Knowledge, Attitude and Uptake of Formal Sector Social Health Insurance Programme in Akwa Ibom State, Nigeria

Uduakobong Inyang
Department of Insurance and Risk Management
University of Uyo
Risk Management & Insurance Research Cluster
University of Uyo
Research for Impact Cluster, University of Uyo, Nigeria

Enobong Gideon Asuquo
Department of Nursing and Midwifery
University of Limerick, Limerick, Ireland
Research for Impact Cluster, University of Uyo, Nigeria

Samuel Sunday Charlie
Department of Accounting
University of Uyo, Akwa Ibom State, Nigeria

https://doi.org/10.61090/aksujacog.2024.034

Abstract
This study investigated knowledge, attitude and uptake of the formal sector social health insurance programme (FSSHIP), a social health insurance pool of the National Health Insurance Authority (NHIA) designed for federal civil servants in Nigeria. The study adopted a qualitative research design to achieve its objectives using federal civil servants in Akwa Ibom State as its population. A purposive sampling technique was adopted in the study and structured interview was used to generate primary data for the study. The thematic analysis method was used in analyzing the data. The result revealed that federal civil servants in Akwa Ibom State were aware of the National Health Insurance Scheme and equally demonstrated a positive attitude towards the Scheme. However, it was discovered that the level of uptake of the National Health Insurance scheme was very low. It was therefore recommended, among others, that sensitization that targets increasing utilization should be conducted for enrollees by the relevant stakeholders, while the scheme should be adequately funded to ensure quality service delivery.

Keywords: Social health insurance, NHIS, awareness, attitude, uptake, Nigeria.

1. Introduction

An efficient healthcare system is crucial to the sustainable and viable economic growth of any nation (Sharma, 2018). Thus, the success of the healthcare system of any nation, in terms of the provision of quality, affordable and equitable healthcare services to its citizens, is largely determined by its funding and management of healthcare funding (Barr, 2023). However, Nigeria has continuously witnessed low government funding of the healthcare sector which unarguably results in poor healthcare infrastructures and poor quality of service in the public healthcare facilities. The appalling state of the public healthcare institutions led to the deregulation of healthcare financing in Nigeria which has given rise to a competitive healthcare providers' market with the emergence of privately-operated healthcare facilities (WHO, 2017).

The private healthcare providers, which operate solely as business entities for profit making, provide better healthcare services when compared to the public healthcare providers, but at a cost that is unaffordable to the lower-middle- and low-income earners in the country. Since Nigeria is a lower-

middle-income country, according to the World Bank, a significant proportion of the populace is priced out of the quality healthcare market. The exclusion of a significant proportion of the population of Nigeria from the quality healthcare market, due to non-affordability, has resulted in a high mortality rate across several demographic classifications and a high level of poverty as out-of-pocket payment remains the preferred method of funding healthcare (Aregbeshola & Khan, 2021).

It was against this background that the government of Nigeria launched the present-day National Health Insurance Authority (NHIA) as the National Health Insurance Scheme (NHIS) in 2005 and the formal Sector Social Health Insurance Programme (FSSHIP) is one of its components (Shio, 2011). In this study, NHIS and FSSHIP are used interchangeably even though NHIS is used predominantly. The National Health Insurance Schemes serve as a social security system where the health care cost of individuals is settled from a pool of contributed funds from the enrollees, the employers and the governments. According to NHIS (2010), the scheme mainly targets providing access to quality healthcare in a manner that ensures financial protection from economic hardship due to medical care bills for Nigerians not minding socio-economic class, age, ethnicity and status. Meanwhile, Wasiu (2010) reported the level of access to medical care through the NHIS by enrollees was low and that the attitude of healthcare workers under the scheme towards users was poor. According to Etiaba et al., (2018), a significant percentage of Nigerians is yet to benefit from the national social health insurance scheme due to poverty, inadequate healthcare infrastructures and consumables, inadequate number of healthcare workers and poor funding.

However, the accomplishment of the aim of establishing the NHIS is dependent on its uptake which is influenced by the knowledge of the scheme and the attitude towards the scheme of the populace particularly those that the programme targeted (Agba, et al., 2010; Lawanson & Olamyaw, 2014). Meanwhile, studies that examine knowledge, attitude and uptake of the scheme, especially qualitative studies, are scarce. Therefore, this study is carried out to investigate the knowledge, attitude as well as uptake of the formal sector social health insurance programme component of the National Health Insurance Scheme by federal civil servants in Akwa Ibom State using a qualitative research design. The findings of this study have the potential to influence policy and implementation of the national health insurance scheme in Nigeria for efficiency and can serve as a motivation for developing countries who are considering implementing social health insurance for the citizens.

2. Literature Review

2.1 Social Health Insurance

Social Health insurance, as a social security instrument, guarantees the availability of the necessary healthcare services to individuals on the payment of an agreed amount at regular intervals (James, 2013). Thus, social health insurance settles the medical bills of an enrollee that is faced with the potential of incurring high costs and unplanned medical care expenditure (Sommers et al., 2017). Therefore, social health insurance protects the enrollee from financial difficulty that may arise from large or emergency medical bills (Taubman et al., 2014). Social health insurance achieves its financial protection motive through the creation of a pool of funds from individuals of different health statuses (Fenny et al., 2018). The pooling arrangement supports the spreading of the health risk of individual members in a pool among all members of the pool (Song et al., 2014). Thus, social health insurance is designed as a prepayment, resource pooling and cost-burden-sharing mechanism (Maritim et al., 2022).

