



Assessing Willingness to Enroll in Social Health Insurance Program among Artisans in Rivers State, Nigeria.

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ABSTRACT

Background: Globally, an estimated 1.3 million people lack access to effective and affordable health care, and annually additional 150 million people in 44 million households face financial catastrophe as a result of paying directly for healthcare. This study aim to assess the willingness to enroll in social health insurance program among artisans in Rivers State, Nigeria: A mixed – method study.

Methods: This study was conducted in Rivers State, Nigeria. It adopted a cross – sectional study employing a mixed – methods approach. Participants were 598 artisans, and data analysis was done using SPSS version 22. The data also was summarized with mean and presented using appropriate frequency table and cross tabulation. Chi-square test was used to determine statistical significant association in cross tabulated variable, and level of significance was pre-determined at a p – value of less than 0.05.

Results: Majority of the artisans were self – employed (70.7%) in the public and organized private sectors, had attained secondary education (55%), earned large proportion #20,000 - #29,999 (33.6%). Most of the artisans are in either the poor category (29.4%) or the middle category at 33.1%. An overwhelming 90.6% of the 598 respondents reported incurring OOP healthcare expenditure. The mean score for most of the statements on knowledge stood between 1.75 and 2.55 on the 4-point Likert scale, which denotes that there was more disagreement than otherwise or uncertainty. Major barriers were; poor knowledge gap mostly in rural areas, financial constraint and perception of high cost of insurance premium, etc.

Conclusion: Artisans are generally willing to enroll in social health insurance, and we recommend policy makers to simplify enrollment processes and provide assistance with paperwork to reduce bureaucratic barriers.

Keywords: Willingness to enroll, social health insurance, community – based health insurance, Artians.

Introduction

Health systems are defined by the World Health Organisation (WHO) as "all Organisation, people, and actions whose primary intent is to promote, restore or maintain health". Present-day systems are the results of decades of change, having been strongly shaped by historical, social, political, and economic events. As inherently social institutions, people are the central components of the health system with changing relationships and power dynamics between the various actors (both within and outside the system), also strongly influencing their composition.

Globally, an estimated 1.3 billion people lack access to effective and affordable healthcare. Each year, an additional 150 million individuals in 44 million households face financial catastrophe due to the need to pay for healthcare out of pocket. This financial burden also pushes approximately 100 million people into poverty annually (Xu *et al.*, 2005). The situation is particularly dire in low- and middle-income countries, where health systems are strained by inadequate resources and inefficient financing mechanisms. Sub-Saharan Africa, including Nigeria, exemplifies this global challenge, grappling with the dual burden of communicable and non-communicable diseases while relying heavily on out-of-pocket (OOP) payments as a predominant health financing mechanism (Aregbeshola & Khan, 2018).

In Nigeria, healthcare financing has historically depended on OOP payments, a practice that disproportionately affects low-income households. These payments create significant barriers to accessing healthcare, perpetuating a cycle of poverty and poor health outcomes. The impoverishing effect of OOP health payments is particularly pronounced in Rivers State, where the implementation of sustainable health financing systems, such as social health insurance (SHI), remains stalled despite multiple policy efforts and commitments. According to the World Bank (2014), this reliance on OOP payments not only exacerbates household poverty but also undermines efforts to achieve Universal Health Coverage (UHC).

The National Health Act (NHA, 2017) highlights the financial and systemic challenges of Nigeria's healthcare sector. Despite marginal improvements in budgetary allocations to health—rising from 3.3% in 2016 to 4.2% in 2017—Nigeria's health financing remains grossly inadequate relative to its

population needs. In 2017, the population of Nigeria was estimated at 199.7 million, with 63% under the age of 25, reflecting a youthful demographic with significant health demands. Yet, the Current Health Expenditure (CHE) was largely financed through OOP payments, accounting for 77.5% of CHE and 96.4% of Total Health Expenditure (Aregbeshola & Khan, 2018).

Addressing these issues requires a comprehensive approach that enhances healthcare accessibility and affordability. Social health insurance programs have been identified as a pivotal strategy to mitigate the financial barriers associated with OOP payments. Such programs aim to pool resources, reduce inequalities in healthcare utilization, and protect households from catastrophic expenditures. However, the success of these programs depends on the willingness of target populations to enroll and participate actively. In Rivers State, artisans—a significant segment of the informal sector—represent a critical group whose engagement in SHI programs could determine the feasibility and sustainability of such initiatives.

