WIDOWS AND ORPHANS OF SOLDIERS AND HEALTH INSURANCE POLICY IN NIGERIA: AN ASSESSMENT OF NIGER STATE

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Abstract

Life expectancy is a major yardstick for measuring the level of development of countries in modern times. Soldiers and their families were also among those who wanted to attain maximum life expectancy. Health insurance is a gateway to achieving better life expectancy in this modern world. The objective of this study is to assess the health insurance policy challenges for families of soldiers who died in active service. The expectancy theory of motivation was adopted as the theoretical frame. The study targeted widows and orphans of soldiers in Niger state. The respondents were served a questionnaire. The staff of the accredited hospital with a facility by the National Health Insurance Scheme (NHIS) were interviewed to provide health care services insurance information. The sample size for the questionnaire was 135 calculated from 60,047 widows and orphans of soldiers. 120 questionnaires were returned and analyzed. Data analysis was done using SPSS version 23. Frequency tables and simple percentages were generated and analyzed. The time boundary is from 2017 to 2022. Proper implementation of health insurance policy would serve as motivation for soldiers to give their best to the service of their fatherland.

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Introduction

The history of health insurance dates back to 1883 in Germany when Emperor Otto Von Bismarck enacted mandatory legislation on the 'sickness funds' for working Germans Bauernschuster, Driva, and Hornung (2018). Since then, different types of health insurance have continued to evolve among various countries of the world. Payment for health care services can take different forms. For example, out-of-pocket payment, Insurance (which can be made by private or government organisation), and free health service scheme which is mainly carried out by the government or religious bodies. In the developing world, out-of-pocket payment for healthcare services takes the highest degree (Spaan, Mathijssen, Tromp, et al, 2012). This discourages health care accessibility and utilisation, particularly among the financially less privileged group in society. The World Health Organisation (WHO) considers health insurance schemes a worthy means for making universal health care coverage a reality (WHO, 2010). Nigeria has over 80 per cent of its population relying heavily on out-of-pocket expenditures for individuals and family members.

Corporate organisations pay for their workforce through arrangements with private hospitals on a retainership basis, although recently some of them have gradually embraced one form of Health insurance scheme or the other. Spaan, Mathijssen, Tromp, et al (2012) posit that South Americans emphasize that the heavy burden and challenges posed to individuals by out-of-pocket payment for healthcare services have discouraged accessibility to health care facilities in African states. Health insurance scheme which serves as a better option is yet to gain solid ground in most developing countries.

In an attempt to address the burden of out-of-pocket payment for health care services, the Nigerian government under the leadership of former President Olusegun Obasanjo, launched the National Health Insurance Scheme (NHIS) on 6th June 2005. The commencement of services to enrollees, however, started in September 2005 (NHIS, 2014).

The initial enrollees under the scheme were majorly from the formal sector which comprises the public sector, the Armed forces and Allied services. The past two years have witnessed additional registration of organised private sector, students of tertiary institutions and voluntary contributors.

As of 2013, NHIS has only achieved registration of about 5 million enrollees' in a country with an estimated population of over 200 million people since its inception. Has the scheme created sufficient public awareness to encourage individuals to come on board or are there other impediments delaying the increasing surge in the number of enrollees in a country with a serious burden of out-of-pocket expenditure in the health care industry?

The objective of the study is to determine the access of widows and orphans of soldiers to the National Health Insurance Scheme (NHIS) in three Senatorial Zones in Niger state.

Objectives of the study

a. To determine the awareness of soldiers' families of NHIS policy in Niger State from 2017 to 2022,
b. To examine the nature of visits by soldiers' families for medical treatment services in hospitals Niger State from 2017 to 2022,
c. To examine the inclusive nature of NHIS policy on widows and orphans of dead soldiers Niger State from 2017 to 2022.

Research Questions of the Study

a. What is the level of awareness of soldiers' families of NHIS policy Niger State from 2017 to 2022?
b. What is the nature of medical treatment services in hospitals visited by soldiers' families Niger State from 2017 to 2022?
c. How inclusive is the present NHIS policy on widows and orphans of dead soldiers Niger State from 2017 to 2022?

