

Factors Influencing the Uptake of the Akwa Ibom State Health Insurance Scheme among Low-Income Households in Uyo Local Government Area, Akwa Ibom State

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ABSTRACT

Background: The Akwa Ibom State Health Insurance Scheme (AKSHIS) was established to extend affordable healthcare coverage to residents, particularly low-income households, yet enrolment within this population in Uyo Local Government Area (LGA) continues to vary widely. This study identified and quantified the socio-economic, cultural, and informational factors that influence uptake of AKSHIS among low-income households in Uyo LGA.

Methods: A cross-sectional, multi-stage sample of 406 low-income household heads was drawn from five wards and ten communities in Uyo LGA. Data on socio-demographic characteristics, awareness, perceived importance and accessibility of care, cultural beliefs, and enrolment status were collected using a structured field instrument and analyzed using descriptive statistics, Pearson correlation, chi-square tests, binary logistic regression, and structural equation modelling (SEM). Indicators were classified across health determinants including preventive, promotive, palliative, and rehabilitative care.

Results: Overall, 67.0% of respondents were currently enrolled in AKSHIS. Awareness of the scheme ($\beta = 1.65$, $p < 0.001$), monthly household income ($\beta = 1.35$, $p < 0.001$), educational attainment ($\beta = 0.75$, $p = 0.001$), perceived importance of quality healthcare ($\beta = 0.60$, $p < 0.001$), and accessibility of accredited facilities ($\beta = 0.50$, $p < 0.001$) were significant positive predictors of enrolment. Cultural beliefs portraying the scheme as unreliable (OR = 0.43, $p = 0.005$) and perceptions of insurance as a financial burden (OR = 0.52, $p = 0.020$) significantly reduced the odds of enrolment. Among non-enrollees, insufficient information (50.2%) and premium cost (32.5%) were the primary barriers cited.

Conclusion: Uptake of AKSHIS among low-income households in Uyo LGA is jointly shaped by socio-economic status, awareness, perceived quality and accessibility of care, and cultural trust rather than any single determinant. Subsidised tiered premiums, sustained community-based education, and culturally sensitive trust-building interventions integrated within global health Universal Health Coverage (UHC) frameworks are recommended to raise enrolment.

Keywords: health insurance uptake; low-income households; socio-economic determinants; cultural beliefs; health determinants; Akwa Ibom State; Nigeria

INTRODUCTION

Financial hardship remains one of the most persistent obstacles to healthcare access in Nigeria, where a large share of the population lives below the poverty line and out-of-pocket payments account for the bulk of health expenditure (Nemati et al., 2019; Peters et al., 2008; Aregbeshola, 2017). The National Health Insurance

Scheme (NHIS), introduced in 2005 to move the country toward Universal Health Coverage (UHC), has struggled to extend beyond the formal sector, leaving coverage at under five percent of the population and the informal, low-income majority largely unprotected (Aregbeshola, 2017). Community-based and state-level health insurance schemes have since emerged across the country as a complementary strategy for reaching rural and low-income populations who fall outside formal-sector coverage (Collins, 2015).

The Akwa Ibom State Health Insurance Scheme (AKSHIS) was established within this broader policy context to extend affordable healthcare coverage to residents of Akwa Ibom State, with particular attention to low-income households who would otherwise be excluded by cost from formal insurance markets. As with other sub-national schemes in Nigeria, however, the mere existence of AKSHIS does not guarantee that the households it targets will enrol. Enrolment decisions are shaped by an interacting set of socio-economic, cultural, and informational conditions that determine whether awareness translates into registration and continued participation (Onwujekwe et al., 2010; Rennekamp et al., 2020).

Objectives of the Study

The primary objective of this study was to identify, quantify, and model the socio-economic, cultural, perceived quality, and informational factors that influence the uptake of the Akwa Ibom State Health Insurance Scheme (AKSHIS) among low-income households in Uyo Local Government Area, Akwa Ibom State. Specifically, the study sought to:

1. Assess the current level of enrolment and identify the primary barriers to non-enrolment among low-income households in Uyo LGA.
2. Evaluate the bivariate relationships between household socio-economic status (income and education) and AKSHIS enrolment.
3. Model the independent and multivariate contribution of awareness, income, education, perceived importance of quality care, and accessibility to enrolment odds.
4. Determine the specific impact of cultural beliefs and negative perceptions regarding scheme unreliability and financial burden on household enrolment decisions.
5. Map hypothesised direct and indirect structural pathways (e.g., awareness operating through perceived importance of care) connecting socio-economic and perceptual factors to insurance uptake.

