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RESEARCH ARTICLE

UTILIZATION AND BARRIERS TO USE OF PRIMARY HEALTH CARE SERVICES AMONG ATTENDEES IN IJERO-EKITI, EKITI STATE, NIGERIA

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Abstract

Primary Health Care Centre (PHC) serves as the first contact between individuals and the health system, offering essential services such as immunization, maternal and child health care, treatment of common illnesses, and referrals to higher levels of care. Since its formal adoption in 1978, the PHC model has evolved through global commitments like the Astana Declaration (2018), which reaffirmed the importance of integrated, people-centered care and called for renewed investment in PHC as a foundation for resilient health systems. Despite PHC being the foundation of Nigeria's health system, gaps in consistent utilization persist across many communities. This study therefore determined the utilization and barriers to use of PHC services among attendees in Ijero Ekiti, Ekiti State, Nigeria. A cross-sectional descriptive research design was used for the study and the respondents were adult attendees. The sample size was 360 but 357 were recruited with a multistage sampling technique used to select the respondents. A structured and expert validated instrument was used for collection of data. Frequency counts, percentages, and chi-square tests were used for data analysis at a significance level of 0.05. The mean age was 37.5 ± 1 . Analysis of the data revealed that 110 (30.8%) respondents frequently made use of the PHC services while the major barriers were long waiting time 268 (%), attitude of health care workers 210 (58.8%) and drug unavailability 230 (64.4%). The hypotheses revealed no significant association between religion and utilization of PHC services ($p=0.591$) but a significant association between occupation and barriers to use of PHC services ($p=0.005$). This study concluded that certain systemic barriers hinder optimal use of PHC services. It is recommended that strengthening community health education and making PHC services friendly would go a long way in improving the health services that are rendered.

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Introduction:-

Primary Health Care (PHC) is a whole-of-society approach that ensures individuals and communities receive comprehensive, accessible, and affordable care at the first level of contact with the health system²⁵. It encompasses not only the treatment of illness but also health promotion, disease prevention, rehabilitation, and palliative care, while addressing broader determinants of health²³. According to the World Health Organization (WHO,2023)²⁵, PHC plays a critical role in ensuring that every individual has access to essential healthcare services that are affordable, available, and socially acceptable. This aligns with the principles of the Alma-Ata Declaration of 1978, which emphasized universal access, community participation, and equity in health service delivery.

Globally, PHC is central to achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDG)³²⁶. Countries such as Cuba, Rwanda, and Thailand have demonstrated that strong PHC systems can lead to improved population health indicators, expanded access to preventive services, and better alignment of healthcare resources with local needs²⁷. Primary Health Care (PHC) underpins universal health coverage, yet many health systems—including Nigeria's—continue to struggle with effective implementation and utilization of PHC services²⁵. In high-income countries, PHC delivery is often hampered by staff shortages, geographic isolation, and patient dissatisfaction²⁵. For instance, rural communities in the United States experience limited access to PHC services due to inadequate healthcare providers and poor distribution of medical personnel⁶. Similarly, in the United Kingdom, long waiting times and staff burnout have reduced patient satisfaction and continuity of care, undermining core PHC functions by decreasing timely access to services, weakening patient-provider relationships, disrupting preventive and chronic disease management, and driving patients toward emergency or alternative care pathways⁸.

The African Union Development Agency (AUDA-NEPAD) emphasizes PHC's role in enhancing community engagement, supporting maternal and child health, and maintaining routine services through its Continental Primary Health Care Programme (2024–2030). This initiative aims to close gaps in health workforce capacity and improve outcomes by empowering Community Health Workers (CHWs) and strengthening service delivery at the primary level. In Ghana, cultural beliefs and mistrust in public facilities lead many to seek care from traditional healers, contributing to persistent underuse of formal PHC services^{25;4}. In Kenya, poor road networks and transport barriers limit access to PHC centres in rural²⁴. Likewise, Cameroon's conflict-affected areas face insecurity and logistical breakdowns that further restrict healthcare delivery²⁰.