Literature Review

National Health Insurance Scheme

The idea to build a national health insurance that would greatly address out-of-pocket payment for health care services was muttered in 1962 after Nigerian independence from her colonial master. Various governments that succeeded the then government attempted to take steps into actualising the dream of a national health insurance scheme but none of them did any palpable work to realise the vision. To worsen the situation, the country was forced into a military dictatorship that lasted for over 3 decades. None of the military Head of State took a giant stride into actualising health insurance for a teaming Nigeria population. It was not until the democratically elected government under the leadership of former president Olusegun Obasanjo launched the very laudable National Health Insurance Scheme (NHIS) on 6th June 2005. The scheme was established under Acts 35 of 1999 by the federal government of Nigeria with the singular aim of providing easy access to health care for all Nigerians (irrespective of age) at an affordable cost through various prepayment systems (NHIS, 2004). The journey from 2005 till date to achieve a wider coverage of the population and give succour to Nigerian citizens, especially the widows and orphans of soldiers through NHIS has been a daunting task.

The provision of health care services by the National Health Insurance Scheme (NHIS) is through the pooling of funds from the participating governmental and non-governmental bodies. This is different from the situation witnessed in the National Health System (NHS) in Britain where the government uses tax-payers money to operate the system. The contributions made to NHIS cover different dimensions of health care benefits for the enrollees including the employee, a spouse and four biological children who are under 18 years of age (NHIS, 2014). However, an additional payment by the principal beneficiary can be made under a defined payment system for more dependents or their biological children who are above 18 years old.

The benefit packages for NHIS enrollees are out-patient care for enrollees, approved drugs as prescribed by the physician, pharmaceutical care and laboratory/ diagnostic, tests, Maternity care

which extends to four live births, preventive care like immunization, under the Extended Programme on Immunisation (EPI), health education, antenatal care, postnatal care and family planning. Others are consultation under secondary care with specialists, Hospital admission not exceeding a cumulative 15 days per year, ophthalmological examinations and care but without the provision of spectacles and contact lenses for enrollees, preventive dental care and pain relief and a range of prostheses which is limited to artificial limbs made in Nigeria (NHIS, 2014). Other extended benefits to the enrollees under the NHIS include a referral from one hospital to another depending on the nature or severity of the health problem. For example, a referral of a patient from a primary to a secondary health care facility, or a secondary to a tertiary health care institution. NHIS utilises strategic health communication in its rural community-based programmes to facilitate social change. There are obvious exclusions that are well defined by NHIS in her service to enrollees. They include (but are not limited to) management of infertility, organ transplants, overseeing treatment of chronic health conditions, etc.

The formal sector of the Social Health Insurance programme under NHIS is a social health security system which is designed to take care of employees' healthcare needs from funds created by pooling the various contributions of employees and employers in the formal sector (NHIS, 2014). It is worth noting that the formal sector consists of the public sector, organised private sector, Armed forces, police and allied services, students of tertiary institutions in Nigeria and voluntary contributors. The contributions made into the common fund are earning-related i.e., contributions are made depending on the basic salary of the enrollee. A total of 15% of the employee's basic salary is contributed to the common pool. The employer pays 10% while the employee pays 5%. An additional payment is made by an enrollee when accessing health care services. This time, only 10% of the total cost of drugs dispensed (excluding consultation) is paid to the healthcare facility. The market structure seen in NHIS does not follow a normal market pattern in Structure, Conduct and Performance (SCP) as witnessed in other industries. However, there exists an interplay

between monopolistic competition and oligopoly. Moreover, the healthcare market presents difficulty in measuring its product and cost (TAU, 2014).

NHIS has the characteristics of a matrix organisation. It is a horizontally based organisation which is programme-focused rather than position-oriented. (TAU, 2014). There are different tentacles used by NHIS to provide health care services to enrollees and also judiciously manage the available resources. The Health Maintenance Organisation (HMO) receives money from NHIS and disburses it, in the form of capitation payment for primary care, to Health Care Providers (HCPs). Additionally, the HMO pays fee-for-service to HCP for secondary and tertiary health care services. There is reciprocal accountability on the part of the HPC to give regular information to the HMO about enrollees' usage of healthcare facilities. The NHIS oversees the activities of the HMO and HCP and regularly monitors patient satisfaction with health care services.

