

**POTENTIAL FOR IMPROVING ACCESS TO
EYE HEALTH SERVICES THROUGH
ENROLLMENT IN COMMUNITY BASED
HEALTH INSURANCE (CBHI) SCHEME IN
BUEA, CAMEROON IN JUNE, 2012**



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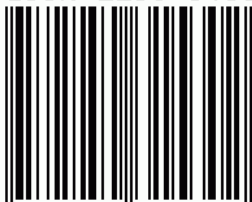
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Preface

In Cameroon, prevalence of blindness is estimated at 1% of the total population (about 20million people) with cataract accounting for 50% of this occurrence. The population at higher risk are rural dwellers and people with lower socio-economic status. The World Health Organisation (WHO) and Centre Intelligence Agency (CIA) stated that 43% of Cameroon population live in rural areas and 40% live below the poverty line. The Cameroon Government and health development partners set up strategies to eliminate preventable blindness in accordance with the WHO-VISION 2020 goal, Right to Sight. However, financing poses a challenge to sustainability of eye care service delivery.

In light of the burden of eye health particularly for persons in rural communities, this study sought to examine knowledge and uptake of eye care services in a selected community in Cameroon. The study involved interviews with eye care service providers and individuals within the community on access to eye health service.

With financial access to health care being a major barrier noted from studies, the study also assessed feasibility of Community Based Health Insurance Schemes (CBHIS) to improving access to eye care services.

Findings from the study note that, despite the perceived benefits of the CBHIS and basic knowledge on importance of eye health, there are gaps in awareness of eye care service provision and CBHIS.

Key recommendation from the study is the need for sensitisation on CBHIS and eye care services to increase enrolment in scheme and encourage uptake of eye care services.

Authors

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Pictures which were taken during the period of study shows; researchers engaging with a community respondent in Buea [cover photo]; and eye health personnel carrying out eye screening at the District hospital eye unit, Buea, South West Region, Cameroon.

CONTENTS

LIST OF FIGURES	9
LIST OF ACRONYMS	10
DEFINITION OF TERMS	11
ABSTRACT.....	12
1. INTRODUCTION	13
1.1 BRIEF COUNTRY PROFILE.....	13
1.2 BACKGROUND TO STUDY	13
1.2.1 EYE CARE IN CAMEROON	15
1.2.2 CBHI IN CAMEROON.....	15
1.3 AIM.....	16
1.4 OBJECTIVES	16
2. METHODOLOGY	17
2.1 STUDY AREA	17
2.2 STUDY DESIGN.....	18
2.3 SAMPLING TECHNIQUES	18
2.3.1 KEY INFORMANT INTERVIEWS	19
2.3.2 COMMUNITY BASED INDIVIDUAL INTERVIEWS	19
2.4 DATA COLLECTION METHOD	20
2.5 DATA ANALYSIS.....	20
2.6 LIMITATION	21
2.7 ETHICS.....	21
3. FINDINGS	22
3.1 STUDY PARTICIPANTS	22
3.2 KEY INFORMANT INTERVIEWS	22
3.2.1 MHO	22
3.2.1.1 MHO AND EYE CARE	22
3.2.1.2 RECOMMENDATIONS BY MHO REPRESENTATIVE AND COMMUNITY MOBILISER.....	22
3.2.2 BEPHA	23
3.2.2.1 BEPHA AND EYE CARE	23
3.2.2.2 RECOMMENDATIONS BY BEPHA REPRESENTATIVE	23
3.2.3 EYE HEALTH PERSONNEL (EHP).....	23
3.2.3.1 RECOMMENDATIONS BY EHP	24

3.3 COMMUNITY BASED IN-DEPTH INTERVIEWS.....	24
3.3.1 KNOWLEDGE OF EYE CARE.....	24
3.3.2 KNOWLEDGE OF CBHI	25
3.3.3 PERCEIVED ADVANTAGE OF CBHI.....	26
3.3.4 CHALLENGES HINDERING PARTICIPATION IN SCHEME.....	26
3.3.5 RECOMMENDATIONS IDENTIFIED BY COMMUNITY RESPONDENTS	27
4. DISCUSSIONS.....	29
4.1 MHO, BEPHA and EYE CARE IN BUEA	29
4.2 COMMUNITY BASED IN- DEPTH INTERVIEWS.....	29
4.2.1 KNOWLEDGE OF EYE CARE.....	29
4.2.2 KNOWLEDGE OF CBHIs; MHO and BEPHA.....	30
4.2.3 COMMUNITY PERCEPTION OF CBHI.....	30
4.2.4 CHALLENGES HINDERING PARTICIPATION IN CBHI SCHEMES (MHO and BEPHA).....	31
4.2.5 RECOMMENDATIONS	32
5. CONCLUSION AND RECOMMENDATIONS.....	33
REFERENCES	35
APPENDIX I: PARTICIPANTS INFORMATION SHEET.....	39
APPENDIX II: PARTICIPANT CONSENT FORM	42
APPENDIX III: SEMI- STRUCTURED QUESTION GUIDES	45
A. KEY INFORMANT INTERVIEW WITH COMMUNITY HEALTH INSURANCE SCHEME MANAGERS.....	46
B. KEY INFORMANT INTERVIEW FOR EYE HEALTH PERSONNEL.....	46
C. COMMUNITY BASED INDIVIDUAL INTERVIEW(S).....	46

LIST OF FIGURES

Figure 2.1: Map of Cameroon showing regions.....	14
Figure 2.2: Map of South West region of Cameroon showing distribution of eye care units. (Oye, 2005)	14
Figure 2.3: showing structure of interviews.....	16
Figure 3.1: showing respondent distribution on ‘level of awareness of eye care’.....	21
Figure 3.2: showing respondents distribution on ‘level of awareness of CBHI’.....	22

LIST OF ACRONYMS

BEPHA- Berlanda Ecclesiastical Province Health Assistance

CBHI- Community Based Health Insurance

CBM- Christian Blind Mission

CIA- Centre Intelligence Agency

CR- Community Respondent

EHP- Eye Health Personnel

EUR- Eye Unit Respondent

GIZ- German International Cooperation

ICO- International Council of Ophthalmologist

ICARE- International Centre for Advancement of Rural Eye care

IDI- In-Depth Interview

INGO- International Non-Governmental Organisation

KII- Key Informant Interviews

MHO- Mutual Health Organisation

NGO- Non Governmental Organisation

SEWA- Self-Employed Women's Association

SSI- Sightsavers International

USAID- United States Agency for International Development

WHO- World Health Organisation

DEFINITION OF TERMS

Catastrophic expenditure-this refers to when families are pushed into poverty as a result of paying for expensive health care services especially for people of lower socio-economic status mostly in the rural areas.

Developing countries- Also referred to as low- and middle-income countries. Describes as nations with low level of material well- being

Eye Care- include basic management of the eyes such as accessing eye screening, identification and management of optical disorders by seeking eye care services.

Eye Care Services- This involves the diagnosis, management and treatment of eye disorder by eye care personnel including referrals.

Eye Health Financing- This includes financing mechanisms for funding eye care services.

Health Financing- Mechanisms for funding health care services such as through government allocation, user fees, donor funds etc.

ABSTRACT

Background: In Cameroon, prevalence of blindness is estimated at 1% of the total population (about 20million people) with cataract accounting for 50% of this occurrence. The population at higher risk are rural dwellers and people with lower socio-economic status. The World Health Organisation (WHO) and Centre Intelligence Agency (CIA) stated that 43% of Cameroon population live in rural areas and 40% live below the poverty line. The Cameroon Government and health development partners set up strategies to eliminate preventable blindness in accordance with the WHO-VISION 2020 goal, Right to Sight. However, financing poses a challenge to sustainability of eye care service delivery.

Aim and Objectives: To explore sustainable means of financing eye care through examining community's knowledge and participation in eye care and the Community Based Health Insurance Schemes (CBHI) in Buea, Cameroon. The objectives include outlining recommendation to address challenges towards promoting viability of scheme to promoting financial sustainability of eye care service provision.

