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Healthcare Access and Socioeconomic Characteristics among Respondents in the Bontonompo Community Health Center Service area

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ABSTRACT
Background: Access to primary healthcare involves the ability to reach and obtain services. Local information on access conditions and community characteristics is needed to inform service planning. This study aimed to describe self-reported healthcare access and the socioeconomic and sociocultural characteristics of respondents in the Bontonompo Community Health Center service area.
Methods: This descriptive cross-sectional online survey included 65 voluntary respondents. A researcher-developed Google Forms questionnaire was distributed directly to community members. Responses were recorded from 10 to 18 January 2026. The instrument had not undergone formal validity or reliability testing. Frequencies and percentages were calculated using the number of nonmissing responses for each item. No inferential analyses were performed.
Results: Of 65 respondents, 48 (73.8%) were female and 59 (90.8%) reported health insurance coverage. Monthly household income below IDR 1,000,000 was reported by 36 of 64 respondents (56.3%). A distance of 1–3 km was reported by 31 of 63 respondents (49.2%), while 39 of 65 (60.0%) reported travel times below 15 minutes. Motorcycles were reported by 61 of 65 respondents (93.8%). Services were rated fairly easy to obtain by 28 of 64 respondents (43.8%); 29 of 65 (44.6%) were fairly satisfied. Twenty of 65 respondents (30.8%) reported no visit during the preceding six months. Twenty-six of 64 (40.6%) reported never attending health education at the health center.
Conclusion: Insurance coverage, motorcycle transport, and short travel times were common among respondents, while reported health education exposure and recent service use varied. These distributions can inform further local assessment of information and transport needs. The voluntary sample and unvalidated self-report instrument limit generalizability; the study does not establish statistical associations or causal relationships.

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INTRODUCTION

Access to primary healthcare is an important concern in assessing whether health services are responsive to the people they serve. The existence of a facility provides a potential source of care, but understanding access also requires attention to the circumstances in which people

identify their needs and obtain services. Levesque et al. (2013) conceptualize access as a process involving recognition of healthcare needs, seeking care, reaching providers, obtaining services, and receiving care appropriate to those needs. This perspective places the interaction between populations and health services at the center of access assessment.

The framework proposed by Levesque et al. (2013) includes five service dimensions: approachability, acceptability, availability and accommodation, affordability, and appropriateness. These interact with people's abilities to perceive a need, seek care, reach services, pay, and engage in care. The framework therefore provides a rationale for examining practical travel conditions alongside economic and social circumstances. In the present study, it serves as a conceptual reference for interpreting selected questionnaire items; the survey was not designed to measure every dimension or produce a comprehensive access score.

Evidence from Indonesia highlights the relevance of socioeconomic conditions when examining contact with primary healthcare services. Wulandari et al. (2025) investigated socioeconomic disparities in primary healthcare utilization in eastern Indonesia using data from the 2018 Indonesian Basic Health Survey. Their analysis included 57,827 respondents and considered characteristics such as education, employment, health insurance ownership, and travel time. This regional evidence supports considering the social and economic context in which service use occurs. However, its outcome was utilization, and regional patterns cannot be assumed to describe the access experiences of a particular health center's service population. Local descriptive information is therefore useful for complementing broader survey evidence.

Geographical accessibility is another relevant part of this context. Castañeda-Torres et al. (2026) examined primary healthcare accessibility in rural areas while explicitly considering vulnerability. Their approach draws attention to the importance of assessing accessibility in relation to the populations being served, rather than treating location alone as a complete description of access. For a local community survey, this provides a rationale for reporting distance and travel conditions together with household characteristics. The international study offers a complementary perspective, while its estimates and setting do not establish the distribution of access conditions in Bontonompo.

