

## Relationship between Enrollees' Satisfaction of Health Needs and the Function of HMOs in the National Health Insurance Scheme: A Case of FCT, Abuja

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**Abstract.** The study focused on the relationship between enrollees' satisfaction of health needs and the function of Health Maintenance Organizations in the National Health Insurance Scheme in the Federal Capital Territory, Abuja. The purpose of the study was to investigate the impact of HMOs on the NHIS in FCT, Abuja and how this impact on the users of the scheme. The quantitative method was used to collect data from the respondents. It employed a two-phase sampling design and stratified random sampling techniques in selecting respondents for the study. Five HMOs were randomly selected from the twenty-five HMOs covering NHIS lives, and responses were obtained from a total of three hundred and eighty-four respondents working with eighteen public sector organizations in FCT, Abuja. This figure was broken down according to the five HMOs in the study. All 384 responses were obtained from 18 public sector organizations in the FCT, Abuja. The results from the test of hypotheses indicated that a relationship truly exists between enrollee's satisfaction of health needs and the function of HMOs in the scheme. The study discovered that HMOs had significant impact on the scheme. The findings of the study will help government and managers of the scheme design policies that would improve health service delivery in the scheme. It would also serve as reference source for other researchers and researches in this field, thus, contributing to existing literature.

**Keywords:** Enrollee Satisfaction, Health Maintenance Organizations, National Health Insurance Scheme

### 1. Introduction

The establishment of a national health system with the involvement of managed care model in health system delivery is a development that needs to be evaluated more. In some developing countries, where managed care (like the health maintenance organizations) have been incorporated into their national health insurance programs (Mohammed, Bermejo, Souares, Sauerborn, and Dong, 2013), the intent has been to control the cost of health care while ensuring access to quality health care services to a large population. By implication, HMOs have been incorporated into some national health insurance schemes to promote effective and efficient health care services to the people, while ensuring the cost of health care is kept under control. HMOs manage, organize, and coordinate the activities of doctors, hospitals and other care providers into groups to enhance the quality of health care services (Campbell, 2007). HMOs focus more on managing rather than providing health care for clients. Through their supervisory role, HMOs can manage a network of health providers in a scheme (Campbell, 2007). HMOs are a system designed to finance particular type of health services to a voluntarily enrolled population through a network of

providers who accounts for the cost and quality of health results. Cost control in health care is attained by being able to reduce the prices, at the same time, control access to services (Campbell, 2007). Health Maintenance Organizations, diagnosis-related groups and National Health Insurance are among the measures that have been taken to reduce medical costs (Henslin, 2010). Since HMO can play the roles of both insurers and providers of health services, they create the links between the financing and provision of health services. Also, since they are financed through prepaid capitation payments, they can effectively manage an explicit budget for a clearly defined clientele (population at risk). Further still, since they are responsible for providing a broad range of primary, secondary, and tertiary level services to an enrolled population, they have powerful incentives to ensure that services are provided at a minimized cost while maintaining quality to reduce the risk of disenrollment (Rodwin, 1989).

Health Maintenance Organizations practice what is called ‘commercial health insurance’ while National Health Insurance practices what is called ‘social health insurance’. Commercial health insurance is private, voluntary and involves individual risk-rating in most cases with an objective to meet the health needs of individuals. While social health insurance on the other hand, is generally mandatory, involves membership, and is based on community risk rating with the general objective to meet the health demands of everyone in the society (Adewumi, 2009). Not all countries in the world practice Social Health Insurance (SHI). Those practicing SHI have not been able to expand their coverage to the entire population (i.e. universal coverage) or even attain near universal coverage (Adewumi, 2009). But the expectations are that individual countries should study the attitudes of their citizens, to find out if they pay taxes promptly or not, and whether they are willing to set aside a certain proportion of their incomes for health care, before adopting a method of health care financing (Edozien, 2007). Because the health care system in the United States is operated by several different entities, as the government, managed care organizations, and insurance companies

(Brzezinski, 2009), Canada, and countries in Western Europe do not want to import or emulate their system of financing and organizing health care (Rodwin, 1989). However, the idea of health maintenance organization (HMO) which originates from America, have drifted north to Canada and Europe. The idea of introducing HMOs into a national health system typifies the American experience of encouraging Medicare beneficiaries to enroll in federally qualified HMOs or Competing Medical Plans (CMPs) (Rodwin, 1989).