In Nigeria, PHC plays a foundational role in the national health system. It supports key goals such as reducing maternal and child mortality, promoting preventive health practices, and ensuring access to essential care across both rural and urban populations. The Federal Ministry of Health⁹ identifies PHC as the key entry point for individuals into the healthcare system, where services such as antenatal care, and postnatal care, immunization, child welfare, treatment of minor ailments, family planning, and health education are provided. Across Nigerian states, primary health care (PHC) facilities contribute significantly to public health advancement¹. For example, Ekiti State has adopted PHC as the backbone of its health delivery system, integrating health education, maternal services, routine immunization, nutrition programs, and disease prevention into its primary-level³. IjeroEkiti PHC network supports community health engagement, encourages healthy behaviors, and strengthens local participation in health decision-making. It provides an important platform for implementing routine services such as, malaria prevention, reproductive health, and environmental health interventions.

Despite robust policies such as the National Health Act and the Basic Health Care Provision Fund in Nigeria, PHC services remain underutilized¹⁶. In Ijero Ekiti, many PHC facilities suffer from inadequate infrastructure, essential drug shortages, and an overstretched workforce. Reports reveal that only about 20% of Nigeria's 34,076 PHC centers are fully functional, with many lacking essential equipment and personnel¹³. In states such as Kaduna and Kano, resource shortages and funding gaps continue to weaken service delivery¹⁷. Even in Abuja, residents report long waiting times, high costs, and inadequate infrastructure as reasons for avoiding PHC facilities⁷. Given the barriers that exists in Ijero Ekiti PHC, this study, therefore, determined the utilization and barriers to use of PHC services among attendees in Ijero Ekiti, Ekiti State, Nigeria.

The following research questions and hypotheses were raised for this study:-**Research questions:-**

1. To what extent do attendees utilize primary health care services in Ijero-Ekiti, Ekiti State, Nigeria?
2. What are the barriers affecting the use of primary health care services among attendees in Ijero-Ekiti, Ekiti State, Nigeria?

Hypotheses:-

H₀₁: There is no significant association between religion and utilization of primary health care services among clinic attendees in Ijero-Ekiti, Ekiti State, Nigeria.

H₀₂: There is no significant association between occupation and barrier to primary health care services among clinic attendees in Ijero- Ekiti, Ekiti State, Nigeria.

Methods and Materials:-

A cross-sectional descriptive research design was adopted for this study which involved adult attendees in Ijero-Ekiti. Ijero-Ekiti is a semi-urban community and serves as the administrative headquarters of Ijero Local Government Area (LGA) and hosts several Primary Health Care facilities within it. The sample size was calculated using the Taro Yamane formula and 357 respondents were used for the study. A step-by-step multistage sampling technique was used to select the respondents who met the inclusion criteria for the study. The first stage was the selection of six out of seven PHC facilities in Ijero-Ekiti, using simple random sampling techniques. The second stage was selection of attendees based on their average monthly patient attendance using systematic random sampling. The third stage was selection of respondents who are willing and ready to participate in the study using simple random sampling. The sampling interval (k) will be calculated by dividing the estimated number of daily attendees by the required number of respondents for that facility. Every kth attendee who meets the inclusion criteria will be selected until the required number is reached.

A structured, validated and self-administered questionnaire which was divided into four sections were used for data collection. The instrument consisted of a total of 38 items which tested the cognitive and affective domains on utilization of barriers to PHC services. Moreover, the face, content, structure validity of the instrument was ensured. A pilot test was carried out with 10% of the number of respondents in a PHC facility in Aramoko outside Ijero LGA. A reliability test result of Cronbach's alpha coefficient of 0.70 was arrived at. Institutional ethical approval was obtained before the collection of data, research assistants were trained and the collection of data with them and the researcher took a period of four weeks. Data was analyzed using Statistical Package for Social Sciences (SPSS) version 25.0 to generate frequency counts and percentages while the inferential statistics used the Chi square statistical tool to test associations between socio demographic variables and utilization of PHC services as well as the barriers associated with its use. The mean score for the high barrier to PHC services was set at 44 while 24 was set as the mean score for the low barrier.