Healthcare of families of military globally (the case of the USA)

Military health care in the United States is faced with low or few practitioners serving during and after the war. This affected many military families as regards the health insurance system. Survey studies in 2007-2015 discovered that only about 2% of military kids had insurance through Tricare in the United States. 37% of its citizens are covered by a government programme called Medicaid. As 51% are insured by privates and 10% were uninsured. Although, children with special needs appear to have less access to Tricare than other types of coverage. It is the same phenomenon in military families. However, having an integrated healthcare insurance policy of Tricare, especially for military widows and orphans. This motivated the military personnel to achieve high success in war and enhanced the state aggression defence (Rapaport, 2019). More than 9 million United States citizens enjoy the Tricare insurance health system. To this, widows and orphans of soldiers were not exempted. Any uninsured persons with public health insurance, are subject to private health insurance and easily accessible for life, unlike the case of Nigeria (Zickofoose, 2013).

To this, many citizens are compared to Tricare, Medicaid and Marketplace plans in health insurance benefits policies. It is therefore obvious that families of military enjoy the health insurance of Tricare of which widows and orphans of soldiers are not exceptional as the case may be.

Health insurance programmes in some selected African states

The burden of ill health especially from communicable diseases and emerging and reemerging diseases in the face of the heavy burden of out-of-pocket payment modality in sub-Saharan Africa, there was a singular need to establish health insurance schemes in countries in the region. Some countries took steps, some years ago to introduce health insurance schemes into their national life. However, the journey towards its full realisation in those countries was challenging and daunting. Problems of poverty, wars and consequential displacement of individuals and communities made it difficult to organise a vibrant health insurance scheme. Liberia, for example, is still recovering from long years of civil war. There is no well-organised and affordable health insurance scheme in place for widows and orphans of late soldiers. The available ones are deeply into for-profit business (Pacific Prime, 2014).

Ghana smoothly kick-started its health insurance scheme in 2004 and it has presently recorded success of about 60 per cent national coverage (Ghana-NHIS, 2010). South Africa has both private and public health care systems. The vast majority of the population access the public health care system, while the wealthiest 20 per cent of the population access their health care needs in the private system. The South African public health care system is chronically understaffed and underfunded. There is no national health insurance scheme in place. However, the present government is taking steps towards actualising national health insurance to cater for the health needs, especially, of the low and middle class. Meanwhile, the Nigerian health insurance scheme has only recorded about 5 per cent national coverage since its inception in 2005. Other countries in sub-Saharan Africa have various levels in the organisation of health insurance programmes for their citizenry.

Theoretical framework

This study adopted the life expectancy theory of motivation that stated increase in life leads to an increase in performance. Such that if an individual works harder, then he or she should prepare a greater presentation on global warming. Various factors affecting this belief may include available resources like materials and time to get the job done. This theory of motivation of expectancy proposes an individual will increase behaviour or act in a certain way because they are motivated to select a specific behaviour over other behaviour due to what they expected as a result of motivation in a given workforce. This implies that motivation for any behaviour performed by an individual depends upon the desirability of the outcome of an input. For instance, a football player is likely to play well in the World Cup because he aims to win, so also a soldier's target is to win a war and the aftermath expected great motivation even if he or she loses his life. The core of this theory solely depends on the cognitive process of how an individual analyses and processes motivational elements and can achieve a set goal. This theory was first motivated by Vroom (1964) of the school of management with the assumption that an individual behaves after contemplating his choices, thus choosing the one that results in maximum pleasure and minimum pain. Vroom (1964) further outlined three core variables in his theory.

Namely; (1) Expectancy (E), (2) Instrumentality (I), and (3) Valence (V).

Expectancy (E)

It's a belief that an increase in effort leads to an increase in performance. That if you work harder, then you will be rewarded in a great way. The factors that affect these are:

a. The available resources such as the latest equipment and time to get the job done.
b. Having the right skills for a job.
c. Necessary support from supervisors and correct information about the job.

This leads to the belief that the job is in fact under control.

Instrumentality (I)

Instrumentality is a belief that an appropriate reward will be received for the right performance. The reward for the first performance also affects the second-level performance. For instance, an individual receives a reward for a car if he or she sells a house well. This belief can be affected by the following factors:

d. The rules of the reward game must be clear. This implies, there should be a clear understanding about what the reward will be for the required performance.
e. The individuals performing must have trust in the authority figures who decide what outcome to receive from other individuals.
f. The process of rewarding a given performance must be transparent.

Valence (V)

Valence is the importance one places on the outcome that is expected. For instance, if a person after his/her retirement or demise would be taken care of, he or she would be motivated by the life of colleagues who had received such privilege. Again, if the person values the privilege of retirement or care for his/her family after active service he/she would not be intrigued by the opportunity to get time off while on any assignment.

