Micro Health Insurance and Poverty Alleviation in Nigeria: Empirical Evidence from Lagos State

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Abstract

The challenge of poverty pervades all economies of the world, though in varying degrees. The challenge is however more serious for a developing economy like Nigeria with her huge population currently estimated at over 170 million. To overcome this challenge and achieve some of the millennium development goals (MDGs), various options must be evaluated. This study therefore evaluates the potentials of micro health insurance in solving the poverty challenge in Nigeria. The study argued that poor health status of individuals limit their production capacity and hence may force them to sell their valuables in order to meet health care and other basic household needs. Using a survey research design, data was collected from 150 randomly selected low income earners in Lagos State, Nigeria through a structured questionnaire administered by the researchers. The collected data was subjected to descriptive statistics, reliability test, ANOVA, correlation, and regression analysis to determine the relationship between the dependent and independent variables, and the explanatory power of the independent variables on the dependant variable. The results suggest that micro health insurance can be used as a strategy for improving the living condition of the poor through the elimination of catastrophic health expenditures that could otherwise cripple their earning capacity. Based on the result, it is recommended that various enlightenment programmes should be employed by stakeholders in the insurance industry to popularise the benefits of micro health insurance among low income earners.

Introduction

Poverty is a major challenge confronting the underdeveloped economies of the world. In Nigeria, an estimated population of 112,470 million out of the estimated 163 million people in 2010 live in relative poverty (National Bureau of Statistics, 2012). This represents about 69% of the population. The statistics further reveal a yearly growth in the population of the poor people in Nigeria between 1980 and 2010. This statistics is presented in table 1 below.

Table 1: Relative Poverty Rate Growth in Nigeria from 1980-2010

Year	Poverty Incidence (%)	Estimated Population (Million)	Population in Poverty (Million)
1980	27.2	65	17.1
1985	46.3	75	34.7
1992	42.7	91.5	39.2
1996	65.6	102.3	67.1
2004	54.4	126.3	68.7
2010	69.0	163	112.47

Source: National Bureau of Statistics (NBS), Nigeria (2011).

Available evidence also indicates that majority of low income earners reside in the rural areas (Dercon, Bold, and Calvo, 2007). This category of persons is subjected to many risks and is susceptible to economic instability (Mukhtar, 2013). Previous studies have identified various

risks that mostly hinder the survival of the poor (see for example, Dercon, et al, 2007; Allianz Group, 2010; Mohammed and Mukhtar, 2012; Mukhtar, 2013). These risks include but are not limited to theft, fire, flood, drought, recession, terrorism, diseases, disability, unemployment and death. The occurrence of these risks tends to aggravate the condition of the low income earners who aside from being poor do not have access to the state provided social security (Dercon, 2008). Among the various risk management techniques available for effective risk control, only three are available to the poor in coping with this pervasive condition of human existence. These are diversification, mutual support networks and savings (Dercon, et al, 2007). The other techniques are quite beyond the reach of the poor owing to the huge financial and technical requirements.

Insurance is another option which has been shown in the literature to be an effective strategy for managing risk (Mohammed and Mukhtar, 2012). Although insurance is aimed at spreading and sharing risks, nevertheless it is sometimes only affordable to the rich (Clarke and Dercon, 2009; Dercon, 2008). With the submission of Clarke and Dercon, one might be tempted to conclude that insurance may not be the best option for managing risks particularly by the poor, especially since certain risks are excluded from the purview of insurance. Notwithstanding, recent studies have shown that insurance could play a significant role in alleviating the suffering of the poor if made available and affordable to them, especially in the form of microinsurance (Dercon, et al, 2007; Mohammed and Mukhtar, 2012; Mukhtar, 2013).

Findings from studies conducted in the developed economies support the position that micro insurance can be effectively used for poverty reduction (see for example, Gooch, 2005; Dercon, et al, 2007; Singh and Gangal, 2011; Parvathi, 2012). Despite these findings, available evidence seems to suggest that the level of insurance penetration still remains very low. According to Parvathi (2012), approximately three percent of the total population of low income earners in the world's 100 poorest countries enjoys microinsurance protection. This leaves about two billion people unprotected. Similarly, Srijanani (2013) posited that out of the estimated four billion people worldwide spending less than 2 dollars per day, only about 10 million could afford one form of modern insurance protection or the other. In Nigeria, the industry's regulator, National Insurance Commission (NAICOM) also posits that micro-insurance can be used as a strategy for poverty alleviation in Nigerians if embraced (Naeche, 2012). The commission subsequently anticipates a huge market for micro-insurance in Nigeria, which it estimated at about 118 million prospective customers (NAICOM, 2013).

