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HEALTH INSURANCE PERCEPTION AND UTILIZATION SURVEY IN AWKA AND IDEMILI SOUTH, ANAMBRA STATE, NIGERIA

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Abstract

Background: Despite the National Health Insurance Authority (NHIA) Act 2022 mandating health insurance for all Nigerians, enrollment remains critically low. In Anambra State, preliminary observations suggested a paradox: high awareness coexists with minimal uptake. Understanding the barriers to enrollment is essential for achieving Universal Health Coverage (UHC) targets.

Objective: To assess health insurance awareness, enrollment patterns, barriers to uptake, and patient-provider perspectives in Awka and Idemili South, Anambra State, Nigeria.

Methods: A cross-sectional survey design was employed. Structured questionnaires were administered to 413 community members and 54 healthcare providers across eleven locations (hospitals, Primary Health Centres, faith-based venues, and community events) between July and December 2025. Data were analyzed using descriptive statistics and Chi-square tests for associations.

Results: Awareness of health insurance was high (87%), but actual enrollment was low (28.1%), creating a 59.8-point conversion gap. The primary barrier was process opacity: 58.1% of respondents reported "I've heard about it, but I don't know where to start." A significant trust deficit was identified, with 65.0% of patients believing insurance negatively affects treatment quality, compared to 77.8% of providers claiming equal care for all patients. Policy knowledge was low: only 38.0% knew Nigerians are entitled to yearly coverage under the NHIA Act. Patient priorities were clear: 89.1% prioritized coverage for drugs, diagnostic scans, and emergencies. Enrollment varied significantly by location, ranging from 33.8% at community events to 17.6% at Primary Health Centres ($\chi^2=52.4$, $p<0.001$). Chi-square tests confirmed significant associations between enrollment and: awareness ($\chi^2=142.3$, $p<0.001$), trust perception ($\chi^2=38.7$, $p<0.001$), policy knowledge ($\chi^2=28.9$, $p<0.001$), and perceived accessibility ($\chi^2=95.1$, $p<0.001$).

Conclusion: The study reveals that awareness alone is insufficient for health insurance enrollment. Process complexity, trust deficits, coverage misalignment, and geographic disparities create a multifaceted barrier ecosystem. Interventions must shift from raising awareness to simplifying enrollment, rebuilding trust, aligning benefits with patient priorities,

and strengthening provider partnerships to achieve meaningful progress toward Universal Health Coverage.

Keywords:

Health Insurance, Perception, Utilization, Awareness, Enrollment Patterns, Barriers to Uptake, Patient-Provider, Perspectives.

1.1 Introduction

Health insurance is a critical mechanism for achieving Universal Health Coverage (UHC) and protecting families from catastrophic health expenses. In Nigeria, the National Health Insurance Authority (NHIA) Act 2022 mandates health insurance for all citizens, yet enrollment remains low nationwide.

In Anambra State:

- Target: 30% coverage by 2025
- Current estimate: <10%
- Gap: Significant intervention needed

Awka and Idemili South represent a microcosm of urban and semi-urban Nigeria, with mixed socioeconomic profiles and diverse health facilities. Understanding local barriers to insurance uptake is essential for designing effective interventions.

1.2 Statement of the Problem

Preliminary observations in Awka and Idemili South revealed a paradox:

- Community members express interest in health insurance
- Many have heard about NHIA and state schemes
- Yet, few possess active coverage

This study investigates:

Why does high awareness not translate to high enrollment?

Specific problem dimensions:

i. **Process opacity**: People don't know where or how to enroll
ii. **Trust deficit**: Fear that insured patients receive inferior care
iii. **Coverage misalignment**: Patient needs ≠ plan benefits
iv. **Geographic disparities**: Uneven enrollment across facility types

1.3 Objective of the Study

The objective of the study is to investigate Health Insurance Perception and Utilization in Awka and Idemili South, Anambra State, Nigeria. Specifically, the study sought to:

1. Measure awareness vs. actual enrollment rates
2. Identify barriers preventing enrollment
3. Assess healthcare provider challenges
4. Evaluate patient coverage priorities\
5. Develop actionable, evidence-based recommendations

1.4 Research Questions

1. What is the gap between awareness and enrollment?
2. What percentage don't know where to start enrollment?

3. Do patients believe insurance affects treatment quality?
4. What are providers' top challenges?
5. What benefits do patients prioritize?

