

Perception and Factors Affecting Utilization of Healthcare Services in Uselu Community, Edo-State, Nigeria

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DOI: <https://doi.org/10.51244/IJRSI.2026.1308000105>

Received: 24 August 2026; Accepted: 29 August 2026; Published: 07 September 2026

ABSTRACT

Proper utilization of health services better the health status of a given population. Socio-economic factors affect access and utilization of health services as availability of health facilities alone is not enough to ensure its use. This descriptive cross-sectional study assessed the perceptions and factors affecting the utilization of health services in Uselu Community, Edo-State, Nigeria. Data was obtained through a structured questionnaire administered to 250 adult respondents in the community using random sampling method. 120 (48%) adult respondents utilized UBTH health facility. There was statistical significant association in the utilization of health services with regard to location ($p=6.64$, calculated value=6.315) and ethnicity ($p=6.64$, calculated value=21.38). The utilization of UBTH (Tertiary) health facility was fair compared to other forms of available healthcare services, the community's perception of high cost of services rendered and long waiting time were identified barriers to satisfactory use of tertiary health services. These identified factors affecting access to effective use of UBTH Healthcare services in Uselu community should be tackled by the appropriate local, state and federal government health authority.

Keywords: Services, Utilization, Healthcare, Community, Perception

INTRODUCTION

The nature of health care in Nigeria is often expressed in statistics on health institutions, medical staff and facilities/hospital beds by population and medical sector distribution/economy (Iyoha 2002). In general, health service providers in rural areas face difficulties in maintaining health care services due to a number of socioeconomic factors. For example, people in southern Nigeria are better educated and more likely to adopt a Western lifestyle involving the use of medical facilities than in the rural north. Several factors have been identified as responsible for health care use and outcomes. For example, available reports reveal that patient satisfaction is related to doctors' advice and treatment, explanations provided, and their listening skills. Among other factors, factors identified that influence the choice of hospital care options include cost, available care options, economics, beliefs/culture, and introduction (Omorogbe, 2017). Omorogbe (2017) also recommended that socioeconomic factors as they affect outcome of in-patients' and utilization of the available health care services be integrated into their medical services in the hospital organization providing health care services especially in teaching hospital. The socio-psychological approach sees utilization of health services from the perspective of a person's Knowledge, beliefs and attitude concerning the symptoms he/she is experiencing; attitude towards the physician and the person's definition of sickness and determination of the necessity for professional care. The organizational approach examines the structure of the health care delivery system; and the social system approach view the health care service system utilization as consisting of interrelated components such as physicians and facilities that interact with one another and the population at large (Anderson, 1973). According to Fang et al (2014), some of the identified socio-economic factors include

medical insurance, income, proximity, free health care, and influence from third party. The report of Xu et al (2006) whose study evaluated the impact of social health insurance on the use of health services and on financial protection in Vietnam indicated that the insurance coverage only increased access to public facility services but not to private facility services. They also found that the insured were also better protected against the heavy financial burdens of health care costs than the uninsured. Babazono (2008) found that the average monthly salary was strongly positively correlated with the use of dental services. They found that if average monthly wages were reduced, a large number of patients would reduce their search for dental services at medical centers. Therefore, they concluded that low wages do not seem to encourage patients to seek medical and dental services in Japan. Said et al. (2016), in their study, found that health status is a very important factor

in determining the type of health service preferred by the elderly hospital. The National Center for Health Statistics (NCHS) study in 2017, found that income is strongly correlated with risk factors for chronic disease: note that people with lower household incomes have higher rates of heart disease, stroke, diabetes or hypertension and have at least four common chronic diseases. NCHS (2017) found that people with lower incomes are more likely to delay seeking medical care due to higher costs than those with higher incomes. Therefore, they conclude that the health care needs of people below the poverty line remain unmet due to their less use of health facilities. Health care cannot be accessed if it does not exist in one place. While health centers may be available in some rural areas, access to care may be impeded by other barriers. One is that the means of transport are not suitable, because the travel time is too long, because there is no public transport and people do not have cars or other alternative means of transportation, or because the transportation costs are high. (MACPAC, 2016; NCHS, 2016). Bakeera et al. (2009) in their study also found that the poorest group identified the availability of free public care when allowing the use of preventive and curative services; while high cost was identified as a barrier to adopting some preventive actions such as the use of mosquito nets and condoms. High cost is also a barrier to the treatment of acute and chronic diseases. A study by Awoyemi (2011) in Kogi State, on the impact of distance on the use of health services, showed that public facilities are preferred over private institutions due to the cost of accessing health services/medical service. Cost was also suggested as a major factor for respondents' use of public rather than private facilities during their years of economic production. According to Girma Jira and Girma (2011), because the need and/or use of health care services vary with age, gender and marital status, the use of health care services also changes accordingly. Studies have generally found a relationship between patient age and health care use. Other influencing factors, such as education and family beliefs, influence the use of health services. For example, a study in Ethiopia found that mothers' education levels were statistically significantly associated with the use of safe delivery services. Lack of funding can lead to self-medication with modern and traditional medicines, as seen in northwestern Ethiopia (Girma et al., 2011). Fang et al (2014) in their study found that age is a statistically significant factor that can affect the use of health services. Age was found to be a negative predictor of health service utilization. Research by Adam and Awunor (2014) on the perception of factors affecting the use of health services in rural communities in southern Nigeria shows that age is not a factor affecting health utilization service.

Health literacy generally refers to factors that affect a person's ability to access, process, understand and communicate health information to make informed decisions. Mwonjoria (2014) also found that the main factor taken into account in the utilization of healthcare facilities was the capacity of healthcare workers to make accurate diagnoses and prescriptions as well as waiting times. This according to Jayadevappa and Chhatre (2011) is a patient-centered approach. Therefore, Hsu (2010) argues that the level of efficiency of a health care facility will determine the level of penetration and output, which will directly affect the provision and use of services. The use of health facilities by people in the community also depends on the attitude of health workers. Moyer et al (2014) found that although it is the duty of health workers to provide health services to all members of the community, attitudes are influenced by social norms and Health care worker beliefs can limit health care delivery and utilization and have an impact on health care quality. care and provide certain medical services. The type of environment people live in will affect how they use healthcare facilities, as poor environmental quality affects people (Healthy People 2020, 2018). Health service utilization (HSU) is an important health outcome indicator (Ngwakongnwi, 2017). Prosser (2007) in his health and healthcare research looking at usage behaviors and unmet health needs in rural Nigeria, found that about 70-80% of people living in Rural areas in Nigeria are sick are using formal health facilities instead of informal

services. In general, in Nigeria, it is found that people hardly go to health facilities unless they are seriously ill, as the majority considers medical care at medical facilities to be too expensive.