Transport research also emphasizes the value of understanding access as experienced by individuals. Ning et al. (2026) developed a population synthesis approach to perceived healthcare accessibility, addressing the challenge of linking individual survey responses with spatial information. Their study highlights the distinction between objective measures of potential access and barriers perceived by individuals. Talukder (2026), in turn, assessed inclusive healthcare access in the haor region of Bangladesh by integrating Ga2SFCA modeling and survey data. Together, these approaches indicate the value of considering spatial information and reported experiences in access research. The present survey uses respondent-reported distance, travel time, transport mode, and ease of obtaining services to describe selected aspects of that experience, without claiming to replicate a spatial accessibility assessment.

These studies provide complementary reasons to consider several types of information when describing a health center service area. Wulandari et al. (2025) contribute a socioeconomic and utilization perspective; Castañeda-Torres et al. (2026) contribute a vulnerability-sensitive geographical perspective; and and Xiao et al. (2026) highlight the importance of equity in the distribution of healthcare accessibility. Meanwhile, Ning et al. (2026) and Talukder (2026) draw attention to perceived accessibility and the integration of survey and spatial evidence. For the present study, their combined relevance lies in supporting a description that includes both reported access conditions and respondents' socioeconomic and sociocultural characteristics. These perspectives guide the selection and interpretation of descriptive information rather than establish relationships among the variables in this sample.

Clear terminology is necessary when presenting these different measures. In this study, healthcare access refers specifically to self-reported conditions for reaching and obtaining services, including distance, travel time, transport mode, and perceived ease of obtaining care. Healthcare utilization refers to reported visits during the preceding six months. Service satisfaction refers to respondents' evaluation of services. Recent attendance and satisfaction are presented separately because they answer different questions from those addressed by the access

items. Likewise, household income, health insurance, exposure to health education, and reported social or cultural characteristics describe the respondents' context; their inclusion does not demonstrate that they explain differences in access.

The local information need addressed by this study is a description of these conditions among people who responded to a survey in the Bontonompo Community Health Center service area. The cited regional and international studies do not provide the item-level distributions for this respondent group. Documenting those distributions can support discussion of topics requiring further local assessment, including travel arrangements, information outreach, and reported difficulties in obtaining services. Because participation was voluntary and recruitment occurred online, the description concerns submitted responses and should not be interpreted as an estimate of access conditions across the entire service-area population.

Accordingly, this study aimed to describe self-reported healthcare access and the socioeconomic and sociocultural characteristics of 65 respondents in the Bontonompo Community Health Center service area. Reported visits and service satisfaction were summarized as separate descriptive measures. The study was designed to provide a local descriptive account that may inform further assessment and subsequent research, rather than to test statistical associations or establish causal effects.

METHODS

Study design and setting

A quantitative descriptive cross-sectional survey was conducted in the Bontonompo Community Health Center service area in January 2026. The available Google Forms export contains 65 submissions timestamped from 10 to 18 January 2026. These dates describe the observed submission period; an earlier invitation date was not documented.

Participants and recruitment

The intended population was community members residing in the health center service area. The researcher distributed the Google Forms link directly to community members, who chose whether to complete it. No population sampling frame or random selection procedure was used. Recruitment is therefore described as non-probability convenience recruitment with voluntary participation. Sixty-five people submitted responses, and all 65 records were retained for item-level descriptive analysis.

No predefined minimum age, minimum duration of residence, or requirement for prior health center use was applied, according to the researcher. The available records do not establish an independent verification of residence. No prospective sample-size calculation was performed. The sample size reflects the number of submissions received, rather than a target based on power or precision. The number of people who received or viewed the link was not recorded, so a response rate could not be calculated.

Questionnaire and measurements

Data were collected using a researcher-developed, self-administered questionnaire comprising 26 substantive items covering demographic, socioeconomic and sociocultural characteristics, healthcare access, service use, and service perceptions. The questionnaire had not undergone formal validity or reliability testing. Healthcare access was assessed through self-reported distance (<1, 1–3, 4–6, and >6 km), travel time (<15, 15–30, and >30 minutes), transport mode, and perceived ease of obtaining services. Public and private cars were combined into one transport category, alongside motorcycles.