Observations

The three elements are important in choosing one element over another because they are clearly defined as effort-performance expectancy (E>P expectancy) (P>O expectancy).

E>P expectancy: Here is an assessment of the probability that our successful efforts will lead to the required performance.

P>O expectancy: Here is an assessment of the probability that successful performance will lead to certain outcomes for the workforce.

Vroom's expectancy theory works on perceptions. Meaning, an employee might think that the company atmosphere is perfect to boost his motivation. However, in the same company, there might be

someone who feels that the process doesn't work for them. Vroom proposed the theory of management and motivation. It is often confusing to apply only to traditional workplaces but can also be recognised and applied in the modern world. For instance, an individual studies for an exam because he or she can score better in the exams (expectancy), and it means the more you study the better the motives viz-a-viz instrumentality. Hence, the expectancy theory developed by Vroom isn't really about an individual's self-interest in rewards, rather it's about the association people make towards expected rewards and the level of performance they can offer to attain those rewards.

The main goal of expectancy theory is to yield the best possible outcome. So, in that sense, to receive maximum performance from individuals, employers must use transparent systems that closely relate rewards with performance. Another thing to look upon is that the rewards offered must be desired by the employees. The vital aspect is that the employee must know that the more effort he or she puts in, the better the outcomes will be. This means that if widows and orphans of dead soldiers are given high consideration in health insurance proportionally, it can lead to soldiers' performance. This shows that the theory is suited for this study.

Methodology

Study setting

The study was conducted in the three senatorial zones of Niger state, namely; Niger south (Zone A), Niger East (Zone B) and Niger North (Zone C) of the targeted widows and orphans of soldiers in Niger state, Nigeria. Specifically, Minna, Suleja, Bida, New Bussa and Kontagora were the settings where the respondents were served questionnaires. Some of the staff of the accredited hospital with facilities by the National Health Insurance Scheme (NHIS) were interviewed to provide health care services insurance information.

Ethical clearance

Permission was obtained from the widows and orphans of the soldiers, the Hospital Ethics committee, and written consent (in the form of a 'ticked consent') was also obtained from the participants after an explanation of the survey and assurance of anonymity and confidentiality.

Study design

This was a cross-sectional survey that made use of pilot a tested questionnaire which was administered to widows and orphans of soldiers in three senatorial zones of Niger-state.

Inclusion criteria

Adults attending the clinics who gave consent conscious and alert patients who could answer questions adequately as regards national health insurance schemes.

Exclusion criteria

Very young (infants) orphans' children of the soldiers were excluded from the study, including unconscious widow patients, were excluded. Those with severe mental illness both widows and orphans of soldiers were also excluded.

Population and Sample size estimation

Nigeria has over 8 million widows and 21 million children (orphans). Niger State has 60,047 widows and orphans of soldiers (TRADOC, 2022). This was estimated to be 135. The sample size was calculated using the formula (Araoye, 2003):

This stated that if the population study is less than 10,000 it applies $N=n/(1+n/N)$ but if it is more than 10,000 is $N = Z^2 p (q \text{ or } 1-p)/d^2$.

N= desired sample when the population is greater than 10,000

Where Z = standard normal deviation which is usually set at 1.96 and corresponds to the 95% confidence level.

P = the proportion in the target population estimated to have a particular characteristic of widows and orphans in Niger state i.e. prevalence here 9.7% = 0.097.
d = degree of accuracy desired which is usually set at 0.05 or tolerable alpha error or level of precision = 5% = 0.05.
q = compliment probability of p=1-p 0.903.
thus; n 1.96^2 X 0.096^2 X 0.097 X 0.903/0.05^2 = 135.

Data collection and analysis
Questionnaires were distributed to 135 respondents. 120 were returned and analyzed. The data collection was done by the researcher and trained assistants from 2017 to 2022. The content of the questionnaire was carefully translated into local languages for those who could not read English without altering the meaning of each question. The questionnaires were collected from the participants immediately after answering them to avoid loss in transit. The information obtained from respondents was coded for easy translation into data. Data analysis was done using SPSS version 23. Frequency tables and simple percentages were generated and analysed.

Data Presentation and Analysis
In this subsection, the data collected through questionnaires in the field is presented and analyzed using frequency and simple percentages.

Bio-social data of Respondents
The biographical data of respondents are analyzed in this section to ascertain the group of respondents who are the target population in this study.

