Nigeria**

- Life expectancy rate is at 52 years which is below African average
- 1 million Nigerian children die by the age of five due to neonatal causes followed by Malaria and pneumonia (Smith and Sulzback 2018).
- Competing priorities make decision on where to allocate resources difficult; political dynamics often have a bigger role in determining the choice than evidence based evaluation of value for money (Gieddion & Diaz 2010)

UHC as an effective way of delivering significant health and economic benefits

1. **Health:** There is significant evidence that UHC bring health improvements to the population of countries that implement them. Researches using data from 153 countries concluded in the Lancet that “broader health coverage generally leads to better access to necessary care and improved population health with the largest gains accruing to poorer people.

2. **Economic:** UHC can be an effective policy to reduce inequalities and poverty levels. The financial protection it provides can help reduce excessive high savings rate in families concerned about unpredictable healthcare costs as has been the case in china. UHC system can generate significant employment in the health and life Sciences sector.

### **Constraints to Achieving UHC in Nigeria**

Inadequate financing, weak governance and enforcement, inadequate infrastructure and poor service quality, household poverty and insufficient risk pooling. (Omehi & Azubuike 2018).

1. Inadequate government financing Dehinde & Osagie listed four main sources of public funding for the public (Non-federal) health sector: State governments, LGAs, direct allocations from the federal government, private industries NGO and international donors (Dehinde & Osagie, 2019).

### **OBJECTIVES OF THE STUDY**

GENERAL OBJECTIVES OF THE STUDY: considering the lack of research regarding catastrophic out of pocket expenditure incurred by enrollee civil servants, the study aims at identifying and appraising the Katsina State Contributory Health Care Scheme as Means to Achieving Universal Health Coverage (UHC).

#### **The Specific Objectives are:**

1. To explore the awareness of the respondents on the different types of Health financing schemes or models
2. Determine the respondents’ perception of the benefits of contributory health care schemes.
3. Determine the respondent’s level of satisfaction with the services offered under the health care scheme.

## METHODOLOGY

### Study Area

Katsina Federal Constituency is represented by Katsina Local Government Area. It is one of the state's thirty-four (34) local governments Areas. It has a projected population of 568,424 people (world population review.com).

The study area experiences a tropical climate, with two (2) distinct seasons; a wet season spanning the period June to October and a dry season lasting between November to May.

### Sampling Method

The study used a quantitative approach where primary data was collected through the administration of questionnaire to 200 respondents out of a total population of 568,424. The 200 respondents were randomly selected Government employees, who are eligible enrollees of the contributory health care scheme at three levels;

1. State Government Employees
2. Local Government Employees, and
3. SUBEB Basic Education Employees

The data analysis was conducted using the Statistical Package for Social Sciences (SPSS).

## RESULTS AND DISCUSSIONS

Correlations			
		Distance of health facility	Registration with KATCHMA
Distance of health facility	Pearson Correlation	1	.090
	Sig. (2-tailed)		.206
	N	200	200
Registration with KATCHMA	Pearson Correlation	.090	1
	Sig. (2-tailed)	.206	
	N	200	200

The Pearson Product-Moment Correlation analysis revealed that there is a weak positive relationship between distance of the facility from respondents' residence and registration with KATCHMA ( $r = 0.090$ ,  $N = 200$ ). However, the relationship was not statistically significant ( $p = 0.206 > 0.05$ ). This indicates that distance from residence does not significantly influence registration with KATCHMA

Sex					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	128	64.0	64.0	64.0
	Female	72	36.0	36.0	100.0
	Total	200	100.0	100.0	

Sex: 64% Male, 36% Female

Age					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-30 years	25	12.5	12.5	12.5
	31-45 years	112	56.0	56.0	68.5
	46-60 years	57	28.5	28.5	97.0
	above 60 years	6	3.0	3.0	100.0
	Total	200	100.0	100.0	

Age: Majority (56%) were 31–45 years

Marital Status					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	27	13.5	13.5	13.5
	Married	162	81.0	81.0	94.5
	Divorced	4	2.0	2.0	96.5
	Widowed	7	3.5	3.5	100.0
	Total	200	100.0	100.0	