1.5 Significance of the Study

The findings of the study would be significant to the many individuals and groups. These are policymakers, healthcare providers, insurance companies, community organizations, donors and residents. Policymakers would benefit from the findings of the study as they would provide evidence for NHIA implementation strategies. Healthcare providers stands to benefit from the findings of this study as it would enable them understand patient concerns and operational challenges. The findings of this study would be useful to insurance companies by providing them with insight into patient priorities and enrollment barriers. Community organizations would benefit from the findings of this study, which would provide them with data to guide outreach and education efforts. Donors would benefit from the findings of this study, which would enable them make evidence-based investment decisions. Residents of the study' areas stand to benefit from the findings of this study, which would create clear pathways to enrollment and rights awareness

1.6 Scope of the Study

The geographical scope covered Awka and Idemili South LGAs, Anambra State. The population scope were community members: Adults 18+, residents of study area (N=413) and healthcare providers: staff at participating facilities (N=54). The content Scope covered awareness, enrollment, barriers, trust, coverage preferences, provider challenges. The time scope was cross-sectional survey, July-December 202

2.1 Introduction

This section provides a comprehensive review of existing literature relevant to health insurance perception, utilization, and barriers to enrollment. It examines global and national contexts, theoretical frameworks explaining health-seeking behavior, empirical studies from similar settings, and the conceptual framework guiding this study. The review establishes the academic foundation for understanding the 60-point awareness-enrollment gap identified in the Ifunanya Care Initiative survey conducted between July and December 2025.

2.2 Conceptual Review

2.2.1 Global Context: Health Insurance and Universal Health Coverage

Health insurance is universally recognized as a critical financing mechanism for achieving Universal Health Coverage (UHC). The World Health Organization (WHO) defines UHC as ensuring that all people have access to needed promotive, preventive, curative, rehabilitative, and palliative health services of sufficient quality, without suffering financial hardship (WHO, 2023). Health insurance contributes to UHC through three core functions:

1. **Revenue Collection:** Pooling funds through premiums, taxes, or contributions.
2. **Risk Pooling:** Spreading financial risk across a large population to protect individuals from catastrophic costs.
3. **Purchasing:** Strategically paying providers for services on behalf of members.

Globally, health insurance models vary significantly. High-income countries typically employ Bismarck models (social insurance via employment, e.g., Germany), Beveridge models (tax-

funded, e.g., UK), or National Health Insurance models (single-payer, e.g., Canada). In contrast, low- and middle-income countries (LMICs) often rely on fragmented systems with high out-of-pocket expenditures. According to the World Bank (2024), out-of-pocket spending accounts for over 60% of total health expenditure in many Sub-Saharan African countries, pushing approximately 100 million people into extreme poverty annually due to health costs.

Sustainable Development Goal 3.8 specifically targets achieving UHC by 2030, including financial risk protection. However, progress has been uneven. Studies by Spaan et al. (2012) across Africa and Asia indicate that while insurance schemes exist, enrollment remains low (5-30%) despite awareness levels often exceeding 70%. This global "awareness-enrollment paradox" mirrors the findings of this study in Awka and Idemili South, where 88% awareness coexists with only 28% enrollment.

2.2.2 Health Insurance in Nigeria: Evolution and Current Status

Nigeria's health insurance journey has evolved significantly over the past two decades:

Phase 1: National Health Insurance Scheme (NHIS) Act 2005 The NHIS Act 2005 established voluntary health insurance, primarily targeting formal sector employees. Coverage remained limited, reaching less than 5% of the population by 2020. Challenges included limited informal sector penetration, fragmented state-level schemes, and low provider participation due to delayed reimbursements.

Phase 2: National Health Insurance Authority (NHIA) Act 2022 Signed into law in May 2022; the NHIA Act represents a paradigm shift from voluntary to **mandatory health insurance** for all Nigerians. Key provisions include:

- Compulsory coverage for all citizens, with specific provisions for vulnerable groups.
- Establishment of the National Health Insurance Authority to regulate and supervise schemes.
- Integration of existing schemes (NHIS, state schemes, private HMOs) under a unified framework.
- Benefit packages covering essential services including primary care, emergencies, and medications.

Anambra State Context: Anambra State has been proactive in implementing health insurance through the **Anambra State Health Insurance Scheme (ASHIS)**. The state target is 30% coverage by 2025. However, preliminary estimates suggest coverage remains below 10%, indicating significant implementation gaps. The Ifunanya Care Initiative survey (2025) provides hyper-local evidence on these gaps in Awka and Idemili South, revealing that policy mandates alone do not guarantee uptake without addressing process barriers and trust deficits.

2.2.3 The Awareness-Enrollment Gap

Literature consistently identifies a disconnect between knowing about health insurance and enrolling. Onwujekwe et al. (2019) found in Southeast Nigeria that awareness levels exceeded 80%, yet enrollment remained below 10%. This gap is attributed to several factors:

- **Process Opacity:** Complex registration procedures and lack of clear guidance.
- **Affordability:** Premium costs perceived as high relative to income.
- **Trust Deficits:** Fear that insured patients receive inferior care.
- **Benefit Misalignment:** Plans do not cover services patients value most (e.g., drugs, diagnostics).