Table 1: Age Group

Variable	Frequency	Percentage
No response	4	3.3
<=20	10	8.3
21-30	35	29.2
31-40	29	24.4
41-50	25	20.8
51-60	13	10.8
61 and above	4	3.3
Total	**120**	**100**

Table 1 above depicts the age group of respondents in this study. It shows the modal age group in this study was 21-40 years (29.2%).

Table 2: Marital/orphaned status of respondents

Single	3	2.5
orphans	72	60.0
Separated	10	8.3
Divorced	1	0.8
Widowed	34	28.3
Total	**120**	**100.0**

Table 2 above depicts the widows/orphans and employees of respondents in this study. There were more orphans (64.2%) than widows (35.8%) in the study.

Table 2: Employment status of respondents

Variable	Frequency	Percentage
No response	3	2.5
Employee	50	41.7
Not employee	31	25.8
Student	24	20.0
Apprentice	6	5.0

Others	6	5.0

On the respondents' employment status, 50 (41.7%) were employed while 31. (25.8%) were not employed. The students among them were 24 (20.0%) and the apprentices were 6 (5.0%), while the rest did not specify their employment status (5.0%) or decided to remain silent on it (2.5%).

Table 3: Sex of Respondents

Males	43	35.8
Females	77	63.2
Total	**120**	**100.0**

Table 3 above depicts the sex of respondents in this study. There are more females than males. The females were more responsive than the males.

Table 4: Marital/orphaned status of respondents

Single	3	2.5
orphans	72	60.0
Separated	10	8.3
Divorced	1	0.8
Widowed	34	28.3
Total	**120**	**100.0**

Table 4 above depicts the marital status of respondents in this study. A greater percentage of the respondents were orphans (60.0%), others were widows (28.3%), those separated 10 (8.3%), and those divorced 1 (0.8).

Table 5: Educational Qualification of Respondents

No response	2	1.7
Primary	8	6.7
Secondary	44	36.7
Tertiary	58	48.3

Others	8	6.7
Total	**120**	**100.0**

Table 5 above depicts the educational qualifications of respondents in this study. A total number of 8 (6.7%) respondents only had primary education, 44 (36.7%) had secondary education, 58 (48.3%) were tertiary, 8 (6.7%) had no formal education, and 2 (1.7%) did not indicate their educational status. The majority of the respondents passed through tertiary education.

Table 6: Widows and orphans of soldiers' enrolment under NHIS and Hospital visit

(Have you visited the hospital before for medical treatment services?)

Response	Percentage
Yes 103	85.8
No 17	14.2
Total 120	**100.0**

Table 6 above depicts the Hospital visits of respondents for medical treatment services.103 (85.8) respondents affirmed that they have visited the hospital for medical treatment services.

Table 7: Mode of payment for health care services

Visit of respondents (Mode of payment for health care services)

Response Variable	percentage
(no response) 17	14.2
Out-of-pocket payment 78	65.0
Insurance (e.g. NHIS or others)13	10.8
Free govt. Health care program 9	7.5
Others 3	2.5
Total 120	**100.0**

Table 7 above contains the information on hospital visits of respondents with the mode of payment for medical treatment. The majority of them

103 (85.8%), indicated that they had visited the hospital for treatment in the past but the rest did not. A far greater percentage of the respondents (65.0%) accessed health care through an out-of-pocket payment modality than the National health insurance scheme; only 10.8% were insured. Others accessed care through free government health care programs (7.2%), while a total of 16.7% did not specify their mode of payment for health care services.

Table 8: Awareness of NHIS (Are you aware of NHIS policy?)

Variable		percentage
Yes 82	68.3	
No 38		31.7
Total 120		**100.0**

Table 8 above depicts the aspect of NHIS awareness, 82 (68.3%) were aware of NHIS while 38 (31.7%) were not aware.

Table 9: Awareness of NHIS (If yes for how long have you been aware of it?)

Variable		percentage
(no response) 38		31.7
<1year 20		16.7
1-3years 48		40.0
4-6years 9		7.5
> 6 years 5		4.2
Total 120		**100.0**

Table 9 above depicts the modal year group as 1-3 years (40.0%).

Table 10: Widows and orphans of soldier beneficiaries under NHIS (Are you still a beneficiary of the NHIS policy?)