Additional items assessed income, employment, insurance, cost-related delays, health information exposure, family support, and treatment beliefs. Health education attendance and information seeking were measured using five frequency categories, ranging from never to very often, without a specified recall period. Utilization was assessed through reported visits during the preceding six months (none, 1–2, 3–4, or >4 visits), while satisfaction was measured separately using a single item without a specified reference period. All items were analyzed individually without calculating a composite access score. Original response categories were

retained, including the ambiguous age category labeled "50 years as recorded." Additional service-use and perception items are presented in Appendix A.

Data Processing and analysis

Google Forms responses were exported and checked using Python and pandas. Data were summarized as frequencies and percentages, with percentages calculated using the number of nonmissing responses for each item. Missing responses were reported separately without imputation, and blank working-hours responses were not classified as unemployment. Category labels were translated into English while preserving the recorded categories. All 65 records were retained, although unique respondent identity could not be verified. No inferential statistical tests were performed.

Research ethics

Participation was voluntary. According to the researcher, no names, email addresses, telephone numbers, or other direct identifiers were collected, and findings are reported in aggregate. No prior ethics committee approval or formal exemption was obtained, and no participant information or informed consent procedure was documented before data collection. These omissions are acknowledged as study limitations.

RESULTS

Respondent characteristics

The analysis includes 65 submitted records. Female respondents accounted for 48 (73.8%), married respondents for 55 (84.6%), and respondents with senior high school education or equivalent for 24 (36.9%). Twenty-two respondents (33.8%) selected the category recorded as "50 Tahun" (Table 1).

Table 1. Respondent characteristics

Variable and response category	n	%
Age category (valid n=65; missing=0)		
<20 years	1	1.5
20-29 years	8	12.3
30-39 years	17	26.2
40-49 years	17	26.2
50 years as recorded	22	33.8
Sex (valid n=65;missing=0)		
Male	17	26.2
Female	48	73.8
Marital status (valid n=65;missing=0)		
Unmarried	6	9.2
Married	55	84.6
Widowed or divorced as grouped in the questionnaire	4	6.2
Highest education (valid n=65;missing=0)		
No formal schooling	2	3.1
Elementary school or equivalent	18	27.7
Junior high school or equivalent	13	20.0
Senior high school or equivalent	24	36.9
Higher education	8	12.3

Percentages use the number of nonmissing responses for each variable. Missing responses are reported separately and are not included in percentage denominators. Totals may differ from 100.0% because of rounding.

Socioeconomic and sociocultural characteristics

Table 2 presents the complete observed distributions. Among 64 respondents answering the education-exposure item, 26 (40.6%) reported never attending health education at the health

center. Thirty-six of 64 respondents (56.3%) reported household incomes below IDR 1,000,000 per month. For the specific question about cost-related delay, 49 of 64 (76.6%) answered no and 15 (23.4%) answered yes. Health insurance coverage was reported by 59 of 65 (90.8%). These are separate distributions; their co-occurrence does not show that insurance prevented cost-related delays.