Marital Status: 81% Married

Education					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary	3	1.5	1.5	1.5
	Secondary	5	2.5	2.5	4.0
	Tertiary	192	96.0	96.0	100.0
	Total	200	100.0	100.0	

Education: 96% Tertiary education

Employer					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	LG	19	9.5	9.5	9.5
	State	175	87.5	87.5	97.0
	SUBEB	6	3.0	3.0	100.0
	Total	200	100.0	100.0	

Employer: 87.5% State government employees

Monthly income					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	70,000-100,000	93	46.5	46.5	46.5
	101,000-200,000	84	42.0	42.0	88.5
	Above 200,000	23	11.5	11.5	100.0

Total	200	100.0	100.0	
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Income: 88.5% earn between ₦70,000–₦100,000

Place of residence					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Katsina	175	87.5	87.5	87.5
	Others	25	12.5	12.5	100.0
	Total	200	100.0	100.0	

Residence: 87.5% reside in Katsina

The dominance of tertiary-educated civil servants explains the high awareness level of the scheme. Educated individuals are more likely to access information and understand contributory health insurance mechanisms.

Awareness of health financing scheme					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	160	80.0	80.0	80.0
	No	40	20.0	20.0	100.0
	Total	200	100.0	100.0	

80% Yes, 20% No. This shows a high level of awareness of the health financing scheme in the study area. The scheme has achieved strong visibility among the population.

Which do you know					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	cash payment	20	10.0	10.0	10.0
	Contributory scheme	166	83.0	83.0	93.0
	Free Govt. care	13	6.5	6.5	99.5
	Community insurance	1	.5	.5	100.0
	Total	200	100.0	100.0	

Contributory scheme – 83%

Cash payment – 10%

Free government care – 6.5%

Community insurance – 0.5%

The majority are familiar specifically with the contributory scheme, indicating that it is the most recognized healthcare financing option in the area.

Have you heard of contributory healthcare scheme					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	187	93.5	93.5	93.5
	No	13	6.5	6.5	100.0
	Total	200	100.0	100.0	

93.5% Yes, 6.5% No

Almost all respondents have heard about the contributory healthcare scheme, confirming widespread awareness.

<b>How long have you known it</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	less than 1 year	27	13.5	13.5	13.5
	1-3 years	75	37.5	37.5	51.0
	greater than 3 years	98	49.0	49.0	100.0
	Total	200	100.0	100.0	

Greater than 3 years – 49%

1–3 years – 37.5%

Less than 1 year – 13.5%

Nearly half of respondents have known about the scheme for over three years, suggesting sustained awareness over time.

<b>Source of Information</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Radio/Television	99	49.5	49.5	49.5
	Health workers	57	28.5	28.5	78.0
	Community leaders	12	6.0	6.0	84.0
	Friends/Family	32	16.0	16.0	100.0
	Total	200	100.0	100.0	

Radio/Television – 49.5%

Health workers – 28.5%

Friends/Family – 16%

Community leaders – 6%

Mass media is the primary source of information, followed by health workers. This shows media campaigns are effective communication tools.

<b>Do you understand how it works</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	152	76.0	76.0	76.0
	No	48	24.0	24.0	100.0
	Total	200	100.0	100.0	

76% Yes, 24% No

Most respondents understand how the scheme operates, though about one-quarter lack adequate understanding.

<b>Do you know how government and individuals contribute</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	157	78.5	78.5	78.5
	No	43	21.5	21.5	100.0
	Total	200	100.0	100.0	

78.5% Yes, 21.5% No

Majority understand the funding structure of the scheme, which reflects good public education.

<b>Do you know where to register</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	177	88.5	88.5	88.5
	No	22	11.0	11.0	99.5
	3.00	1	.5	.5	100.0
	Total	200	100.0	100.0	

88.5% Yes, 11% No

Most respondents know where to register, indicating good accessibility of enrollment information.

<b>Are you registered with KATCHMA</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	176	88.0	88.0	88.0
	No	24	12.0	12.0	100.0
	Total	200	100.0	100.0	

88% Yes, 12% No

Enrollment is very high among respondents, suggesting strong acceptance of the scheme.

<b>What type of facility are you registered with</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Private	84	42.0	42.0	42.0
	Public	116	58.0	58.0	100.0
	Total	200	100.0	100.0	

Public – 58%

Private – 42%

More respondents are registered in public facilities, possibly due to affordability or availability.