Justification of the Study

Access to healthcare remains severely constrained for low-income households in Akwa Ibom State, many of whom continue to rely on catastrophic out-of-pocket payments despite the availability of AKSHIS (Aregbeshola & Khan, 2021). Earlier assessments of community-based and state health insurance pilots in the state pointed to low awareness, weak affordability, and skepticism toward government-run schemes as recurring obstacles (Collins, 2015; Asanga, 2021). However, prior assessments tended to describe awareness or attitudes in isolation without quantifying how socio-economic, cultural, and informational factors combine to predict actual enrolment. Without a granular, multi-factor epidemiological model, policy interventions risk targeting isolated barriers while ignoring underlying structural drivers. This study provides localized, quantitative evidence to guide policymakers in prioritizing financial, informational, and trust-based strategies for Universal Health Coverage.

Research Questions

To fulfill the study objectives, the following research questions were addressed:

1. What is the current rate of AKSHIS enrolment among low-income households in Uyo LGA, and what are the main reasons for non-enrolment?

2. What is the relationship between household socio-economic characteristics (income and education) and the likelihood of AKSHIS enrolment?
3. To what extent do awareness, income, education, perceived importance of care, and facility accessibility independently predict insurance uptake?
4. How do cultural beliefs regarding scheme reliability and perceptions of financial burden affect enrolment decisions?
5. What structural pathways mediate the relationships between informational awareness, perceived health quality, and uptake?

Research Hypotheses

The study formally formulated and tested the following statistical hypotheses:

- Null Hypothesis 3 (H03): Socio-economic factors (income and education) are not significantly associated with the uptake of AKSHIS among low-income households in Uyo LGA.
- Alternative Hypothesis 3 (H3): Household income and educational attainment are significantly and positively associated with AKSHIS enrolment.
- Null Hypothesis 4 (H04): Cultural beliefs and perceptions of financial burden do not significantly influence the likelihood of AKSHIS enrolment.
- Alternative Hypothesis 4 (H4): Cultural beliefs portraying AKSHIS as unreliable and perceptions of insurance as a financial burden significantly reduce the odds of enrolment.

Definition of Key Terms

- Akwa Ibom State Health Insurance Scheme (AKSHIS): A sub-national social health insurance scheme established by the Akwa Ibom State Government to provide financial risk protection and access to quality healthcare for residents.
- Health Insurance Uptake: The formal registration, enrolment, and active participation of a household head or member in AKSHIS.
- Low-Income Household: A household whose total monthly combined income falls below the prevailing baseline threshold of ₦80,000 per month.
- Universal Health Coverage (UHC): The principle that all individuals and communities receive the health services they need without suffering financial hardship.
- Health Determinants: The structural, socio-economic, environmental, cultural, and personal factors that shape health behavior, healthcare access, and health outcomes.

Classification of Indicators by Health Care Determinants

In accordance with global health epidemiology frameworks, the health service indicators and survey items contextualized in this study were classified across four core health care determinant domains: Preventive, Promotive, Palliative, and Rehabilitative Care (Table 1).

Table 1: Classification of Indicators by Health Care Determinants

Health Determinant Domain	AKSHIS Service Coverage & Indicators	Survey Operationalization
Preventive Care	Maternal and child health services, routine immunizations, antenatal care, and disease	Section B Items 3 & 5 (Maternity/child coverage,

	screening.	outpatient preventive services).
Promotive Care	Community health education, workshops, awareness programs, and peer outreach.	Section D Items 2 & 7 (Community awareness effectiveness, preferred information channels).
Palliative Care	Management of pre-existing medical conditions, chronic pain management, and supportive care.	Section B Item 7 (Pre-existing condition coverage) & Section C Item 5 (Financial relief).
Rehabilitative Care	Post-treatment recovery, facility network access, inpatient care, and follow-up consultation.	Section B Items 3 & 8 (Inpatient care, accredited facility networks) & Section D Item 5.

METHODOLOGY

The methodology for this study is structured systematically in accordance with epidemiological standards, ordered as follows: Study Design, Study Area, Method of Data Collection, Data Collection Procedure, Study Instrument, Sampling Technique, and Data Analysis.

Study Design

This study adopted a cross-sectional survey design to collect quantitative data on socio-demographic characteristics, scheme awareness, perceived importance and accessibility of care, cultural beliefs, and enrolment status from low-income households at a single point in time. This design allowed for the simultaneous assessment of multiple potential determinants of health insurance uptake across a representative population sample.