Given the insight from the literature and the argument of the industry regulatory agency, this study therefore explores the potentials of micro-insurance as a strategy for alleviating the sufferings of the poor in Nigeria. Put differently, the study explores the potential of micro-insurance as a strategy for poverty reduction in the country. In particular, it addresses the first of the Millennium Development Goals (MDGs) of reducing by half, the population of poor and hungry people by 2015 (Rom, Rahman, and Hassan, 2012). It also evaluates the level of micro-insurance awareness among low income earners in the country that micro-insurance are particularly intended to protect (Churchill, 2010). Recommendations for useful policy formulation, based on the findings of the study, would also be made. In order to achieve these objectives, the remaining part of the study is organised into four sections. First, a review of the existing literature is done with the intention of locating the current work within the broader micro-insurance literature by showing the gap in knowledge and providing a justification for the study. Second, the method used in identifying the population of study, selecting a representative samples and collecting information from them is stated. In the section that follows, we present the various analyses to answer our research questions and test the hypotheses. Results of the analyses were also discussed in the light of findings from previous works. Lastly, we discuss the limitations of the study, its implications for policy formulation and give some recommendations.

Literature Review and Hypotheses
Like most social sciences constructs, micro-insurance is fraught with lack of global agreement on what the construct actually means (McCord, Steinmann, and Ingram, 2012). Notwithstanding this lack of consensus, it is generally seen as a tool of protecting the low income earners from the financial burden likely to be created by conditions characterised by uncertainty. Aseffa (2010) views micro-insurance as a type of insurance produced for people earning as low as 2 US dollars per day. According to Young (2006), it is an aspect of microfinance responsible for delivering insurance services to the low income earners.

Historically, the micro-insurance forms the basis of the operation of conventional insurance mechanism. This assertion is quite mirrored in the submission of Churchill (2010) that insurance in the 17th and 18th centuries began as a mutual protection schemes for low income earners which today, has become a sophisticated tool exclusively reserved for complex risks and the rich. In other words, the insurance mechanism in the developing countries as we see it today did not pass through the developmental process it did during the centuries that Churchill (2010) was alluding to, with its attendant consequences. One of such consequences today is that more than half of the world's populations that are susceptible to various risks are not provided for. Corroborating this assertion, Aseffa (2010), reports that about 70% of the potential micro insurance customers in Africa are left out of coverage. This according to Rom, Rahman, and Hassan (2012) is due to the inability of the low income earners to afford the price of insurance.

Rom, Rahman, and Hassan (2012), citing Matul (2005), identify some factors that could influence the decision of the poor to demand micro insurance. Among these factors are: the extent to which the needs for insurance are felt, ability to pay, decision making process within the household, awareness level, past experience and perception towards insurance, and level of trust in insurers. In a related study, Akotey, Osei, and Gemegah (2011) adopt the probit model to investigate the factors that influence the demand for micro insurance in Ghana. The study revealed that premium flexibility, income level, and nodal agency are the three main determinants of the demand for micro insurance. According to the authors, insurance education, trust, and marital status are other factors that could affect the demand for micro insurance. The study however did not identify a direct link between formal education and the demand for micro insurance.

In a recent empirical study, Mohammed and Mukhtar (2012) evaluate the prospects of micro insurance in the rural areas of Nigeria, using logit regression. The study reveals that the level of income of rural dwellers, type of assets owned, and their literacy level are the three major factors that could influence micro insurance acceptance among the rural poor. The study further establishes a direct relationship between the availability of infrastructure and micro insurance embracement. Tom, Ibok, and Awok (2012) corroborate the findings of earlier studies by identifying sincerity of insurers when claim arises, insurance knowledge and awareness generally among potential insureds, degree of professionalism exhibited by insurance marketers and technicalities involved in policy documentation as the factors that affect insurance patronage among residents of Akwa Ibom state in Nigeria. These factors, according to the study, constitute the major obstacles to the acceptance and utilisation of micro insurance facilities among the poor. Despite the findings reported in these studies, Akotey, Osei, and Gemegah (2011) documents that micro insurance is gaining popularity among the low income earners of Ghana in particular and in the developing countries generally.