<b>How far is the facility from your residence</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 5km	115	57.5	57.5	57.5
	6-10 km	62	31.0	31.0	88.5
	above 10km	23	11.5	11.5	100.0
	Total	200	100.0	100.0	

Less than 5 km – 57.5%

6–10 km – 31%

Above 10 km – 11.5%

Most respondents live within 5 km of their facility, indicating reasonable physical access.

<b>Is the scheme important</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	164	82.0	82.0	82.0
	No	36	18.0	18.0	100.0
	Total	200	100.0	100.0	

82% Yes, 18% No

The majority believe the scheme is important, showing positive perception.

<b>Does it help people get care easily</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	145	72.5	72.5	72.5
	No	55	27.5	27.5	100.0
	Total	200	100.0	100.0	

72.5% Yes, 27.5% No

Most respondents feel the scheme improves healthcare access.

<b>Does it reduce hospital cost</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	158	79.0	79.0	79.0
	No	42	21.0	21.0	100.0
	Total	200	100.0	100.0	

79% Yes, 21% No

The scheme is widely perceived as reducing financial burden.

<b>Does it help poor people</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	149	74.5	74.5	74.5
	No	51	25.5	25.5	100.0
	Total	200	100.0	100.0	

74.5% Yes, 25.5% No

Most believe the scheme benefits economically disadvantaged individuals.

<b>Does it encourage early hospital visit</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	145	72.5	72.5	72.5
	No	55	27.5	27.5	100.0
	Total	200	100.0	100.0	

72.5% Yes, 27.5% No

The scheme appears to promote early healthcare seeking behavior.

<b>Does it improve service quality</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	125	62.5	62.5	62.5
	No	75	37.5	37.5	100.0
	Total	200	100.0	100.0	

62.5% Yes, 37.5% No

Although a majority agree, a significant proportion do not perceive improvement in quality.

<b>Does it help families save money</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	146	73.0	73.0	73.0
	No	54	27.0	27.0	100.0
	Total	200	100.0	100.0	

73% Yes, 27% No

The scheme is seen as financially protective for families.

<b>Do children and pregnant women benefit</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	166	83.0	83.0	83.0
	No	34	17.0	17.0	100.0
	Total	200	100.0	100.0	

83% Yes, 17% No

Strong perception that vulnerable groups benefit significantly.

<b>Does it reduce deaths due to lack of money</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	106	53.0	53.0	53.0
	No	94	47.0	47.0	100.0
	Total	200	100.0	100.0	

53% Yes, 47% No

Opinions are divided, showing uncertainty about the scheme’s life-saving impact.

Is it beneficial to the community					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	152	76.0	76.0	76.0
	No	46	23.0	23.0	99.0
	3.00	2	1.0	1.0	100.0
	Total	200	100.0	100.0	

76% Yes, 23% No

Most respondents see broader community benefits.

When last did you use the service of KATCHMA					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3 months	71	35.5	35.5	35.5
	4-6 months	44	22.0	22.0	57.5
	7-12 months	55	27.5	27.5	85.0
	Never	30	15.0	15.0	100.0
	Total	200	100.0	100.0	

3 months – 35.5%

4–6 months – 22%

7–12 months – 27.5%

Never – 15%

Majority have used services within the past year, though some registered members have never used them.

How often do you use the service					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Often	33	16.5	16.5	16.5
	Sometimes	102	51.0	51.0	67.5
	Rarely	65	32.5	32.5	100.0
	Total	200	100.0	100.0	

Sometimes – 51%

Rarely – 32.5%

Often – 16.5%

Utilization is moderate; regular use is relatively low.

Are you satisfied with the service					
		Frequency	Percent	Valid Percent	Cumulative Percent

Valid	Yes	106	53.0	53.0	53.0
	No	94	47.0	47.0	100.0
	Total	200	100.0	100.0	

53% Yes, 47% No

Satisfaction is slightly above average, but nearly half are dissatisfied.

Are drugs available					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	101	50.5	50.5	50.5
	No	99	49.5	49.5	100.0
	Total	200	100.0	100.0	

50.5% Yes, 49.5% No

Drug availability is almost evenly split, indicating inconsistency in supply.