Variables		**percentages**
Yes 38	31.7	
No 82		68.3
Total 120		**100.0**

The table above depicts the information on enrolment into NHIS which revealed that only 38 (31.7%) were enrolled at the time of this study. Others 82 (68.3%) were yet to be enrolled on the scheme.

Table 11: Awareness of any Health Insurance Program vs. Present inclusive of widows and orphan's status benefits

Variables	**percentages**
Yes 39	32.25
No 81	67.75
Total 120	**100**

The above table indicates that most of the respondents' responses 81 (67.75%), answered in the negative, while 39 (32.25%) are in the affirmative in regards to widows and orphans' inclusive benefits in NHIS across the three senatorial zones in Niger state.

Analysis of qualitative data on Health insurance policy for families of military personnel

A newspaper report is qualitative data used in this research to back up the findings of the study. The report explains the meeting held with major stakeholders in the military regarding the establishment of health insurance policies for the military. Tricare is the service provider for military personnel and their families. They are expected to enroll with national health insurance to receive health care benefits at low or no cost. Odita (2022) in the Nigerian Guardian news reports an event that.

The Managing Director, Military Health Management Limited (MHML), retired Rear. Admiral Azeez Afolayan called on serving and retired military family personnel to properly enrol in the National Health Insurance Scheme (NHIS). Afolayan made the call at a one-day parley with military veterans with the theme, "Strengthening Health Insurance Cover for the Military Veterans" in Abuja. He said the welfare and comfort of military veterans was a thing of concern, adding that military serving, retirees, widows and orphans were accorded the status of special citizens and respected and treated as such in many

advanced countries. Afolayan, a surgeon, said military veterans generally are unaware of the contents of the benefits package in the MHML programme, saying the interactive meeting was intended to bring the veterans closer to the organisation.

Odita in the Nigerian Guardian news report reports (2022) further that:

> He added that the meeting was also convened to enable them to interact with veterans in such a way as to fully benefit from the various provisions made for their health insurance coverage with MHML. He observed that the health insurance benefits package for retired personnel is the same as that for the serving personnel and should be extended to widows and orphans of deceased military officers. "The idea that as retirees, and families of the deceased military officers some items in the benefits package have been removed. In fact, as a result of advancing age and the predisposition to several chronic illnesses, more funds are expended on retirees and deceased military officers than on serving personnel… Likewise, more time and attention are required in proffering solutions to the many health challenges of retired and deceased officers compared to serving personnel. The benefits package for military veterans is very comprehensive and covers virtually all commonly encountered medical scenarios, including your dental and ophthalmic needs"

In the same report, there was an assessment of the participation of ex-servicemen and their families and that of widows and orphans of dead soldiers:

> Director, of Joint Services, Ministry of Defence, Mrs. Olu Mustapha, represented by the Deputy Director, Veteran Affairs Division, Dr Jude Alozie, said there had been low awareness of the activities of the agency among retirees and even with the exemption of orphans and widows.
>
> Mustapha said the interactive meeting would provide an opportunity for veterans to get a grasp of the programme of MHML, how to assess ii and make contributions on how to make

> it work better. She urged participants to be open and make their honest contributions. The director assured them that the government would continue to care for them, especially in the area of health.
>
> The Secretary-General, Nigerian Legion, retired Group Capt. Kayode Abe said the meeting was long overdue because a lot of retirees and ex-servicemen were not truly aware of what the organisation had been doing. He said that while many people retired and went to their villages, they had not been able to enrol on the programme to enable them to benefit. He said that one of the challenges encountered by those under the scheme was the disparity in treatments in terms of the quality of drugs. And exemptions for many widows and orphans of soldiers. He stressed further that, the interactive session will be an avenue to expose all the shortcomings in the system and a lot of facts are coming up as to why we may not be able to have complete medical coverage under this arrangement. He called on the services to provide more support for MHML to be able to provide better services to the veterans. And or the widows and orphans of the soldiers (Odita, 2022).

On a final note, Odita reports that

> Earlier, the Head of Administration, MHML, retired Commander Joshua Alabi, said the main objective of the organisation is to ensure that all military personnel, both serving and retired, their spouses, and biological children below age 18 should have easy access to good health services. Alabi said the initiative was born out of the desire to ensure that the health of retired men and women was taken care of. Which required that of widows and orphans of soldiers concurrently.

He urged participants to disseminate to their colleagues who had not enrolled to do so to benefit from the health package provided by the system. The system should also recognise the deceased's widows and orphans of the military (Odita, 2022).