In a social health insurance arrangement, pre-payments are typically fixed either as a proportion of the salary or wages of an enrollee or as flat rates to be contributed by the enrollee (Fenny et al., 2018). In this regard, the payment may not be proportional to the health risk exposure of individual beneficiaries (Adewole et al., 2017). Through the pre-payment arrangement, social health insurance extends the sources of financing healthcare and lessens dependence on government budgeting (Uzochukwu et al., 2015). Also, health insurance supports risk pooling solving equity and affordability problems in providing and financing healthcare, while harnessing the participation of the private sector

in the provision of medical care services (Maritim et al., 2022). Health insurance can be offered as private health insurance products or social (public) health insurance plans (Sohn & Jung, 2016). Private health insurance involves an individual paying for the coverage responsive to the health risk exposure of the buyer, while social health insurance covers the health risk of members of the pool typically on the application of community rating on the members of the pool (Paez et al.; Gottschalk, 2018).

Social health insurance arrangements support reasonable prediction of the healthcare cost of a large group taking advantage of the large number of participants in a pool (Maritim et al., 2022; Sohn & Jung, 2016). Typically, social health insurance reduces the cost of coverage for members of a pool (Akwaowo et al., 2021) The affordable access to health care made possible by social health insurance programmes provides individuals the incentive to seek medical care more frequently than they ordinarily would, thus preventing potential critical illness (Inyang et al., 2023). The national health insurance scheme in Nigeria is designed to operate in a social health insurance arrangement (Adebisi et al., 2019).

2.2 National Health Insurance Authority

The National Health Insurance Authority (NHIA), formerly the National Health Insurance Scheme, is a government agency established by Act 35 of 1999 of the Federal Government of Nigeria with the main aim of ensuring access to affordable medical care by all Nigerians (Nwanaji-Enwerem et al. 2022). James (2013) stated that the National Health Insurance Scheme was designed by the federal government of Nigeria as a complementary source of funding healthcare to improve the quality and affordability of medical care available to all Nigerians. The objectives of the NHIA are to ensure equitable access to affordable healthcare, control the demand cost of healthcare, provide families financial protection from impoverishing healthcare costs, maintain quality healthcare delivery, boost funding for healthcare in Nigeria and ensure effectiveness and sustainability of the social health insurance programmes designed by the NHIA (Adebisi et al., 2019).

According to NHIS (2006), the fundamental rationale for the scheme is the benefit of pooling resources for cross-subsidization of healthcare costs where individuals in the high-income bracket subsidize the healthcare cost of those in the low-income class, the healthy subsidize the sick and the young subsidize the old. The cross-subsidization is achieved through the premium paid by all members of the pool while a few unfortunate sick members of the pool will utilize the cover (Ilesanmi et al., 2014). The distribution of healthcare costs among various socio-economic strata makes the scheme truly social in nature. Also, the scheme makes the shared funding of health care services between government, private sector operators, non-governmental organizations and enrollees possible (Uzochukwu et al., 2015).

The scheme covers outpatient care, pharmaceutical care as specified in the NHIS essential drug list, diagnostic tests as contained in the NHIS diagnostic test list, maternal care for up to four life births, preventive care to include immunization, health education, antenatal and postnatal care, in-patient hospital care like admission in a general ward limited to 15 days in a year, eye care and preventive dental care (Inyang et al., 2023). Beneficiaries do not need to pay out-of-pocket to access medical care except for the 10% co-payment for the cost of drugs (Ajibola & Timothy, 2018).

NHIA manages various social health insurance programmes for different socio-economic groups in Nigeria and one of the plans is the Formal sector social health insurance programme, FSSHIP (Okpani & Abimbola, 2015).

2.3 Operational Framework of Formal Sector Social Health Insurance Programme (FSSHIP)

The Formal Sector Social Health Insurance Programme (FSSHIP) is designed for employees in the formal employment sector in Nigeria (Igwe et al., 2022). Accordingly, the legal framework of NHIS makes it mandatory for organizations in formal private and public sectors with up to ten (10) employees to participate in the scheme (Ekhator-Mobayode et al., 2022). Typically, employers are to enrol their employees in the scheme. Upon enrolment is an affiliation of the employer with an NHIS-approved

Healthcare Care Provider (HCP), which must be a functional healthcare-providing outfit typically a hospital or clinic that is registered and accredited by the NHIA for the purpose of partaking in the national social health insurance programme (Eboh et al., 2016). The NHIA collect contributions from eligible employers and employees, collects contributions from voluntary contributors to the scheme, pays health care providers for services rendered and maintains quality assurance of the programme where the state government is yet to adopt the programmes of the authority ((Obalum & Fiberesima, 2012). When the state has adopted the programmes of the NHIA, a government agency established by the state government, takes up the responsibilities of administering the programme (Obikeze & Onwujekwe, 2020).

Health care services are accessed by enrollees in NHIA accredited health care institutions which can be public and privately-owned hospitals that are referred to as health care providers (HCPs) (Eboh et al., 2016). The HCPs can be primary health care, secondary health care or tertiary health care providers (Ogundeji et al., 2023). Enrollees on the scheme register with the HCPs near them and can only access medical care as specified in the NHIA benefit list from that HCP (Inyang et al., 2023). An enrollee can only change HCP on the basis related to relocation or unsatisfactory service delivery by HCP (Alawode & Adewole, 2021).