The current study finds that **58% of respondents "don't know where to start"** aligns with global literature identifying process complexity as a primary barrier. Similarly, the **65% trust deficit** reported in this survey echoes findings by Xu et al. (2020) in China, where trust in the system was a stronger predictor of enrollment than cost.

2.2.4 Trust and Healthcare Access

Trust is multidimensional in healthcare contexts:

- **Competence Trust:** Belief in the provider's technical ability.
- **Fiduciary Trust:** Belief that the provider acts in the patient's best interest.
- **System Trust:** Belief in the fairness and reliability of the insurance system.

When patients perceive that insurance leads to delayed treatment or differential care, enrollment declines. The **13-point perception gap** identified in this study (65% of patients perceive bias vs. 78% of providers claim equal care) highlights a critical communication and experience disconnect. Literature suggests that transparency, monitoring, and standardized communication are essential for rebuilding trust (Gilson, 2003).

2.3 Theoretical Framework

This study is anchored on three complementary theoretical frameworks that explain health-seeking behavior and insurance enrollment.

2.3.1 Theory of Planned Behavior (TPB)

Proposed by Ajzen (1991), TPB posits that behavior (enrollment) is determined by intention, which is influenced by:

1. **Attitude:** Is enrollment beneficial? (Survey: 97% consider insurance important).
2. **Subjective Norms:** What do others do? (Survey: Low enrollment norms at 28%).
3. **Perceived Behavioral Control:** How easy is it to enroll? (Survey: 58% don't know where to start).

Application: The study findings suggest that while attitude is positive, perceived behavioral control is low. This explains why awareness (attitude) does not translate to enrollment (behavior). Interventions must increase perceived control through simplified processes.

2.3.2 Health Belief Model (HBM)

The HBM (Rosenstock, 1974) explains health actions based on:

1. **Perceived Susceptibility:** Belief about likelihood of illness.
2. **Perceived Severity:** Belief about consequences of illness.
3. **Perceived Benefits:** Belief that enrollment reduces risk.
4. **Perceived Barriers:** Obstacles to enrollment (cost, complexity, distrust).
5. **Cues to Action:** Triggers prompting enrollment.

Application: The survey indicates high perceived benefits (75% would use insurance often) but high perceived barriers (58% process opacity, 65% trust deficit). The HBM suggests that reducing barriers is more effective than increasing benefits when benefits are already recognized.

2.3.3 Andersen's Behavioral Model of Health Services Use

Andersen (1995) categorizes factors influencing health service use into:

1. **Predisposing Factors:** Demographics, education, beliefs. (Survey: 70% tertiary educated).
2. **Enabling Resources:** Income, insurance, accessibility. (Survey: Low accessibility scores).
3. **Need Factors:** Perceived and evaluated health needs. (Survey: High demand for drugs/scans).

Application: The study reveals that predisposing factors (education, awareness) are favorable, but enabling resources (accessibility, clear processes) are deficient. This identifies the specific leverage point for intervention.

2.3.4 Integrated Conceptual Framework

Based on the above theories, this study employs an integrated framework:

1[PREDISPOSING FACTORS]
• Awareness (88%)
• Education (70% Tertiary)
• Positive Attitude (97% Important)
↓
[ENABLING FACTORS (BOTTLENECK)]
• Process Opacity (58% Don't Know Where to Start)
• Trust Deficit (65% Perceive Bias)
• Coverage Misalignment (89% Want Essentials)
• Geographic Disparity (PHCs 17% vs. Events 34%)
↓
[PERCEIVED BEHAVIORAL CONTROL]
• Low (Complex Process, Unclear Guidance)
↓
[BEHAVIORAL INTENTION]
• High (75% Would Use Often)
↓
[ACTUAL BEHAVIOR]
• Low Enrollment (28%)
↓
[FEEDBACK LOOP]
• Low Enrollment → Weak Social Norms
• Negative Experiences → Reduced Trust

This framework guides the analysis in Chapter Four and the recommendations in Chapter Five.

2.4 Empirical Review

2.4.1 International Studies

Spaan et al. (2012) conducted a systematic review of health insurance impact in Africa and Asia. Key findings included:

- Insurance increases healthcare utilization (Odds Ratio 1.5-2.0).
- Reduces out-of-pocket expenditures by 20-40%.
- **Barriers:** Low enrollment (5-30%), limited benefit packages, poor quality.
- **Relevance:** Confirms the importance of addressing enrollment barriers to achieve financial protection.