Health status and the need for health-care services to improve or maintain health are major determinants of health-care utilization. The World Health Organization (WHO) states that health is determined by a person's individual characteristics and behaviors, physical environment, and socioeconomic environment (WHO, 2017). People's individual characteristics include their biology and genetics, such as inherited diseases and conditions that require medical care. The prevalence of those conditions differs by sex, age, race and ethnicity, employment status, and other factors. Physical environments can affect health because of pollutants or other environmental health hazards. Individual behaviors, such as smoking or lack of exercise and overeating, also cause health conditions that require health care (ODPHP, 2017a). Recent attention to social determinants of health, such as education, economic stability, community safety, and availability of adequate housing and healthful food, has shown that they correlate with healthier populations (ODPHP, 2017a). People who have unmet social needs are more likely to be frequent ED users, to have repeat “no-shows” for medical appointments, and to have poorer glycemic and cholesterol control than those who are able to meet their needs (Thomas-Henkel and Schulman, 2017).

How need affects differential health-care utilization by specific populations of interest is discussed below with reference to poverty and its correlates and geographic area of residence, race and ethnicity, sex, age, language spoken, and disability status. Ideally, need should be the major determinant of health-care utilization, but other factors clearly have an effect. One of those factors is the ability to access care—including whether it is available, timely and convenient, and affordable (Figueroa et al., 2017).

Access to health care is defined as having timely use of personal health services to achieve the best possible health outcome (IOM, 1993). Access requires gaining entry into the health-care system, getting access to sites of care where patients can receive needed services, and finding providers who meet the needs of patients and with whom patients can develop a relationship based on mutual communication and trust (AHRQ, 2010). Clinicians note that timely access to health care is important inasmuch as it might enable patients and physicians to prevent illness, control acute episodes, or manage chronic conditions, any of which could avoid exacerbation or complication of health conditions (NCHS, 2017b). There are many ways to think of access, and the term access is often used to describe factors or characteristics that influence one's initial contact with or use of services. Anderson and Newman (2005) present a framework of health-care utilization that includes predisposing factors, enabling factors, and magnitude of illness. More recently Levesque et al. (2013) defined access to health care by presenting five dimensions of accessibility: approachability, acceptability, availability and accommodation, affordability, and appropriateness. They saw access as the opportunity to identify health-care needs; to reach, obtain, or use health-care services; and to have the need for services fulfilled. Access can be seen as a continuum: even if care is available, many factors can affect ease of access to it, for example, the availability of providers who will accept a person's insurance (including Medicaid), ease in making an appointment with a given provider, the ability of a patient to pay for care (even if a patient is insured, due to cost-sharing copayments and deductibles), and the difficulty of arranging transportation to and from healthcare facilities (AHRQ, 2010, MACPAC, 2016).

People cannot access care if it does not exist in their geographic area, or if providers will not treat them because of insurance or other issues. Rural areas in particular have been identified as lacking a sufficient supply of specialty physicians and, in particular, mental health-care providers (Meit et al., 2014; Douthit et al., 2015). Assuming that services are available, access to care might be impeded by other barriers. One is inadequate transportation, either because travel time is excessive, because no public transportation is available and the person does not have a car or other alternative transportation, or because the cost of transportation is prohibitive. Providers might refuse to see patients because no appointment times are open, or because they do not accept patients' insurance. Providers might be unable to communicate with patients because of language issues, or their offices might not be accessible to people with disabilities. Excessive wait times to obtain appointments or to see providers at their places of service might also deter use (MACPAC, 2016; NCHS, 2016).

Access to health care is tied to the affordability of health insurance. Financial barriers to care, particularly among low-income people and the uninsured, have been greater in the United States than in other high-income countries (Davis and Ballreich, 2014; Squires and Anderson, 2015). According to a 2013 Commonwealth Fund survey of adults in 11 high-income countries, the United States ranks last on measures of financial access to care (Schoen et al., 2013). The Kaiser Commission on Medicaid and the Uninsured notes that people who lack insurance coverage have worse access than people who are insured, and 20 percent of uninsured adults in 2015 went without needed medical care because of cost (KFF, 2016). The lack of health insurance has been identified as an important driver of health-care disparities (IOM, 2002).

Uninsured people who are 18–64 years old are more likely than those who have Medicaid or private coverage to report difficulties in affording needed medical care and prescription drugs, and are more likely than the insured to delay or forgo them because of cost (KFF, 2016). During 2004–2014, uninsured adults were 4–5 times more likely than those who had private coverage and 1.5–3.0 times more likely than those who had Medicaid to report difficulty in medical care and prescription access. For adults who had Medicaid, medical care access problems were stable until 2008 and then decreased through 2014. For those who had private insurance, medical care access problems increased until 2009 and then decreased through 2014 (NCHS, 2016). For the uninsured, problems with medical care and prescription access increased until 2010 and 2009, respectively, and then were stable for medical care and decreased through 2014 for prescriptions. Prescription access problems were stable in 2004–2014 for those who had private insurance but decreased for adults who had Medicaid (NCHS, 2016).

Having insurance coverage does not mean that coverage is adequate or is not associated with burdensome cost-sharing through premium payments, copayments, and deductibles (Lavarreda et al., 2011; Fang et al., 2016). Surveys have categorized underinsured people as those who say they have insurance but are worried about medical bills, who are paying them off over time, or who have not obtained selected types of health-care services because of cost. A study by Magge et al. (2013) estimated that more than one-third of low-income adults were underinsured (defined as spending more than 5 percent of household income on medical care) and that 8 percent and 13 percent deferred or delayed obtaining medical care or prescription medications, respectively (Magge et al., 2013). Avoiding or delaying medical care correlates strongly with coverage under a high-deductible health plan (in which a person must make a substantial out-of-pocket [OOP] contribution before insurance payment begins) and with depression, poor perceived health, or poverty. However, it is relatively independent of the percentage of income spent on OOP costs, so the percentage of income spent on OOP costs is a poor measure of health-care unaffordability. People who spend a small percentage of their income on health care might be extremely burdened by their health-care plan when financial concerns prevent access to health care (Kielb et al., 2017). Current evidence also suggests that high-deductible health plans are associated with lower health-care costs as a result of a reduction in the use of health-care services, including appropriate services (Agarwal et al., 2017).