Contributions to FSHIP are earnings-related. The employer contributes 10 per cent and the employee contributes 5 per cent, which adds up to 15% of the employee's basic salary (Etiaba et al., 2018). Alternatively, an employer can choose to make payment for the entire contribution for the employee. Moreover, an employer may make extra contributions to increase the benefit package for an employee (Ekhator-Mobayode et al., 2022). The package takes care of the health care cost of the enrolled employee, a spouse and four biological children of the enrollee below the age of 18 years (Onwujekwe et al., 2019). An additional cash contribution by the principal beneficiary guarantees cover for more dependents or children above 18 years.

FSHIP like other programmes of NHIA grants the beneficiaries certain rights including the right to medical care access as enumerated in the benefits package, the right to change HCP after six months of issuance of the programme's identity card, if not satisfied with the quality of service received or in the case of job-related relocation, right to access medical care in any NHIA accredited HCP within the country if an emergency arises, right of disclosure of the names of the drugs administered to the beneficiary, right to ask for and be told the total cost of drugs to facilitate transparency and accountability in the payment of the 10 per cent co-payment, access to genuine and efficacious drugs, right to identify the area of specialization of the medical personnel that attends to an enrollee and right of complain on poor services from HCPs (NHIS, 2010).

2.4 Theoretical Review

The theoretical underpinning of this study is the theory of reasoned action (TRA), by Martin Fishbein and Icek Ajzen in 1980. The theory of reasoned action focuses on establishing the association between beliefs, attitudes, norms, intentions, and behaviours of individuals. Thus, the theory of reasoned action opines that the behaviour of an individual is influenced by intention while the intention is subjective to attitude and norms (Al-Suqri & Al-Kharusi, 2015). According to the theory of reasoned action, an individual's attitude towards a specific behaviour is influenced by the individual's belief in the consequences of the behaviour, as well as the rational evaluation of the consequences. Thus, the building blocks of beliefs are the individual's subjective perception that performing a specific behaviour will yield specific results. Consequently, the theory of reasoned action submits that external stimuli determine attitudes by altering the structure of the person's beliefs.

Furthermore, the theory of reason action submits that the influence of behaviour by all other factors, which are also referred to as external variables, is indirect in nature. Consequently, the political environment, the nature of the task and its implementation strategy as well as the interface (the user) and the organizational structure are recognized as the external variables. In addition, the probability of the outcome and the expected positivity or otherwise of the outcome are identified in the theory as the

two factors that may influence behavioural intentions which can lead to a positive, negative or neutral attitude. From the foregoing, the theory of reasoned action anchors on the existence of a direct correlation between attitudes and outcomes, in a manner that the belief of an individual on the outcome of a particular behaviour is the sole driver of attitude.

This theory applies to this study as an individual’s intention to participate in a health insurance scheme may be influenced by the individual’s attitude towards the scheme which may be influenced by a person's knowledge of the health insurance scheme and the subjective norm which, in this case maybe the compulsory enrolment on the scheme as an employee of a registered employer. Usually, positive attitude as well as subjective norms is expected to enhance public knowledge of formal sector social health insurance programmes with an effect on the use of the scheme.

2.5 Empirical Review

2.5.1 Awareness and National Health Insurance Scheme

Akintaro & Adewoyin (2015) conducted a primary study to assess the level of knowledge and attitude of staffers of the Nigerian research institute towards the National Health Insurance Scheme using a four-point Likert scale structured questionnaire for data collection. Data was collected from 291 respondents and regression was used as the method of data analysis. A low level of awareness of the existence of the NHIS amongst the respondents and a poor attitude towards the scheme was reported. The study therefore recommended mass mobilization of personnel in charge of enrolments of employees on the scheme to increase the enrolment rate which will influence the attitude of enrollees on the scheme.

Sanusi (2009) conducted a study to examine the level of awareness of the National Health Insurance Scheme in Oyo state, Nigeria using a descriptive survey design and structured questionnaire as an instrument for data collection. Descriptive statistics of simple percentages were applied as the method of data analysis. The result showed that 87.4 per cent of the respondents were aware of the programme 83.2 per cent were registered under the programme, while 58.9 per cent of the respondents agreed to have used medical care under the programme. The author concluded that the awareness and enrolment on the programme were high while the utilization was moderate. A further study to identify reasons for the non-overwhelming use of the programme was recommended by the author.

A similar study conducted by Andrew (2007) used a stratified random sampling technique to select 300 participants whose data were collected with the use of a structured questionnaire to assess awareness of the National Health Insurance Scheme in Asaba, Delta state. The findings of the study obtained with the use of simple percentages indicated that 92 per cent of the respondents were aware of the scheme and 47 per cent of the respondents had utilized the scheme. It was concluded that the awareness level of the programme was high in the study area while the utilization was low. Further study to unravel the possible causes of the low utilization was recommended.

Also, Abdulqadir et al., (2012) examined the perception and satisfaction of clients with the National Health Insurance Scheme at the general hospital in Minna, Nigeria. The researchers used a multi-stage sampling technique to sample 144 clients receiving NHIS services and a structured self-administered questionnaire was used to collect data from the respondents. The researchers used descriptive statistics of simple percentages for data analysis. The study reported a 100% awareness rate of the study participants a below-average level of perception and a low level of satisfaction with the deliverables of the NHIS. Based on the findings, the researchers emphasized the success of NHIS in the area of study would require an urgent improvement in the quality of health care services rendered to enrollees by the administrators of the scheme at various levels of its implementation.