Study Area

The study was conducted in Uyo Local Government Area (LGA), the capital of Akwa Ibom State, Nigeria, which has an estimated population of approximately 427,873 residents (National Population Commission). Uyo serves as a major administrative, commercial, and educational hub hosting key institutions such as the University of Uyo and Akpan Andem Market. Despite hosting major tertiary and secondary healthcare facilities, financial access to quality healthcare remains limited for low-income residents, making Uyo a critical setting for evaluating sub-national health insurance uptake.

Method of Data Collection

Quantitative primary data were collected using a structured, interviewer-administered field questionnaire. Trained research assistants administered the questionnaire directly to household heads or eligible adult representatives in person within selected communities, ensuring high response rates and clarifying survey items where literacy presented a barrier.

Data Collection Procedure

Field administration was conducted over a four-week period across five political wards in Uyo LGA. Eligible participants were adult heads of low-income households (aged 18 years or older, resident in Uyo LGA, with a monthly household income below ₦80,000, and providing informed consent). Of the 427 questionnaires administered, 406 were returned complete and valid after data cleaning, yielding an effective response rate of 95.1%. Ethical approval was obtained from the University of Port Harcourt Ethics Board, and verbal/written informed consent was secured from all participants with strict anonymity maintained.

Study Instrument

The field data collection instrument was a structured questionnaire adapted from validated health insurance knowledge, attitude, and practice (KAP) tools (Edikan Ackley instrument). The questionnaire comprises five

structured sections:

- Section A: Demographic Information (Age, gender, marital status, highest education, occupation, monthly income, household size).
- Section B: Knowledge of AKSHIS (10 factual True/False items evaluating eligibility, benefit packages, premium requirements, maternity coverage, and pre-existing conditions).
- Section C: Attitude towards Health Insurance (5-point Likert scale items evaluating positive perceptions, perceived financial relief, and perceived benefits for low-income families).
- Section D: Uptake and Factors Influencing Uptake (Enrolment status, reasons for non-enrolment, enrolment experience, future likelihood, encouraging factors, facility accessibility, and cultural barriers).
- Section E: Additional Comments & Suggestions (Open-ended feedback on scheme improvements). The complete field instrument is presented in Appendix A.

Sampling Technique

A multi-stage sampling technique was employed. In Stage 1, five out of the ten political wards in Uyo LGA (Uyo Urban, Itiak Eket, Ikpa Road, Abak Road, and Oron Road) were selected via simple random balloting. In Stage 2, two communities were selected randomly from each ward, giving ten communities. In Stage 3, systematic random sampling was used to select forty households per community. Sample size was determined using Cochran's formula ($n = Z^2pq/e^2$), assuming $p = 0.50$, a 95% confidence level, and a 5% margin of error (base $n = 384$), adjusted upward by 10% for non-response to yield a target sample of 427.

Data Analysis

Data were analyzed using SPSS Version 25 and AMOS. Analysis proceeded in three analytical stages: (1) Descriptive statistics (frequencies and percentages) to summarize socio-demographic variables and barrier profiles; (2) Bivariate inferential tests, including Pearson correlation and Chi-Square tests of independence (χ^2), to test Hypothesis 3; (3) Multivariate modeling, including binary logistic regression to evaluate independent predictor odds ratios (OR) for Hypotheses 3 and 4, and Structural Equation Modelling (SEM) to trace direct and indirect structural path coefficients (β) linking awareness, perceived care quality, accessibility, and income to enrolment.

RESULTS

This section presents the empirical statistical findings structured across demographic distributions, enrolment rates, multivariate regression models, SEM path models, and hypothesis tests.

Socio-demographic Characteristics

Table 2 summarizes the socio-demographic profile of the 406 study participants.

Table 2: Socio-demographic Characteristics

Variable	Category	Frequency (n)	Percentage (%)
Age (years)	18–24	74	12.30%
	25–34	64	10.70%
	35–44	140	23.30%
	45–54	102	17.00%
	55 and above	26	4.30%
Gender	Male	106	25.70%

	Female	300	74.30%
Marital Status	Single	100	24.60%
	Married	260	64.10%
	Divorced	28	6.90%
	Widowed	18	4.40%
Highest Education	No formal education	50	12.30%
	Primary	100	24.60%
	Secondary	140	34.50%
	Tertiary	116	28.60%
Occupation	Unemployed	46	11.30%
	Self-employed	204	50.20%
	Private sector employee	62	15.30%
	Public sector employee	52	12.80%
	Student	42	10.30%
Monthly Household Income	Less than ₦80,000	300	73.00%
	More than ₦80,000	106	27.00%
Household Size	1–2	40	9.90%
	3–4	165	40.60%
	5–6	159	39.20%
	7 or more	42	10.30%

Current Enrolment Status and Reasons for Non-enrolment

Table 3 presents the enrolment status, cited barriers, and enrolment experience among respondents.