Poverty and Micro-insurance
Poverty is usually measured by level of income. Oriola (2009) notes that persons whose income falls below an amount required to provide life's necessities within a defined period are poor. Recent studies agreed on spending less than two dollars per day as the yardstick for measuring poverty level (Allianz Group, 2010; Aseffa, 2010; Lagarde, 2013). However, Oriola (2009)

further opines that the benchmark for measuring poverty surpasses income. The others include health, food sufficiency, literacy, and access to other basic infrastructures. Mohammed and Mukhtar (2012) refer to a study conducted by Moller (2004) on quality of life in developing countries and report that income and social security (ability to provide for family, insurance against illness/death and income in old age) are key indicators of quality of life.

Janzen and Carter (2013) conducted a research to examine the impact of micro insurance on asset accumulation and human capital investments during a season of drought in Kenya. The data for the study was obtained from 924 households living in northern Kenya. The results of the analysis indicate that insured households are more confident of getting sufficient food than uninsured households during a drought. In addition, the study reveals that insured households would not require food aid or any other type of support as oppose to their uninsured counterpart. In an earlier study carried out by Hamid, Roberts, and Mosley (2010) in Bangladesh to investigate the ability of micro health insurance to reduce poverty among rural dwellers using primary data collected from 329 households, it was found that a positive relationship exists between micro health insurance and all the dependent variables (food sufficiency, household income, owner of non-land assets, and reduction of poverty). However, while the relationship was significant for food sufficiency, it was not significant for the other three variables.

Jegede, Kehinde, and Akinlabi (2011) also investigate the impact of microfinance on poverty alleviation in Nigeria and discovered the existence of a wide gap in terms of economic capacity and income generation, between entrepreneurs who utilise micro credit and those who do not obtain credit facilities from microfinance banks. However, Rom, Rahman, and Hassan (2012) found that 80% of low income earners in Malaysia could not afford insurance premium and hence, are not insured despite their willingness to participate in insurance programme. In addition, the study revealed that most people from rural areas could conveniently part with approximately 10.5% of their income to enjoy certain benefits including health, death insurance and savings.

Micro-Insurance and Health Care

Like regular insurance, micro-insurance offers a wide range of products. Among the various micro insurance products designed to cater for the risk management needs of the poor, micro health insurance seems to be the most sought after. This is because low income earners generally accord the highest priority to their health. Jutting (2004) posits that health related risks pose the greatest challenge to the lives and livelihood of the poor. The author established a link between health condition and earning capability of the poor. Churchill (2010) corroborates this submission with a World Health Organisation (WHO) report that about 100 million people yearly fall into poverty as a result of excessive cost of health care. In a related and recent study, Parvathi (2012) reports that 25% of persons hospitalised in India become poorer as a result of their stay in the hospital. The study further reveals that 40% of these hospitalised persons depend on their assets or credit facilities to settle hospital bills.

The outcome of these studies place micro health insurance at the forefront of the different micro insurance products available to the poor. Like conventional health insurance which protects against the risk of incurring medical expenses among individuals, micro health insurance is designed to protect the low income earners from unexpected costs of medical service. According to Leppert (2010), micro health insurance refers to risk management tool meant for low-income households to cover the costs of certain predefined illness-related losses up to a certain limit. The author further identifies two main features of micro health insurance. The first is that premium is prepaid on a regular basis prior to the occurrence of an illness. Secondly, the premium is affordable to low-income earners.

Acha and Ukpong (2012) cited the report of a survey conducted in 2010 by the Centre for Microenterprise Development. The study was carried out among the low income earners in

the two most populated states in Nigeria, Lagos and Kano. The results indicate that 73.2% and 69.6% of the total respondents in Lagos and Kano states respectively preferred health among four insurance products included in the study. In support of this assertion, Allianz Group (2010) in a report submits that there is a mismatch between the demand and supply of micro-insurance. As shown in figure 1 and 2 below, while low income earners demand more of health related insurance, micro-insurance providers find it suitable to supply life insurance coverage.

Figure 1: DEMAND: Risk management needs prioritized by low-income people in 11 countries
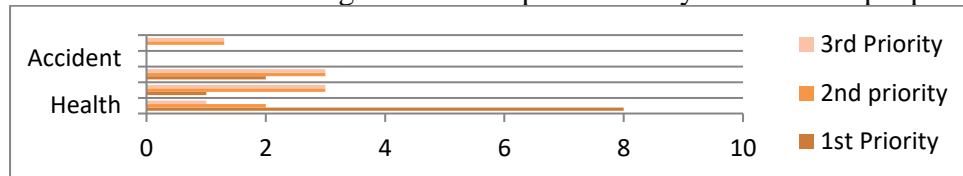
Source: Adopted from Allianz group (2010).