2.5.2 Attitude and National Health Insurance Scheme

Sabitu & James (2015) conducted a study in the Minna metropolis in Niger State, Nigeria on knowledge, attitudes and opinions of healthcare providers towards the national health insurance scheme (NHIS) using descriptive survey research design and questionnaire as an instrument for data collection.

Results obtained from the use of simple percentages indicated that the majority of the respondents (87.1%) expressed willingness to participate in the scheme and the majority (71.2%) expressed optimism that the scheme can succeed in Nigeria. The study revealed a positive attitudinal disposition of health care providers who constituted the subjects of the study to the national health insurance scheme. This, according to the researcher, calls for a conscious publicity drive and intensive educational campaigns from the administrators of the scheme to turn the encouraging attitudinal disposition towards the scheme into actual uptake and use.

Adenike & Wasiu (2010) examined knowledge and attitude towards national health insurance schemes among civil servants in Osun state, Nigeria. The study used a descriptive cross-sectional study design involving 380 civil servants in the employ of the Osun state government as respondents who were selected through a multi-stage sampling technique. The research instruments used by the authors were pre-coded, semi-structured, self-administered questionnaires and the data gathered was analyzed using correlation. The result indicated a significant link between willingness to partake in national health insurance schemes and a significant level of awareness of options of health care financing. Furthermore, the study revealed a significant negative relationship between knowledge of the components and attitude towards joining the scheme. These researchers thus recommended targeted awareness to increase uptake.

Campbell et al., (2015) conducted a study to determine the knowledge and attitude of artisans in Lagos, Nigeria towards the National Health Insurance Scheme, the health-seeking pattern of the respondents and their willingness to join the Scheme, using a descriptive cross-sectional survey design and a multistage sampling technique to recruit 260 participants for the study. A self-administered questionnaire was used in gathering data and simple descriptive statistics of percentage was used to analyze the data. The results indicated a significant proportion of the respondents (87.7%) expressed a negative attitude toward the scheme. However, 76.5% were willing to join the National Health Insurance Scheme. The authors concluded that the negative attitude towards the scheme may be influenced by the low level of awareness of the National Health Insurance Scheme and recommended activities to increase awareness of the scheme.

2.5.3 Level of Uptake of National Health Insurance Scheme

Campbell (2014) conducted a study on the uptake of the National health insurance scheme amongst private healthcare providers in Lagos State, Nigeria. Multi-stage sampling technique was used in selecting 180 private healthcare providers and a self-administered questionnaire was used in collecting data from the respondents. Simple percentages and correlations were used for data analysis. The results obtained showed 156 (97.5%) of the respondents were aware, 110 (66.8%) respondents expressed they were knowledgeable of the existence of the scheme and 97 (60.6%) of the respondents utilized healthcare under the scheme. Half of the respondents - 82 (51.3%) were dissatisfied with the operations of the scheme, while 90 (50%) of the respondents complained that they incurred losses due to the healthcare expenditure irrespective of their enrolment in the NHIS. Furthermore, a significant correlation was found between awareness, level of education, knowledge of NHIS and uptake of the scheme by the respondents. Increased awareness of the benefits of the scheme was recommended.

Similarly, Inegbedion (2015) conducted a study to investigate awareness and uptake of the National Health Insurance scheme in Edo State, Nigeria. A random sampling technique was used to select the 400 respondents from the study area and data was collected using a questionnaire and Focus Group Discussion. Both descriptive and inferential statistics of correlation were used to analyze the data generated. Results indicated that 387 respondents (96.8%) used all the services which included physiotherapy services, immunization, family planning, optical care, preventive dental care, and mental health care. The findings also revealed that the majority of the respondents (90%) were aware of NHIS. The study found age, income, occupation, education, marital status, number of children and religion as major factors that influenced awareness and uptake of NHIS. The authors recommended maintenance of the quality of service provision to sustain the high level of uptake.

A cross-sectional study by Mutinda (2015) in Kibera slum, Nairobi City County in Kenya examined factors that influence health insurance through national Health Insurance Fund (NHIF) scheme uptake among low-income earners, using survey research design and purposive sampling to gather data from 125 respondents, with structured questionnaire as an instrument of data collection. A simple percentage was used to analyze the data. The study found that there was a low uptake of NHIF cover among the respondents. It was further found that a low level of knowledge hampered the uptake of the NHIF scheme. To improve the uptake of NHIF coverage among low-income earners, increased knowledge and awareness of NHIF among the citizens was recommended.

Philip (2018) examined the uptake of health insurance in Kenya using data from the 2015/2016 Kenya National Health Accounts survey with 35,974 individuals as participants. Logistic regression model was used for data analysis. The estimates of the analysis indicated income, marital status, education, health status and awareness of insurance were the determinants of health insurance uptake in Kenya. The study recommended that health insurance enrolment should be made compulsory for all citizens and with subsidization of the premiums for the poor being undertaken by the Government. Sensitization of the public on the types of health insurance schemes available was equally recommended.