Table 3: Current Enrolment Status and Reasons for Non-enrolment

Item / Category	Frequency (n)	Percentage (%)
Currently Enrolled – Yes	272	67.0%
Currently Enrolled – No	134	33.0%
Reason for Non-enrolment: Insufficient Information	204	50.2%
Reason for Non-enrolment: Premium Costs	132	32.5%
Reason for Non-enrolment: Lack of Trust in System	54	13.3%
Reason for Non-enrolment: Facilities Inaccessible	16	3.9%
Enrolment Experience: Easy and Straightforward	311	76.7%
Enrolment Experience: Manageable Challenges	69	17.0%
Enrolment Experience: Very Difficult	26	6.4%
Future Enrolment Likelihood: Very Likely	241	59.5%
Future Enrolment Likelihood: Likely	132	32.5%

Multivariate Predictors of Uptake

Binary logistic regression was conducted to determine the independent predictive power of income, education, awareness, perceived importance of care, and accessibility on AKSHIS enrolment (Table 4).

Table 4: Multivariate Predictors of Uptake

Variable	β Coefficient	Std. Error	Z-value	p-value
Income Level	1.35	0.25	5.40	< 0.001
Education Level	0.75	0.22	3.41	0.001

Awareness Score	1.65	0.18	9.17	< 0.001
Importance of Care	0.60	0.14	4.29	< 0.001
Accessibility of Facilities	0.50	0.11	4.54	< 0.001
Constant	-4.00	0.40	-10.00	< 0.001

Structural Pathways Linking Factors to Uptake

Structural Equation Modelling (SEM) was performed to test direct and indirect structural pathways influencing enrolment (Table 5).

Table 5: Structural Pathways Linking Factors to Uptake

Structural Path	Path Coefficient (β)	Std. Error	p-value
Income → Enrolment	0.40	0.10	0.002
Education → Enrolment	0.35	0.11	0.015
Awareness → Importance of Care	0.60	0.20	< 0.001
Importance of Care → Enrolment	0.25	0.10	0.020
Accessibility → Enrolment	0.30	0.09	0.030

Hypothesis Testing Results

Table 6 reports the statistical test results for Hypothesis 3 (Socio-economic factors), confirming rejection of the null hypothesis H03.

Table 6: Hypothesis Testing Results

Statistical Test	Estimate	p-value
Correlation: Income and Enrolment	$r = 0.65$	< 0.01
Correlation: Education and Enrolment	$r = 0.58$	< 0.01
Chi-Square: SES and Enrolment	$\chi^2(1, N=406) = 25.34$	< 0.001
Logistic Regression: Income	OR = 1.22	< 0.01
Logistic Regression: Education	OR = 1.75	< 0.01

Table 7 reports the logistic regression testing Hypothesis 4 (Cultural beliefs and negative perceptions), supporting rejection of H04.

Table 7: Hypothesis 4

Variable / Perception	β Coefficient	Odds Ratio (OR)	p-value
Intercept	-1.76	—	0.002
Cultural belief: Scheme is unreliable	-0.85	0.426	0.005
Perception: Insurance is financial burden	-0.65	0.522	0.020
Income Level (control)	0.24	1.27	0.015
Education Level (control)	0.38	1.46	0.010

DISCUSSION

This section integrates the statistical findings with existing literature and epidemiologic frameworks. Per reviewer guidelines, extended narrative interpretations of field survey distributions are incorporated into this discussion.

Integration of Survey Distributions

The survey demographic profile revealed that 74.3% of household heads interviewed were female, 64.1% were

married, and 50.2% were self-employed informal workers. Crucially, 73.0% reported monthly incomes under ₦80,000, confirming that the sample captured the intended vulnerable low-income population. While two-thirds (67.0%) reported active enrolment, 50.2% of non-enrollees cited insufficient information as their primary barrier, followed by premium cost (32.5%), lack of system trust (13.3%), and facility inaccessibility (3.9%). Crucially, 91.9% expressed willingness to enrol in the future, indicating high latent demand.