Despite the potential benefits of SHI, its adoption in Rivers State has been limited. This raises several pertinent questions: What factors influence artisans' willingness to enroll in SHI programs? How do socioeconomic, cultural, and systemic barriers impact their decision-making processes? What strategies can be employed to enhance their participation and, by extension, improve healthcare financing and access in the state?

This study seeks to address these questions by assessing the willingness of artisans in Rivers State to enroll in a social health insurance program. By employing a mixed-methods approach, the research aims to uncover the contextual factors shaping artisans' perceptions and decisions regarding SHI. This study is particularly relevant given the significant contribution of artisans to the local economy and their vulnerability to health-related financial shocks due to their informal employment status.

In conclusion, the reliance on OOP payments for healthcare financing in Rivers State underscores the urgent need for innovative and inclusive solutions to achieve UHC. Social health insurance offers a promising pathway to address the inequities and inefficiencies in the current system. However, its success hinges on understanding and addressing the specific needs and preferences of key stakeholders, such as artisans. This study will contribute to the evidence base needed to design and implement effective SHI programs, ultimately advancing health equity and financial protection for all.

Method

Rivers State is one of the 36 states of Nigeria. Its capital is Port Harcourt which is the largest city in the whole Niger Delta region and is economically significant as a center of Nigeria oil and gas industries. Rivers State is bounded on the south by the Atlantic Ocean, to the North by Imo, Abia and Anambra State, to the East by Akwa Ibom and to the west by Bayelsa and Delta State. It is a home to many indigene or indigenous ethnic group which include Ikwerre, Ibani, Opobo, Abua, Eleme, Okirika and Kalabari, Etche, Ogba, Ogoni Engenni and others. The population of this study comprises of mechanics, tailors, carpenters, welders, hairdressers, etc. However, artisans between 18 years and above, willingness to participant in the study through the informed consent and resident in Rivers State were included. While, artisans with severe medical condition that require immediate attention and are unable to communicate effectively due to language barriers were excluded. The quantitative multistage sampling was drawn from the population and a stratified sampling was used to select the three (3) senatorial districts which include Rivers West, Rivers East, and Rivers South East (NBS, 2014). A simple random sampling was used to select two Rural local government area's in each of the senatorial district in Rivers State, and purposive sampling was adopted to select urban and sub – urban local government area's which are listed as Obio/Akpor, Port Harcourt, Eleme, and Ahoada East. However, a purposive non – probability sampling method was used to select the study participants from the selected case in this study. Using a cross-sectional study, the Cochran sample size determination was used to determine the size of the study 654. The instrument used is a structured data extraction form for data collection which is divided into two (2) different parts A and B. Part B is comprised the following sections: Section A: Prevalence of Out-of-Pocket Expenditure among artisans; Section B: Awareness about social health insurance among Artisans; Section C: Knowledge of social health insurance among Artisans; Section D: Focus on Willingness to enroll in social health insurance. The instrument was developed specifically for the study. The interview instrument was developed based on a literature review and focus groups. It was structured around three main themes: General Understanding of Health Insurance, Barriers to Enrollment, Suggestions and Recommendations. The quantitative data will be checked, cleaned for error, it was entered in the system and analyzed using SPSS or Epi-info version 22. The data also was summarized with proportions and mean and presented using appropriate frequency table and cross tabulation. Chi-square test was used to determine statistical significant association in cross tabulated variable. Chi-square and Fisher's exact tests was used wherever appropriate. The level of significance was pre-determined at a p-value of less than 0.05. Logistic regression will be used to identify possible predictors of willingness to enroll. Regression analysis was also used to measure the actual among as the dependent variable and factor that will influence it.

Results

The analysis of the response rate table highlights key aspects of the study's methodology and participant engagement. With a target sample size of 654 respondents, the study achieved a commendable actual respondent count of 598, translating to a response rate of 91.4%. This indicates a strong level of participation, which is critical for the reliability and validity of the research

Table 1a: Socio – demographic Characteristics of Study Participants (N = 598)