Figure 2: SUPPLY: Lives covered by micro insurance products (in millions)

Source: Adopted from Allianz group (2010).

Furthermore, as part of their efforts to alleviate the sufferings of their citizens, and a drastic move towards the achievement of the millennium development goals, countries of the world have shifted attention to adequate health care provision for their populace (Hassan, Jimenez, and Montoya, 2007). Hassan *et al* (2007) reports that in some developing countries (like Colombia, Philippines, and Vietnam), health insurance schemes wholly financed by the government are established to cater for the health needs of the poor people. In contrast, countries like China and Mexico encourage their citizens to embrace subsidised public health insurance programme.

These governmental efforts seem to be yielding positive result in Colombia. In a recent study carried out to investigate impact of health insurance on the demand for HIV test in antenatal care among the poor in Colombia, Ettenger, Barnighausen, and Castro (2013) show that participating in the subsidised health insurance scheme results in a reduction in HIV test during antenatal care in Colombia. This implies that women who are not enrolled in the subsidised scheme will be compelled to undergo HIV test during antenatal care. In another study, Hassan, Jimenez, and Montoya (2007) examine the impact of subsidised health insurance on the poor in Colombia using endogenous dummy models and propensity score matching. The study revealed no difference in embracing the subsidized health program between covered and uncovered persons. However, there is high tendency that individuals with self-perceived poor health condition will utilise the programme more. This is due to the existence of high degree of moral hazard and self-selection in health care utilisation among individuals in Colombia.

In a study conducted in the rural area of Kenya to investigate the impact of community – based health insurance on poor people's access to health care, Jutting (2004) establishes that participants in the community – based health insurance are better-off than non-participants. The study further shows that community – based health insurance prevents further impoverishment of the poor by eliminating catastrophic health expenditures. In a similar study

carried out in Sudan, Mohamed and Osman (2011) observe that there is an increased awareness of health insurance system among the poor. This is as a result of the availability of adequate health centers in various localities. In another study by Asfaw and Jutting (2007) to find out the role of health insurance in poverty reduction among the poor in Senegal, it was revealed that though health insurance brings about reduced health expenditure, majority of the poor who resides in rural areas could not access any health insurance plan.

Based on the insight from the literature as shown above, we therefore propose the following hypotheses in a null form:

H_1:   Micro Health Insurance does not significantly aid income stability among low income earners in Nigeria.

H_2:   Micro health insurance does not significantly contribute to the sustenance of food sufficiency among the poor.

Methods

Population and Sample

The study was carried out in Lagos state, the commercial hub of Nigeria, and arguably the most populated state in the country. The state is occupied by persons of all economic classes and various ethnic backgrounds. The study was directed at low income earners across the formal and informal sectors of the economy. Majority of these persons earn between N10, 000 and N20, 000 per month. The study sample was selected from among subsistence farmers, campus cab drivers, artisans, shop attendants, vendors, clerical staffs, cleaners, etc. Previous researches suggest that individuals living on less than two dollars per day fall below the poverty line and are as such poor (Allianz Group, 2010; Aseffa, 2010; Lagarde, 2013). This, therefore, forms the basis for selecting the sample for the current study.

Giving these arrays of respondents and the population they constitute, we were quite challenged about achieving a random and representative sample. Realizing that achieving a random sample will be quite onerous, we resulted to conducting a convenience and purposive sampling to get our target respondents. Again, considering that this group of Nigerians are quite large, we simply follow the assumption in the literature that representation is not only achieved by the number of subjects included in the sample but their distributions, we contended with having a sample size large enough to enable us avoid the violation of the normality assumptions for conducting a regression analysis.

Data was therefore collected through a structured questionnaire design by the researchers and divided into four sections. Copies of the questionnaires were personally administered by the researchers with the support of two trained assistants. A total of 450 copies were administered, out of which 133 were retrieved and found useful. We were confronted with the challenge of translating the contents of the questionnaires to local languages while gathering data for the study particularly for those respondents who were not literate. This challenge was overcome by the researchers' familiarity with the study area, and our understanding of the dominant language/dialect in the study area.