3. Research Methodology

3.1 Study Design and Area

A qualitative research design was used in the study. This approach supported an in-depth description of the phenomenon under consideration based on primary qualitative data collected from the respondents via interview.

The area of this study was Uyo Local Area of Akwa Ibom State. Uyo is a city in the south-south region of Nigeria and is the capital of Akwa Ibom State. Uyo, which doubles as a Local Government Headquarter, is bounded by Itu Local Government in the North, Ibesikpo Asutan and Etinan Local Government Areas in the South, Abak Local Government in the West and Uruan Local government Area in the East. Residents in the research area are predominantly Christians.

As the state capital, Uyo is the seat of state public service where ministries and agencies are located. Also, the federal ministries and agencies have their state and regional offices in Uyo. Therefore, a significant proportion of residents in Uyo are public and civil servants who serve in different government ministries, agencies and departments.

3.2 Population of the Study, Sampling Technique and Sample Size

The targeted population of this study was civil servants in different ministries and departments in the federal government employed in the study area. A non-probabilistic sampling technique, purposive sampling technique was used in selecting 10 departments from four federal ministries that have offices in the study area. The federal ministries selected were the Ministry of Health, Ministry of Youth and Sports, Ministry of Education and Ministry of Works and Housing. The purposive sampling technique was further used in selecting a respondent from each of the ten selected departments for a sample size of 10 respondents used in the study. The study had five male and five female respondents for a sample size of 10 respondents which is ideal for a qualitative study (Boddy, 2016).

3.3 Method of Data Collection

The interview method was used in generating data used in the study. The respondents were asked the same set of questions and their responses were documented by the interviewer using a voice recorder. A voice recording documentation of the responses was done to ensure complete information capturing from the respondents. The interview was conducted on a face-to-face basis at the respondents' duty post.

3.4 Method of Data Analysis

Data generated through the interview were analyzed using thematic analysis. The data collected during the interview were fully transcribed. In-depth interviews were coded into themes and patterns during data processing. An Excel spreadsheet was used to help with the coding. Each interview response was put in a separate row and sorted by theme. Strictly, the key themes that guided the analysis of the data qualitatively were "aware", "attitude" and "uptake". The data were closely examined sequentially. The respondents were profiled descriptively. For purposes of confidentiality, the names of the respondents used were not their actual names as practice demands.

3.5 Ethical Approval and Consent

This study was approved by the research ethics department, Federal Ministry of Health, Akwa Ibom state office. Informed verbal consent was given by the respondents.

4. Presentation of Result and Discussion of Findings

4.1. Profiling of the Respondents

Table 1 presents the profiling of the respondents. A total of 10 respondents were interviewed with an equal number of five per gender indicating that 50% of the sample interviewed were male and 50% were female. 4 (40%) of the respondents were below 40 years of age, while 6(60%) were 40 years and above in age. The respondents were predominantly Christians 9(90%) as only 1(10%) of the respondents was of a different religion other than Christianity. In terms of level of education, 3(30%) had a secondary school certificate as their highest qualification while 7(70%) had tertiary education qualifications. With regards to the number of years in service, 5(50%) had worked for less than 10 years, 2(20%) had worked between 10 years to 20 years and 3(30%) had worked for more than 20 years.

Table 1 - Profiling of the Respondents **N = 10**

Attribute	Frequency	Percentage
Gender		
Male	5	50
Female	5	50
Age (Years)		
Below 40	4	40
40 and above	6	60
Religion		
Christianity	9	90
Others	1	10
Level of Education		
Secondary	3	30
Tertiary	7	70
Years in Service		
Less than 10	5	50
10 – 20	2	20
More than 10	3	30

Source: Computed by the Authors from interview data Using Stata 13 (2024)

4.2 Presentation of the Findings

4.2.1 Awareness of National Health Insurance Scheme

Concerning the level of awareness of the national health insurance scheme, all the civil servants interviewed responded that they were aware of the scheme and that the scheme is available for all civil servants who work in the Federal Government Agencies, Ministries and Departments (MDAs). Participant A, a staff in the administrative department of the Federal Ministry of Environment stated thus:

"I am aware of the national health insurance scheme in Nigeria; the scheme is available to all civil servants who work in federal Ministries, agencies and Departments."

Also, another participant in the study, Participant B, a staff in the Department of Finance and Accounts Federal Ministry of Environment said:

"I am aware of the NHIS programme. It is available in the federal civil service. For me, the scheme is in operation even though my colleagues are not participating."

More so, Participant C, who is a staff in the Department of Administration and Supplies, Federal Ministry of Health said:

"I have full knowledge of the scheme and I am aware that it is available to only civil servants working in federal civil service not for workers in the state and local government civil service."

Participant D, a staff of the High Ways Designs Department in the Federal Ministry of Works and Housing also pointed out she is aware of the scheme. Mrs Udoh said:

"I am aware of the national health insurance scheme. It is available to all federal civil service workers and it is in operation."

4.2.2 Attitude towards National Health Insurance Scheme

On the attitude towards National Health Insurance scheme, the finding revealed that civil servants in federal civil service demonstrated a positive attitude towards the scheme. This is evident in the level of enrollment in the scheme. Participant E, of the Department of Climate Change, Federal Ministry of Environment said:

"I enrolled in the scheme and also encourage my colleagues who did not enroll to do so. My attitude towards the scheme is positive".