Method: Qualitative research involving Key Informant Interviews (KII) and Community-based individual interviews. Recruiting 16 respondents from the community and district eye care units as well as key officers engaged in programmes. Interviews were transcribed and data coded by thematic analysis.

Results: Although there was a fairly high perception of benefit of CBHI schemes, identified as the Mutual Health Organisation (MHO) and Bermanda Ecclesiastical Province Health Assistance (BEPHA), to providing financial protection for health care, the community members interviewed lacked adequate knowledge of schemes and participation rate was low. Limited knowledge of eye care was also identified as a barrier to uptake of services.

Conclusion: To improve cost recovery towards promoting financial sustainability for eye care service provision in Buea, increased sensitisation for eye care to promote uptake is necessary. Community awareness of benefit of scheme would encourage registration in schemes and increased pooling of funds. Findings from the study infer accessible community health insurance scheme are beneficial to improving financial access to health care services including eye care. However, lack of knowledge by health care users of health care services for eye care and health financing schemes relevant to limiting financial barriers pose a constraint for uptake of services.

1. INTRODUCTION

The World Health Organisation (WHO, 2012) states that “285 million people are visually impaired worldwide: 39 million blind and 246 million with low vision”. The WHO identifies the highest prevalence of visual impairment in developing countries, stating “90% of the world’s visually impaired live in developing countries”. Research has shown that visual impairment and blindness can result in significant economic and health burden to families and the community (Unite for Sight, 2012). In spite of collaboration of International Non-Governmental Organisations (NGOs) and country’s government to address preventable causes of blindness through strategies such as provision of equipments and training of eye care personnel (Oye, 2005), financing and sustainability of eye care services remains an area for concern (VISION 2020, 2011; Carrin, 2003; Shamanna et al., 2001).

This study seeks to explore means to financial sustainability for eye care service provision. The study examines level of community engagement with eye care and CBHI schemes with the notion that level of uptake and participation could influence financing and sustainability of eye care service provision in Buea, South West Region, Cameroon.

1.1 BRIEF COUNTRY PROFILE

Cameroon is a Central African Country with an estimated population of over 20 million people (July 2012 estimate) (Centre Intelligence Agency [CIA], 2012). It consists of 10 regions (see figure 2.1) divided into French and English-speaking areas. Cameroon benefits from rich agricultural produce such as cocoa, coffee, rubber, banana, grains, livestock etc. Industrial activities include petroleum production and refining, aluminium production, textiles amongst others.

In spite of the availability of the above-named resources, Cameroon which is a developing country, has 40% of its population living below the poverty line (CIA, 2012). The WHO Cameroon Health Statics profile 2010, states 43% of the country’s population live in rural areas.

Life expectancy at birth in Cameroon is averaged at 53years (WHO, 2012). There is very high degree of risk of infectious diseases such as food or water borne diseases, water contact diseases example schistosomiasis, vector borne diseases, animal contact and respiratory diseases (CIA, 2012). The expenditure for health in Cameroon is 5.6% of its GDP (Gross Domestic Product).

1.2 BACKGROUND TO STUDY

With the realisation of the global burden of visual impairment and blindness by WHO, strategies were developed to eliminate preventable blindness and promote the Right to Sight (WHO, 2011). VISION 2020, the WHO mission for the eradication of the global burden of blindness was set up with a goal to bring health developmental partners and country’s government together to develop policies and interventions for tackling eye diseases (Faal and Gilbert, 2007).

The most common eye diseases resulting in blindness include cataract, onchocerciasis (also known as river blindness), trachoma, childhood blindness, glaucoma and age-related macular degeneration, with cataract (WHO, 2012). The WHO states that the burden is highest in developing countries especially in the rural areas which often constitute a high percentage of most countries' population.

Some strategies adopted by the WHO and its partners for tackling these eye disease burdens include; developing National programs such as the National Program for Prevention of Blindness (NPPB) in Cameroon, awareness creation on eye care to communities, training eye health personnel, providing eye equipment to eye units, distribution of eye medications such as ivermectin for onchocerciasis and screening for visual impairment such as in schools, amongst others.

In spite of these efforts towards eliminating preventable blindness and reducing the burden of visual impairment to Public Health, previous research has shown challenges in financing affecting sustainability of the eye care system. These financial constraints include; poor remuneration of eye health personnel in some cases, resulting in de-motivation and lack of finance for maintenance of eye equipment and field vehicles (SSI, 2012). These appear to be threats to sustainability of the eye care system. Hence the need to explore means for financial sustainability in eye care service provision.

Eye-health financing mechanisms (as part of health financing) mainly include; through government budgets and tax generation; user charges; donor funds and health insurance (Carrin et al., 2005). User charges often also referred to as user fees or out of pocket payments for health care services were introduced in most developing countries to generate revenue for health care financing (Shamanna et al., 2001). Consequently, the implementation of user charges where patients have to pay for health care services had often resulted in catastrophic expenditure (see definition above) for health (Carrin, 2003). International organisations such as the World Bank have proposed the formation of schemes for prepayment of health care services to address catastrophic expenditure for health, resulting in poverty (Chankova et al., 2008; Carrin et al., 2005).

This study hence, sought to examine Community Based Health Insurance scheme as a means to supporting and strengthening financial sustainability for eye care service provision.

CBHI is a voluntary, non-profit health insurance scheme, involving a group of identified persons or a community ('community' described by the WHO [2002], as group of people grouped by geographical location; common interest; identity and shared resources) to contribute agreed premiums for payment of health care services (Carrin, 2003). This aims to provide financial protection and reduce financial burden for health as a result of out of pocket payments for health care services (Chankova et al., 2008). This targets the informal sector and people in rural areas who are more vulnerable and at higher risk to diseases and health burdens (Kamuzora and Gilson, 2006). Health economists and researchers have identified CBHI as a supplementary means of financing health care with the potentials for promoting sustainability for health care service delivery (Carrin, 2003; Ranson, 2002).

CBHI is also seen as a decentralisation tool in Primary health care especially for low income countries (Jutting, 2003). This allows community members through management of schemes adopt responsibility for their health thereby promoting acceptability and sustainability for health care services (Carrin et al., 2005).

Previous studies and research have identified lack of knowledge of eye care and CBHI schemes to hinder community involvement and participation in eye care and CBHI schemes (Banwat et al., 2012?; Oye, 2005). This has been noted to have a significant effect on cost recovery for eye care and pooling of funds for CBHI schemes. Therefore this study seeks to explore knowledge, participation and challenges of community engagement with eye care and CBHI schemes.

1.2.1 EYE CARE IN CAMEROON

The Cameroon government set up the National Program for Prevention of Blindness whose primary focus is to implement policies and activities in line with the VISION 2020 goal to eliminate avoidable blindness (Oye, 2005). The Cameroon government partners with International Non-Governmental Organisations (INGOs) such as the WHO's VISION 2020, Sight Savers International, Christian Blind Mission (CBM), and International Council of Ophthalmology (ICO), to implement eye health activities (WHO, 2012). Sightsavers International (SSI), an International eye health organisation working in Cameroon, states that the level of blindness is estimated at 1% of Cameroon's population with Cataract as the leading cause resulting in 50% of blindness in Cameroon (SSI, 2012; VISION 2020, 2012?). In Cameroon, Public eye health initiatives include awareness creation, training, screening, provision of eye equipment, and distribution of Ivermectin for Onchocerciasis etc (SSI, 2012). Recent publications by SSI, on the experience of eye care so far in Cameroon identifies financing as a major constraint to sustainability of eye care service provision.