After the collection of data, we tested for the hypothesized relationships by conducting multiple regression analysis. The linear multiple regression models developed for the study is mathematically expressed as follows:

$Level_y = \infty o + \infty_1 MHI + e$

$Level_y =$ Level of income of the respondents (poverty level).

$MHI =$ Micro health insurance for the respondents.

The data was analysed using descriptive statistics, spearman rank and Kendall's tau correlations, coefficient of determination (R^2), and ANOVA (F). These are in addition to linear regression and ordinary least square regression techniques. The descriptive analysis was used to describe the Socio-Demographics and Economic Characteristics of the respondents. Analysis of variance, test of correlation, and the regression analysis were used in establishing

a relationship between the dependent and independent variables and thus answer our research questions.

Results and Discussion

We analysed and tested stated hypotheses using statistical techniques of ANOVA (Analysis of variance), Spear Man Correlation, and OLS (Ordinary Least Square) regression, all with the aid of the statistical software of Statistical Package for Social Sciences (SPSS, version 17). The two hypotheses stated in the study were tested at 0.05 significant levels.

H₁: *Micro Health Insurance does not significantly aid income stability among low income earners in Nigeria.*

This section presents the test of the first hypothesis formulated for this study. The test is conducted with correlation statistics to establish whether there is a significant relationship between Micro Health Insurance and income stability among low income earners in Nigeria. The spearman rank and Kendall's tau correlations coefficient is 0.900(*) and 0.850(**) respectively while the *p* value is 0.000. The **Ho** that micro health insurance does not significantly aid income stability among low income earners is rejected since *p* value (0.000) is less than 0.05.This is affirmed by the result which was flagged with one and two asterisks showing that there is a significant relationship between micro health insurance and low income earners.

The hypothesis was further subjected to another test of *F*—statistics (value). These produced the Fval ^{of} 483.754 and F^{tab} of 3.91 which is significant at *p<0.05* level of significance *(F^{val} = 483.754,p<0.05)*. However, from the statistical analysis the F^{val} is greater than the F^{tab} which means that the null hypothesis *(H₀)* is rejected and alternative hypothesis *(H₁)* is accepted. This implies that there is a significant relationship between the two variables.

This result supports the outcome of a study conducted by Jutting (2004) which established that persons who patronize community – based health insurance are better-off than non-participants because insurance prevents further impoverishment of the poor by eliminating catastrophic health expenditures. The author further reports that the poor prefer the prepaid health care delivery to the pay-as-you-go type. In another study by Asfaw and Jutting (2007), it was revealed that health insurance brings about reduction in health expenditure, thereby granting health care access to the poor whenever necessary. Also, in relation to a World Health Organisation (WHO) report (Churchill, 2010), this present study shows an inverse relationship between the embracement of micro health insurance and the number of people who become poorer as a result of severe cost of health care.

H₂: *Micro health insurance does not significantly contribute to the sustenance of food sufficiency among the poor.*

This section presents the test of the second hypothesis formulated for this study. The test is conducted with correlation statistics to find out whether there is a significant relationship between Micro Health Insurance and sustenance of food sufficiency among the poor. The spearman rank and Kendall's tau correlations coefficient is 0.938(*) and 0.919(**) respectively while the *p* value is 0.000.The **Ho** that micro health insurance does not significantly contribute to the sustenance of food sufficiency among the poor is rejected since *p* value (0.000) is less than 0.05.This is confirmed by the result which was flagged with one and two asterisks showing that there is significant relationship between micro health insurance and sustenance of food sufficiency among the poor.

The hypothesis was further subjected to another test of *F*—statistics (value).These yielded the Fval ^{of} *1115.78 and F^{tab} of 3.91* which is significant at *p<0.05* level of significance *(F^{val} = 1115.78,p<0.05)*. However, from the statistical analysis the F^{val} is greater than the F^{tab} which means that the null hypothesis *(H₀)* is rejected and alternative hypothesis *(H₁)* is accepted. This implies that there is a significant relationship between the two variables. The outcomes of the tested hypotheses are provided in table 2 below.

Table 2: Summary of Hypotheses Tested

Hypothesis	Variables	Spearman's rank Correlation Coefficient	Kendall's Tau correlation coefficient	F- value	F – table	Remark
H_1	Micro health insurance and income stability among the poor	0.900(*)	0.850	483.75	3.91	Reject H_o
H_2	Micro health insurance and sustainance of food sufficiency among the poor	0.938(**)	0.919	1115.78	3.91	Reject H_o

Source: Research Survey, 2014.