Results:-

Data on socio demographic characteristics of respondents revealed a mean age of 37.5 ± 1 with 210 (58.8%) females and the married were 227 (63.6%). Almost half of the respondents had secondary education 150 (42.0%) and are traders 112 (31.4%)—Figure 1.

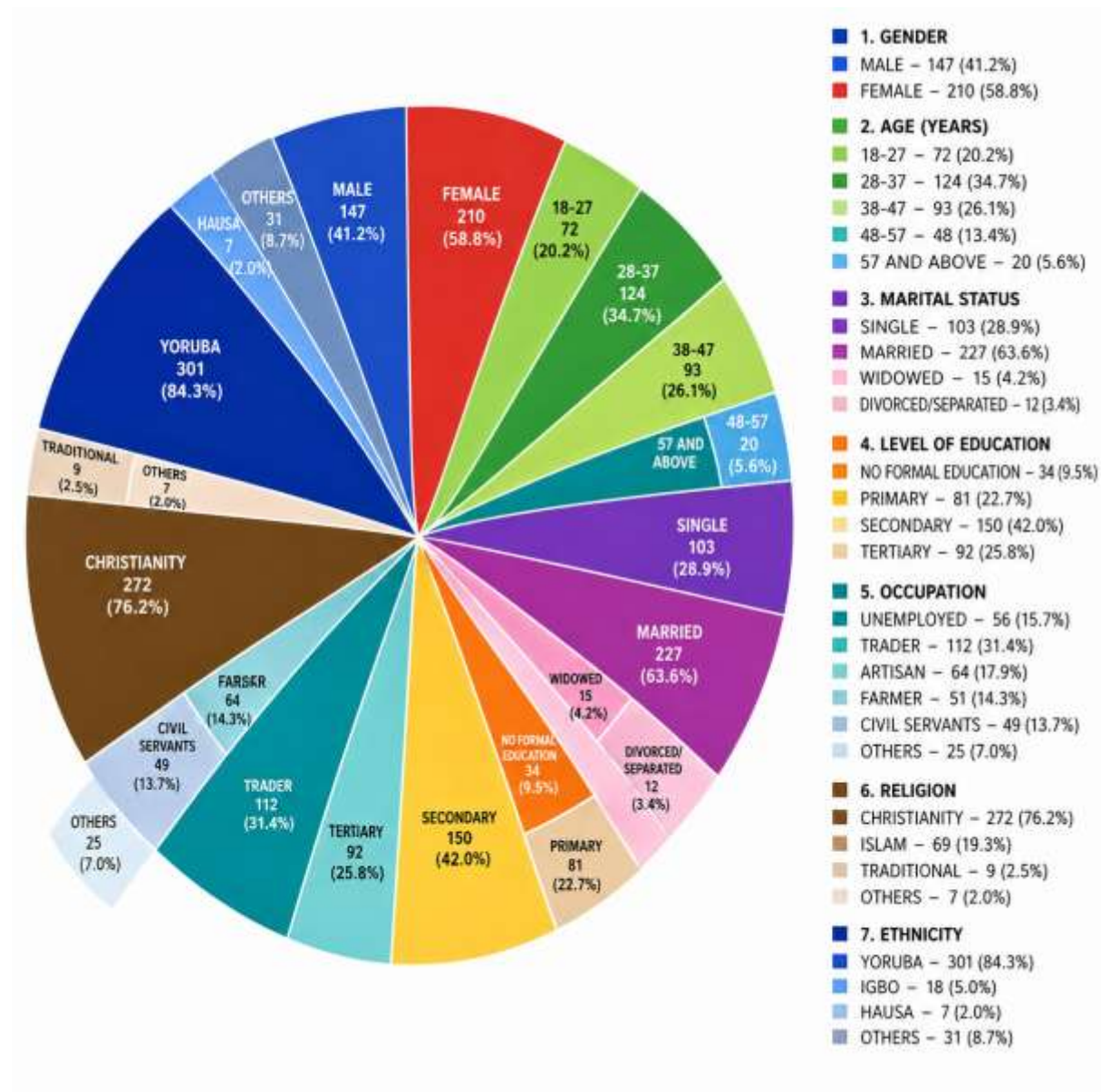


Figure 1: Socio Demographic Characteristics of the Respondents

Research Question 1: To what extent do attendees utilize primary health care services in Ijero-Ekiti, Ekiti State, Nigeria?

Table 1 revealed that 179 (50.1%) occasionally visits the PHC, 189 (52.9%) consented to the fact that the PHC is usually their first port of call for treatment and 167 (46.8%) are very satisfied with the services that are rendered.

Table 1: Utilization pattern of PHC services

VARIABLE	CATEGORY	N	PERCENTAGE
Frequency of visits to the PHC	First time	68	19.0
	Occasionally	179	50.1
	Frequently	110	30.8
Usual first place for treatment when ill	PHC	198	52.9
	Private clinic	83	23.2
	General hospital	47	13.2
	Chemist/patent medicine shop	30	8.4

	Traditional healer	8	2.2
Satisfaction with PHC services	Very satisfied	97	27.2
	Satisfied	167	46.8
	Neutral	154	15.1
	Dissatisfied	39	10.9
Perceived affordability of PHC	Yes	249	69.7
	No	62	17.4
	Not sure	46	12.9
Preference for phc over private clinics	Yes	173	48.5
	No	89	24.9
	Sometimes	95	26.6
Intention to return to phc in future	Yes	238	66.7
	No	49	13.7
	Not sure	70	19.6