Ideally, utilization of health-care services reflects a need for care, but that is not the case, for several reasons. Many factors affect health-care utilization independently of need and are reflected in differences, some of which are remediable, among population groups. Some of these factors are related to biologic or environmental differences among groups, such as disproportionate residence in polluted environments, access to healthful food and adequate housing, and education associated with effective use of health care. Others are related to differences in access; such as health insurance coverage or income needed to obtain services, ease of obtaining services, and discriminatory practices of providers. Racial and ethnic disparities are found in many sectors of American life. Black people, people of Hispanic origin, American Indians, Pacific Islanders, and some Asian Americans might be disproportionately represented in the lower socioeconomic ranks, in lower-quality schools, and in poorer-paying jobs (IOM, 2002). Racial residential segregation is a key mechanism through which racism produces and perpetuates social disadvantage. Black and Latino adults are more likely to live in disadvantaged neighborhoods and to have inadequately resourced schools, which yield lower educational attainment and quality (Braveman et al., 2014). Those factors can result in some racial and ethnic minorities experiencing higher rates of chronic and disabling illnesses, infectious diseases, and higher mortality than white Americans. Minority populations have more difficulty than the majority population in

locating a “usual source” of medical care, and black and Hispanic adults report greater difficulty than whites in obtaining medical care at a consistent location (IOM, 2002; AHRQ, 2010).

Black adults have earlier onset of multiple illnesses, greater severity and more rapid progression of diseases, higher levels of comorbidity and impairment throughout the life course, and higher mortality than whites up to the age of 65 years. Similar patterns are evident in American Indians, Pacific Islanders, Asian populations of low socioeconomic status, and US-born Latinos (Williams and Wyatt, 2015). A recent report by the Kaiser Family Foundation (2016) on health and health care by race and ethnicity found that disparities in health and health care continue to pose a persistent challenge in the United States.

Lack of insurance, more than any other demographic or economic barrier, adversely affects the quality of health care received by minority populations (OMH, 2011). In the United States, black and Hispanic people have disproportionately lower income and higher rates of uninsurance, which might result in poorer health outcomes and different health-care utilization trends. In 2015, the percentage of people who lacked health insurance coverage for the entire calendar year was 9.1 percent or 29.0 million (USCB, 2016). Non-Hispanic whites had the lowest uninsured rate, 6.7 percent; blacks and Asian people had rates of 11.1 percent and 7.5 percent, respectively; and people of Hispanic origin had the highest rate, 16.2 percent. From 2014 to 2015, the overall rate of health insurance coverage increased in people of Hispanic origin by 3.6 percentage points, in Asian people by 1.9 percentage points, and in non-Hispanic white people by 0.9 percentage points.

During that period, the trend in lack of coverage varied by racial and ethnic group. From 1999 to June 2015, among people 18–64 years old, people of Hispanic origin had the highest percentage without coverage (27.2 percent in the first 6 months of 2015), and non-Hispanic white adults had the lowest except in the first 6 months of 2015, when non-Hispanic Asian adults had the lowest percentage. The difference between the highest and lowest percentages of people 18–64 years old who did not have health insurance among the four racial and ethnic groups narrowed from 1999 to June 2015. The difference was 24.9 percentage points in 1999 (adults of Hispanic origin compared with non-Hispanic white adults) and 19.9 percentage points in the first 6 months of 2015 (adults of Hispanic origin compared with non-Hispanic Asian adults) (NCHS, 2016).

Chen et al. (2016) examined racial and ethnic disparities in health-care access and utilization after the ACA health insurance mandate was fully implemented in 2014. They used the 2011–2014 National Health Interview Survey (NHIS) to examine changes in health-care access and utilization. They noted that the full implementation of the ACA (year indicator, 2014) was associated with substantial reductions in the probabilities of being uninsured, delaying necessary care, and forgoing necessary care, with an increase in the probability of having physician visits compared with the reference year (2011).

A systematic review of 37 studies examined the extent and measurement of racism in health-care providers (Paradies et al., 2014). A number of databases and electronic journal collections were searched for articles published in 1995–2012 (including Medline, CINAHL, PsycInfo, and Sociological Abstracts). The search included published reports (in English) of empirical studies of any design that measured or discussed racism in health-care providers. The studies used a number of measurement approaches and dealt primarily with physicians in the United States. Of the 37 studies, 26 found statistically significant evidence of racist beliefs, emotions, or practices among health-care providers. A 2015 “Perspective” in the *New England Journal of Medicine* (Ansell and McDonald, 2015) noted evidence that physicians hold stereotypes that are based on patients' race that can influence clinical decisions. The authors stated that despite physicians' and medical centers' best intentions to be equitable, black–white disparities persist in patient outcomes, medical education, and faculty recruitment.

A 2002 Institute of Medicine report, *Unequal Treatment*, reviewed hundreds of studies of age, sex, and racial differences in medical diagnoses, treatments, and health outcomes. It concluded that black people received less effective care than white people for each disease studied even after matching for socioeconomic factors and insurance status. It found evidence of the role of bias, stereotyping, and prejudice in perpetuating racial and health disparities. Multiple factors contribute to racial disparities in health-care access and utilization, but unconscious bias on the part of medical professionals might contribute to deficits in the quality of care.

The more recent annual National Healthcare Quality and Disparities Report (QDR) provides an overview of the quality of health care received by the US population and highlights continued disparities in care that are experienced by different racial and socioeconomic groups (AHRQ, 2017). The 2016 QDR states that disparities were getting smaller from 2000 through 2014–2015 but that disparities persist, especially for poor and uninsured populations. Furthermore, although 20 percent of measures show disparity decrease for black people and people of Hispanic origin, most disparity have not changed more than a small amount for any racial and ethnic groups. More than half the measures³ show that poor and low-income households had worse care than high-income households; more than 40 percent of the measures show that middle-income households had worse care than high-income households. Nearly two-thirds of the measures show that uninsured people had worse care than privately insured people.

Women overall have higher health-care utilization than men. Although it had been thought that women receive health care primarily during child-bearing years for reproductive health, many health-care utilizations occur during and after menopause for such issues as cardiovascular disease and osteoporosis (Owens, 2008). Other studies have shown that women make more primary care visits and receive more diagnostic services, screening services, diet and nutrition counseling, and sexual health care than men even though men generally have higher rates of obesity and cardiovascular problems (Salganicoff et al., 2014). Among people 18–64 years old, women have higher rates of disability and self-reported fair or poor health status. Among all people 18 years and older, women are more likely to delay or not receive care, or to not receive prescription drugs, because of cost. Women are more likely to have a health-care visit in a given year, to have 10 or more visits, and to have a hospitalization or Emergency Department visit (NCHS, 2017b). Those findings indicate that although women utilize health-care resources at greater rates, health-care needs go unmet.