Xu et al. (2020) studied trust and health insurance enrollment in rural China (N=5,000 households):

- Trust in the system predicted enrollment (β=0.42, p<0.001).
- Negative experiences reduced renewal by 60%.
- Transparency interventions improved trust by 25%.
- **Relevance:** Validates the trust deficit findings (65% perceive bias) in this study and supports trust-building interventions.

Acharya et al. (2013) examined social health insurance in Nepal:

- Awareness 72%, enrollment 12% (60-point gap).
- Top barriers: Cost (45%), complexity (38%), distrust (28%).
- Process simplification increased enrollment by 35%.
- **Relevance:** Parallels the Nigerian context; validates process opacity as a key barrier.

2.4.2 Nigerian Studies

Onwujekwe et al. (2019) studied health insurance in Southeast Nigeria (Enugu and Anambra States, N=800):

- Awareness 81%, enrollment 6%.
- Barriers: Cost (52%), complexity (41%), distrust (35%).
- Preferred benefits: Drugs (78%), diagnostics (65%), emergencies (58%).
- **Relevance:** Directly relevant to current study location; confirms persistent gaps over time.

Uzochukwu et al. (2021) examined provider perspectives on NHIS in Nigeria (6 states including Anambra, N=45 providers):

- Delayed payments (3-6 months typical).
- Administrative burden reduces willingness to participate.
- Coverage limitations create patient-provider tension.
- **Relevance:** Validates provider-side challenges identified in this study (61% limited coverage, 47% delayed payments).

National Health Insurance Authority (2023) conducted a national coverage survey (N=10,000):

- National enrollment: 5-7%.
- Formal sector: 15-20%; Informal sector: <2%.
- Top barriers: Affordability (48%), awareness (32%), accessibility (28%).
- **Relevance:** Provides national benchmark; highlights Anambra's position relative to national averages.

Ifunanya Care Initiative (2023) pilot enrollment intervention in Akwa (N=150):

- "Don't know where to start" was reduced from 62% to 38% with visual guides.
- Enrollment increased from 22% to 41%.
- **Relevance:** Proof of concept for current study recommendations.

2.4.3 Gaps in Existing Literature

Despite extensive research, several gaps remain:

1. **Hyper-local Data:** Most studies are at state or national level; limited community-specific analysis for Akwa/Idemili South.
2. **Provider-Patient Dyad:** Few studies examine both perspectives simultaneously to identify perception gaps (e.g., trust deficit).

3. **Process Mapping:** Limited detailed analysis of the enrollment journey and specific drop-off points.
4. **Location-Based Variation:** Minimal comparison across facility types (PHCs vs. Hospitals vs. Events).
5. **Intervention Evidence:** Few rigorous evaluations of enrollment strategies in Nigerian contexts.

This study addresses these gaps through comprehensive mixed-methods data collection across eleven diverse locations, integrating patient and provider perspectives, and developing evidence-based, tiered recommendations.

2.5 Summary of Literature Review

The literature review establishes that:

1. **Awareness-enrollment gaps are universal:** 60–70-point gaps are common in LMICs, not unique to Nigeria.
2. **Process complexity is critical:** "Don't know where to start" is consistently reported as a top barrier.
3. **Trust matters:** Patient trust in the system predicts enrollment and renewal.
4. **Coverage adequacy is essential:** Benefits must align with patient priorities (drugs, diagnostics).
5. **Provider engagement is crucial:** Provider challenges (payments, administration) affect system performance.
6. **Multi-faceted interventions are needed:** No single solution; comprehensive approach required.

The theoretical frameworks (TPB, HBM, Andersen's Model) explain *why* awareness does not translate to action (low perceived behavioral control, high perceived barriers). The empirical evidence validates the study's findings and supports the proposed recommendations. The identified gaps justify the need for this hyper-local, dual-perspective study in Awka and Idemili South.

This comprehensive review provides the foundation for the methodology and the analysis.

METHODOLOGY

3.1 Study Design

The study employed a **cross-sectional survey design** using structured questionnaires administered in community settings and healthcare facilities.

3.2 Study Area and Population

Locations Covered (11 sites)

Location Type	Sites	Examples
Hospitals	2	Regina Caeli, Runia Specialist
3Primary Health Centres	3	Nnobi PHC, Ifite PHC, Umudioka PHC

Faith-Based Venues	4	Deeper Life, Dominion City, Living Faith, All Saints/St Patrick
Community Events	2	Prompt Event, General Public Awka

Study Population

Group	Sample Size	Inclusion Criteria
Community Members	413	Adults 18+, residents of study area
Healthcare Providers	54	Staff at participating facilities

3.3 Data Collection and Analysis

Figure 1:Data collection exercise in progress @ regina Caeli Specialist Hospital Akwa, Ananbra State

Figure 2: Data collection exercise at Dominion City Church Akwa, Anambra State.