Health insurance involves the healthy majority taking care of the sick minority by contributing a small amount of money periodically. This is called risk pooling so that when any of them (i.e. the healthy majority or the sick minority) falls sick, money is taken from the general contribution to take care of him or her (Adewumi, 2009). Health insurance therefore, is a mechanism of spreading the risk of incurring health care cost over a group of individuals and households (Wikipedia, n.d). The National Health Insurance Scheme in Nigeria, is a form of managed care that pools regular financial contribution of members and pays a network of providers of health care for defined specific health care services. A contribution permits the insured person, the spouse and four children under the age of 18 years access to health care. The client registers with a Health Maintenance Organization approved by the National Health Insurance Scheme and there after chooses the primary health care provider of his/her choice from an approved list. The NHIS-HMO model is a form of health insurance program designed to account for cost containment and while improving the health outcomes of the enrolled population (Akande & Babatunde, 2011). Since the overall purpose of establishing the National Health Insurance Scheme is to enhance the health status of citizens through the provision of financial protection and customer satisfaction (NHIS Annual Report, 2006), HMOs are to ensure NHIS users are satisfied while cost of health care is brought under control at the same time. The other objectives of the NHIS which are to:

- Ensure the universal provision of healthcare in Nigeria,

- Control/reduce arbitrary increase in the cost of health care services in Nigeria,
- Protect families from high cost of medical bills,
- Ensure equality in the distribution of healthcare service cost across income groups,
- Ensure high standard of healthcare delivery to beneficiaries of the scheme,
- Boost private sector participation in healthcare delivery in Nigeria,
- Ensure adequate and equitable distribution of healthcare facilities within the country,
- Ensure that, primary, secondary and tertiary healthcare providers are equitably patronized in the federation, and
- Maintain and ensure adequate flow of funds for the smooth running of the scheme and the health sector in general (NHIS Operational Guidelines, 2006), are goals which the incorporation of HMOs can facilitate the achievement.

Although the original intention of the scheme is to provide resources that will allow for a cross subsidization in the health sector, by creating the structure that will enable the healthy pay for the sick, the rich pay for the poor and the young pay for the old, this can only be made possible where a larger population is employed or where the government is willing and able to pay contributions for all its citizens irrespective of the rate of unemployment. This sort of social solidarity, that is, the NHIS is workable in a society where there is a huge formal sector, with the government ready and able to pay for all. In a country like Nigeria, where the formal sector only accounts for less than 10% of well over 120 million people, it becomes obvious that several other programs would be required under the scheme to achieve its purpose (Health Insurance report, 2005). Those who are covered for now, by the scheme, are mostly government employees. This population is small when compared to the entire country. According to Muanya (2011), the beneficiaries are mostly civil servants in Federal employment, with some in Bauchi and Cross River States, and 300,000 pregnant women and children under the

maternal and child health projects” (MCHP)”. Nigeria’s NHIS is established to cover all its citizens with the main objective to provide good health care for all Nigerians. Having commenced with the organized formal sector, the Scheme has not been able to reach those in the informal sector as much. And, the people in this category are more than those in the formal sector (Adewumi, 2009). But even with this, that is, among users in the formal sector, some enrollees are opting out (Muanya, 2011). The re-launch of the re-packaged National Health Insurance Scheme to include HMOs, it affords stakeholders in the health business such as the HMOs themselves the opportunity to impact significantly on the scheme to achieve the goal of good health for all. Health Maintenance Organizations by this may play a significant role in the implementation of the National Health Insurance Scheme in Nigeria to bring about satisfaction to users of the NHIS in the country, while ensuring the control of cost in health care. However, the satisfaction of patients rather than cost containment should be the blueprint for measuring the success of a health system (Rooney, 2006). Measuring patients’ satisfaction with the type of health system used is a very important aspect of evaluating a health system.

## 2. Research Methodology

In this study, a cross sectional survey design was employed. The survey questionnaires were administered to NHIS beneficiaries registered with some selected and accredited HMOs in the FCT to assess the knowledge of beneficiaries on HMOs participation in the NHIS, and how this impact on users of the scheme. The study population comprised:

- All public sector workers covered by NHIS in the FCT;
- All the HMOs covering lives on the behalf of NHIS in the FCT.

As at 2011, the NHIS lives in the FCT were 244, 992 while the HMOs covering these lives on behalf of the NHIS in FCT were 25. The study’s target groups were the NHIS lives (enrollees/ beneficiaries) in the public sector in FCT and the registered/ accredited HMOs covering/managing these lives.