Table 2. Socioeconomic and sociocultural characteristics

Variable and response category	n	%
Frequency of attending health education at the health center (valid n=64; missing=1)		
Never	26	40.6
Rarely	20	31.3
Sometimes	13	20.3
Often	4	6.3
Very often	1	1.6
Frequency of seeking health information through media (valid n=64; missing=1)		
Never	7	10.3
Rarely	18	28.1
Sometimes	21	32.8
Often	15	23.4
Very often	3	4.7
Main ocupation (valid n=65;missing=0)		
Not working	9	13.8
Farmer or fisher	9	13.8
Laborer	5	7.7
Civil servant or military or police personnel	3	4.6
Enterpreneur	3	4.6
Other	36	55.4
Woriking hours per day (valid n=53;missing=12)		
<4 hours	15	28.3
4-7 hour	22	41.5
>7	16	30.2
Perceived influence of working hours on time to seek care (valid n=62; missing=3)		
Strongly no influence as worded in the questionnaire	2	3.2
No influence	31	50.0
Sometimes influential	24	38.7
Influential	3	4.8
Very influential	2	3.2
Monthly household income (valid n=64; missing=1)		
<IDR 1,000,000	36	56.3
IDR 1,000,000–2,500,000	19	29.7
IDR 2,500,001–4,000,000	4	6.3
>IDR 4,000,000	5	7.8
Cost as a reason for delaying care at the health center (valid n=64; missing=1)		
Yes	15	23.4
No	49	76.6
Health insurance coverage (valid n=65; missing=0)		
Yes	59	90.8
No	6	9.2
Family support for seeking care when ill (valid n=63; missing=2)		
Strongly unsupportive	2	3.2
Sometimes supportive	8	12.7
Supportive	40	63.5
Very supportive	13	20.6
Greater trust in traditional treatment than medical treatment (valid n=64; missing=1)		
Strongly do not believe	1	1.6
Do not believe	22	34.4

Variable and response category	n	%
Sometimes believe	37	57.8
Believe	1	1.6
Strongly believe	3	4.7
Community or religious leaders recommending health center care (valid n=64; missing=1)		
Strongly do not recommend	3	4.7
Do not recommend	1	1.6
Sometimes recommend	10	15.6
Recommend	37	57.8
Strongly recommend	13	20.3

Percentages use the number of nonmissing responses for each variable. Missing responses are reported separately and are not included in percentage denominators. Totals may differ from 100.0% because of rounding.

Access and service statisfaction

A distance of 1–3 km was the largest distance category, selected by 31 of 63 respondents (49.2%), rather than a majority of all respondents. Thirty-nine of 65 (60.0%) reported travel times below 15 minutes. Sixty-one (93.8%) reported motorcycle transport and four (6.2%) selected public/private car transport. The combined car category does not support the original statement that no respondent used public transport.

Services were rated fairly easy to obtain by 28 of 64 respondents (43.8%). Satisfaction was rated fairly satisfied by 29 of 65 (44.6%) and satisfied by 22 (33.8%). Twenty-three of 64 respondents (35.9%) considered distance moderately influential on their desire to visit. Table 3 separates these perceptions from observed service use.

Table 3. Self-reported access and separate service statisfaction item

Variable and response category	n	%
Self-reported distance from home to the health center (valid n=63; missing=2)		
<1 km	2	3.2
1–3 km	31	49.2
4–6 km	26	41.3
>6 km	4	6.3
Self-reported travel time (valid n=65; missing=0)		
<15 minutes	39	60.0
15–30 minutes	23	35.4
>30 minutes	3	4.6
Main transport mode to the health center (valid n=65; missing=0)		
Motorcycle	61	93.8
Public or private car as one combined category	4	6.2
Perceived ease of obtaining services (valid n=64; missing=1)		
Difficult	4	6.3
Fairly easy	28	43.8
Easy	24	37.5
Very easy	8	12.5
Satisfaction with health center services (valid n=65; missing=0)		
Dissatisfied	6	9.2
Fairly satisfied	29	44.6
Satisfied	22	33.8
Very satisfied	8	12.3
Perceived influence of distance on desire to visit (valid n=64; missing=1)		
No influence	20	31.3
Little influence	17	26.6
Moderately influential	23	35.9

Variable and response category	n	%
Very influential	4	6.3

Percentages use the number of nonmissing responses for each variable. Missing responses are reported separately and are not included in percentage denominators. Totals may differ from 100.0% because of rounding.