Research Question 2: What are the barriers affecting the use of primary health care services among attendees in Ijero-Ekiti, Ekiti State, Nigeria?

The most prominent barrier reported by the respondents was long waiting time 151 (42.3%). Moreover, the respondents complained about unavailability of drugs 132 (37.0%) and poor attitude of health workers 109 (30.5%) – Table 2.

Table 2: Perceived barriers to PHC utilization

Item	SA	A	UN	D	SD
Distance prevents me from coming regularly	40 (11.2)	106 (29.7)	52 (14.6)	93 (26.1)	66 (18.5)
Transportation costs discourage me	58 (16.2)	121 (33.9)	49 (13.7)	75 (21.0)	54 (15.1)
Long waiting time is a major barrier	151 (42.3)	117 (32.8)	26 (7.3)	40 (11.2)	23 (6.4)
Drugs are often unavailable	132 (37.0)	98 (27.5)	37 (10.4)	55 (15.4)	35 (9.8)
Attitude of workers discourages me	101 (28.3)	109 (30.5)	45 (12.6)	61 (17.1)	41 (11.5)
PHC lacks adequate facilities	119 (33.3)	104 (29.1)	29 (8.1)	60 (16.8)	45 (12.6)
Cultural beliefs stop me from using PHC	25 (7.0)	52 (14.6)	61 (17.1)	119 (33.3)	100 (28.0)
I sometimes use traditional medicine instead	44 (12.3)	83 (23.2)	69 (19.3)	96 (26.9)	65 (18.2)

H₀₁: There is no significant association between religion and utilization of primary health care services among clinic attendees in Ijero-Ekiti, Ekiti State, Nigeria.

The analysis of hypothesis 1, revealed that there was no significant association between religion and utilization of PHC services ($X^2=1.913$; $p=0.591$) – Table 3.