1.2.2 CBHI IN CAMEROON

A CBHI Scheme known as the Mutual Health Organisation (MHO) was set up by the Cameroon government as a non-profit, apolitical community based contributory mechanism to overcome financial barriers to quality care (Donfouet and Mahieu, 2012). This was set up to supplement other financial mechanisms for health care such as government budgets, donor funds and reduce the catastrophic effect of user charges on access to health care (Guda, 2007). The MHO also receives material and technical support which include drugs and training of personnel, from partners like the German International Cooperation (GIZ) (Schmidt-Ehry et al., 1997)). The MHO has been set up also in other developing countries like countries in sub Saharan Africa and with a recorded increase in number of MHOs over the past years (Chankova et al., 2008).

MHO members benefit from 50- 75% depending on the services while the member pays the balance for health care services. Examples of health care services covered include hospitalisation (medical and surgical care), some laboratory examination, essential and generic medicines sold within the hospital or health care centre only.

As revealed by a government document on MHO in the South West Region, the scheme is at a pilot phase covering only a few districts. In spite of the benefits of the scheme to improving community's access to health care, there are challenges which include fraud and abuse, opportunistic healthcare billings, low awareness of population and low enrolment etc.

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Another well acknowledged CBHI scheme in Buea is the Bamenda Ecclesiastical Province Health Assistance (BEPHA) formed by the Catholic Church to provide financial assistance against health-related risk (Catholic Diocese of Buea, 2012).

1.3 AIM

To examine community's knowledge of eye care and participation in Community Based Health Insurance Scheme(s) for financing eye care, as a mechanism towards promoting financial sustainability in eye care service provision- in Buea, South West region, Cameroon.

1.4 OBJECTIVES

- Identify CBHI schemes for eye care in Buea
- Assess level of community awareness of Eye Care and CBHI schemes(s)
- Identify barriers to community's participation in CBHI scheme(s) for eye care service provision
- Outline recommendations to strengthen community's participation in the CBHI scheme(s) towards promoting financial sustainability for eye care service provision.

2. METHODOLOGY

2.1 STUDY AREA

Buea, the capital town of the South West Regional Province of Cameroon (figure 2.2) has an estimated population of about 200,000 people. Buea is located by the Mount Cameroon and has its indigenes living around the mountain slopes. Its indigenes are known as the Bakweris, though there is the presence of other tribes from within Cameroon. The Bakweri language is widely spoken by natives, with English and French as official language for general interaction. The inhabitants also communicate more commonly in Pidgin English. Literacy rate is 60- 75% of youths having access to education and 45% of the population has access to basic health services (Buea Council, 2010).

The choice of selection of this town for this study was in line with recommendations from host organisation with interest in identifying key issues in the community's involvement with eye care and the Community Based Health Insurance Scheme, already existing in the study area- Buea.

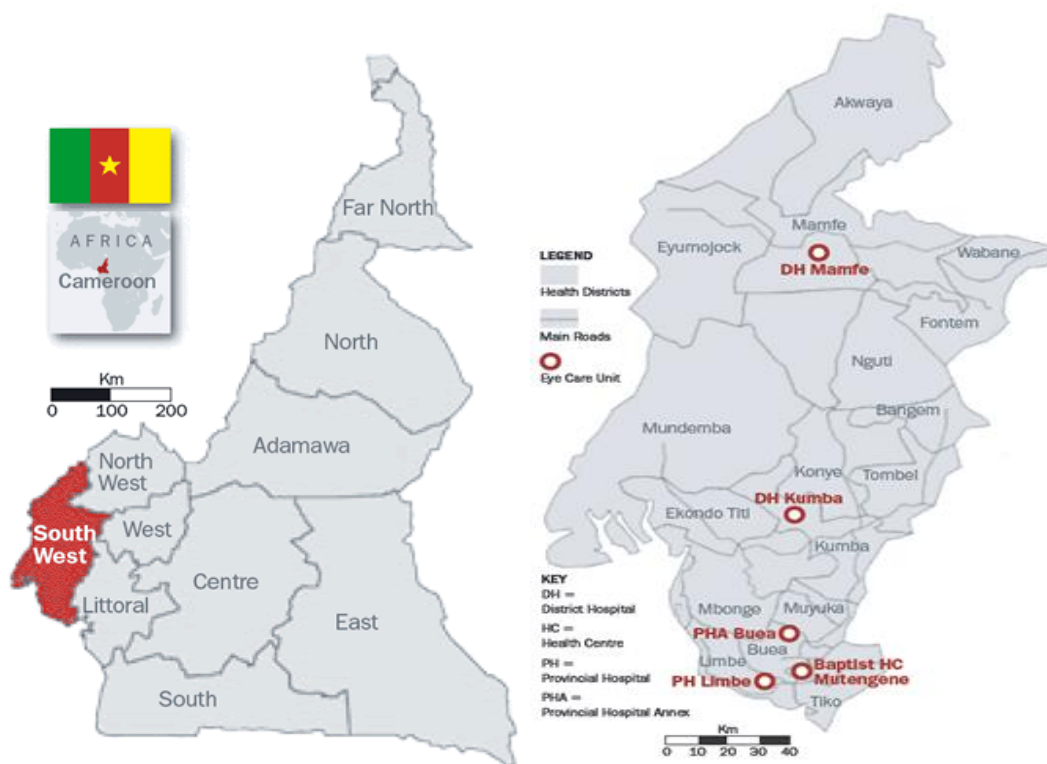


Figure 2.1 (left); Map of Cameroon showing regions

Figure 2.2 (right); Map of South West region of Cameroon showing distribution of eye care units. (Oye, 2005)

2.2 STUDY DESIGN

This study used qualitative method of research. This involved the application of semi structured question guides with open ended questions (Green, 2005) to explore through interviews knowledge of eye care and participation in CBHI schemes in Buea.

A qualitative approach allows for detailed information through in-depth interviews with individuals (Boyce and Neale, 2006). Holloway (2005) describes qualitative research as a tool to understanding the emotions, perceptions and actions of people. As a result of limited available research documents on eye care and CBHI in Buea, it is necessary to apply a qualitative method of research to allow better understanding (Avis, 2005) of the situation of eye care and CBHI in Buea.

Buea is one of the Pilot towns for the CBHI and has benefitted from eye care strengthening initiatives such as training of eye health personnel and provision of eye care equipment to the district eye units. It is however assumed that there is some level of community interaction with eye care and CBHI scheme(s).

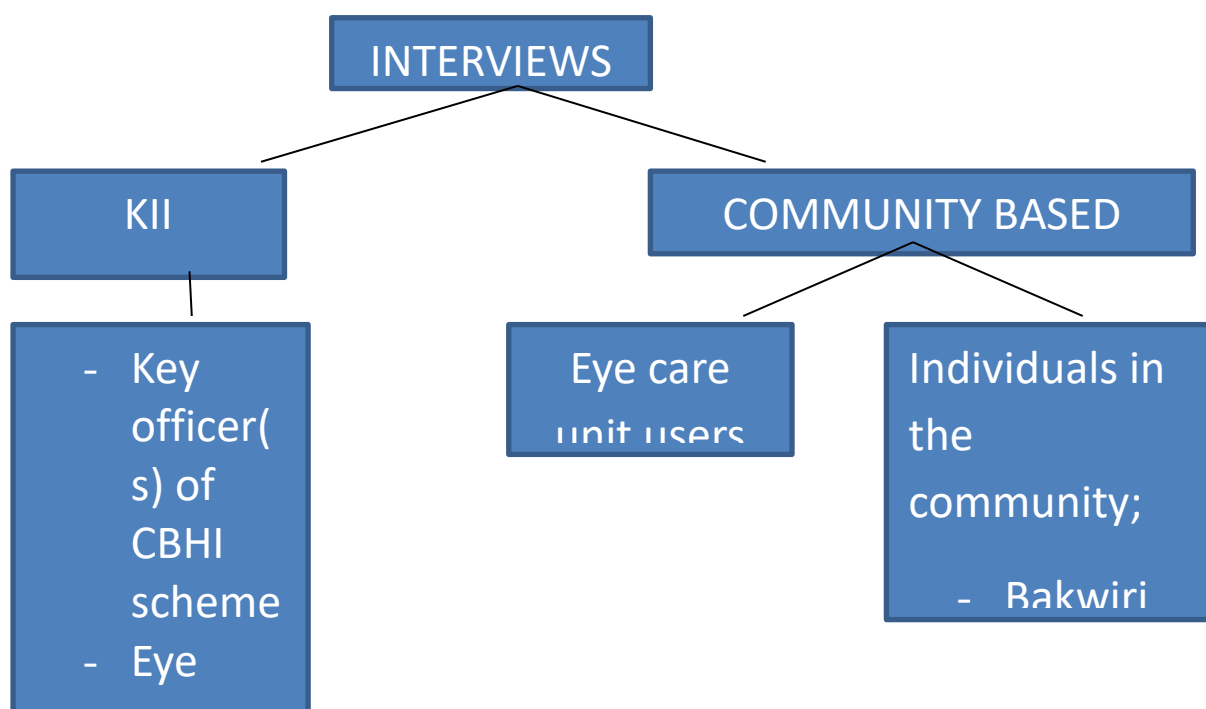
This study also seeks to investigate (Taylor, 2005) the role of CBHI in contributing to eye care financing through the lens of CBHI function to health care financing. Therefore, understanding the situation by conducting Key Informant Interviews (KIIs) is paramount as there is limited data or research showing CBHI's contribution to eye care financing.