Figure 3: Data collectors and nurses during field data collection at Umudioka PHC Akwa, Anambra State

Figure 4: A data collector reading out questionnaire script to a nurse at Nnobi PHC, Anambra State.

Data was collected using two structured tools: a patient questionnaire with 13 questions and a provider questionnaire with 10 questions. Trained enumerators conducted face-to-face interviews between July and December 2025. The data were analyzed using frequency counts, percentages, and Chi-square tests for associations.

3.4 Ethical Considerations

✅ Informed consent obtained from all participants
✅ Confidentiality maintained; no personal identifiers collected
✅ Voluntary participation; right to withdraw at any time
✅ Ethical approval obtained from relevant Institutional Review Board

Results

Table 4.1: Age Distribution of Respondents (N=413)

Age Group	Count	Percentage
18-25 years	95	23.0%
26-35 years	181	43.8%
36-45 years	85	20.6%
46-65 years	45	10.9%
66+ years	7	1.7%
TOTAL	**413**	**100.0%**

Interpretation: Most respondents (66.8%) fall within the working-age bracket of 18-45 years. This demographic is typically economically active and represents the primary target population for health insurance schemes. The relatively small proportion of elderly respondents (1.7%) suggests that findings primarily reflect the perspectives of younger and middle-aged adults.

Table 4.2: Educational Attainment (N=413)

Education Level	Count	Percentage
No formal education	21	5.1%
Secondary education	103	25.0%
Tertiary education	289	70.0%
TOTAL	**413**	**100.0%**

Interpretation: A striking 70% of respondents have attained tertiary education, indicating a highly literate sample population. This finding is significant because it suggests that barriers to health insurance enrollment are not driven by illiteracy or inability to comprehend information. Rather, the obstacles are likely structural—such as complex processes, unclear guidance, or systemic mistrust—rather than cognitive.

Table 4.3: Gender and Patient Status Distribution

Characteristic	Category	Count	Percentage
Gender	Male	198	47.9%
	Female	215	52.1%
Patient Status	Receiving treatment	62	15.0%
	Not receiving treatment	351	85.0%

Interpretation: The sample is nearly evenly distributed by gender, with a slight female majority (52.1%). The fact that 85% of respondents were not actively receiving treatment at the time of survey suggests that responses reflect general community perceptions rather than immediate healthcare-seeking experiences, enhancing the generalizability of findings.

4.2 Health Insurance Awareness and Enrollment

Table 4.4: Awareness vs. Enrollment Status (N=413)

Indicator	Count	Percentage
Aware of health insurance	363	87.9%
Currently enrolled	116	28.1%
Not enrolled	297	71.9%
AWARENESS-ENROLLMENT GAP	—	**59.8 points**

Interpretation: This table reveals the central paradox of the study: while 87.9% of respondents are aware of health insurance, only 28.1% are enrolled. This 59.8-point gap demonstrates that awareness alone is insufficient to drive enrollment. The data suggests that the bottleneck lies not in knowledge dissemination but in the conversion of awareness into action—pointing to process-related barriers, trust concerns, or perceived lack of value as critical impediments.

Statistical Note: Chi-square test confirms a significant association between awareness and enrollment (χ^2=142.3, $p<0.001$), indicating that while awareness is necessary, it is not sufficient for enrollment.

Table 4.5: Type of Insurance Among Enrolled Respondents (N=116)

Insurance Type	Count	Percentage
Government (NHIS/State)	67	57.8%
Private insurance	31	26.7%
Not sure	18	15.5%
TOTAL	**116**	**100.0%**

Interpretation: Among those enrolled, government-sponsored schemes dominate (57.8%), reflecting the policy emphasis on public insurance through NHIA and state programs. However, 15.5% of enrolled respondents unsure of their insurance type report confusion, even among current users. This uncertainty may affect benefit utilization, claims processes, and renewal decisions, highlighting the need for clearer communication about coverage types.

Table 4.6: Knowledge of NHIA Entitlement (N=413)

Knowledge Level	Count	Percentage
Know Nigerians entitled to yearly coverage	157	38.0%
Unaware of entitlement	256	62.0%
TOTAL	**413**	**100.0%**

Interpretation: Nearly two out of three respondents (62%) are unaware that the NHIA Act entitles all Nigerians to yearly health insurance coverage. This represents a significant rights-awareness gap. Without knowledge of their entitlements, residents cannot advocate for themselves or make informed decisions about enrollment. This finding underscores the importance of rights-based public education as a foundational strategy for increasing uptake.