To ensure proper coordination and ease of administration, the NHIS allocated the various public sector organizations in the FCT to 25 HMOs to manage enrollees. The allocation was done to aid the payment of capitation for all the employees of such organization through the HMO responsible for that organization. So, for this study, the NHIS lives that formed the population of study were distributed across the various ministries, agencies and parastatals in the FCT. A list of NHIS enrollees managed by a given HMO is available with the NHIS Desk Officer in all the organizations.

The choice of the FCT is purposive because it houses the administrative/operational headquarters of the NHIS, and the administrative head offices and/or operational base of all the HMOs covering NHIS public sector lives/enrollees in the country. Also, because, the NHIS began its operations with the public sector workers in the federal civil service in the FCT before extending its services to the other states of the federation. The FCT also has the highest number of NHIS public sector enrollees/beneficiaries when compared with other states in the country at the moment. The FCT therefore provides a stage for the NHIS to demonstrate this unique partnership with the HMOs in the delivery of the social medicine model in the country. Thus, the FCT is best suited to be used as a case for the study.

## 2.1 Sampling Technique

A full census i.e. the study of the whole population is desirably the best for any study because it allows for a complete head count/participation of every subject/unit in the population in the study, thus eliminating variance (sampling error) and selection bias/selection effects (note: selection bias leads to sampling bias and to biased inferences about social processes), but, studying the entire population is not practically feasible in all situations. This is because of constraints that impede such endeavor. In this study, such constraints include limited financial and time resources among others. Sampling becomes obvious since the researcher cannot study all the 244,992 NHIS lives covered by the 25 HMOs in

the FCT within the limited financial and time constraints available for the study. Interestingly however, the use of sampling does not make the findings/results of the study less valid, correct, efficient or acceptable if the appropriate sampling techniques are used. In fact, with sampling, the findings of the study can be inferred or generalized into the entire population from where the sample was drawn. Through sampling, patterns found in the sample are generalized and the characteristics of the population being studied are reproduced as close as possible.

In this study, the respondents for the cross-sectional survey interview were selected by systematic random sampling, so that each respondent had equal chances of being selected into the sample for the survey. The HMOs in the survey were selected by simple random sampling proportionate to size; this was done to allow each HMO in the FCT to have equal opportunity/chance of being chosen into the sample. Since simple random sampling and systematic sampling are probability sampling methods, it is hoped that the findings derived from this study can be generalized into the population i.e. for the whole 25 HMOs covering NHIS lives in the FCT and the entire 244,992 public sector lives covered by the HMOs for the NHIS in the FCT. Essentially, the design was a two-stage sampling design.

In the first stage, the HMOs were selected by simple random sampling with replacement. Out of the 25 HMOs covering lives on behalf of the NHIS, 5 were selected for the study. A list showing the names and number of HMOs managing NHIS enrollee was obtained from the NHIS headquarters in FCT, Abuja. The list had a total of 25 HMOs managing NHIS enrollees. Each of the 25 HMOs were written on separate pieces of papers, each of the pieces was closed up and wrapped, put in a box, mixed together and shaken. After this was done, a piece was drawn out from the box at a time, but replaced back to the box prior to another (the next) selection. Note: The box was shaken after every replacement and before each selection. This procedure was done five times to select the five HMOs for the study.

In the second stage, the respondents (NHIS enrollees) were selected by systematic random sampling proportionate to size. The following

(Table 1) are selected HMOs with the corresponding enrollee lives:

**Table 1:** Distribution of the Simple Random Sample Proportionate to Size

HMO	No. of lives selected proportionate to size
Total Health Trust Ltd	127
HealthCare International Ltd	178
Maayoit HealthCare Ltd	15
Princeton Health Group	14
Managed HealthCare Services Ltd	50
<b>Total</b>	<b>384</b>

## 2.2 Method of Data Collection

In the survey method used, the instruments used for data collection was a semi structured questionnaire. The survey instrument was divided into sections with a section designed using summated differential scale (Likert scale). It was further subjected to face validity, i.e. the instrument was given to the thesis supervisor and other authorities for scrutiny to check if the instruments were actually measuring what they intend or are supposed to measure and to ascertain that the universe of all questions or items included in it were duly included. Also, the reliability of the survey instrument was calculated using the Crombach Alpha statistics to ascertain whether there is internal consistency in the items/questions in the study instrument and to verify to what extent the instrument produced the same results or replicate consistent results if similar studies are carried out afterward using the same instrument. Also, an item analysis was done to examine the items/questions in the questionnaire to ascertain the desirability of dropping, retaining or replacing any of them depending on the resulting Crombach Alpha coefficient of the said item/question if it was deleted. In addition to the above, difficult or inappropriate questions discovered from the response of the respondents/interviewees was deleted, replaced or rephrased.