Similarly, Participant F of the Department of Planning, Federal Ministry of Works and Housing also responded that her attitude towards the scheme was positive. Participant F narrated thus:

"I am aware of the scheme, my colleagues registered for the scheme. My attitude towards the scheme is positive as I have attempted to use it and have seen others do the same"

On his part, Participant G of the Department of Climate Change Federal Ministry of Environment affirmed his attitude towards the scheme is positive by stating thus:

"My attitude towards the NHIS is positive. I know that the scheme is in existence and I encourage my colleagues who are yet to enroll to do so".

4.2.3 Level of uptake of National Health Insurance Scheme

Concerning the level of uptake of the national health insurance scheme, respondents said it is very low because most enrollees have yet to access medical treatment under the scheme. The respondents affirmed effective monthly deductions for the scheme from their salaries but have never received adequate medical attention from medical personnel at the point of service delivery. Participant H in the Department of Finance and Account, Federal Ministry of Environment lamented thus:

"I have never benefited from the scheme since I enrolled in the year 2011, but I have been going to the hospital for treatment under the scheme yet I have never been treated under it. The level of uptake is very low from my own experience, though it is a welcome development, I am not impressed with the level of uptake."

Similarly, Participant I in the Department of Planning Federal Ministry of Works and Housing stated:

"I have visited the hospital for treatment but have never been treated under the scheme. In my opinion, the level of uptake by civil servants in Uyo is very poor though it is a nice initiative. As such, I prefer to seek medical care outside the NHIS centre or I visit a pharmacy or chemist for my drugs and pay for the treatment. The government has to put resources together and intensify efforts to strengthen the capacity for the successful implementation and utilization of the National Health Insurance Scheme."

In collaboration, Participant J of the Department of Finance and Accounts, Federal Ministry of Environment said:

"I have visited the hospital for treatment under the scheme, but I have never been treated even once since I started working in 2013. To me, generally, the level of uptake is below expectation, it is not encouraging, and it is very low. I see it as a welcome development if the government provides the hospital with the resources to support the effective implementation of the programme"

It is evident from the findings that the level of uptake of NHIS is very low despite the high level of awareness and positive attitude of the civil servants towards the scheme.

4.3 Discussion of Findings

Findings on the awareness level revealed a high level of awareness among civil servant in the study area on National Health Insurance Scheme. This was evident in the responses of the interviewees. This finding is in line with Sanusi (2009) who reported a high level of awareness, 87.4 percent, of National Health Insurance Scheme in Oyo state, Nigeria.

Findings on the attitude towards the scheme, revealed a significant positive attitude of federal civil servants in the study area towards National Health Insurance Scheme. This was evident in the fact that majority of the respondents demonstrated a positive attitude towards the scheme. This finding collaborate with earlier finding by Adenike and Wasiu (2010) whose study revealed a significant positive relationship between knowledge of the components and fair attitude towards joining the scheme. In contradiction with this finding, Campbell**,** Owoka and Odugbemi (2015) in their study observed that majority of artisans in Lagos Nigeria, (87.7%), expressed negative attitude toward the scheme.

Findings with regards to the level of uptake revealed a very low level of uptake of the National Health Insurance Scheme among civil servant in the study area. From the responses, majority said generally, the level of uptake of the scheme by the civil servant is below expectation, not encouraging and very low. This finding is in line with Philip (2018) who reported a very low level of uptake of National health insurance scheme in Kenyan.

5. Conclusion

This study examined knowledge, attitude and uptake of the national health insurance scheme among federal civil servants in Akwa Ibom state, Nigeria. A qualitative research design was used in the study as data collated from interviews of the respondents was analysed using the thematic analysis method. The results indicated that federal civil servants in Akwa Ibom state were aware of the National Health Insurance Scheme and also demonstrated a positive attitude towards the social health insurance scheme though the level of uptake was reported to be very low.

It is thus concluded that the high level of awareness may have had an influence on the positive attitude towards the scheme but did not support a high level of uptake among the respondents. Thus, these findings suggest that a high enrolment rate and positive disposition towards a public social programme does not guarantee uptake or utilization.

6. Recommendation

It was therefore recommended that all healthcare service providers in the scheme should strive to provide quality service and the monitoring agencies should step up their monitoring and supervision in order to ensure quality and satisfactory service delivery to the enrollees to support an increase in uptake. Also, increasing sensitization on the benefits of the scheme to the enrollees is necessary to encourage uptake. Increase in strategic funding of the scheme is also necessary to improve and increase the capacity of the service providers.

7. Suggestion for Future Study

The key limitation of this study was the small sample size used in the study in line with practice in qualitative research design. Thus, adopting a quantitative research design which will support the use of a large sample size in examining the awareness, attitude and uptake of the scheme will be a valuable extension of knowledge in the area.

Availability of data: Data used in this study cannot be made publicly available for ethical reasons to guard against compromise of the participants' identities. However, the underlying data are available from the Risk Management and Insurance research cluster, University of Uyo, Nigeria, upon request by those who meet the criteria for access to confidential data.

Funding: This research was funded by RHAB-YES research support fund.

Conflict of interest: The authors have declared that conflicting interest does not exist.

References

Abdulqadir, I. S., Alhaji, A. A. & Adamu, S. U. (2012). Perception and clients' satisfaction with national health insurance scheme at general hospital Minna, Niger State-Nigeria. Presented at 13th World Congress on Public Health.