The study therefore includes KII's and community based In-depth interviews (IDI).

This study in Buea which included data collection, transcription and initial analysis was carried out over a period of 3 weeks.

2.3 SAMPLING TECHNIQUES

Using the purposive sampling strategy, 18 interviews were conducted of which 2 were pilot interviews. Identification and recruitment of respondents was aided by support from local host organisations -Sight Savers International through the South West Regional Delegation of Public Health, Buea. The research proposal was reviewed and approved by the Regional Delegation of Public Health Buea, prior to commencement of study. The regional Delegation of Public Health, Buea therefore assigned a local supervisor who was instrumental in assisting with identification and recruitment of respondents with the aid of a research assistant. Interviews were categorised into key informant interviews and community based individual interviews.



Above: Figure 2.3 showing structure of interviews

2.3.1 KEY INFORMANT INTERVIEWS

Key officers such as eye care personnel and CBHI representatives were identified and interviewed using specific semi structured question guides to suit respondent (see Appendix III). With limited knowledge of eye care and CBHI in Buea due to limited access to literature, the key informant interview therefore provided a brief situational analysis. Participants were requested to go through information sheets provided and consent forms were signed (see Appendix I and II). Participants were contacted and briefed of the survey to agree on appropriate times to conduct interviews. Interviews were conducted in offices.

2.3.2 COMMUNITY BASED INDIVIDUAL INTERVIEWS

To ascertain a fair representation of knowledge of eye care and participation in CBHI schemes, community-based respondents included eye facility users and individuals from different settlements in the community. Criteria identified for recruitment of participants include; respondents within age 25- 70 and equal number and female and male respondents from the community. An approval to carry out study in the health facility was received prior to commencement of research. Eye facility users were recruited and interviewed within the eye care units at the district hospital, Buea. Participants were asked to read information sheets and nature of study was further explained where necessary. Consent forms were signed and documented.

Participants for community individual interviews (within the community) were spread across three settlements. These settlements were selected randomly with the support and recommendations from the local supervisor and research assistant. Study sought to represent views from an urban environ (main town), semi- urban and rural settlements within Buea; Bakweri town, Vasingi and Bokwaongo village respectively. Information sheets were provided and also verbal explanation of nature and purpose of study was provided to participants. Consent forms were duly signed and documented. Participants included equal

number of male and female respondents. Interviews were conducted within the community mostly around respondent's residence or shops. It was ensured that interviews were conducted in safe locations suitable to researcher(s) and participant.

2.4 DATA COLLECTION METHOD

Interviews were conducted using semi structured question guides to suit category of respondents. Brief discussions and review of study was carried out with local hosts and supervisor. Decisions regarding structure of data collection which included identifying key informants were reached. Question guides were however reviewed and adjusted where necessary.

Major adjustments were however made to suit final agreed topics (after review with in-country host), "Community knowledge of eye care and participation in CBHI" as the initial proposal was broadly targeted at "Financial sustainability in eye care". Aims and objectives, information sheet and question guides were also adjusted to suit the topic.

Separate question guides were developed for different category of respondents (see Appendix III). Further explanation on study was provided especially for the community based individual interviews as the pilot studies revealed that CBHI is referred or understood largely as Mutual Health Organisation (MHO) scheme and in other cases BEPHA (Bermenda Ecclesiastical Province Health Assistance) within the community.

Interviews were designed to last 45 minutes to 1 hour. Participants were allowed to discuss as the questions were asked. Probes were used when responses were not clear and the participants were allowed to ask questions as the need arose (Kelly, 2010). Interviews were mostly conducted in English and in a few cases, pidgin English. However, conversing in Pidgin English did not pose a constraint to engaging in interviews with ability to communicate in the language.

Interviews were recorded upon receipt of permission, using tape recorders and taking down written notes where necessary by researcher and research assistant. Interviews were reviewed by research team (researcher and research assistant) daily.

2.5 DATA ANALYSIS

Interviews were transcribed (Pope et al., 2000) within the period of data collection to allow familiarisation and adjustments to study structure or design where necessary. Thematic analysis involved tabulation of responses accordingly to interpret data (Attride-Stirling, 2001). Priori themes were identified in line with aims and objectives of study. This provided a framework from which questions were derived. Themes were further analysed in categories (Hancock, 1998) with regards to type of respondents based on settlement, age, occupation etc (see Appendix IIIc). Grounded theories emanating from data collected were included in analysis, such as 'perceived benefit of scheme' (Hancock, 1998).

Numerical codes were developed to further interpret and categorise findings. Charts were developed to present summary of some findings.

A triangulation method (Hancock, 1998) to validate and re-affirm findings included the use of tape recorders to capture information, field notes and de-briefing sessions with research

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assistant. To further validate key findings, a de-briefing feedback session with key officers was held to discuss findings from study before developing report.

2.6 LIMITATION

Taking into account the limited sample size of study, the probability that the data represents a larger population cannot be established (Hodkinson and Hodkinson, 2001). Therefore, this study might not be generalisable.

Limited expertise and skill of researcher in the subject area and in conducting field research may also affect quality of the study research (Anderson, 2010). Although literature reviews were imperative to improve researcher's knowledge and capacity to engage with the study.

The study is also restricted to time and resources. Therefore, a more focused yet purposive approach to determining sampling size and locations of study within the study area especially for community-based interviews was employed.

2.7 ETHICS

Ethical approval for study was granted by Leeds Institute of Health Sciences Ethical Committee United Kingdom. Research proposal was also reviewed and approved by host organisations SSI and South West Regional Delegation of Public Health, Buea. Information sheets and further explanation on nature and purpose of research was provided to respondents (Fritz, 2008). Participation in interview was voluntary and participants consent was documented in signed consent forms (see Appendix II).

To ensure confidentiality and anonymity, participant's responses have been assigned numerical and alphabetical codes.

3. FINDINGS

3.1 STUDY PARTICIPANTS

Four (4) KIIs and 12 Community based interviews was carried out.

Participants of key informant interviews include representatives of CBHI scheme; MHO and BEPHA, eye health personnel and community mobilisers for schemes. Although the study focused more on the MHO scheme which is a country wide CBHI scheme, it also acknowledged the BEPHA scheme as it is also recognised by the community members in area of study (Buea).

The community based in- depth interviews was equally divided into 4 sets which include; participants recruited at the eye units, and from the 3 randomly selected settlements representing the urban, semi- urban and rural settlements (Bakweri town, Vasingi and Bokwaongo village).