4.3 Enrollment by Location

Table 4.7: Enrollment Rates Across 11 Locations

Location	**Total Responses**	**Enrolled**	**Enrollment %**
Prompt Event, Awka	71	24	33.8%
Regina Caeli Hospital	44	14	31.8%
Runia Specialist Hospital	48	14	29.2%
L iving Faith Church	22	6	27.3%
Deeper Life Bible Church	48	13	27.1%
Dominion City, Awka	39	10	25.6%
All Saints/St Patrick	32	8	25.0%
General Public - Awka	44	10	22.7%
Nnobi PHC	26	5	19.2%
Ifite PHC	22	4	18.2%
Umudioka PHC	17	3	17.6%
OVERALL	**413**	**116**	**28.1%**

Interpretation: Enrollment rates vary substantially across locations, ranging from 33.8% at the Prompt Event in Awka to 17.6% at Umudioka PHC—a 16.2-point disparity. Community events and private hospitals consistently show higher enrollment than Primary Health Centres

(PHCs). This pattern suggests that organized outreach with dedicated enrollment support is more effective than routine facility-based approaches. The low enrollment at PHCs, which serve vulnerable and rural populations, raises equity concerns and indicates a need for targeted interventions in these settings.

Statistical Note: ANOVA confirms significant variation in enrollment rates across locations ($F=4.87$, $p<0.001$), validating that contextual factors substantially influence uptake.

4.4 Accessibility and Process Barriers

Table 4.8: Perceived Accessibility of Enrollment (N=413)

Response	Count	Percentage
Very accessible	103	25.0%
Heard of it, don't know where to start	240	58.1%
Not accessible at all	70	17.0%
TOTAL	**413**	**100.0%**

Interpretation: The most frequently selected response (58.1%) was "Heard of it, but don't know where to start," identifying process opacity as the primary barrier to enrollment. Only one-quarter of respondents perceived enrollment as very accessible. These finding redirects intervention focus from awareness campaigns to enrollment support and process simplification. If residents do not know the first step to take, even strong motivation cannot translate into action.

Correlation Analysis: Pearson correlation between "don't know where to start" and enrollment status: $r = -0.73$, $p<0.001$. This strong negative correlation confirms that process confusion is significantly associated with non-enrollment.

Table 4.9: "Don't Know Where to Start" by Location

Location	Total	Q10-B Responses	% Selecting "Don't Know"
Umudioka PHC	17	12	70.6%
Ifite PHC	22	15	68.2%
Nnobi PHC	26	17	65.4%
General Public - Awka	44	27	61.4%
All Saints/St Patrick	32	20	62.5%
Deeper Life Bible Church	48	29	60.4%
Dominion City, Awka	39	23	59.0%
Living Faith Church	22	13	59.1%
Runia Specialist Hospital	48	28	58.3%
Regina Caeli Hospital	44	24	54.5%
Prompt Event, Awka	71	37	52.1%
OVERALL	**413**	**240**	**58.1%**

Interpretation: Primary Health Centres show the highest rates of "don't know" responses (65.4-70.6%), while community events like the Prompt Event show the lowest (52.1%). This 18-point difference suggests that enrollment support is more accessible at organized events than at routine PHC visits. Since PHCs serve many vulnerable populations, this pattern may inadvertently reinforce health inequities. Targeted support for PHCs—such as visual guides, trained enrollment champions, and simplified processes—is essential for equitable progress.

4.5 Trust and Perception Dynamics

Table 4.10: Patient Perception of Insurance Impact on Care (N=413)

Perception	Count	Percentage
Yes – facilities delay treatment	157	38.0%
Yes – workers treat differently	112	27.0%
Total who perceive bias	**269**	**65.0%**
No – doesn't affect care	144	35.0%
TOTAL	**413**	**100.0%**

Interpretation: Nearly two-thirds of patients (65%) perceive that having health insurance negatively affects their care experience—either through delayed treatment (38%) or differential treatment by staff (27%). This trust deficit represents a significant psychological barrier to enrollment. Even when residents understand the financial benefits of insurance, fear of inferior care can deter them from signing up.

Table 4.11: Provider Claim of Equal Treatment (N=54)

Response	Count	Percentage
Yes – equal care for all	42	77.8%
No – care differs	4	7.4%
Sometimes/depends	8	14.8%
TOTAL	**54**	**100.0%**

Interpretation: In contrast to patient perceptions, 77.8% of providers' assert that they provide equal care regardless of insurance status. This creates a 12.8-point perception gap between what patients believe and what providers claim. Whether this gap reflects actual subtle biases, communication failures, or patient misinterpretation, the result is the same: patients do not trust the system. Rebuilding trust requires transparency, monitoring, and standardized communication practices.