Discussion

In consideration of the daunting challenge facing both widows and orphans who access healthcare facilities through national health insurance but end up in out-of-pocket payments in hospitals and healthcare centres who need not continue their practice despite the present economic downturn, this study has painstakingly assessed the public awareness of the National Health Insurance Scheme (NHIS) policy among widows and orphans accessing the accredited health cares (hospitals) across the three senatorial zones in Niger state, Nigeria. There were more females (64.2%) than males (35.8%) among the respondents in the study because of the targeted study.

This could be a result of improved uptake of antenatal, post-natal, and other maternal/child care aspects of health care services for both orphans and widows. Also, in support of this, was the greater number of respondents in the various reproductive age groups viz-a-viz 21-30 years (29.2%), 31-40 years (24.2%) and 41-50 years (20.8%). Other age groups did not individually record above 10.8%.

Additionally, 'widows' respondents (60.0%) were indicated as the highest among the various target statuses in the study.

A greater number of respondents were educated in secondary (36.7%) and Tertiary education (48.3%). This was against the number of respondents under Primary education (6.7%), none (6.7%) and undecided (1.7%). However, the association between educational level and awareness of NHIS on widows and orphans of soldiers was weakly statistically significant ($p=0.045$). In the study done similarly by Sabouhi et al (2011), educational level and awareness were statistically significant, although the study was not, particularly on NHIS alone but on widows and orphans of soldiers' continuity of health insurance benefits.

Worthy of note was the greater number of respondents (68.3%) who were aware of NHIS compared with those who were not aware (31.7%). Out of this (those aware) about 56.7%, Some of the widows and orphans only got to know about NHIS policy for the past 5 years. This reveals that increasing publicity of the Scheme must have been put in place for the past 5 years. Earlier studies done within the three

geopolitical zones of Niger state, after a few years of the inception of the NHIS, reported high levels of non-inclusiveness of widows and orphans of soldiers in health insurance. Omosehin et al. (2006) reported 99.5% poor concern about NHIS among widows and orphans of soldiers respondents in his study, while Sanusi and Awe (2009) had 87% low inclusiveness of widows and orphans of soldiers in NHIS policy.

The study by Omosehin et al. (2006) was on healthcare providers of selected healthcare facilities for the army in Lagos with poor outcomes. Sanusi and Awe (2009) researched healthcare consumers residing in Ibadan, Nigeria. Both cities are urban areas in Nigeria and are more developed than the area of the present study. Meanwhile, the present study was done on military patients who were accessing healthcare services from an accredited healthcare facility in Niger senatorial zones, Nigeria. Although the inclusiveness and continuity of soldiers' widows and orphans were low among respondents, regrettably only 31.7% of respondents were privileged of its continuity under the Scheme at the time of data collection.

Conclusion

The continuity of NHIS policy effects was low among widows and orphans of soldiers that were accessing health care services in some accredited health care facilities in Niger state. However, the number of widows and orphans of soldiers among them was much lesser than expected as compared to other beneficiaries. A greater number of respondents still rely on out-of-pocket expenditure for payment of health care services in Niger state, than effective NHIS policy of continuity on widows and orphans of soldiers. It is revealed that efforts should be geared towards improving the rate of soldiers' widows and orphans via NHIS care beneficiaries and continuity processes, especially in the face of the heavy burden of out-of-pocket payment expenditure in health care services in the state and Nigeria at large to motivate the serving soldiers for giving sincere service in the state and the country at large.

Recommendations

Based on the findings of this study, the following are recommended:

- There is still a significant number of Nigerians widows and orphans of soldiers who are not under any health insurance coverage for the continuity of their living. Therefore, NHIS management should be encouraged by the government to improve on widows and orphans of soldiers' continuity of enrolment, and benefits of Nigerians into the National Health Insurance Scheme for wider coverage across the state, of which military families should be prioritised.
- Efforts should be intensified by the National Health Insurance Scheme in providing widows and orphans of soldiers health care services for life.
- Training and retraining of special personnel in this area of health care services should be undertaken seriously so that soldiers can put in their best in serving the state.
- Further research on this topic should be encouraged by using a more in-depth approach through qualitative and quantitative research methods to uncover other issues which may not have been touched by a quantitative study. More legal corporate bodies should be encouraged in providing health insurance to widows and orphans of soldiers as in the case of the United States with central system control.

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