Reported visits in the preceding six months

Thirty-three respondents (50.8%) reported 1–2 visits in the preceding six months, while 20 (30.8%) reported none (Table 4). All 20 respondents reporting no visit in that period nevertheless answered the satisfaction item. Their responses may relate to earlier experiences or expectations, but the questionnaire cannot establish that basis. Satisfaction results therefore describe all submitted ratings, not a verified survey of recent patients.

Table 4. Reported visits in the preceding six months

Variable and response category	n	%
Number of health center visits during the preceding six months (valid n=65; missing=0)		
None	20	30.8
1–2 visits	33	50.8
3–4 visits	8	12.3
>4 visits	4	6.2

Percentages use the number of nonmissing responses for each variable. Missing responses are reported separately and are not included in percentage denominators. Totals may differ from 100.0% because of rounding.

DISCUSSION

Socioeconomic context and health information

The coexistence of relatively low household income and high health insurance coverage among respondents provides an important context for understanding healthcare accessibility in the Bontonompo Community Health Center service area. Lala et al. (2025) highlighted the relevance of socioeconomic conditions, geographical barriers, and service-related factors in healthcare access and utilization among older adults. Similarly, Wulandari et al. (2025) identified socioeconomic disparities in primary healthcare utilization in eastern Indonesia, emphasizing the importance of considering individual and household characteristics when examining healthcare service use. Snead et al. (2026) further discussed the relevance of area-level socioeconomic conditions, healthcare access, and insurance coverage to healthcare-related outcomes. Collectively, these studies suggest that healthcare accessibility should be understood within a broader socioeconomic context. Nevertheless, the present study does not establish whether income or insurance coverage influenced healthcare access or utilization, as the analysis was limited to describing respondents' characteristics and reported experiences.

Financial accessibility represents another important consideration in understanding healthcare access. Although most respondents did not identify cost as a reason for delaying healthcare-seeking, this finding does not necessarily indicate the absence of financial barriers. Zakkar et al. (2026) highlighted the persistence of financial challenges among socioeconomically disadvantaged populations, while Jyotsana et al. (2026) discussed structural and contextual challenges experienced by older adults managing chronic health conditions. These perspectives indicate that financial accessibility may involve circumstances beyond insurance ownership, including indirect expenses and other practical difficulties in obtaining care. In the Bontonompo context, health insurance may provide financial protection, but its contribution to respondents' reported access conditions cannot be determined from the available descriptive data. Further investigation is needed to understand the nature of cost-related delays, including potential

transportation expenses and other out-of-pocket costs that were not specifically assessed in this study.

Beyond economic considerations, access to health information and effective communication are relevant to understanding healthcare accessibility. Amasa et al. (2026) emphasized the importance of health literacy in relation to healthcare access and patients' healthcare experiences. Inácio et al. (2025) identified informational, institutional, and geographical barriers in accessing healthcare services, while also highlighting the potential contribution of social support and community networks. Similarly, French et al. (2026) discussed the relevance of communication, service responsiveness, and information provision in shaping healthcare experiences. These findings provide a conceptual basis for considering health information and social circumstances when interpreting the Bontonompo results. The presence of respondents who reported no previous participation in health education activities suggests a need to review the reach of health information initiatives. However, nonparticipation in health education does not necessarily indicate low health literacy, as this was not directly measured. Likewise, family support and recommendations from community or religious leaders describe the respondents' sociocultural context without demonstrating an influence on healthcare-seeking behavior. Future research could examine information needs, preferred communication channels, and perceived barriers to obtaining health information to support more responsive community-based healthcare services.