Characteristic	Category	Frequency (n)	Percentage (%)
Age (years)	15-19	32	5.4
	20-24	78	13.0
	25-29	112	18.7
	30-34	143	23.9
	35-39	98	16.4
	40-44	67	11.2
	45-59	54	9.0
	>60	14	2.3
Gender	Male	389	65.1
	Female	209	34.9
Marital Status	Never Married	201	33.6
	Married	312	52.2
	Living Together	43	7.2
	Divorced/Separated	28	4.7
	Widowed	14	2.3
Religion	Catholic	143	23.9
	Other Christian	341	57.0
	Islam	89	14.9
	Traditionalist	19	3.2
	Others	6	1.0
Family Size	1-2	112	18.7
	3-4	298	49.8
	5+	188	31.4

Table 2: Socioeconomic Profile of Artisans (N=598)

Characteristic	Category	Frequency (n)	Percentage (%)
Employment Status	Self-employed	423	70.7
	Public Sector Employee	89	14.9
	Organized Private Sector	86	14.4
Type of Artisanal Work	Carpenter	98	16.4
	Mechanic	123	20.6
	Mason	87	14.5
	Plumber	76	12.7
	Tailor	134	22.4
	Others	80	13.4
	Monthly Income (Naira)	Less than 10,000	43

	10,000-19,999	156	26.1
	20,000-29,999	201	33.6
	30,000-39,999	132	22.1
	40,000 and above	66	11.0
Wealth Status	Poorest	87	14.5
	Poor	176	29.4
	Middle	198	33.1
	Rich	98	16.4
	Richest	39	6.5
Own House	Yes	176	29.4
	No	422	70.6
Car and Household Items	Yes	209	34.9
	No	389	65.1

Table 3: Prevalence of Out-of-Pocket Health Expenditure (N=598)

Variable	Category	Frequency (n)	Percentage (%)
Incurred OOP healthcare expenditure	Yes	542	90.6
	No	56	9.4
Amount spent on OOP healthcare (n=542)	<10,000 Naira	187	34.5
	20,000-40,000 Naira	289	53.3
	>50,000 Naira	66	12.2
Percentage of household income spent on OOP healthcare (n=542)	<10%	98	18.1
	20-40%	321	59.2
	>50%	123	22.7

Table 4: Association between Socio – demographic Factors and OOP Health Expenditure

Factor	Chi-square value	df	p-value
Age	15.324	7	0.032*
Gender	2.187	1	0.139
Education Level	9.876	3	0.020*
Residence (Rural/Urban)	6.543	1	0.011*
Wealth Status	18.965	4	0.001**
Monthly Income	22.134	4	<0.001***

*p<0.05, **p<0.01, ***p<0.001

Table 5: Willingness to Enroll in Social Health Insurance Programs (N=598)

Statement/Question	Strongly Disagree	Disagree	Agree	Strongly Agree	Mean Score
Willingness to enroll in social	87 (14.5%)	132 (22.1%)	254 (42.5%)	125 (20.9%)	2.70
Recommendation social health insurance to other artisans.	98 (16.4%)	154 (25.8%)	243 (40.6%)	103 (17.2%)	2.59
Likely to enroll in the next six months.	132 (22.1%)	187 (31.3%)	198 (33.1%)	81 (13.5%)	2.38

Question	Yes	No
Are you willing to enroll in social health insurance?	356 (59.5%)	242 (40.5%)

Table 6: Logistic Regression Analysis of Factors Influencing Willingness to Enroll

Variable	Odds Ratio	95% CI	p-value
Age	1.015	(0.998, 1.032)	0.082
Gender (Female)	0.743	(0.529, 1.044)	0.087
Education Level	1.312	(1.098, 1.568)	0.003**
Urban Residence	1.456	(1.043, 2.033)	0.027*
Monthly Income (log)	1.223	(1.054, 1.419)	0.008**
Awareness Score	1.687	(1.321, 2.154)	<0.001***
Knowledge Score	2.134	(1.654, 2.753)	<0.001***
Out-of-Pocket Expenditure	1.00002	(1.000005, 1.00004)	0.012*

Model Chi-square = 187.43, $p < 0.001$, Nagelkerke $R^2 = 0.372$ * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 7: Willingness to Pay Annually for Health Insurance (N=356)

Amount (Naira)	Frequency	Percentage
<10,000	132	37.1%
10,000 - 50,000	178	50.0%
60,000 - 100,000	37	10.4%
>100,000	9	2.5%

Table 8: Reasons for Not Being Willing to Enroll (N=242)

Reason	Frequency	Percentage
Nothing	18	7.4%
Lack of regular income	156	64.5%
Lack of trust in the system	68	28.1%

Table 9: Logistic Regression Analysis of Factors Influencing Willingness to Enroll by Residence