The average retirement age in the United States in 2013 was 64 years for men and 62 years for women (Munnell, 2015). However, because of disability or for other reasons, many workers leave the workforce before Social Security retirement age or before they become eligible for pensions or vested savings. There is no question that increased functional limitations and consequent health-care utilization occurs in people as they age; that is true for working-age people and for older adults (NCHS, 2017b). There has also been an increase in rates of health-care utilization and functional limitation in people 45–64 years old (Freid et al., 2012). About 4 percent of people who were 18–44 years old had self-reported heart disease compared with about 12 percent of people 45–64 years old; corresponding rates of cancer were 2 percent and 7 percent, respectively. Almost one-fourth of people 18–44 years old reported low back pain compared with 35 percent of people 45–64 years old (NCHS, 2017b). Rates of self-reported disability among working-age adults and mental illness among all people 18 years and older have remained stable in recent years (Ahrnsbrak et al., 2017; NCHS, 2017b).

Many Americans in racial and ethnic minorities experience language barriers and have low or no proficiency in speaking, reading, or comprehending English. In a health-care setting, those barriers can present serious challenges to both patients and providers. A systematic review of studies of language barriers in health care for Latino populations showed that access to care, quality of care, and health status all suffer as a result of language barriers. If a patient does not speak the language of his or her health-care provider, multiple adverse effects on the patient's health care might occur. For example, a patient's inability to understand a provider's diagnosis or treatment plan can lead to poor patient satisfaction, poor compliance, and underuse of services (Timmins, 2002).

Flores (2006) examined language barriers to health care in the United States and noted that some 49.6 million Americans speak a language other than English at home, and 22.3 million have low English proficiency, speaking English less than “very well” according to self-ratings. From 1990 to 2000, the number of Americans who spoke a language other than English at home grew by 15.1 million, and the number with low English proficiency grew by 7.3 million. Many patients who need medical interpreters have no access to them. According to one study, in 46 percent of ED cases that involved patients who had low English proficiency, no interpreter was used (Baker et al., 1996). Few clinicians receive training in working with interpreters; only 23 percent of US teaching hospitals provide any such training, and most of them make it optional (Flores, 2006).

Patients who face language barriers are less likely than their English-speaking counterparts to have a usual source of medical care, receive fewer preventive services, and have a greater likelihood of no adherence to

medication prescriptions. Psychiatric patients who encounter language barriers are more likely than others to receive a diagnosis of a severe psychopathologic condition—but are also more likely to leave the hospital against medical advice. Such patients are less likely than others to return for follow up appointments after visits to an Emergency Department (ED) and they have higher rates of hospitalization and drug complications (Flores, 2006).

Income correlates highly with risk factors for chronic disease: for example, people who have lower family income have higher rates of heart disease, stroke, diabetes, or hypertension, and have four or more common chronic conditions (NCHS, 2017b). People in families whose income is less than 200 percent of the federal poverty level are more likely to be obese and to smoke cigarettes than wealthier people. Adults who live in poverty are also more likely to have self-reported serious psychological distress, as measured by a series of questions about their perceived mental health. Economic resources (such as income and wealth) enable access to material goods and services, including health-care services. In 2009–2010, people of all racial and ethnic groups who were 18–64 years old and had a family income below 200 percent of the poverty level were more likely than those who had higher family income to delay seeking or not to receive needed medical care because of cost (NCHS, 2012). From 2000 to 2010, the percentage of people 18–64 years old who did not get or delayed seeking needed medical care during the preceding 12 months because of cost increased in all family income groups. During that period, the percentage who had unmet needs for medical care decreased as family income increased from below 200 percent of the poverty level to 400 percent or more of the poverty level. Failure to receive needed medical care because of cost was equally likely in families below the poverty level and those whose income was 100–199 percent of the poverty level.

More recent findings indicate that in 2014 28.6 percent of adults who were living under the poverty level had one or more ED visits compared with 13.5 percent of adults who were at 400 percent of the poverty level, and 8.1 percent of adults under the poverty level had at least one hospitalization compared with 3.8 percent of adults at 400 percent of the poverty level. Despite the high utilization of health-care services by low-income people, adults under the poverty level reported greater rates of not receiving or of delaying medical care, obtaining prescription drugs, and receiving dental care because of costs than adults who were at 400 percent of the poverty level. Thus, health-care needs of those under the poverty level are still being unmet despite their higher utilization of emergency and hospital services (NCHS, 2017b).

The extent of urbanization has been shown to be associated with health-care utilization in several ways, including the correlation of residents' sociodemographic characteristics with need, risk factors, and access to care. Communities that differ in urbanization differ in their demographic, environmental, economic, and social characteristics, and those characteristics correlate with the magnitude and types of health problems that the communities face. For example, more-urban counties tend to have more health-care providers per capita, and residents of more-rural counties often live farther from health-care resources. Most studies have compared aggregated magnitude of urbanization—primarily metropolitan compared with nonmetropolitan areas. However, a few studies have compared utilization by more granular urbanization groupings: metropolitan geographic areas, inner cities of large metropolitan areas, fringes of large cities (sometimes called suburbs), and small metropolitan areas; and two categories of nonmetropolitan areas, namely, large rural areas that contain small population centers and rural areas that contain very small population centers (Ingram and Franco, 2014). Those studies show some differences by magnitude of urbanization, but other differences are more pronounced between suburban fringe areas of cities (which tend to have higher average income) and other areas.

Residents of rural areas differ from residents of urban areas in a number of important characteristics that correlate with health-care utilization. Rural residents have low incomes: 17 percent of rural workers earn less than the poverty level (\$11,490 per year for an individual) compared with 14.6 percent of urban workers (Mueller et al., 2014). They are more likely to classify themselves as white. The greatest racial and ethnic diversity was found in central counties of large metropolitan areas. In 2010, the population of central counties nationwide was 27 percent Hispanic origin, 17 percent non-Hispanic black, 9 percent non-Hispanic Asian or Pacific Islander, 2 percent people identifying with multiple races, and less than 1 percent non-Hispanic or American Indian or Alaska Native (AI/AN) origin. All those groups except AI/ANs were less likely to live in nonmetropolitan counties than in central counties. Among all regions, fringe counties of large metropolitan

areas (suburban areas) had the lowest concentration of people in poverty in 2011 (9–13 percent). The proportions of the populations in poverty in all other urbanization levels were comparable.