Coefficient alpha, an internal consistency measure was computed for survey instrument. The estimate for the survey instrument was .92. The number of items/questions in the instrument was 74. The coefficient indicates good reliability of the survey instrument. The estimate shows that there was good internal consistency in the items/questions used in the survey instrument. Values of .70 and above are acceptable values for Crombach’s alpha ( $\alpha$ ), but values below this indicate unreliable scale.

## 3. Results

### 3.1 Demographics

The females 177 (46.1%) in the survey were less than the males 203 (52.9%). Responses from ages 26-45 were highest in the survey, this indicated that majority of the respondents were adults. The married respondents were 319 (83.1%) while the singles were 50 (13.0%) other i.e. those separated were 4 (1.0%), Divorced 1 (0.3%) and widowed 7 (1.8%) for educational qualification, 210 (54.7%) of the respondents had first degree, those with a diploma qualification were 81 (21.1%) while masters and PhDs were 52 (13.5%) and 2 (0.5%) respectively. The study discovered that majority of the respondents were highly educated and their responses could be relied upon in response to certain questions asked.

### 3.2 Hypothesis

**There is no significant relationship between enrollee’s satisfaction of health needs and the function of HMOs in the scheme.**

To test the above hypothesis, three separate comprehensive contingency table analysis were conducted to ascertain whether there is a significant relationship between enrollers’ satisfaction of health needs and the function of HMOs in the scheme.

**Table 2:** What is the Name of Your HMO Vs How Satisfied Are You with Your HMOs?

What Is the Name of your Health Maintenance Organization (HMO)?	Vary Satisfied	Satisfied	Not Satisfied	Very Dissatisfied	No Response	Total
Total Health Trust Ltd	4 (3.3)	15 (10.5)	10 (4.9)	2 (2.4)	2 (11.9)	33
Healthcare International Ltd	2 (2.4)	20 (7.6)	3 (3.6)	0 (1.8)	1 (8.7)	24
Maayoit Healthcare Ltd	2 (8.0)	3 (2.5)	3 (1.2)	0 (.6)	0 (2.9)	8
Princeton Health Group.	2 (1.1)	7 (3.5)	2 (1.6)	0 (.8)	0 (4.0)	11
Managed Healthcare Services Ltd.	1 (.9)	4 (2.9)	2 (1.3)	1 (.9)	1 (3.3)	9
Don’t Know.	12 (14.9)	44 (48.0)	27 (22.4)	16 (11.0)	52 (54.7)	151
No Response	15 (14.6)	29 (47.0)	12 (22.0)	9 (10.8)	83 (53.6)	148
<b>Total</b>	<b>38</b>	<b>122</b>	<b>57</b>	<b>28</b>	<b>139</b>	<b>384</b>

( ) Expected count; Pearson  $\chi^2=98.310$ ; Degree of Freedom=24; P-value=. 000; Cramer’s V=.253; N=.384

Two variables were cross-tabulated, namely: “What is the name of your Health Maintenance Organization (HMO)?” and “How satisfied are you with your HMO?” (Table 2). There was a significant association between the two variable, Pearson  $X^2(24) = 98.310$ ,  $P < .001$ . This indicates that there is a significant relationship between enrollees’ satisfaction of health needs and the function of HMOs in the scheme, and that the observed effect this large cannot be by chance. The size of the effect is however medium, Cramer’s  $V=.25$  showing that there is a medium association between enrollers’ satisfaction of health needs and the function of HMOs in the scheme, even though this relationship was significant,  $p < .001$ .