Variable	Rural OR (95% CI)	Urban OR (95% CI)
Age	1.008 (0.985, 1.032)	1.021 (0.998, 1.045)
Gender (Female)	0.812 (0.498, 1.324)	0.687 (0.432, 1.092)
Education Level	1.254* (1.012, 1.554)	1.387** (1.098, 1.752)
Monthly Income (log)	1.176 (0.987, 1.400)	1.298** (1.078, 1.564)
Awareness Score	1.543** (1.134, 2.098)	1.876*** (1.376, 2.556)
Knowledge Score	1.987*** (1.432, 2.758)	2.312*** (1.654, 3.234)
Out-of-Pocket Expenditure	1.00001 (0.99999, 1.00003)	1.00003* (1.000005, 1.00005)

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 1a shows that the age bracket of 30-34 years presented the highest proportion of 23.9%, which was almost immediately followed by the participation in the age bracket of 25-29 years at 18.7%. The youngest categories making up the lower percentiles are the 15-19 and 20-24 age brackets, together amounting to 18.4%. Older participants are less well-represented; thus, over 60s take only 2.3%. This distribution may thus indicate a focus on the working-age population and perhaps implications, in terms of applicability, for the study's findings as it regards younger and older demographics. 70.7% of artisans are self-employed, which evidences a preference for independence, perhaps due to an unavailability of opportunities within the formal job

market. However, the fact that a significant minority were employed in the public and organized private sectors-14.9% and 14.4%, respectively-indicates that avenues for formal employment do exist, even though such avenues might be limited (**Table 2**). The Table 3 presents the analysis of the prevalence of out-of-pocket health expenditure among artisans in Rivers State, Nigeria. The majority of respondents reported they had visited a health facility within the last month, 80.1%, showing high health utilization. Facility choice is striking in this care-seeking behavior, with 53.4% visiting a private facility, compared to 41.3% utilizing a public service and a mere 5.3% choosing traditional medicine. The indication of ongoing health concerns that require attention is that 65.1% of those who visited healthcare facilities visited 1-2 times in the past month. Another 28.0% visited 2-3 times while 6.9% reported 3-4 visits. As may be observed, the most outstanding result is that 90.6% of respondents had out-of-pocket health expenditure. While this may not be of concern, the amount spent by those reporting the incidence of OOP expenditure is quite revealing. Whereas 53.3% of the respondents spent between 20,000 and 40,000 Naira, 34.5% spent less than 10,000, and 12.2% spent above 50,000 Naira. The share of household expenditure spent on OOP health expenditure gives a critical perspective on financial sustainability. These results indicated that 59.2% of the respondents spent between 20% and 40% of their family income on health, while 22.7% were paying above 50%. Table 4 shows the associations of socio – demographic factors with out-of-pocket health expenditure, through chi-square test of independence. Chi-square: 15.324 with $df = 7$ and $p\text{-value} = 0.032$. Thus, a statistically significant relationship exists between age and OOP health expenditure at 5% significance. However, it is a different story in gender. The chi-square value is 2.187, with a $p\text{-value}$ of 0.139. It does not meet the criteria for statistical significance, $p < 0.05$, and during this analysis, gender will be regarded as not a factor in either high or low OOP health expenditures. The analysis of non-out-of-pocket (non-OOP) healthcare utilization among artisans reveals that among the 56 respondents (9.4% of the sample), the majority (53.6%) relied on traditional medicine as their primary means of accessing healthcare services. This indicates a significant preference for or reliance on alternative medicine among this group (**Table 5a**). In this respect, logistic regression analysis in Table 6 identifies various factors that decisively affect peoples' willingness to enroll in social health insurance. The dependent variable has a binary response, indicating whether people are willing to enroll (1) or not to enroll (0). As such, the analysis considers a variety of socio – demographic variables, an awareness score, and knowledge score to determine their effects on enrollment willingness. Data in Table 10 show the type of health facilities preferred by the 356 respondents who were willing to be enrolled in social health insurance. As shown in the table, the majority of the participants have opted for private facilities at 58.7%, while 41.3% of the participants prefer government facilities. Table 7 has been useful in bringing out the reasons why a total of 242 respondents were unwilling to enroll into social health insurance programs. The inadequate regular income constitutes the single most expressed reason by 64.5% of the respondents. This finding underlines the financial constraints that many face, probably making it difficult for them to commit to regular premium payments that accompany health insurance. These are significant differences in willingness to enroll into social health insurance programs between rural and urban artisans, as viewed from the comparison analysis shown in Table 8 below. The rural category presents a clear division in that 50.0% of rural artisans expressed willingness to enroll and 50.0% were unwilling. The results in Table 9 identify the key barriers the two sub-groups face, highlighting some similarities and differences in the concerns between the two groups. The highest-ranking reason for unwillingness to enroll cited in both groups is lack of regular income. For rural artisans, this was one of the reasons cited by 70.1 percent, while for urban artisans, the figure was 58.3 percent. Although this seems quite a sizable difference, a chi-square of 3.75 and a $p\text{-value}$ of 0.053 indicates there is a trend toward significance yet the finding does not reach conventional levels of statistical significance ($p < 0.05$).