Travel condition and transport representation

Short reported travel times and the predominance of motorcycle use among respondents suggest relatively favorable geographical access to Bontonompo Community Health Center for those who participated in the survey. However, these findings do not necessarily indicate that transportation is equally accessible to all residents in the service area. Ouma and Njung'e (2026) discussed systemic barriers that may contribute to delays in obtaining healthcare services in rural settings, while Nassar et al. (2026) identified transportation and affordability as relevant considerations in healthcare access. Similarly, French et al. (2026) highlighted the importance of contextual differences in understanding healthcare access experiences. These perspectives emphasize that geographical proximity alone may not fully reflect individuals' ability to reach healthcare facilities. In the present study, online recruitment and voluntary participation may have underrepresented residents with limited internet access, restricted mobility, or dependence on others for transportation. Furthermore, vehicle ownership, transportation costs, disability, and the availability of accompanying persons were not directly assessed. Therefore, the reported travel conditions should be interpreted as characteristics of the respondents rather than evidence of transportation accessibility across the entire Bontonompo service area.

The importance of considering transportation availability alongside geographical distance is further supported by studies examining spatial accessibility and population vulnerability. Castañeda-Torres et al. (2026) incorporated population vulnerability into a spatial model of primary healthcare accessibility, demonstrating the relevance of socioeconomic and geographical conditions when assessing access in rural areas. Similarly, Talukder (2026) integrated spatial accessibility modeling with survey evidence to examine inclusive healthcare access in the haor region of Bangladesh. Chen et al. (2026) further highlighted the importance of transportation connectivity and first- and last-mile accessibility in understanding spatial disparities in access to public healthcare facilities. Collectively, these studies demonstrate the value of considering geographical conditions, transportation systems, and population characteristics when assessing healthcare accessibility. Although motorcycle use was common among Bontonompo respondents, the present survey did not establish whether individuals without independent transportation experienced greater difficulties obtaining care. Consequently, conclusions regarding transportation equity would require additional information from residents with limited mobility, restricted transportation options, or greater dependence on household resources.

Perceptions of geographical distance provide an additional dimension for understanding healthcare accessibility. Although respondents generally reported relatively short travel times, their perceptions of the influence of distance on their willingness to visit the community health

center varied. Ning et al. (2026) emphasized the importance of distinguishing perceived transportation barriers from objective measures of spatial accessibility, highlighting the relevance of financial, temporal, and contextual circumstances in shaping individuals' experiences of access. This perspective suggests that physical proximity and perceived accessibility should be examined as related but distinct aspects of healthcare access. In the Bontonompo context, respondents' assessments of distance provide useful descriptive information about their perceived travel conditions. However, the cross-sectional design and descriptive analysis do not establish whether geographical distance influenced actual healthcare utilization, as no statistical association between perceived distance and reported visits was examined. Future research could combine household-level transportation information, subjective accessibility measures, and geographical data to provide a more comprehensive understanding of mobility-related barriers and identify populations requiring additional support in reaching primary healthcare services.

Distinguishing access from service use and statisfaction

Levesque et al. (2013) conceptualized healthcare access as a multidimensional process involving individuals' abilities to recognize healthcare needs, seek care, reach providers, obtain services, and engage in appropriate care. Within this framework, the present study examined selected conditions related to reaching and obtaining healthcare services, while healthcare utilization and service satisfaction were treated as separate descriptive measures. French et al. (2026) highlighted the relevance of communication and responsiveness to patients' needs in understanding healthcare access experiences, while Inácio et al. (2025) emphasized the importance of considering individuals' and families' experiences when navigating healthcare systems. Similarly, Chan et al. (2026) examined organizational and contextual barriers and facilitators to healthcare access and care-seeking. These perspectives suggest that geographical proximity and favorable perceptions of service availability do not necessarily represent all aspects of healthcare access. In the Bontonompo context, respondents' generally favorable perceptions of obtaining healthcare services and their reported satisfaction provide useful information about their experiences. However, perceived ease of access should not be equated with actual healthcare utilization, and satisfaction should not be interpreted as a comprehensive or validated measure of accessibility. Maintaining this distinction is essential to avoid interpreting favorable ratings as evidence that all healthcare needs were adequately met.