Rural residents have a higher percentage of several risk factors associated with poorer health than urban residents. For example, self-reported obesity rates vary by urbanization and increase with increasing rurality. In 2010–2011, people living in central counties of large metropolitan areas nationwide had the lowest age-adjusted prevalence of obesity, and women in the most rural counties had the highest (Meit et al., 2014). In people 20 years old and over, urbanization patterns in ischemic heart disease (IHD) death rates differed by region. In the South, 2008–2010 IHD death rates were lowest in fringe counties of large metropolitan areas and more than 25 percent higher in the most rural counties. In the Midwest, IHD death rates were highest in the most rural counties. For the United States as a whole, limitation of activity due to chronic health conditions in adults is more common in nonmetropolitan counties than in large metropolitan counties. In all regions except the Midwest, the rate of activity limitation due to chronic health conditions in both men and women generally increases as rurality increases.

Using the more aggregated metropolitan/nonmetropolitan grouping, data show that adults who live in nonmetropolitan areas are more likely to report having 10 or more visits to doctors' offices, visits to EDs, or home visits in the preceding year than are people who live in metropolitan areas (NCHS, 2017b). In particular, they have higher rates of ED visits. Nonmetropolitan residents have a slightly higher rate of at least one hospital stay during the year and a similar rate of two or more hospital stays (NCHS, 2017b). Inpatient hospital discharge rates of people 18–64 years old were higher in small metropolitan counties than in metropolitan and nonmetropolitan counties. The average length of stay was highest in central counties of large metropolitan areas (Meit et al., 2014).

Douthit et al. (2015) conducted a literature review of the provision of health care and access in rural areas of the United States. Their findings indicate a reluctance to seek health care because of cultural and financial constraints, which are often compounded by a scarcity of services, a lack of trained physicians, insufficient public transportation, and poor availability of broadband Internet services. Rural residents were found to have poorer health than urban residents, and rural areas had more difficulty in attracting and retaining physicians than their urban counterparts. The urbanization pattern of the supply of physicians and other providers depends on specialty. However, physician supply generally decreases steadily as rurality increases both nationally and regionally. The National Center for Health Statistics (2017b) NHIS4 found that in 2015, about 10 percent of people who were 18–64 years old had difficulty in accessing needed medical care, which included experiencing delays or not receiving needed care because of cost. The difficulty varied by region: people in the South and the Midwest had the most difficulty, and those in the Northeast and West had the least (NCHS, 2017b).

Urban and rural locations differ in transit options, which affects whether patients can access care. Syed et al. (2013) studied issues of cost, availability of transit, distance to healthcare providers, and travel burden by time and distance. Their literature review found that transportation barriers affect health-care access in as little as 3 percent or as much as 67 percent of the population, depending on the area. Their findings collectively suggest that lack or inaccessibility of transportation might be associated with less health-care utilization, lack of regular medical care, and missed appointments.

Residents of central counties of large metropolitan areas and nonmetropolitan counties have similarly high percentages of residents who lack health insurance. In general, central counties of large metropolitan areas often have the most adverse health measures in the Northeast and Midwest, and nonmetropolitan counties tend to fare the worst in the South and West (Meit et al., 2014). Including all income levels, fringe counties of large metropolitan areas had the largest proportion of privately insured people less than 65 years old in each of the four regions. The coverage gaps in rural America exist in large part because rural Americans have less access to private insurance. Only 64 percent of rural employers offer their workers' health insurance compared with 71 percent in urban areas (Coburn et al., 2009). The prevalence of such jobs as farming and contracting means that self-employment is more prevalent in rural America. Not only are the self-employed in all parts of the country insured at lower rates than wage earners, but the self-employed in rural America are insured at even lower rates than the self-employed in urban areas.

Geographic markets also differ with respect to managed care penetration, payer involvement, and state and local oversight (Horwitz and Nichols, 2011; Colla et al., 2016). Physicians in rural areas receive 20 percent of their revenue from Medicaid compared with 17 percent for physicians in urban areas (Bailey, 2012). Up to 84 percent of rural physicians accept new Medicaid patients compared with 65 percent of urban physicians (UnitedHealth Center for Reform & Modernization, 2011).

Variation in surgical rates by geographic area, particularly hospital referral regions, is high and represents both gaps in outcomes research and poor patient decision quality. Outcomes differ from place to place even when patient differences are controlled for. The Dartmouth Atlas Project has conducted extensive research designed to examine local differences in practice patterns (Goodney et al., 2015). It used the hospital referral regions as the geographic unit of study. In 2007 and 2011, rates of bariatric surgery in Medicare beneficiaries varied by a factor of more than 20 and rates of therapeutic endovascular interventions by a factor of more than 6. The rate of open leg bypass surgery was 4.1 per 1,000 Medicare beneficiaries who had diabetes and peripheral artery disease; this rate varied from under 2 to more than 9 procedures per 1,000 people among hospital referral regions.

In 2013, the Institute of Medicine report *Variation in Health Care Spending: Target Decision Making, Not Geography* evaluated geographic variation in magnitude and growth of health-care spending by people in the United States who have Medicare, Medicaid, private insurance, or no insurance. The report presented findings of analyses of traditional, fee-for-service Medicare (and to a smaller extent Medicare Advantage, or Part C) and commercial insurance. It noted that because of methodologic challenges and data limitations, it did not include separate analyses of variation in the Medicaid and uninsured populations, although estimates of spending by those two groups are included in the area-wide estimates of total healthcare spending. The report's findings are instructive in examining geographic determinants of health-care use.

THEORITICAL FRAMEWORK

This section outlines the various theories of utilization of health care services. The theories that were discussed are the Suchman's theory of stages of illness and medical care, Mechanic's theory of help seeking behavior and Parson's theory of sick role.

Theory of Sick Role

The theory of sick role explains the rights and responsibilities that are particularly for the people who are ill. According to Parson (1951) the society adapts and allows for some level of deviation from the norm for those who are diagnosed with any form of illness. The theory of sick role provides four main components that govern that a sick individual is exempted from performing the regular roles and activities, the sick individual do not willfully get to their state of illness and necessary assistance should be accorded to them to enhance their recovery, having an illness is recognized as being in undesirable condition and that the individual should receive medical care and comply with the treatment to facilitate their recovery. According to Scarince (2003) Parsons states two rights and two responsibilities that are awarded to a sick person. The patient has a right to be granted leeway by the people in the society in which they live in regard to performance of normal activities and also possess the right for no blame for their illness. Nevertheless, it is the responsibility of the patient to make recovery their priority and also their responsibility to seek medical attention from a health provider for recovery from their condition. These rights and responsibilities are temporally as they are only effective for the period of illness. With subsequent criticism of the theory, the society has differed with some of Parson's considerations that viewed a sick person as a helpless being. Today, the society reasonably accommodates the sick and those with disability by creating favorable working conditions for those who are terminally ill or disabled but can work (Scarince, 2003).