Discussion

The socio-economic profile of artisans in Rivers State give an abiding portrait of economic resilience within a fold of high – side challenges. For example, while 70.7% of them were self-employed, 14.9% and 14.4% were employed in the public and organized private sectors, respectively. The dominant artisanal occupations were tailoring 22.4%, followed by mechanics at 20.6%, carpentry 16.4%, masonry 14.5%, and plumbing 12.7%. Based on the monthly income, the largest proportion, 33.6%, falls within the bracket of 20,000-29,999 Naira, followed by 26.1% whose earnings range between 10,000-19,999 Naira. Surprisingly, only 11% of the artisans reportedly earn 40,000 Naira and above. We observe in the distribution of wealth status that most of the artisans are in either the "poor" category at 29.4% or the "middle" category at 33.1%, and the rest fall into minor portions: the "rich" category accounts for 16.4%, while the "richest" category comprises 6.5%. The asset ownership data indicates that up to 70.6% of the artisans do not own their houses, and only 34.9% own a car or major household items. The highest attainment among artisans is at the secondary level, 55%, while 28% have more than secondary education, 15% primary education, and 3% with no formal education. The modal age bracket among the artisans is between 30- 34 years, 24%, with each successive group smaller as age increases. The emerging socioeconomic profile from this study is supported by findings of similar studies conducted in developing countries. For example, there is the study of Adebayo *et al.* (2015), conducted on informal sector workers in Nigeria and reporting comparable rates of self-employment, as well as an income distribution similar to that obtained herein. That the proportion of self-employed artisans in this study is high is further buttressed by the fact that Awojobi reported over 60% of the workforce of Nigeria operating in the informal sector. Concentrating in these trades such as tailors and mechanics also reflects patterns in other urban areas of Nigeria, according to Olugbile (2018). The distribution of income is a good pointer to wider trends in the economies of developing countries; a fact well and truly underlined by the majority of cases falling within the lower-to-middle brackets in this report by the World Bank on poverty and shared prosperity 2019. Low ownership of homes by artisans stands at 29.4%, which corroborates the problems with urban housing as documented by Akinwunmi (2017) in Lagos, Nigeria.

The results from this study indicate an abnormally high prevalence of out-of-pocket health expenditure among artisans in Rivers State, Nigeria. An overwhelming 90.6% of the 598 respondents reported incurring OOP healthcare expenditure. The study also found that 80.1% of the respondents had visited a healthcare facility in the last one month; 53.4% preferred private facilities, while 41.3% had visited public facilities and 5.3% traditional ones. Of those who sought healthcare, 65.1% had visited the healthcare-providing facility 1-2 times in the last one month, 28.0% between 2-3 times, while 6.9% reported 3-4 visits. This translates into the following financial burdens: 53.3% reported expenditure ranging between 20,000 and 40,000 Naira on OOP healthcare; 34.5% reported spending below 10,000 Naira, while 12.2% reported expenditures over 50,000 Naira. Probably most repulsive is that