3.2 KEY INFORMANT INTERVIEWS

3.2.1 MHO

The interview with the MHO representative centred on the structure of the organisation and engagement with eye care services in particular. The representative pointed out that the MHO is relatively new and at a pilot stage, and that it is a government initiative set up to improve access to basic health care. Another interview with an MHO community mobiliser at the district hospital described the scheme as “*a kind of insurance to reduce hospital bills*”. MHO partners with GIZ essential drug funds, providing only drugs supplied by this fund. However there have been challenges, as the MHO remains flexible and dynamic while in the process of developing a legal framework.

Some of the challenges identified include medical malpractice such as over billing and over prescriptions resulting in fraud; issues in selection process as people more likely at risk enrolled the most posing a burden on available funds pooled. The MHO representative also pointed out that strategies are being put in place to address some of these challenges especially with pooling of funds such as working with other community groups already engaged in pooling funds for health and other emergencies for its members.

3.2.1.1 MHO AND EYE CARE

MHO engagement with eye care is at a developmental stage and covers only a few basic eye care services. The MHO community mobiliser stated that eye medications are not included in scheme as it is not part of the essential drugs. MHO engagement with eye care however faces some challenges affecting effective coordination. These challenges include limited information on prices of eye medicines and services, weak engagement with the eye health system at this stage.

3.2.1.2 RECOMMENDATIONS BY MHO REPRESENTATIVE AND COMMUNITY MOBILISER

- Continuous sensitisation about scheme

- Improve health promotion programs
- Need for government intervention for regularisation of prices of medical services
- Strengthen information sharing processes amongst partners like for eye care.
- To strengthen organisation collaboration with eye care and review essential drug package to include basic eye medications.

3.2.2 BEPHA

Interview with a BEPHA representative and community mobiliser, on the structure of the organisation described BEPHA as an organisation founded by the Catholic Bishop to assist community members registered in scheme to access basic health care. The scheme covers 75% of member's hospital bills including purchase of essential drugs. However, payment is made directly to the hospital accounts.

3.2.2.1 BEPHA AND EYE CARE

Although the BEPHA representative sounded uncertain about coordination of BEPHA and eye care services, the BEPHA representative stated that some eye medications are catered for by the scheme and the payment for the medication would depend on the price. The organisation carries out sensitisation on scheme through word of mouth and sharing of flyers; through peer groups in the community; in hospital units like the ante-natal wards; and church announcements.

Challenges identified included lack of proper coordination with the eye unit especially with regards to patient paying for eye services and medications provided by the eye unit. Patients pay for the services and medication and are not reimbursed as the organisation pays directly to the hospitals general account for services used by members. The BEPHA representative also pointed out that most members of the church are registered with the scheme.

3.2.2.2 RECOMMENDATIONS BY BEPHA REPRESENTATIVE

- Strengthen coordination with eye unit, and for managers of scheme and eye health personnel to outline eye medicines and services with fixed prices to be included in scheme.

3.2.3 EYE HEALTH PERSONNEL (EHP)

Interview conducted with EHP at the eye unit in the district hospital revealed that there is poor integration and collaboration of the eye unit with the schemes. The EHP acknowledged awareness of the scheme but do not have full information to engage with scheme. One of the major challenges identified by the EHP is the effect of collaborating with the scheme on cost recovery for the eye unit, pointing out that the eye unit sells eye medications and spectacles to patients. Funds recovered from the sales are collected periodically into the hospitals account from where the eye unit is sustained. The unit however accepts a waiver card for consultancy fees as it is more easily accounted for but patients would have to pay full price for medications purchased within the unit. This however causes rift between patients and EHP as patients believe the CBHI organisations should cover cost or some cost for treatments.

3.2.3.1 RECOMMENDATIONS BY EHP

- Sensitise and provide necessary technical support for eye unit personnel to engage in scheme
- Need for proper collaboration with the hospital and eye unit and develop guidelines to allow effective engagement
- Community sensitisation on eye care

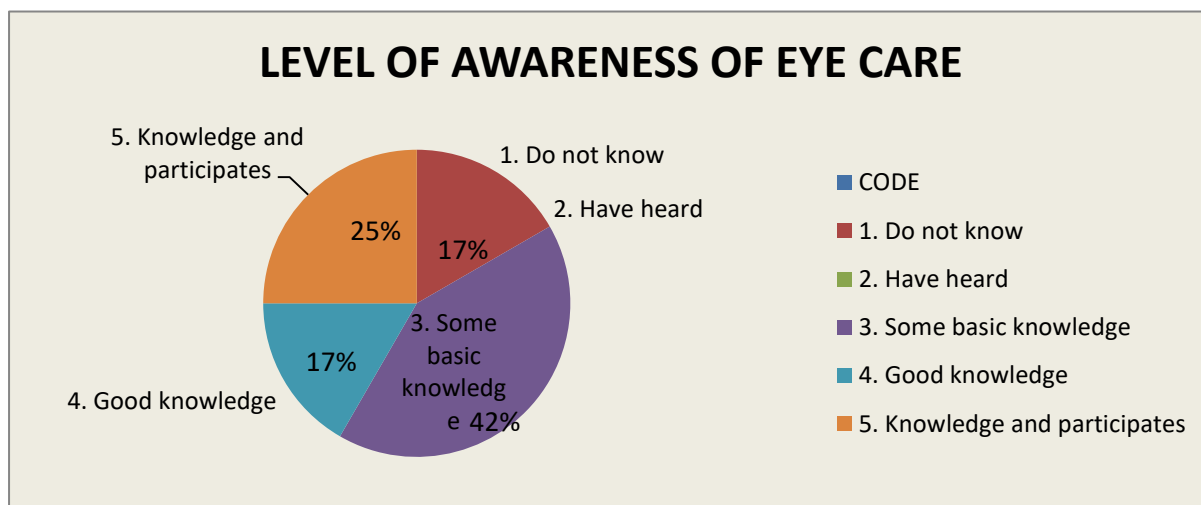
3.3 COMMUNITY BASED IN-DEPTH INTERVIEWS

This includes 3 eye health users and 9 participants within the community, 3 from the 3 communities- Bakweri town, Vasingi and Bokwaongo village. 6 male and 6 female between the ages of 25 and 70 were interviewed in total.

In line with the objectives of the survey, interviews and responses from participants were categorised using themes. These include

- Knowledge of eye care
- Knowledge of CBHI; MHO and BEPHA
- Perceived benefits of CBHI
- Challenges hindering participation in CBHI
- Recommendations for CBHI and Eye Care

3.3.1 KNOWLEDGE OF EYE CARE



Above; Figure 3.1 showing respondent distribution on 'level of awareness of eye care'

Most respondents had basic knowledge of eye care such as general care for the eye. One of the respondents stated,

"I know you have to be careful with the eyes and keep it away from danger, also to be careful what you rub around the eyes to avoid harming the eyes". (CR4, male)

Respondents however had no formal education about care of the eyes and have not come across any form of sensitisation on care of the eyes. Respondents who had good knowledge of eye care were eye unit users who seek eye care services when needed. An eye unit user interviewed stated,

“I come for eye check-up and to check my glasses from time to time”. (EUR2, female)

The question guide for community-based interviews was designed to identify respondents by occupation and to relate responses to socio- economic status (see Appendix IIIC). This revealed that eye care unit users were educated and were either employed in the formal sector or owned businesses. The study however noted that respondents with less education qualification and out of work persons had little or no knowledge of care of the eyes. An unemployed respondent when asked about knowledge of eye care stated,

“I do not know anything about eye care”. (CR5, male)