Mechanic's Theory of Help Seeking Behavior

Mechanic's theory of help seeking behavior defines illness behavior as the presence of a state of health that triggers concern of an individual to seek help for the symptoms exhibited. Mechanic (1995) asserts that different people respond differently to various bodily indications. This theory is therefore concerned with the

way in which people monitor their body states, interpret symptoms and make decisions to utilize health care. He defines illness behavior as a socio-cultural response which individuals' exhibit based on lessons learnt, their social jurisdictions and the past experiences. The response given to certain signs and symptoms is determined by the contextualized definition of the present situation (Mechanic, 1978). Individuals who are close can also influence the decision taken by the sick person. The determinants of illness behavior include symptoms perception, nature, interpretation and their residual category (Mechanic, 1978). The perception is influenced by recognition and visibility of the symptoms, their perceived danger, cultural assumptions, knowledge level and the available information. The nature of the symptoms further influences decisions based on the extent to which they affect one's work, family and social networks. The persistence and frequency of the symptoms also affect the illness behavior as they act as the measure for the level of tolerance for the symptoms. One interprets the symptoms based on the availability of basic needs and other needs vis-à-vis illness response. The residue category includes the financial and psychological costs which can either be in form of time, money, effort requirement, stigma and humiliation among many others (Matchesi, Meulemans, & Timmerman, 2005).

Suchman's Theory of Stages of Illness and Medical Care

Suchman's theory provides the five stages of decision-making process taken by an individual in an attempt to determine whether or not to seek health care. The five stages are; symptoms experience, assumption of sick role, seeking medical care, dependent- patient role and finally recovery and rehabilitation (Suchman, 1965). The first stage of symptoms experience orients the individual to the illness through physical changes observed, severity of the change, emotional reaction, denial, acceptance all which lead to delay thus increasing the severity of the symptoms with time. During the second stage, the individual discovers his or her lay referral system and validates the sick role hence seeks for treatment options (Oreskovic, 2015). It is in the third stage that the individual seeks assistance from a health professional. The period taken on this stage is dependent on whether the patient accepts or refuses to confirm their sick role. Those who are parochial take longer than those who are cosmopolitan. Acceptance leads to the fourth stage of dependent-patient role. At this level some patients are resistant and incontinent to treatment regimen but gradual approach to normal roles is achieved when the physician and the patient are working towards the same goal of recovery. The fifth stage involves recovery and rehabilitation where the person recovers and if the illness has no cure they assume the role of a chronically ill person (Rebhan, 2015).

The study utilized a four-level nested logit model with the individual having to choose from four choices which are; whether or not to report an illness, whether or not to seek formal treatment, the specific provider to visit and the means of transport to the health provider. They found out that the quality of the facility, the cost of services offered, income of the household, the travel costs, and travel time affect the choices that individual's make with regard to the facility from which to seek health care. Nevertheless, the study has existing gaps in that the survey was carried out in rural areas only and did not include health insurance as one of the variables which will be addressed in this study. A study carried out by Acton (1975) found out that in instances when the user charges for health services are zero or close to zero, the time required to consume the services rations utilization of the health services. Also, some studies indicate that the demand for health care services is independent on the travel time and price of services (Akin et al. 1986; Heller, 1982). This is contrary to most of the studies which show that travel time and prices indeed effect utilization of health services (Gertler et al. 1987; Lavy & Quigley, 1993; Mwabu et al. 1993; Ellis & Mwabu, 2004). The studies vary depending on the methods of model estimation, countries where the studies were carried out, number and type of investigated variables which contributes towards the discrepancies in the final results. For example, Lavy & Quigley (1993) model the static conditional provider choice whereas Heller (1982) model the number of visits to health provider. Prosser (2007) carried out a study on health and medical services utilization with specific concern on the factors that affect health care seeking behavior and individual unmet health needs of individuals. The study used univariate analysis and multiple logistic regression analysis to investigate the outcome variable. The findings indicate that education and literacy levels, gender, distance, costs of seeking treatment, and time taken are the main factors that influence utilization of medical services in rural areas. Nevertheless, the study failed to assess the impact of quality of care, health insurance and disease severity in utilization of health care. In addition, the study results are regionally demarcated as the survey focused only on rural areas. Bakeera et al. (2009) carried out a study on to determine the perceptions and factors that affect

health services use in Uganda. According to the results health service delivery, health seeking process and social resources are imperative determinants of utilization of healthcare services. The survey used qualitative study design with the data being analyzed using content analysis and the Health Access Livelihood Framework used in examination and interpretation of findings. Specifically, income availability, health literacy, affordability of means of transport, social networks, and poor staff attitude were identified as the most predominant factors that influence utilization. This study was quite informative since the technique used sought responses from the respondents using open ended questions which were used in Focus group discussion hence able to get first hand opinions from the interviewees without restrictions by the questionnaire. Nevertheless, there are inadequacies in that the study was conducted in three villages in the same Health Sub-District hence the results cannot be generalized to the general population. Manzoor, Hashmi, & Mukhtar (2009) investigated the determinants and patterns of utilization of health care services by the learned individuals through a survey that was conducted on postgraduate students. The findings indicate that majority of the respondents seek health care from private health facilities as compared to the public sector. In consistency with majority of the previous studies, the survey indicated that most of the Pakistan women prefer private health providers more than men. The reasons for seeking health care from private health facilities include short waiting time, easy accessibility, availability of drugs, adequate staff, better staff attitude and flexible and longer opening hours. Marital status of the respondent had a significant association with the choice of health provider since majority of the married people have preference for private health facilities with a large number opting for specialists. Nevertheless, most unmarried individuals seek health care from general practitioners. Moreover, it was noted that the choice for specialists rather than general practitioners changed with increased income, advanced age and high education level. This study was carried out on a selected group of people hence the inadequacy in generalization of the results to the general population. Muriithi (2013) investigated on the determinants of health-seeking behaviour in Nairobi slums. The data used for the study was collected in Kibera slum. He used the multinomial logit model in data analysis. He found out that distance has a significant negative effect on choice of health provider with increased distance increasing the likelihood of self-treatment; gender affects choice of health provider with the females having a higher likelihood of visiting a health provider than their male counterparts; and user fees decreases the likelihood of seeking health care from a formal health professional. The factors that had significant positive impact on seeking health care from a health provider include trust, wealth, size of household, education, quality of care, and increased information on health service quality. The current study borrows a lot from this study, but with changes in the factors considered. The most outstanding factor that will be considered in this study is health insurance. Gakii (2013) utilized the 2007 Nigeria Household Health Expenditure and Utilization Survey (NHHEUS) to investigate on the demand for health care in Nigeria. The main aim was to identify the impact of health insurance on health care utilization, health status and the choice of health provider. The study used the probit model of health care decisions and health production conditional to presence of illness. The findings indicate that there is a positive relationship between health insurance and the health status of population. Moreover, health insurance increases the probability of seeking medical care in occurrence of illness and increases demand for private rather than public health care providers. The study provided thorough information on the influence of having insurance cover in utilization of health care. Nevertheless, there exists gaps in that there are other non-insurance factors that affect utilization and this study comes in handy to address the gap. Moreover, the study utilized the 2007 NHHEUS while this study will use the 2013 NHHEUS thus giving insights of health care utilization based on latest data. Otieno & Macharia (2014) carried out a study in Homa Bay County to investigate the factors that affect utilization of health care services in the area. They used both qualitative and quantitative data with a sample of 384 household interviews and 16 Key Informant Interviews. The study revealed that quality of care, accessibility; health financing, service delivery and equity are the main factors that affect the health seeking behavior of the people living in the County. The study recommends the government to improve infrastructure in health facilities, increase budget allocation on health services, hire more trained health personnel and improve drugs and medical supply. Nevertheless, the study did not include the health insurance variable which will be addressed in this study. Moreover, it is not possible to generalize the results with regard to other Counties since the study only covered a specific geographical region which has unique characteristics. Adam & Awunor (2014) carried out a study in a rural community called Anegbette in Southern Nigeria to determine the factors and perceptions that affects utilization of health care services in the region. A descriptive cross-sectional survey was carried out through administration of structured questionnaire to the respondents. The findings indicate that perception of poor quality by the people, inaccessibility to health facility and inadequacy