Table 3: Religion versus utilization of PHC services

Religion	High Utilization	Low Utilization	Total	Total	ES (95%CI)	df
Christianity	224	48	272	$X^2=1.913$ $p=0.591$	0.0732	3
Islam	57	12	69			
Traditional	7	2	9			
Others	6	1	7			
Total	294	63	357			

H₀₂: There is no significant association between occupation and barrier to primary health care services among clinic attendees in Ijero- Ekiti, Ekiti State, Nigeria.

Table 4 revealed that occupation had a significant association between barriers to PHC services in the study location ($X^2=16.728$; $p=0.005$).

Table 4: Occupation and barriers to PHC services

Occupation	High Barrier	Low Barrier	Total	Total	ES (95%CI)	df
Unemployed	31	25	56	$X^2=16.728$ $p=0.005$	0.2165	5
Trader	78	34	112			
Artisan	41	23	64			
Farmer	37	14	51			
Civil Servant	18	31	49			
Others	10	15	25			
Total	215	142	357			

Discussion:-

The study determined the utilization of PHC services and also, the barriers to its use among adult attendees in Ijero-Ekiti, Ekiti State, Nigeria. From the findings, it can be deduced that there is moderate utilization of PHC services in the study location and factors such as long waiting time, unavailability of drugs and poor attitude of health workers stood as barriers to effective use of PHC services. The relatively better utilization of PHC services in Ijero-Ekiti may reflect differences in facility readiness, staffing pattern, or community engagement, and may also be related to the fact that respondents were active clinic attendees at the time of data collection. The factors could be attributed to shortage of staff and the increase number of attendees.

This is contrary to what Ojo et al. (2022) found from a previous study which said that less than half of respondents in southwestern states regularly used PHC centres, preferring private providers due to perceived inefficiency and lack of drugs. Similarly, Oche et al. (2024) in Benue State reported that awareness of PHC was high, but only 42% used PHC regularly, mainly because of long waiting times and negative staff attitudes. Ibrahim and Yusuf (2024) also observed that many community members bypassed PHC centres in favour of general hospitals, citing poor infrastructure and lack of confidence in health workers.

The finding that cost and perceived quality of care are key determinants of utilisation aligns with evidence from Ethiopia (Girma et al., 2021; Tegegn et al., 2022; Ayele et al., 2021) and Nigeria (Nwankwo et al., 2025; Ojo et al., 2022). In all these contexts, individuals are more likely to use PHC services when they perceive them as affordable, accessible and effective. The Turkish experience described by Hone et al. (2017) and Tuzun et al. (2023) also supports this, showing that system reforms that improved organisation and quality of PHC led to higher utilisation and a shift from hospital-based to PHC-based first contact.

Moreover, Olayemi et al. (2023) reported that patients in Ekiti State often avoided PHC centres because essential medications were unavailable, forcing them to buy drugs elsewhere and increasing their out-of-pocket expenses. Oche et al. (2024) and Nwankwo et al. (2025) also emphasized poor infrastructure, negative staff attitude, lack of essential medical supplies, and poor record-keeping as central barriers to PHC utilisation. In addition to the above, the study demonstrated that there was no statistically significant association between religion and utilization but that does not rule the fact that religious or cultural factors are not important.

Conclusion:-

The study concludes that the extent of PHC utilization among attendees of PHC in Ijero-Ekiti is moderate, with many respondents recognising PHC as their first point of care and expressing satisfaction with services. Nevertheless, PHC utilisation was associated with perceived quality of care, affordability, drug availability, and staff attitude. Barriers to PHC usage in this study are predominantly service-related and institutional, rather than cultural or religious.

Limitation of the study:-

The findings cannot be generalized for all attendees of health facilities in Ijero Ekiti or Ekiti State.

Declarations:-**Funding:-**

None.

Conflict of Interest:-

None declared.

Ethical approval:-

Institutional Approval Obtained

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