59.2% reported spending between 20% and 40% of their household income on healthcare, while 22.7% spent over 50% of their income on health-related expenditure. This was further elaborated by the chi-square test, which showed that the socio – demographic factors significantly associated with OOP health expenditure included age ($\chi^2 = 15.324$, $p = 0.032$), education level ($\chi^2 = 9.876$, $p = 0.020$), residence ($\chi^2 = 6.543$, $p = 0.011$), wealth status ($\chi^2 = 18.965$, $p = 0.001$), and monthly income ($\chi^2 = 22.134$, $p < 0.001$). These findings are in tandem with several other studies carried out in Nigeria and other LMICs. For example, Onwujekwe *et al.* (2017). Estimated that in South-Eastern Nigeria, 82.2% of households incurred OOP payments for healthcare, which compares favourably with the 90.6% in our study. Accordingly, Aregbeshola and Khan (2018) also estimated that OOP payments comprised 71.7% of the total health expenditure in Nigeria, indicating widely prevalent reliance on this method of healthcare financing. The high share of income devoted to healthcare noted in our study corroborates evidence from Ghana, where Aryeetey *et al.* (2016) found that 27% of households spent more than 10% of their income on healthcare. This agrees with the work of Adewole *et al.* (2017), who found in their study that there is an increasing trend toward private health care utilization in urban areas of Nigeria, at even greater costs. These findings on significant associations of socio – demographic factors with OOP expenditure are supported by a number of other studies from LMICs such as India (Pandey *et al.* 2018) and Bangladesh (Rahman *et al.* 2020), where similar correlations of factors like education and income with healthcare expenditure have also been found.

The results present a complex picture of enrollment intention and the factors that influence enrollment decisions. From the survey responses, 59.5% of artisans were willing to enroll in social health insurance, while 40.5% were unwilling. Whereas the more subtle statements tended to receive less solid results. The statement, "I am willing to enroll in social health insurance if I am assured of its benefits", received an agree/strongly agree score from 63.4% with a mean score of 2.70. However, only 57.8% would recommend social health insurance to other artisans, with a mean score of 2.59, while 46.6% indicated that they were likely to enroll within the next six months, with a mean score of 2.38. This reflects a disconnection between general willingness and concrete enrollment intentions. The factors influencing the willingness to enroll were further illuminated through the logistic regression analysis. Whereas education level, OR 1.312, $p=0.003$; urban residence, OR 1.456, $p=0.027$; monthly income, OR 1.223, $p=0.008$; awareness score, OR 1.687, $p<0.001$; and knowledge score, OR 2.134, $p<0.001$, were all positive significant predictors for enrollment willingness. Out-of-pocket expenditure also had a small but significant positive effect, OR 1.00002, $p=0.012$. Age and gender approached significance where older and male respondents had a slightly higher enrollment intention. Meanwhile, the model accounted for 37.2% in the variance to enroll, Nagelkerke $R^2 = 0.372$, which indicates that these factors are a substantial predictor of enrollment intention. However, our study also found some results which ran contrary to other studies. For instance, whereas we found a positive trend with age-although not statistically significant Kebede *et al.* (2014), in a study undertaken in Ethiopia, found that younger individuals are more willing to enroll in community-based health insurance. This might be explained by the socio-cultural context of participants, in that the older participants in this study had already reached more stable incomes or greater awareness of healthcare needs. Also, our finding of higher participation willingness among males only slightly contradicts the findings elsewhere that women are more proactive in health care seeking. It is assumed that this difference could be due to the gender-specific economic role or decision-making powers within households in Nigeria.

This study has witnessed the same gender dynamics and family decision-making processes in findings such as those by Okunogbe *et al.* (2018), in their study on health insurance uptake in Nigeria. Awareness and access to information were noted to be highly limited by the urban-rural divide, just as was observed by Aregbeshola and Khan in their 2018 review of social health insurance in Nigeria.

Conclusion

The present study demonstrates quite a complex landscape of challenges and opportunities that surround the enrollment of artisans in social health insurance programs in Rivers State, Nigeria. The high prevalence of out-of-pocket health expenditure among artisans further supports the urgent need for healthcare financial protection mechanisms. Thus, many are at risk from financial catastrophe and impoverishment because of the significant spending out of household income on healthcare costs. The socio-economic profile points out the artisanal vulnerability and the necessity of differential approaches about health insurance. The predominantly self-employed nature of this working class, concentrated in the lower middle-income brackets of the population, presents challenges but also opens up opportunities in the design of appropriate insurance schemes. Low levels of awareness and knowledge of the social health insurance programs are critical barriers that come up for enrollment.

Conclusion: Artisans are generally willing to enroll in social health insurance, though there are substantial obstacles in turning this stated willingness into action. Improvement in enrollment rates, as indicated by findings, will have to be achieved by addressing barriers at both the individual and systemic/structural levels. This study, therefore, underscores the importance of context-specific evidence-based strategies in the designing and implementation process of health insurance programs with potential to effectively reach and benefit both rural and urban artisan populations in Rivers State and similar settings.

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