of the available services such as inadequate staff, negative attitude by the staff and lack or high cost of drugs are the main determinants of utilization of health care services. Additionally, the results indicated that there is no statistical significant relationship in utilization of medical services with reference to socio-demographic variables such as age, gender and education level which is contrary to most of the other studies in the country. Nevertheless, the study results could not be generalized to the entire country since the data covered only the village of interest whose characteristics are unique. Oladipo (2014) carried out a study on utilization of health services in urban and rural areas with a thorough exploration of the existing disparities and their implication on management and planning of healthcare delivery systems. The factors were divided into need, predisposing, enabling and health services which amounted to 31 variables. The data was analyzed using cross tabulation and factor analysis in a 4-stage model of use of healthcare services. It was found out that 12 of the variables were the most dominant predictors of health services utilization. They include quality of care, health insurance, availability, proximity, symptoms, disease, income, family size, age, sex, education, and beliefs. All the need variables covered in this study showed importance but disease and symptoms were more powerful than the health status and disability days. Most of the factors identified to be predictors of utilization are included in the current study in Nigeria.

STATEMENT OF THE PROBLEM

It has been determined that there is a significant difference between need and need for healthcare. Access to health care for some segments of the population is said to be complex and difficult to deal with (Ramage, 2001). Soon the new emphasis on demand-driven strategies to increase the use of health care services is a recent feature of health system development, especially in developing countries like Nigeria. Although the necessary supply-side interventions through infrastructure development, human resource mobilization, provision of essential drugs and equipment, and various forms of income are often insufficient to ensure distribution equity and effective health services. Providing access to needs-based health services has become more complex in light of the growing role of private providers and often a more limited role of the public sector. Where health systems are characterized by high out-of-pocket payments and understanding the Healthcare Seeking Behaviors (HSB) of different communities and population groups by many public/private healthcare providers are critical if adequate access to services and protection against unsustainable medical costs are to be achieved.

As a branch of public health, epidemiology is instilled in the spirit that epidemiological information should be used to promote and protect public health. Thus, epidemiology deals with both science and public health practice. Researchers have shown that the heaviest burden of disease falls on disadvantaged and marginalized populations. Gender is a recurring theme (Yamasaki...Nakagawa et al 2001) found that women in Nepal were more likely to seek help from healers first than men. Aregbeyen (1992) in his view, noting that the nature of illness coupled with poverty, ignorance and lack of medical facilities are some of the reasons for seeking health care while Adeagbo (1998) noted that, dissatisfaction with the cost and quality of health services, are the main factors of health-seeking behavior. However, Orubuloye (2002) opined that among other factors affecting health seeking behavior of people include: better services provided in some of the established hospitals, nearness to the home of the patients, availability of relatives in the hospital and family decision. Second, delayed access to appropriate medical care, in particular because of limited access to proper diagnosis, introduces costly inefficiencies (Cohen et al. (2011) Wilkinson (2001) also identified the main elements of health-seeking behavior are: Sharp differences in HSB according to socio-economic status and geographical location. A high degree of somatization of psychosocial and economic problems; Lack of understanding of how modern allopathic health care works (including diagnosis and treatment); Traditional perceptions of causal relationships of illness and disease causing health-shopping' behavior; A significant proportion of all illnesses and injuries untreated; The central role of the kru Khmer (traditional healer) in health seeking behavior; A cultural preference for curative health care to take place in, or near to, the home Self-medication as the first recourse for the majority of health seekers; A marked preference for private providers and/or traditional healers as first points of contact, clue to, easy access, flexibility of payment and availability of drugs and/or injections, Limited knowledge or actual misinformation about costs and availability of services at health centers; Lack of information crucial in hampering informed choice. The study is designed to identify the barriers to receipt of health care among a cross-section of the population. This information is needed before an

effective dental public health program against barriers to health care access can be designed for our environment. Most of these diseases are preventable and treatable. There is very little research on the health-seeking behavior of people in Nigeria. There is a gap in the evidence about health vision behavior, especially in the field of research.

The study aimed to evaluate health care usage patterns in the Uselu community

METHOD

The study is a descriptive cross-sectional study of the respondent in Uselu Community on healthcare utilization of University of Benin Teaching Hospital. The questionnaires were administered to the randomly to 300 residents of Uselu Community, however only 250 residents returned their completed questionnaires.

RESULT

Socio-Demographic Data Respondents

Table 1: The Number of respondent by sex

SEX	NO OF RESPONDENT	PERCENTAGE
MALE	100	40
FEMALE	150	60
TOTAL	250	100

Source of Data: Field Survey, 2023

Table 1, gives the summary of the respondent by sex. The tables shows that 100 of total number of respondent identify as male, representing 40% of the total number of respondent, while 150 respondent identify as female, representing 60% of the total number of respondent.