Are you satisfied with the quality of the drugs					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	98	49.0	49.0	49.0
	No	102	51.0	51.0	100.0
	Total	200	100.0	100.0	

49% Yes, 51% No

More respondents are dissatisfied with drug quality, which is a concern.

Is the out of pocket expenditure on drugs affordable					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	125	62.5	62.5	62.5
	No	74	37.0	37.0	99.5
	3.00	1	.5	.5	100.0
	Total	200	100.0	100.0	

62.5% Yes, 37% No

Most respondents find drug costs affordable, though over one-third do not.

What is your opinion on the attitude of the staff					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Good	69	34.5	34.5	34.5
	Fair	107	53.5	53.5	88.0
	Poor	24	12.0	12.0	100.0
	Total	200	100.0	100.0	

Fair – 53.5%

Good – 34.5%

Poor – 12%

Most respondents rate staff attitude as fair, suggesting room for improvement.

Is waiting time acceptable					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	109	54.5	54.5	54.5
	No	90	45.0	45.0	99.5
	3.00	1	.5	.5	100.0
	Total	200	100.0	100.0	

54.5% Yes, 45% No

Opinions are divided; waiting time remains a challenge for many.

Overall Satisfaction					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very satisfied	39	19.5	19.5	19.5
	Satisfied	80	40.0	40.0	59.5
	Not satisfied	61	30.5	30.5	90.0
	Very dissatisfied	20	10.0	10.0	100.0
	Total	200	100.0	100.0	

Satisfied – 40%

Very satisfied – 19.5%

Not satisfied – 30.5%

Very dissatisfied – 10%

Overall, about 59.5% express satisfaction, but a significant minority are dissatisfied.

What are the problems associated with the scheme					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Poor awareness	38	19.0	19.0	19.0
	High Cost	18	9.0	9.0	28.0
	Long time waiting	39	19.5	19.5	47.5
	Lack of drugs	96	48.0	48.0	95.5
	Distance	9	4.5	4.5	100.0
	Total	200	100.0	100.0	

Lack of drugs – 48%

Long waiting time – 19.5%

Poor awareness – 19%

High cost – 9%

Distance – 4.5%

The major challenge is drug shortage, followed by waiting time and awareness gaps.

Suggestions to improve the scheme					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	It should be optional	34	17.0	17.0	17.0
	Good drugs should be provided	81	40.5	40.5	57.5
	It should cover more areas but only in the township	4	2.0	2.0	59.5
	The staff of KATCHMA should have a good manner	23	11.5	11.5	71.0
	The Scheme should cover emergency services like ambulance	8	4.0	4.0	75.0
	Transparency and accountability in fund management	4	2.0	2.0	77.0
	Upgrade primary healthcare infrastructure and modern equipment	24	12.0	12.0	89.0
	Improvement of Network service	3	1.5	1.5	90.5
	Frequent inspection from the authority overseeing the scheme	5	2.5	2.5	93.0
	The programme should be cancelled/abolished	5	2.5	2.5	95.5
	Qualified staff and good equipment	9	4.5	4.5	100.0
	Total	200	100.0	100.0	

Provision of good drugs (40.5%)

Upgrade primary healthcare infrastructure (12%)

Improve staff attitude (11.5%)

Qualified staff & equipment (4.5%)

## CONCLUSION

The findings indicate that the Katsina State Contributory Health Scheme under KATCHMA has achieved:

- High awareness
- High registration rate
- Positive perception of benefits

However, the scheme faces critical service delivery challenges:

- Drug shortages
- Drug quality concerns
- Waiting time issues
- Moderate dissatisfaction level

While enrollment is strong (88%), satisfaction is only moderate (59.5% satisfied or very satisfied). This gap suggests that coverage expansion has outpaced service quality improvement.

The non-significant correlation between facility distance and registration suggests that participation is likely employment-driven rather than access-driven.

The health financing scheme demonstrates strong awareness and enrollment among civil servants in Katsina State.

## RECOMMENDATIONS

Sustainability and long-term acceptance of the scheme depend heavily on improving the following:

- Drug supply systems
- Quality assurance
- Health worker attitude
- Infrastructure development

Without addressing these operational weaknesses, beneficiary trust may decline despite high enrollment levels.

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