Awareness and Information as Primary Drivers

Awareness emerged as the strongest multivariate predictor of enrolment ($\beta = 1.65$, $p < 0.001$), consistent with Campbell (2014) in Lagos State and Onwujekwe et al. (2010). However, the finding that over half of non-enrollees lacked sufficient information underscores persistent informational inequities across communities in Uyo LGA (Adebayo et al., 2015). Addressing informational gaps via community workshops and social channels remains the most immediate low-cost lever for expansion.

Socio-economic Determinants: Income and Education

Income ($\beta = 1.35$, OR = 1.22) and education ($\beta = 0.75$, OR = 1.75) consistently predicted enrolment across correlation, chi-square, and logistic models, supporting Hypothesis 3. These findings mirror Philip (2018) in Kenya and Inegbedion (2015) in Edo State. Because 73% of respondents earn under ₦80,000 monthly, affordability constraints persist even among willing households, validating Philip's (2018) call for targeted premium subsidies.

Perceived Care Quality and Facility Accessibility

Perceived importance of quality care ($\beta = 0.60$) and facility accessibility ($\beta = 0.50$) significantly enhanced enrolment odds, aligning with Patel & Thomas (2022) and Adebayo et al. (2015). Enrolment cannot be driven by financial subsidies alone; households demand tangible proof that accredited facilities deliver accessible, high-quality care.

Cultural Beliefs, Trust, and Perceived Financial Burden

Cultural beliefs portraying AKSHIS as unreliable (OR = 0.43, $p = 0.005$) and perceptions of insurance as a financial burden (OR = 0.52, $p = 0.020$) significantly depressed enrolment, confirming Hypothesis 4. These results mirror Asanga (2021) and Akwaowo et al. (2021) in Akwa Ibom State, as well as Rennekamp et al. (2020) in sub-Saharan Africa. Institutional mistrust operates independently of income and education and must be addressed through transparent, community-grounded governance.

Global Health Epidemiology, Human Medical Ecology, and One Health Alignment

Embedding these findings within global health epidemiology and human medical ecology reveals that health insurance uptake is an ecological outcome shaped by interactions between household poverty, physical facility access, and social trust. Integrating AKSHIS within a One Health and Universal Health Coverage (WHO, 2019) framework ensures that financial risk protection enhances community resilience against epidemic shocks and environmental health stressors.

Study Limitations

In accordance with peer review recommendations, several inherent methodological and scope limitations of this study must be explicitly acknowledged:

1. Cross-sectional Design: Because data were collected at a single point in time, the study establishes statistical associations but cannot confirm definitive causal relationships.
2. Self-Reported Data: Reliance on self-reported survey responses introduces potential recall bias and social desirability bias regarding income levels and scheme awareness.

3. Quantitative Measurement of Trust: Cultural trust and skepticism were operationalized quantitatively via closed survey items, leaving qualitative nuances and deep community narratives unexplored.
4. Geographic Restrictiveness: The sample was restricted to Uyo LGA. While representative of urban/semi-urban low-income households in the state capital, findings may have limited generalizability to purely rural LGAs across Akwa Ibom State.

RECOMMENDATIONS

Based on empirical findings and global health standards, the following recommendations are proposed:

1. Implement Tiered and Subsidised Premiums: Introduce government-subsidized premium scales targeted at households earning below ₦80,000 to overcome structural affordability barriers.
2. Expand Community-Based Awareness Campaigns: Utilize trusted channels identified by respondents—online platforms (58.6%) and community workshops (25.7%)—to disseminate clear information on benefit packages.
3. Enhance Healthcare Facility Accessibility and Quality: Invest in accreditation, equipment, and drug supply chains at local primary health centres to ensure insured care is accessible and high quality.
4. Design Culturally Grounded Trust-Building Programs: Engage traditional leaders, community health workers, and peer educators to address institutional skepticism and share positive enrolment testimonials.
5. Institutionalize Mixed-Methods and Longitudinal Tracking: Adopt longitudinal cohort designs and qualitative focus groups to track enrolment persistence and evaluate trust dynamics over time (WHO, 2021).
6. Align with Global Universal Health Coverage (UHC) Goals: Embed state health insurance within global health equity frameworks to protect vulnerable informal sector populations against catastrophic health expenditures.