Table 2: The number of Respondent by age

AGE	NO OF RESPONDENT	PERCENTAGE
18-29	70	28
30-39	120	48
40-49	50	20
50 and Above	10	4
Total	250	100

Source of Data: Field Survey, 2023

Table 2, gives a summary of the respondents by age. The table shows that a total of 70 respondents, representing 28% of the total number of respondent are in the age bracket of 18-29 years. A total of 120 respondents, representing 48% of the total number of respondent are in the age bracket of 30-39, while 50 respondents, representing a total number of 20% respondents are in the age bracket of 40-49. Finally 10 respondents, representing 4% of the total number of respondents are in the age bracket of 50 years and above.

Table 3: The number of respondents by Educational qualification.

HIGHEST EDUCATION QUALIFICATION	NO OF RESPONDENT	PERCENTAGE
WAEC/GCE	40	16
NCE/OND	60	24
MBBS/B.Sc/HND	150	60
Total	250	100

Source of Data: Field Survey, 2023

Table 3 shows the representation of Educational qualification. The table shows that a total number of 40 respondents, representing 16% of the total number of respondent have WAEC/GCE. A total number of 60 respondents, representing 24% of the total respondent have NCE/OND, while 150 respondents, representing 60% of the total respondents have MBBS/B.Sc/HND educational qualification.

Table 4: is there a Government or Private Hospital in your residential area?

VARIABLES	NO OF RESPONDENTS	PERCENTAGE
YES	240	80
NO	10	20
TOTAL	250	100

Source of Data: Field Survey, 2023

Table 4 shows the number of respondents work status. A total number of 240 respondents, representing 80% of the total respondents identify that there is Government or Private Hospital in their residential area , while 10 respondents, representing 20% of the total respondents identify there is no Government or private hospital in their residential area.

Table 5: The number of respondents by Profession

PROFESSIONS	NO OF RESPONDENT	PERCENTAGE
STUDENT	40	16
TRADER	70	28
TEACHER	5	2
ADMINISTRATOR	35	14
CIVIL SERVANT	35	14
UNEMPLOYED	30	12
OTHERS	35	14
TOTAL	250	100

Source of Data: Field Survey, 2023

Table 5 shows the number of respondents by profession. A total number of 40 respondents, representing 16% of the total number of respondents identify as Student, while 70 respondents, representing 24% of the total respondents identify as trader. 5 respondents, representing 2% of total number of respondent's identity as teachers, while 35 respondents each (Administrator, civil servant and other) represent 14% from each categories. Finally, 30 respondents, representing 12% of the total respondents identify as unemployed.

Table 6: The number of respondents by salary grade level

SALARY GRADE LEVEL	NO OF RESPONDENT	PERCENTAGE
BELOW 18,000	-	-
18,000-30,000	-	-
31,000-50,000	120	48
51,000-60,000	80	32
61,000-70,000	50	20
81,000-90,000	-	-
91,000-100,000		
ABOVE 100,000		
TOTAL	250	100

Source of Data: Field Survey, 2023

Table 6 shows that 120 of the total respondents, representing 48% of the total respondents identify as grade level 31,000-50,000. A total of 80 respondents, representing 32% of the total respondents identify as salary grade level 51,000-60,000, while 50 respondents, representing 20% of the total respondents identify as salary grade level 61,000-70,000

Section B:

Table 7: Factors that affect utilization of health facility

No.	Factors	Response	Percentage (%)
1	Inadequate number of staff	5	2
2	Lack of drugs	10	4
3	High cost of drugs	40	16
4	Long waiting time	80	32
5	Incompetent staff	15	6
6	Attitude of staff	28	11.2
7	Long distance to health facility	60	24
8	Facility not working 24/7	12	4.8
Total		250	100

Source of Data: Field Survey, 2023

The table above shows that 5 respondents, representing 2% of the total respondent identify that inadequate number of staff is Factors that affect utilization of health facility, while 10 respondents; representing 4% of the total population identity that lack of drug is the factor affecting the utilization of health facility. A total of 40 respondents, representing 16% of the total population identify that high cost of drug is the factor affecting the utilization of health facility, a total of 80 respondents, representing 32% of the total population identify that long waiting time as the factor affecting the utilization of health facility. A total of 15 and 28 respondents, representing 6% and 11.2% identify that incompetent staff and attitude of staff as the factor affecting the utilization of health facility respectively, while 60 respondent, representing 24% of the total respondent identify that long distance to health facility is the factor affecting the utilization of health facility. A total of 12 respondents, representing 2.8 percent identify that facility not working 24/7 is the factor affecting the utilization of health facility in their residential area.

Table 8: Where did you go to receive treatment more often?

Source	Response	Percentage (%)
9. A Pedestrian herb hawker	30	12
10. A traditional healer	20	8
11. A nearby pharmacy	40	16
12. A primary health care center	10	4
13. A secondary healthcare facility (Central Hospital)	10	4
14. A tertiary facility (University of Benin Teaching Hospital, UBTH)	140	56
TOTAL	250	100

Source of Data: Field Survey, 2023

The table above shows that 30 respondents, representing 12% of the total respondent identify that they receive treatment more often from Pedestrian herb hawker, while 20 respondents; representing 8% of the total population identity that they receive treatment more often from traditional healer. A total of 40 respondents, representing 16% of the total population identify that they receive treatment more often from nearby pharmacy, a total of 10 respondents, representing 4% of the total population identify that they receive treatment more often from both primary healthcare centers and secondary healthcare center respectively. A total of 140 respondents, representing 56% identify that they receive treatment more often from tertiary facility.

Table 9: Perceive ways of improving Health services?

Variable	Response	Percentage (%)
15. Provision of staff	10	4
16. Drug availability	30	12
17. Reduce waiting time	160	64
18. Health education of client	20	8
19. Better attitude of staff	18	7.2
20. Facility working 24/7	12	4.8
Total	250	100

Source of Data: Field Survey, 2023

The table above shows that 10 respondents, representing 4% of the total respondent Perceive that Provision of staff will improving Health services, while 30 respondents; representing 12% of the total population Perceive that Drug availability will improving Health services. A total of 160 respondents, representing 64% of the total population identify Perceive that Reducing waiting time will improving Health services, a total of 20 respondents, representing 8% of the total population Perceive that Health education of client will improving Health services. A total of 18 respondents, representing 7.2% Perceive that Better attitude of staff will improving Health services, while 12 respondents, representing 4.8% of the total population Perceive that Facility working 24/7 will improving Health services.

We therefore recommend that Increase Awareness and Health Education, Strengthen Healthcare Infrastructure, Establish Mobile Clinics and Outreach Programs, Affordable and Inclusive Healthcare Services, strengthen Community Engagement and Enhance Telemedicine and Digital Health Solutions as well as Strengthen Collaboration with Local Stakeholders will help to improve healthcare utilization in the Uselu community.

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