Healthcare utilization provides additional descriptive information but should not be interpreted as a direct indicator of accessibility or unmet healthcare needs. McGill et al. (2026) emphasized the relevance of healthcare utilization patterns for understanding population needs and informing healthcare service organization. Xie et al. (2025) and Sarayu et al. (2026) similarly examined healthcare access or utilization in relation to social and demographic circumstances, providing broader perspectives on the context in which healthcare services are used. Snead et al. (2026) further considered the relevance of socioeconomic conditions, healthcare access, and health insurance coverage to healthcare-related outcomes. These studies support the importance of distinguishing the circumstances surrounding healthcare utilization from the actual occurrence of service use. In the present study, some respondents reported no visits to Bontonompo Community Health Center during the preceding six months. This may reflect the absence of a perceived healthcare need, utilization of alternative healthcare providers, or difficulties obtaining care; however, the questionnaire did not distinguish among these explanations. Consequently, nonattendance cannot be interpreted as evidence of unmet healthcare needs. Furthermore, because respondents who reported no recent visits also provided satisfaction ratings, the timing and basis of these evaluations remain uncertain. The descriptive findings therefore do not establish which aspects of healthcare delivery contributed to respondents' satisfaction or dissatisfaction.

Assessing the quality and responsiveness of healthcare services requires information beyond subjective ratings of accessibility and satisfaction. Williams et al. (2026) examined the implications of timely treatment access for healthcare utilization and socioeconomic outcomes, illustrating the importance of service timeliness in understanding healthcare experiences. Xiao et al. (2026) considered accessibility and equity in the context of primary healthcare service

integration, highlighting the relevance of healthcare system organization and the distribution of access opportunities across populations. Together with the perspectives discussed by French et al. (2026) and Chan et al. (2026), these studies provide a rationale for considering service organization, communication, timeliness, and responsiveness when conducting more comprehensive assessments of healthcare accessibility. However, the present study did not directly measure waiting times, opening hours, independently assessed service availability, or unmet healthcare needs. Additional questionnaire responses concerning service adequacy and facility conditions were based on subjective single-item assessments and cannot substitute for an objective evaluation of healthcare facilities or service quality. Therefore, the findings should be regarded as a descriptive account of respondents' reported experiences rather than evidence of specific service deficiencies or the effectiveness of particular interventions. Further research could incorporate objective service assessments, more detailed measures of patient experiences, and information on unmet needs to identify potential areas for improving primary healthcare accessibility and service delivery in Bontonompo.

Study limitations

The small voluntary sample was not randomly selected and cannot represent the prevalence of access conditions across the service-area population. The number invited was unknown, residence was not independently verified, and no predefined age or prior-use criteria were applied. The ambiguous final age label prevents a defensible estimate of the proportion aged 50 years or older. The <20-year category does not establish whether its respondent was an adult.

The questionnaire was developed by the researcher without formal validity or reliability testing. Self-report introduces recall and interpretation error. Several items lack recall periods or frequency anchors, and the distance categories have imprecise boundaries. Missing responses varied across items; particularly, working-hours blanks cannot reliably be classified as nonapplicable. No verified mechanism established one submission per person. Satisfaction was collected without verifying the period of the experience being rated, and some follow-up questions lacked demonstrable skip logic.

The descriptive cross-sectional design cannot establish temporality, statistical associations, or causal relationships. Transport ownership, travel expenditure, waiting time, opening hours, assessed service availability, and unmet need were not established. The absence of ethics review and documented prior informed consent is a further limitation that cannot be remedied by changing manuscript wording. Future data collection should use an appropriate ethics review process and a documented participant information and consent procedure.

CONCLUSION

Among 65 voluntary respondents, insurance coverage, motorcycle transport, and travel times below 15 minutes were common. Never attending health education was reported by 26 of 64 respondents, and 20 of 65 reported no health center visit in the preceding six months. These descriptive results support further local assessment of information and transport needs, including outreach to people less likely to complete online surveys. Future research should use clearer eligibility criteria, tested measures, and appropriate ethics and consent procedures. No statistical association or causal effect was established.

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