Adebisi, S. A., Odiachi, J. M., & Chikere, N. A. (2019). The national health insurance scheme (NHIS) in Nigeria: has the policy achieved its intended objectives? *Academic Journal of Economic Studies*, 5(3), 97-104.

Adenike, O.& Wasiu, O. A. (2010). Knowledge and attitude of civil servants in Osun state, Southwestern Nigeria towards the national health insurance. *Nigerian Journal of Clinical Practice,* 13(4), 421-6.

Adewole, D. A., Adebayo, A. M., & Osungbade, K. O. (2017). A qualitative survey of pre-payment scheme for healthcare services in a rural Nigerian community. *African Journal of Biomedical Research*, 20(1), 17-24.

Agba, O A., Ushie, E. M. & Osuchukwu N. C. (2010). National health insurance scheme and employees‟ access to healthcare services in Cross-River State, Nigeria. *Global Journal of Human Social Science,* 10(7), 14 - 26.

Ajibola, S. S., & Timothy, F. O. (2018). The influence of national health insurance on medication adherence among outpatient type 2 diabetics in Southwest Nigeria. *Journal of patient experience*, 5(2), 114-119.

Akintaro, O. E. & Adewoyin, O. O. (2015). Knowledge and attitude towards national health insurance scheme in Nigerian research institutes. *Huria Journal*, 20, 81-89.

Akwaowo, C. D., Umoh, I., Motilewa, O., Akpan, B., Umoh, E., Frank, E., & Onwujekwe, O. E. (2021). Willingness to pay for a contributory social health insurance scheme: a survey of rural residents in Akwa Ibom State, Nigeria. *Frontiers in Public Health*, 9, 1-9.

Alawode, G. O., & Adewole, D. A. (2021). Assessment of the design and implementation challenges of the National Health Insurance Scheme in Nigeria: A qualitative study among sub-national level actors, healthcare and insurance providers. *BMC Public Health*, 21, 1-12.

Al-Suqri, M. N., & Al-Kharusi, R. M. (2015). Ajzen and Fishbein's theory of reasoned action (TRA) (1980). In *information seeking behavior and technology adoption: Theories and trends* (pp. 188-204). IGI Global.

Andrew, C.T. (2007). Access and utilization of health care services in the petroleum producing region of Nigeria, *Social Science and Medicine*, 10, 241-255

Aregbeshola, B. S., & Khan, S. M. (2021). Out-of-pocket health-care spending and its determinants among households in Nigeria: a national study. *Journal of Public Health*, 29, 931-942.

Barr, D. A. (2023). *Introduction to US health policy: The organization, financing, and delivery of health care in America*. JHU Press.

Boddy, C. R. (2016). Sample size for qualitative research. *Qualitative Market Research: An International Journal*, 19(4), 426-432.

Campbell, P. C. (2014). National health insurance scheme: How receptive are the private healthcare practitioners in a local government area of Lagos state. *Nigerian Medical Journal,* 55(6), 512-516.

Campbell, P. C., Owoka, O. M. & Odugbemi, T. O. (2015). National health insurance scheme: Are the artisans benefitting in Lagos state, Nigeria? *Journal of Clinical Science,* 13, 122-31

Eboh, A. L. F. R. E. D., Akpata, G. O., & Akintoye, A. E. (2016). Health care financing in Nigeria: an assessment of the national health insurance scheme (NHIS). *European Journal of Business and Management*, 8(27), 24-34.

Ekhator-Mobayode, U. E., Gajanan, S., Ekhator, C., Ekhator-Mobayode, U., & Ekhator, C. (2022). Does health insurance eligibility improve child health: Evidence from the national health insurance scheme (NHIS) in Nigeria. *Cureus*, 14(9), 1-19.

Etiaba, E., Onwujekwe, O., Honda, A., Ibe, O., Uzochukwu, B., & Hanson, K. (2018). Strategic purchasing for universal health coverage: examining the purchaser–provider relationship within a social health insurance scheme in Nigeria. *BMJ Global Health*, 3(5), 1-9.

Fenny, A. P., Yates, R., & Thompson, R. (2018). Social health insurance schemes in Africa leave out the poor. *International Health*, 10(1), 1-3.

Gottschalk, M. (2018). *The shadow welfare state: Labor, business, and the politics of health care in the United States*. Cornell University Press.

Igwe, A. A., Ejike, I., & Ukpere, W. I. (2022). Formal Sector Social Health Insurance Programme (FSSHIP) regulatory reforms: Critical factors. *Journal of Governance and Regulation*, 11(1), 327-336.

Ilesanmi, O. S., Adebiyi, A. O., & Fatiregun, A. A. (2014). National health insurance scheme: how protected are households in Oyo State, Nigeria from catastrophic health expenditure? *International Journal of Health Policy and Management*, 2(4), 175-180.

Inegbedion, U. E. (2015). Awareness and utilization of National Health Insurance scheme in Edo State, Nigeria. A Thesis Submitted to the School of Postgraduate Studies, Ahmadu Bello University, Zaria, Nigeria.

Inyang, U., Asuquo, E. G., Oleka, C. D., & Okeke, D. C. (2023). Impact of User and Service Provider Related Variables on Utilisation of Tertiary Institution Social Health Insurance Programme (TISHIP) in the University of Uyo, Nigeria. *International Journal of Scientific and Management Research*, 6(9), 49-62.