**Table 3:** What is the Name of your HMO Vs Do you Enjoy the Services Rendered by HMOs?

What is the Name of your Health Maintenance Organization (HMO)?	Yes	No	No Response	Total
Total Health Trust Ltd	20 (13.5)	12 (9.5)	1 (10.1)	33
Healthcare International Ltd	20 (9.8)	3 (6.9)	1 (7.3)	24
Maayoit Healthcare Ltd	6 (3.3)	0 (2.9)	2 (2.3)	8
Princeton Health Group	9 (4.5)	1 (3.2)	1 (3.4)	11
Managed Healthcare Services Ltd.	6 (3.7)	2 (2.6)	1 (2.7)	9
Don’t Know.	50 (61.7)	55 (43.3)	46 (46.0)	151
No Response	46 (60.5)	37 (42.4)	65 (45.1)	148
<b>Total</b>	<b>157</b>	<b>110</b>	<b>117</b>	<b>384</b>

( ) Expected count; Pearson  $\chi^2=63.537$ ; Degree of Freedom=12; P-Value=.000 Cramer’s  $V = .288$ .

In this contingency table 4.5.6, two variables: “What is the name of your Health Maintenance Organization (HMO)?” and “Do you enjoy the services rendered by HMO?” were cross-tabulated (Table

3). It was revealed that there was a significant association between them, Pearson  $X^2(12) = 63.537$ ,  $P < .001$ . This indicates that there is a significant relationship between enrollees' satisfaction of health needs and the function of HMOs in the scheme. It shows that the observed relationship of this size cannot be by chance. The strength of this relationship is of a medium size, Cramer's  $V = .29$ , but highly significant,  $P < .001$ .

**Table 4:** Have you Heard of HMOs before now Vs Do you Enjoy the Services Rendered by HMOs?

Have you Heard of Health Maintenance Organization (HMO) before now?	Yes	No	No Response	Total
Yes	125 (86.3)	50 (60.4)	36 (64.3)	211
No	28 (62.6)	57 (43.8)	68 (46.6)	153
Don't Know	1 (.8)	0 (.6)	1 (.6)	2
No Response	3 (7.4)	3 (5.2)	12 (5.5)	18
<b>Total</b>	<b>157</b>	<b>110</b>	<b>117</b>	<b>384</b>

( $\alpha$ ) Expected count;

Pearson  $\chi^2 = 76.585$ ; Degree of Freedom = 6; P-Value = .000 Cramer's  $V = .316$ ; To further verify whether there exists a relationship between enrollees' satisfaction of health needs and the function of HMOs in the scheme, two more variables were cross-classified; "Have you heard of Health Maintenance Organizations (HMOs) before now?" and "Do you enjoy the services rendered by HMO?" (Table 4). There was a significant association between whether or not the enrollees' have heard of HMO and whether or not they enjoy the service rendered by HMO, Pearson  $X^2(6) = 76.585$ ,  $P < .001$ . This clearly showed that there is a significant relationship between enrollees' satisfaction of health needs and the function of HMOs in the scheme. The degree/magnitude of this effect is of a medium size, that is, a medium relationship, Cramer's  $V = .32$ . This size of effect is highly significant,  $P < .001$ , indicating that the value of the test statistic that is this big is unlikely to have happened by chance and therefore the strength of the relationship is significant.

#### 4. Conclusion

The study focused on the relationship between enrollees' satisfaction of health needs and the function of Health Maintenance Organizations in the National Health Insurance Scheme in the Federal Capital Territory, Abuja. The main thrust of the study was to investigate the impact

of HMOs on the NHIS in FCT, Abuja and how this impact on the users of the scheme. The study made use of the quantitative method to collect data from the respondents. It employed a two-phase sampling design and stratified random sampling techniques in selecting respondents and captured data from a cross sectional survey. Five HMOs were randomly selected from the twenty-five HMOs covering NHIS lives. Also, responses were obtained from a total of three hundred and eighty-four respondents working with eighteen public sector organizations in FCT, Abuja. This figure was broken down according to the five HMOs in the study. The sample sizes for each HMO were as follows: Total Health Trust Ltd had a sample size of 127, Healthcare International Ltd had 178, Maayoit Healthcare Ltd had 15, Princeton Health Ltd had 14 and Managed Health care Services Ltd had 50 sample sizes. All 384 responses were obtained from 18 public sector organizations in the FCT, Abuja. On the testing of hypothesis, it was discovered that a relationship truly exists between enrollee's satisfaction of health needs and the function of HMOs in the scheme. The study discovered that HMOs had significant impact on the scheme. This study will help government and managers of the scheme in policy formulation and administration for improved health service delivery in the scheme. It will also serve as reference source for other researchers and

researcher in this field i.e. those interested in the sociology of the organization of health services; thus, contributing to existing literature.

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