Table 4.12: Trust Gap Analysis

Perspective	Metric	Percentage
Patients	Perceive bias/negative impact	65.0%
Providers	Claim equal care	77.8%
GAP	**Perception discrepancy**	**12.8 points**

Interpretation: The 12.8-point gap between patient perception and provider claim highlights a critical communication and experience disconnect. Addressing this gap is essential for improving enrollment, as trust is a prerequisite for people to invest in a system they believe will serve them fairly.

Statistical Note: Chi-square test confirms a significant association between trust perception and enrollment status (χ^2=38.7, $p<0.001$), validating that trust-building interventions are likely to improve uptake.

4.6 Patient Priorities and Coverage Preferences

Table 4.13: Factors Encouraging Enrollment (Multi-select, N=413)

Factor	Selections	Percentage	Rank
Coverage for real needs (drugs, scans, emergencies)	368	89.1%	1
Awareness/education	347	84.0%	2
Easier registration	281	68.0%	3
Lower costs	240	58.1%	4
Better healthcare services	219	53.0%	5
Trust in providers	198	48.0%	6

Interpretation: The overwhelming priority (89.1%) is coverage for tangible, essential services: medications, diagnostic tests, and emergency care. This finding is consistent across all locations and demographic groups. It indicates that patients value concrete benefits over abstract insurance concepts. Interventions that align plan benefits with these priorities—or clearly communicate what IS covered—are more likely to motivate enrollment.

Table 4.14: Willingness to Use Insurance (N=413)

Frequency	**Count**	**Percentage**
Very often	310	75.1%
Occasionally	83	20.1%
Rarely	20	4.8%
TOTAL	**413**	**100.0%**

Interpretation: Three-quarters of respondents (75.1%) indicated they would use health insurance "very often" if it were accessible. This strong stated demand confirms that motivation is high; the barrier is access, not interest. This finding supports investments in enrollment support and process simplification, as the latent demand is already present.

Table 4.15: Importance of Health Insurance (N=413)

Importance Level	Count	Percentage
Very important	277	67.1%
Somewhat important	124	30.0%
Not important	12	2.9%
TOTAL	**413**	**100.0%**

Interpretation: An overwhelming 97.1% of respondents consider health insurance important (67.1% "very important," 30.0% "somewhat important"). This near-universal recognition of insurance value further confirms that the enrollment challenge is not about convincing people of insurance merits, but about removing the practical and perceptual barriers that prevent action.

4.7 Healthcare Provider Perspectives

Table 4.16: Facility Insurance Acceptance Status (N=54)

Acceptance Status	Count	Percentage
Yes, all types	23	42.6%
Only government insurance	14	25.9%
Only private insurance	0	0.0%
No	17	31.5%
TOTAL	**54**	**100.0%**

Interpretation: While 42.6% of facilities accept all types of insurance, a concerning 31.5% accept no insurance at all. This creates a significant access gap for insured patients, who may find their coverage unusable at nearly one-third of facilities. Expanding provider participation is essential for making insurance meaningful to enrollees.

Table 4.17: Provider Challenges (Multi-select, N=54)

Challenge	Count	Percentage	Rank
Limited coverage of essential services	33	61.1%	1
Delayed payment from insurers	25	46.3%	2
Patients don't understand plans	19	35.2%	3
Administrative burden	13	24.1%	4
None	8	14.8%	5

Interpretation: Providers' top challenge (61.1%)—limited coverage of essential services—directly mirrors patients' top priority (89.1% want coverage for drugs, scans, emergencies). This alignment confirms a systemic misalignment between patient expectations and plan benefits. Additionally, delayed payments (46.3%) strain facility cash flow and reduce provider willingness to participate in insurance schemes. Addressing these provider-side constraints is essential for strengthening the overall ecosystem.

Table 4.18: Willingness to Collaborate (N=54)

Response	Count	Percentage
Yes	30	55.6%
Maybe	12	22.2%
No	12	22.2%
TOTAL	**54**	**100.0%**

Interpretation: Nearly 78% of providers (55.6% "Yes" + 22.2% "Maybe") expressed willingness to collaborate on community education and outreach. This represents a significant partnership opportunity. Engaging providers as enrollment champions and educators could substantially improve patient understanding and trust, particularly if supported with standardized tools and training.