James, E. (2013). Knowledge, attitude and opinion of health care providers towards the national health insurance scheme: A case study of Minna town. Unpublished MPH Thesis, Ahmadu Bello University, Zaria.

Maritim, B., Koon, A. D., Kimaina, A., & Goudge, J. (2022). Acceptability of prepayment, social solidarity and cross-subsidies in national health insurance: A mixed methods study in Western Kenya. *Frontiers in Public Health*, *10*, 957528.

Meng, Q., Fang, H., Liu, X., Yuan, B., & Xu, J. (2015). Consolidating the social health insurance schemes in China: towards an equitable and efficient health system. *The Lancet*, *386*(10002), 1484-1492.

NHIS (2005). Standard treatment guidelines and referral protocol from primary health care providers. Federal Ministry of Health Publication.

NHIS (2006). National Health Insurance Scheme: Panacea to quality health system in Nigeria. Abuja, Nigeria: Federal Ministry of Health Publication.

NHIS (2010). National Health Insurance Scheme and Employees? Access to Healthcare Services in Cross River State, Nigeria. *Global Journal of Human Social Science,* 10(3), 9-16.

Nwanaji-Enwerem, O., Bain, P., Marks, Z., Nwanaji-Enwerem, P., Staton, C. A., Olufadeji, A., & Nwanaji-Enwerem, J. C. (2022). Patient satisfaction with the Nigerian National Health Insurance Scheme two decades since establishment: A systematic review and recommendations for improvement. *African Journal of Primary Health Care & Family Medicine*, 14(1), 1-10.

Obalum, D. C., & Fiberesima, F. (2012). Nigerian national health insurance scheme (NHIS): An overview. *Nigerian Postgraduate Medical Journal*, 19(3), 167-174.

Obikeze, E., & Onwujekwe, O. (2020). The roles of health maintenance organizations in the implementation of a social health insurance scheme in Enugu, Southeast Nigeria: a mixed-method investigation. *International Journal for Equity in Health*, *19*, 1-14.

Ogundeji, Y., Abubakar, H., Ezeh, U., Hussaini, T., Kamau, N., Love, E., & Gilmartin, C. (2023). An assessment of primary health care costs and resource requirements in Kaduna and Kano, Nigeria. *Frontiers in Public Health*, *11*, 1226145.

Okpani, A. I., & Abimbola, S. (2015). Operationalizing universal health coverage in Nigeria through social health insurance. *Nigerian Medical Journal*, *56*(5), 305-310.

Onwujekwe, O., Ezumah, N., Mbachu, C., Obi, F., Ichoku, H., Uzochukwu, B., & Wang, H. (2019). Exploring effectiveness of different health financing mechanisms in Nigeria; what needs to change and how can it happen? *BMC Health Services Research*, 19, 1-13.

Paez, K. A., Mallery, C. J., Noel, H., Pugliese, C., McSorley, V. E., Lucado, J. L., & Ganachari, D. (2014). Development of the Health Insurance Literacy Measure (HILM): conceptualizing and measuring consumer ability to choose and use private health insurance. *Journal of health communication*, 19(sup2), 225-239.

Philip, D. S. (2018). Uptake of health insurance in Kenya: An empirical analysis using 2005/06 Kenya national health accounts survey**.** *International Journal of Economics, Commerce and Management*, 6(8), 721 - 733.

Sabitu K, James E. (2005). Knowledge, attitudes and opinions of health care providers in Minna town towards the national health insurance scheme (NHIS). *Annals of Nigerian Medicine,* 1(2), 9-13.

Sanusi, R. A., & Awe, A. T. (2009) An Assessment of awareness level of National Health Insurance Scheme among Health Care Consumers in Oyo State, Nigeria. *The Social Science Journal*, 4(2), 19-30.

Sharma, R. (2018). Health and economic growth: Evidence from dynamic panel data of 143 years. *PloS one*, 13(10), e0204940.

Shio, G. (2011). The awareness of NHIS in Kano, *Social Science,* 3(2), 94-105

Sommers, B. D., Gawande, A. A., & Baicker, K. (2017). Health insurance coverage and health—what the recent evidence tells us. *New England Journal of Medicine*, 377(6), 586-593.

Song, S. O., Jung, C. H., Song, Y. D., Park, C. Y., Kwon, H. S., Cha, B. S., & Lee, B. W. (2014). Background and data configuration process of a nationwide population-based study using the Korean national health insurance system. *Diabetes & metabolism journal*, 38(5), 395.

Sohn, M., & Jung, M. (2016). Effects of public and private health insurance on medical service utilization in the National Health Insurance System: National panel study in the Republic of Korea. *BMC Health Services Research*, 16, 1-11.

Taubman, S. L., Allen, H. L., Wright, B. J., Baicker, K., & Finkelstein, A. N. (2014). Medicaid increases emergency-department use: evidence from Oregon's Health Insurance Experiment. *Science*, *343*(6168), 263-268.

Uzochukwu, B. S., Ughasoro, M. D., Etiaba, E. A., Okwuosa, C., Envuladu, E., & Onwujekwe, O. E. (2015). Health care financing in Nigeria: Implications for achieving universal health coverage. *Nigerian journal of clinical practice*, 18(4), 437-444.

WHO (2017). World Health Report Executive Summary - achieving health for all. Geneva: World Health Organization.