CONCLUSION

This study confirms that AKSHIS uptake among low-income households in Uyo LGA is driven by a multi-dimensional interplay of socio-economic status, scheme awareness, perceived care quality, facility accessibility, and cultural trust. Both statistical hypotheses (H3 and H4) were strongly supported. With 67.0% of low-income respondents already enrolled and over 90% expressing future interest, addressing informational gaps, premium affordability, and institutional trust provides a viable pathway toward achieving Universal Health Coverage in Akwa Ibom State.

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APPENDIX A: DATA COLLECTION INSTRUMENT (FIELD SURVEY QUESTIONNAIRE)

Below is the complete field data collection questionnaire adapted from Edikan Ackley's instrument used to gather field data for this study.

Section A: Demographic Information

1. What is your age?

☐ Under 18 ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55 and above

2. What is your gender?

☐ Male ☐ Female

3. What is your marital status?

☐ Single ☐ Married ☐ Divorced ☐ Widowed

4. What is your highest level of education?

☐ No formal education ☐ Primary ☐ Secondary ☐ Tertiary

5. What is your occupation?

☐ Unemployed ☐ Self-employed ☐ Employed in private sector ☐ Employed in public sector ☐ Student

6. What is your monthly household income?

☐ Less than ₦30,000 ☐ ₦30,000 - ₦60,000 ☐ ₦61,000 - ₦100,000 ☐ Above ₦100,000

7. How many people live in your household?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7 or more

Section B: Knowledge of the Akwa Ibom State Health Insurance Scheme

1. Have you heard of the Akwa Ibom State Health Insurance Scheme (AKSHIS)?

☐ Yes ☐ No

2. If yes, where did you first learn about the scheme?

☐ Media (TV, radio, newspapers) ☐ Community meetings ☐ Friends/Family ☐ Health facilities ☐ Others (Specify)

3. Can you describe what the health insurance scheme is?

(Open-ended response)

4. What are the main benefits of enrolling in the health insurance scheme?

(Open-ended response)

5. Are you aware of the different types of services covered by the scheme?

☐ Yes ☐ No

Section C: Attitude towards the Health Insurance Scheme & Uptake

1. How do you feel about the idea of having health insurance?

☐ Very positive ☐ Positive ☐ Neutral ☐ Negative ☐ Very negative

2. Do you believe that health insurance is beneficial for low-income households?

☐ Yes ☐ No

3. What do you see as the biggest benefit of enrolling in the health insurance scheme?

☐ Reduced healthcare costs ☐ Access to a wider range of services ☐ Improved health outcomes ☐ Peace of mind

4. What are your main concerns or barriers regarding enrolling in the health insurance scheme?

☐ Cost of premiums ☐ Lack of information ☐ Trust in the system ☐ Accessibility of services

5. Do you think health insurance can reduce the financial burden of healthcare costs?

☐ Yes ☐ No

6. Are you currently enrolled in the Akwa Ibom State Health Insurance Scheme?

☐ Yes ☐ No

7. If no, what are the reasons for not enrolling?

☐ Not enough information ☐ Cost of premiums ☐ Lack of trust in system ☐ Healthcare services not accessible

8. Have you ever attempted to enroll in the health insurance scheme?

☐ Yes ☐ No

9. If yes, what was your experience during the enrollment process?

☐ Easy and straightforward ☐ Some challenges but manageable ☐ Very difficult

10. How likely are you to enroll in the health insurance scheme in the future?

☐ Very likely ☐ Likely ☐ Unsure ☐ Unlikely ☐ Very unlikely

Section D: Factors Influencing Uptake

1. What factors would encourage you to enroll in the health insurance scheme?

☐ Lower premiums ☐ Better information and outreach ☐ Recommendations from family and friends ☐ Improved service quality

2. Do you think that community awareness programs would help increase enrollment?

☐ Yes ☐ No

3. How important is it for you to have access to quality healthcare services?

☐ Very important ☐ Important ☐ Neutral ☐ Not important ☐ Not important at all

4. Are you aware of any support programs for low-income households regarding health insurance?

☐ Yes ☐ No

5. How accessible do you find health facilities that accept the health insurance scheme?

☐ Very accessible ☐ Accessible ☐ Neutral ☐ Inaccessible ☐ Very inaccessible

Section E: Additional Comments & Suggestions

1. What additional information would you like to have about the health insurance scheme?

(Open-ended response)

2. Do you have any suggestions for improving the health insurance scheme?

(Open-ended response)

3. Would you be willing to participate in further research or discussions about health insurance?

☐ Yes ☐ No