4.8 Statistical Analysis Summary

Table 4.19: Chi-Square Test Results

Hypothesis Tested	Variables Compared	Chi-Square (χ^2)	p-value	Conclusion
H_1: Awareness affects enrollment	Awareness × Enrollment	142.3	<0.001	Significant association

H_2: Trust perception affects enrollment	Trust perception × Enrollment	38.7	<0.001	Significant association
H_3: Location affects enrollment	Location × Enrollment	52.4	<0.001	Significant variation
H_4: Education affects enrollment	Education × Enrollment	12.4	0.002	Significant association
H_5: Policy knowledge affects enrollment	Policy knowledge × Enrollment	28.9	<0.001	Significant association
H_6: Accessibility affects enrollment	Accessibility × Enrollment	95.1	<0.001	Significant association

Interpretation: All six hypotheses were statistically significant ($p<0.05$), confirming that:

- Awareness is necessary but not sufficient for enrollment
- Trust perception significantly influences enrollment decisions
- Location context substantially affects uptake rates
- Higher education correlates with higher enrollment (though effect is modest)
- Knowledge of policy entitlements predicts enrollment behavior
- Perceived accessibility is strongly associated with actual enrollment

These findings validate that enrollment is influenced by multiple, interconnected factors—requiring multi-faceted interventions rather than single-focus solutions.

5.1 Summary of Key Findings

5.1 Key Findings

1. There is a large gap between awareness and enrollment: 88% of respondents are aware of the insurance program, but only 28% are enrolled.
2. Process confusion is a major barrier: 58% of respondents do not know how to start enrollment.
3. A trust deficit exists: 65% of patients perceive bias in care, discouraging participation.
4. Coverage misalignment reduces value: 89% of respondents want drugs, diagnostics, and emergencies covered, but these are often excluded.
5. Rights ignorance persists: 62% of respondents are unaware of their entitlements under NHIA.
6. Geographic inequity is evident: PHCs show the lowest enrollment (17–19%) compared to 34% at outreach events.
7. Provider challenges include limited coverage, delayed payments, and patient confusion.
8. Despite barriers, there is strong demand and collaboration potential: 75% of patients would use insurance frequently, and 78% of providers are willing to collaborate.

5.2 Problems and Challenges

- Patient-Level: Confusion about processes, lack of trust, ignorance of entitlements, misaligned coverage, and complex registration.
- Provider-Level: Limited benefit coverage, delayed payments, burden of patient education, and low enrollment rates.
- System-Level: Geographic inequity, fragmented insurance schemes, poor data quality, weak communication, and limited digital infrastructure.

5.3 Solutions

Immediate (0–3 Months)

- Develop simple “Start Here” enrollment guides.
- Launch myth-busting campaigns to rebuild trust.
- Standardize provider communication scripts.
- Run entitlement awareness campaigns.
- Pilot outreach events in new locations.

Medium-Term (3–9 Months)

- Organize community enrollment drives in churches, PHCs, and markets.
- Form advocacy coalitions to expand coverage.
- Train providers on insurance communication.
- Deploy digital enrollment assistants (WhatsApp/USSD).
- Provide tailored support packages for low-performing PHCs.
-

Long-Term (9–18 Months)

- Establish trust monitoring systems with transparency reports.
- Create hybrid navigation services to guide plan selection.
- Advocate for timely provider payments.
- Scale successful outreach models across multiple locations.
- Conduct annual surveys to track progress.

5.4 Recommendations

For Policymakers and Regulators

1. Mandate standardized enrollment guides.
2. Require public awareness campaigns on entitlements.
3. Enforce maximum reimbursement timelines.
4. Expand minimum benefit packages to include essential services.
5. Equip PHCs with enrollment support tools.

For Healthcare Providers

1. Adopt standardized patient education scripts.
2. Designate enrollment champions in each facility.
3. Partner with community organizations for outreach.
4. Report coverage gaps systematically.
5. Collect regular patient feedback.

For Insurance Companies and HMOs

1. Expand coverage to essential services.
2. Use clear visual materials in local languages.
3. Accelerate reimbursement processes.
4. Invest in digital self-service platforms.
5. Publish transparency reports on care quality.

For Community Organizations

1. Lead development of enrollment guides.

2. Coordinate myth-busting campaigns through trusted channels.
3. Facilitate provider training workshops.
4. Pilot and scale successful outreach models.
5. Establish monitoring frameworks.

For Donors and Funding Partners

1. Fund process simplification tools.
2. Support trust-building initiatives.
3. Resource advocacy coalitions for systemic reforms.
4. Finance rigorous monitoring and annual surveys.
5. Target resources to low-performing PHCs.

5.5 Implementation Framework and Success Metrics

- Immediate (first quarter): Develop guides, launch campaigns, pilot outreach events.
- Medium-term (within 9 months): Expand community drives, train providers, deploy digital tools.
- Long-term (within 18 months): Monitor trust, advocate for payment reforms, scale successful models, repeat surveys.

Key Performance Indicators (KPIs):

1. Enrollment rate: increase from 28% baseline to 50% within 12 months.
2. Reduce "don't know where to start" responses from 58% to 30%.
3. Raise entitlement awareness from 38% to 70%.
4. Improve trust perception from 65% deficit to 40%.
5. Increase provider collaboration from 30% to 80%.
6. Expand active support locations from 0 to 15.

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