Another response was,

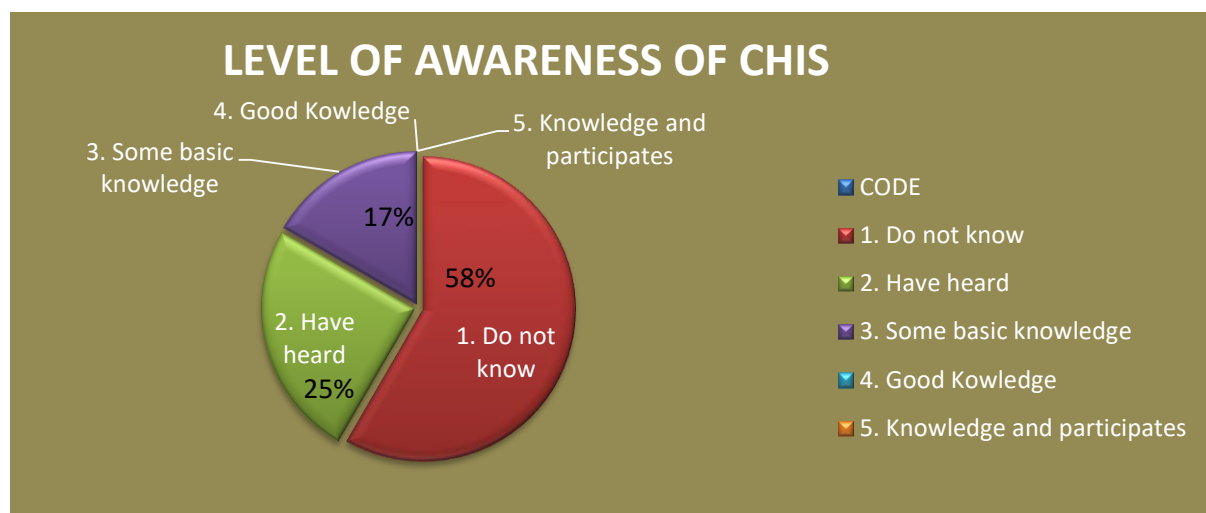
“I have only heard about eye care from elderly people who suffer from eye problems”. (CR9 female)

In spite of the lack of good knowledge of basic eye care, all respondents had heard of onchocerciasis or river blindness and treatments with mectizan during campaigns, sensitisation and mectizan distribution in communities.

There was no clear-cut disparity in knowledge of eye care between male and female respondents. However, the more educated male and female respondents had better knowledge of eye care than the less educated respondents.

Participants interviewed in the urban and semi-urban settlements who were mostly traders or civil servants, had better knowledge of eye care than participants from the rural settlements who were mostly farmers and out of work persons.

3.3.2 KNOWLEDGE OF CBHI



Above; Figure 3.2 showing respondents distribution on ‘level of awareness of CBHI’

Majority of respondents had no knowledge and had never heard of the CBHI schemes. Participants interviewed at the eye units were asked about their knowledge of scheme, most had heard of the scheme but had limited knowledge of the scheme and paid for their eye care services out of pockets. One of the eye unit respondents stated,

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“I have heard of MHO some time ago but not sure what it is really about and I do not know anyone who participates in it”. (EUR2, female)

Respondents who had basic knowledge of the scheme had come across the scheme through some sensitization some time ago, contact through work as one respondent stated,

“I made some flyers for BEPHA and referred some neighbours who have been happy with the scheme but I did not register”. (CR4, male)

Another respondent said

“I have heard of the schemes but I have been with a different insurance scheme which I am happy with”. (CR3, male)

However, an elderly respondent who is a retired health worker interviewed within the rural settlement admitted to having basic knowledge of MHO and had once registered with scheme.

Again, respondents who were educated and in urban and semi urban settlements had some knowledge or have heard about schemes compared to respondents from rural settlements. However, no respondent reported to be currently enrolled in scheme (see figure 3.1).

3.3.3 PERCEIVED ADVANTAGE OF CBHI

Most respondents perceived potential benefits of scheme for different reasons. Reasons mentioned include reducing financial risk for health and improving health benefits. A participant interviewed at the eye unit said

“I believe joining such scheme could encourage uptake of eye care services and other health care services”. (EUR1, female)

Some respondents' also perceived benefits for families and the community as one said,

“If the scheme is well organised it will be beneficial to families and the community”. (CR8, female)

Most female respondents showed more interest and willingness to participate in schemes. Only a few people felt in-different about perceived benefits of schemes as they had limited knowledge of schemes.

3.3.4 CHALLENGES HINDERING PARTICIPATION IN SCHEME

Response from participants on the challenges hindering registration in scheme was unanimous identifying lack of awareness of schemes to be the main hindrance to registering with schemes. Challenges identified by participants are outlined below.

Lack of awareness of scheme; Most respondents stated that they did not know about the schemes and even those that had some knowledge or have heard had limited understanding of what the schemes was all about hence less motivation to join schemes.

Lack of trust; Some respondents reiterated lack of trust for scheme especially as money was involved. Some respondents referred to previous similar schemes which were not successful

while others expressed bias for government led initiatives such as the MHO. A participant response was

“I am not sure about credibility of scheme” (CR2, male)

Another respondent expressed doubts about sustainability saying

“I am worried that the scheme is not sustainable and cannot be managed effectively so I am not willing to register”. (CR3, male)

Price of premium; while some respondents identified the price of premium being too low and recommending increase in price of premium and inclusion of other services to encourage enrolment in scheme, some complained that premium was expensive and could not be maintained. A respondent in favour of increasing the price of premium stated

“I would be glad to register in scheme if more services are included, maybe the premium could be increased a bit to cater for other services”. (EUR2, female)

On the other hand, a respondent who complained about the price of premium said

“I had registered some time ago with the Mutual Health scheme but I could not afford to continue especially as I have no source of income”. (CR7, male)

However, it was noted that respondents who recommended increase in premium were employed and respondents who complained about the price of premium being too high were either unemployed, retired or elderly persons especially within the rural settlement.

Lack of inclusion of some health care services; Some participants pointed out that some members they know are dissatisfied with the services rendered by the scheme as the schemes do not include some services which they considered essential. As stated by a respondent

“I am not sure if I would really like to join the schemes because some members, I know complain that some health care services which are important are not included”. (EUR2, female)

This study, however did not seek to explore or analyse services covered in scheme.

It could therefore be noted that most response to challenges hindering participation in scheme could be attributed to lack of adequate awareness of schemes.

3.3.5 RECOMMENDATIONS IDENTIFIED BY COMMUNITY RESPONDENTS

- Awareness creation. Providing adequate and accessible information to the public on the schemes and benefits to health care. According to a respondent’s recommendation *“I think the scheme should be made popular through seminars to ensure everyone is fully aware”*. (CR2, male)
The participant’s recommendations also identified some effective means of awareness and sensitisation which included through village chiefs and town criers especially in the rural areas.
- Credibility. Some participants who worried about trust and credibility of scheme recommended that the schemes should assure the community of credibility. One respondent stated

“I would like to hear the experience of others in the schemes first before considering if to register”. (CR1, female)

- Strengthen capacity of scheme. Respondents recommended schemes should seek professional and technical assistance to allow for proper management. They also mentioned this could result in improved credibility of scheme thereby boosting confidence and encouraging participation in scheme.
- Other recommendations include to review prices of premium as there were divided opinions to either increase or decrease premiums. Also, to review health care services included in the schemes.

4. DISCUSSIONS

Having outlined the findings, analysis and discussions would be focused on the strengths and weaknesses, drawing references from literatures, previous research and experience of other developing countries.

4.1 MHO, BEPHA and EYE CARE IN BUEA

Although this study did not seek to analyse structure of the schemes, it would be however necessary to discuss responses on community participation in scheme and relate with findings on situation analysis from the KIIs. The study revealed that the most popular CBHI schemes in Buea are the MHO and BEPHA set up primarily to provide financial protection for health. The schemes however are not without challenges especially as they are relatively young with the MHO at pilot stage and in the process of developing a legal framework. Carrin (2003) argues that though most CBHI schemes are young and may not portray immediate giant strides with regards to achievements, some well performing schemes have however shown how CBHI can contribute significantly to financial protection and to access. An example is the Self- Employed Women's Association (SEWA) Health insurance scheme in Gujarat, India, which contributed in reducing catastrophic spending (Ranson, 2002). The SEWA CBHI scheme significantly reduced the percentage of patients at risk of catastrophic spending for hospital care from 35.6% to 15.1% by providing high prepayment ratio of 76% and including costly impatient care in the benefit package (Carrin, 2003).