This result is consistent with the findings of Janzen and Carter (2013) which shows that micro-insurance has the capacity of granting food security to households during a drought and it could also reduce the possibility of insured households requesting food aids or any other support for survival. Similarly, the result supports the outcome of a study by Hamid, Roberts, and Mosley (2010) which revealed that there is a significant positive correlation between micro health insurance and food sufficiency among rural households in Bangladesh.

The **model** obtained from the result of the analysis represents a simple regression model which relates the dependent variable **(Level of income stability of the respondents (poverty level))** to the independent variable **(Micro Health Insurance)** and it is represented below as:

* $Level_y = 2.021 + \infty_1 0.628 + e$

Where:

$Level_y =$ Level of income stability of the respondents (poverty level).

The regression model above shows the relationship between income stability and micro health insurance. The coefficient of the variable in the estimate is positively related to the level of income stability of the respondents with its constant term.

In assessing the coefficient of the independent variable from the regression model, the result is positive. This indicates that there is a positive relationship between level of income stability of the respondents and the adoption of micro health insurance. This means that the more the embracement of micro health insurance, the higher the income stability level of the respondents. The slope value of .628 means that for a unit change in micro health insurance, the probability of having improved on living condition of the poor increases by 62.8 percent.

The co-efficient of determination (R^2) shows that the regression equation supports the observed data since it is able to explain only 58.4 % of total variation in the income level. The F^*- statistics 183.623 when compared with the sig. F^* change value of 0.000 shows that the model is significant, it further justifies that the explanatory variable; micro health insurance is able to justify the trend in income stability level of the respondents. When subjected to further test t- ratio, the result further confirms that both the constant and the explanatory variable coefficients are significant at 5% level of significance. This further suggests that the model is unbiased and could predict the influence of Micro Health Insurance (MHI) on income stability level of the respondents which is a proxy for poverty level.

Conclusion and Recommendations

Health is widely recognised as an important criterion for measuring poverty. This recognition is mirrored in the saying that "health is wealth". The import of this saying is that only healthy individuals that can work and earn income to meet life's basic needs, sustain themselves and their families and thus achieve improved living conditions. This study was therefore driven by the possibility of using micro-insurance and more specifically micro health insurance to improve accessibility of the poor to quality health care at affordable price. The outcome of the study suggests that micro health insurance can provide a shock absorber for the consequences

of illness, such as income loss and impoverishment. This finding seems to address the first of the Millennium Development Goals (MDGs) of reducing the population of poor and hungry people by half in 2015. As discussed earlier, micro-insurance is insurance made affordable to the low income earners in order for them to also enjoy the basic benefits of insurance. And as shown by the outcome of the study, micro health insurance has the potential of preventing the poor from fallen deeper into the poverty trap by ensuring that they enjoy good quality health care at a very affordable price as opposed to paying out of their small earnings. This conclusion finds support in the literature that micro health insurance can eliminate or reduce health expenditure thereby making health care accessible to the poor. In addition, the study reveals that micro health insurance contributes to the sustenance of food sufficiency among low income earners. It is logical to imply that excessive health expenditure will limit household spending on feeding. Low income earners without micro health insurance may be forced to sell their valuables to meet both health and household expenditures.

On the basis of the findings reported in this study, we therefore suggest the following recommendations:

i. Stakeholders in the insurance industry should intensify efforts to increase the level of insurance awareness among Nigerians, particularly the low income earners. This will further enhance the level of acceptability of insurance and micro insurance in Nigeria.

ii. The ability of micro health insurance to fight poverty should be made known to the citizenry through various enlightenment programs in order for people to understand why they should embrace it.

iii. Insurance services providers in Nigeria should be granted the enabling environment to include micro insurance in their line of businesses. This should include granting the appropriate regulatory framework for micro insurance to thrive in Nigeria.

iv. Micro health insurance seems to be a veritable alternative to the National Health Insurance Scheme (NHIS), particularly for low income earners who are not formally employed. It is hereby suggested that consideration should be giving to this while amending the relevant laws of NHIS.

v. Insurance services providers interested in transacting micro health insurance should consider the opportunities provided by the various community-based health facilities and trade associations to reach the rural poor.

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