Although the schemes identify some eye care services in package, poor engagement with scheme by eye care personnel and the eye care unit shows weakness in coordination. The potential for community participation in scheme to aid increase uptake of eye care services, cost recovery and financial sustainability (Carrin et al., 2005) in eye care service provision is acknowledged by the key informants.

4.2 COMMUNITY BASED IN- DEPTH INTERVIEWS

4.2.1 KNOWLEDGE OF EYE CARE

About 80% of respondents had basic knowledge of eye care (figure 3.1) and understand the importance of care of the eyes. This shows some level of awareness and acceptability for primary eye care. Findings from the study also show participants awareness of care and prevention for onchocerciasis or river blindness (a neglected tropical disease caused by filarial worm resulting in blindness in countries in sub Saharan Africa) through sensitisation.

Respondents who had more knowledge of eye care and are more likely to seek eye care services were the educated and the employed. Respondents who were less educated, unemployed and in the rural settlement had limited knowledge of eye care.

Studies have shown that lack of awareness of eye care such as cataract could impede uptake of services (Oye, 2005). Oye (2005), while describing the experience of eye care programme in the South West Province/Region of Cameroon noted that funds for sustaining eye care services in general could be generated from eye care services such as optical services. A recent study on 'access to primary and secondary eye care in England, Wales, Scotland and Northern Ireland' identified limited community awareness of eye health as a barrier to

accessing eye care services (Hayden et al., 2012). However, the study pointed out that sight is seen as very important as there is the fear of blindness, also revealing that community members who accessed optometry services was in response to deteriorating sight.

Awareness creation for eye care is part of Primary Eye care (Gilbert, 1998). Gilbert (1998) identified Primary Eye Care as an essential building block for prevention of blindness in communities. Note that eye unit users interviewed at the District Hospital eye unit sought optical services as the need arose and not necessarily due to sensitization on eye care. It was also observed that the rate of uptake of eye care services was considerably low as an average of 3- 10 patients sought optical services daily.

Therefore, increase in uptake of eye care services could result in generation of funds for sustainability of eye care services. Community sensitization and awareness creation on eye care (International Centre for Advancement of Rural Eye care [ICARE], 2009) would increase uptake of eye care services (Gilbert, 1998).

4.2.2 KNOWLEDGE OF CBHIs; MHO and BEPHA

Most respondents had limited knowledge of schemes (figure 3.2). This had a significant influence on participation in scheme as participants expressed willingness to participate once the aims of the schemes were briefly explained to them during the interview. Lack of awareness was however identified as a barrier to participation in scheme. Mebratie (2102), while analysing the effectiveness of a pilot CBHI scheme in Tanzania points out that awareness creation of scheme is a precondition to encouraging community registration and participation in scheme, thereby enhancing the risk sharing capacity of the scheme. The study also identified that educated persons and respondents from the urban settlements had better knowledge of scheme than the less educated and respondents from rural settlements. A similar study on CBHI knowledge and willingness to pay in rural Nigeria identified that lack of knowledge of CBHI scheme as a barrier to participating in schemes especially for rural dwellers that are the main target of the scheme (Banwat et al., 2012?).

4.2.3 COMMUNITY PERCEPTION OF CBHI

Identification of perceived positive benefits of scheme by most respondents to families and the community reflected willingness to participate in scheme (Benwat et al., 2012), with better knowledge of scheme. This highlights potential for increased enrolment thereby enhancing viability of scheme (Carrin et al., 2005). Although there is an encouraging response on perceived benefits of scheme and willingness to participate in scheme, willingness to pay premiums could pose a challenge (Benwat et al., 2012?) as this could be determined by price of premium, socio- economic status, quality of care etc (Chankova et al., 2008). Studies from developing countries such as the study on implementing CBHI in Anambra state Nigeria has identified information and the perceived benefits of CBHI to provide financial protection for health, to enhancing community support and participation (Uzochukwu et al., 2010). This was also observed from a study in Ghana on house hold perception and enrolment in health insurance scheme, stating that “perceptions related to schemes are most important and have the strongest association with enrolment and retention decisions” (Jehu- Appiah et al., 2011 p. 2).

4.2.4 CHALLENGES HINDERING PARTICIPATION IN CBHI SCHEMES (MHO and BEPHA)

Although lack of awareness or adequate knowledge of scheme was the key factor identified hindering community participation and enrolment in scheme, some other underlying issues were mentioned by participants interviewed. As outlined in the findings, these factors include; trust for scheme, price of premium and content of package. Lessons from the SEWA CBHI scheme in India identified the above-mentioned factors as constraints to joining scheme (Ranson et al., 2006).

As mentioned in section 4.2.3 above, respondents expressed willingness to enrol and participate in scheme with perceived benefits. A study on community's willingness to pay for CBHI schemes revealed that respondent from urban and semi-urban areas that were aware of benefits of scheme expressed willingness to pay and participate in scheme (Onwujekwe et al., 2009). Therefore, increased awareness is essential for increase demand for scheme. Tabor (2005) suggests that adequate and concise information on benefits of scheme provided to clients determines enrolment rates and continuity of membership payments in schemes.

Affordability of premium was identified as a threat to continuity of payment of premium especially for the unemployed and low-income earners, elderly and rural dwellers. A review of case study on community financing schemes in Senegal, revealed that people of lower socio-economic status who struggle daily for survival were unlikely to consistently and promptly pay insurance premium (Jutting, 2009). This phenomenon however excludes the poorest households in the community due to constraints in affordability of premiums (Jutting, 2003). Research in low- and middle-income countries on determinants of enrolment in CBHI schemes have identified high premiums as a major constraint (Rao et al., 2009). Wiesmann and Jutting (2009?) suggest that reduced premium rates would increase demand for health insurance scheme, subsequently increasing enrolment rates, enhance programs ability to pool resources, raise revenues, recover cost, and increase access to health services by lowering financial barriers (Rao et al., 2009).

Trust, as identified by participants in this study affects community members decision to enrol in scheme thereby having an adverse effect on revenue collection and pooling of resources (Carrin et al., 2005). Trust issues include integrity and management of schemes. Previous studies on other country experiences has identified that community participation either through community representatives (Uzochukwu et al., 2010) in the operations of scheme, could serve as a back bone towards promoting trust and acceptability for CBHI schemes (Carrin et al., 2005).

Reports of other people's experiences on health services included in package influenced some respondent's decision to enrol in schemes. KIIs revealed that schemes are relatively new, hence weak collaboration with some health services such as eye care. Although this study did not seek to assess in details 'benefit of package' of scheme, researchers have however, identified content of 'benefit of package' to encourage demand and increase enrolment in scheme (Jutting, 2003). Toonen (1995 p. 13) stated that "Community financing gives the community the right to demand that services are acceptable and responsive to their priorities". Experience from the MHO in Rwanda revealed that 'regulation and management' of the CBHI scheme based on partnership between the community and health care providers with support from government and Non-Governmental Organisations like USAID, encouraged community participation and decentralisation in decision making thereby promoting acceptance (World Bank, 2008).

4.2.5 RECOMMENDATIONS

Two (2) key recommendations could be deduced from the responses with regards to Community participation in CBHI scheme for eye care financing.

Sensitisation

Increase community awareness of eye care is essential to encourage uptake of eye care services. Studies have revealed that there is a general perception of the importance of the eyes however there is limited knowledge on care for the eyes towards preventing blindness and the health and socio-economic burden in the communities.

Increase awareness of benefits of scheme would encourage participation and increased pull of resources to promote cost recovery. Literature review has shown that CBHI is a potential means for supplementary eye care financing especially for developing countries with insufficient government allocation for health financing and to reduce reliance on donor funds.

Strengthen collaboration between CBHI schemes and Eye Care Service providers.

The key informant interview identified strengthening of collaboration between the schemes and the eye care units to promote efficiency in managing cost recovery. Strengthening strategies identified include capacity building and developing a legal framework to allow effective collaboration between Eye Care Service providers and managers of the schemes.

5. CONCLUSION AND RECOMMENDATIONS

CONCLUSION

CBHI schemes have been set up in developing countries to improve access to health and provide financial protection especially for the informal sector and people in the rural areas. Although the initiative of community financing for health is relatively new, studies from the experience of developing countries such as Ghana and India have shown that financial sustainability in health care is achievable through well managed CBHI schemes.

This study sought to explore the CBHI schemes as a means to financial sustainability for eye care service provision in Buea, South West Cameroon. The scope of the study sought to assess community's knowledge and participation in eye care and CBHI schemes as a determinant for accessing eye care services and viability of CBHI schemes.

Findings from the study revealed that limited knowledge of eye care was a barrier to uptake of eye care services. With limited allocation of funds from the Government for health in Cameroon (5.6% GDP), the health sector relies on other means of funding for sustaining health care service- donor fund and user fees. User fees which is the most common financing mechanism for cost recovery is depended on uptake of services. However, due to the catastrophic effect of user fees on community access to health care, pre-payment schemes such as CBHI to provide financial protection for health care were formed.

The CBHI schemes in Buea identified as the MHO and BEPHA are constrained by low membership affecting pooling of funds. The schemes were found to be at a developmental stage and hence encountered weak engagement with some health care service providers such as for eye care. Findings from the study identified that lack of knowledge of the scheme by community members was the principal barrier to enrolment and participation in scheme. Other barriers or challenges hindering community participation identified by interviewed participants include, lack of trust for scheme, price of premium and content of benefit package. However these were linked to limited knowledge of scheme.

Recommendations from this study and drawing from other developing country's experience have identified increased awareness and knowledge through providing information of eye care and CBHI to community members would increase uptake and pooling of funds for eye care services.

This study therefore concludes that there CBHI schemes as observed by some other studies has the potential for improving financial sustainability in eye care service provision. However there is the need for sensitization, strengthened collaboration and further research as detailed in recommendations below.

RECOMMENDATIONS

- Policy recommendation would be for key stakeholders for the CBHI scheme and eye care; Community representatives; CBHI representatives (MHO and BEPHA); Eye health coordinators, personnel and INGOs to develop a framework for effective collaboration to strengthen engagement with scheme for cost recovery.
- Eye health coordinators and CBHI managers should engage in sensitising the community on benefits of eye care and CBHI adopting effective sensitisation strategies such as through community and religious leaders, peer groups, use of Information Education and Communication materials (IEC), like flyers and bill boards etc.
- Eye health coordinators and CBHI managers to conduct a broader research for a reliable representation on community views and participation, for eye care and CBHI.

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APPENDIX I: PARTICIPANTS INFORMATION SHEET

INFORMATION SHEET

COMMUNITY'S KNOWLEDGE OF EYE CARE AND PARTICIPATION IN COMMUNITY BASED HEALTH INSURANCE (CBHI) SCHEME IN BUEA, CAMEROON.

You are invited to participate in a brief field study. This is an information sheet with details of purpose and nature of study to understand the reasons for selecting you to participate in this study. Kindly take some time to read through and discuss or ask questions if anything is not clear before deciding to take part.

Thank you.

PURPOSE

Eye care services in Cameroon involve collaboration of the government, Non Governmental Organisations (NGOs) and the community. Studies have identified financing as a constraint to accessing and promoting eye care service delivery.

1. This study aims to understand community's involvement in the community health insurance scheme(s) as one of the financing mechanisms for eye care service provision in Buea, South West region of Cameroon.
2. You have been selected for this study as a key officer for this scheme/eye health personnel/community health worker(s)/community member. This study would focus on seek to understand the nature of the scheme, benefits/ success while identifying gaps that could be strengthened.
3. The study would be carried out over a period of 2 – 3 weeks and would include 15 interviews.
4. This study would involve an interview which would last about **an hour** asking you to discuss freely on the community health insurance scheme for eye care using a loose question guide.
5. Your choice and decision to or not to participate would be respected and you are free to withdraw from the study at any time. However if you choose to participate, I would request you sign a consent form. A copy of the signed consent form and information sheet would be given to you if you decide to participate.
6. All information provided will be kept confidential and would only be assessed by members of the research team. The audio recording of the interview would be used only for analysis. Your responses would be kept anonymous and you will not be identifiable or identified in any reports as codes will be used during analysis.
7. There are no risks in participating in this study. Benefits of participating in this study would help provide information to stakeholders on issues with the community health insurance schemes for eye care service provision.
8. The results and findings from this study would be written in a report for further research and stakeholder's interventions, presentations and publications. A copy of the report would be made available and could be accessed from Regional delegation of Public Health Office, Buea.
9. This research is funded and organised by the Sight Savers International and the researcher, with the support of the University of Leeds, United Kingdom and Regional delegation of Public Health Office, Buea.
10. Contact details for further information on study;

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Ndellejong Cosmos Ejong (Local Supervisor) – Tel: +23799393155

Address: Regional delegation of Public Health Office,
Buea.

Researcher's supervisor: Dr Andy Cassels- Brown at the University of Leeds, United Kingdom.

Thank you for your participation.

APPENDIX II: PARTICIPANT CONSENT FORM

Model Participant Consent Form

Title of Research Project: COMMUNITY'S KNOWLEDGE OF EYE CARE AND PARTICIPATION IN COMMUNITY BASED HEALTH INSURANCE (CBHI) SCHEME IN BUEA, CAMEROON.

Name of Researcher. Ozioma Nwagwu

Please initial box

1. I confirm that I have read and understand the information sheet dated 31st May, 2012 explaining the above research project and I have had the opportunity to ask questions about the project.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.

Researcher's contact detail: +23776865219

3. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will **not** be linked with the research materials, and I will **not** be identified or identifiable in the report(s), publications and presentations that result from the research.

4. I agree for the data collected from me to be used in future research

5. I agree to take part in the above research project.

Name of Participant

Date

Signature

(or legal representative)

Name of person taking consent

Date

Signature

(if different from lead researcher)

To be signed and dated in presence of the participant

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Lead Researcher

Date

Signature

To be signed and dated in presence of the participant

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APPENDIX III: SEMI- STRUCTURED QUESTION GUIDES

A. KEY INFORMANT INTERVIEW WITH COMMUNITY HEALTH INSURANCE SCHEME MANAGERS

- How was this organisation formed?
 - a. Focus and aims
- What has been the experience so far?
 - a. Generally
 - b. With eye care
- How do you engage with the government? And for eye care services
- How do you engage with NGOs? And for eye care services
- How do you engage with the community? And for eye care services
- What are the benefits and challenges with engaging with eye care services?
- What recommendations would you suggest for strengthening engagement with the community based health insurance scheme for eye care service provision?

B. KEY INFORMANT INTERVIEW FOR EYE HEALTH PERSONNEL

- Please give a brief overview of eye care services provided
 - a. What financing mechanisms are in place for eye care service provision
- What is your experience with the community health insurance scheme(s) for eye care service provision?
- What have been the benefits so far?
 - a. To the health unit?
 - b. To the community and its members
- What are the challenges
- What recommendations would you suggest to strengthen engagement with the community health insurance scheme for eye care service provision?

C. COMMUNITY BASED INDIVIDUAL INTERVIEW(S)

Age

Area of residence

Occupation

Sex

- What is your knowledge of eye health and eye care services in your community and how did you learn of it?
- What do you know about community based health insurance for eye care service provision?
- Do you or anyone you know participate in this scheme? How and Why?
- What are the perceived advantages of this scheme? To you and your community?
- What are the challenges with engaging with this scheme? For you and the community?

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- What recommendations would you suggest to improve participation in the community health insurance scheme for eye care service provision?